Determinants of Health Report

ESSEX COUNTY CIVILIAN TASK FORCE SUBCOMMITEE

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Executive Summary

Essex County Correctional Facility (ECCF)

As of November 2021, the Essex County Correctional Facility (ECCF) has a jail population of 2,707. A total of 2,590 of these individuals are men, and 117 are women, including people incarcerated at the Delaney Hall Detention Facility. The Delaney Hall Detention Facility is a medium-security prison privately owned by the GEO Group and contracted to house Essex County inmates. Understanding that persons housed at ECCF are being processed through the criminal justice system, it is important to recognize that this facility primarily houses individuals who have become increasingly relegated to the margins of American society due to systemic forces and unequal distribution of resources and power rooted in structural and social inequities of racism and discrimination. [1,2,3,4,5,6] Many of these individuals require complex medical and social services because of conditions such as substance use disorders, psychiatric illnesses, chronic health conditions, and pregnancy.[7,8,9]

Unique Strengths of ECCF

ECCF has strong leadership under the guidance of Director Alfaro Ortiz, Medical Director Dr. Lionel Anicette, and Mental Health Director Dr. Jason Fleming. Together, they lead a professional staff as racially and ethnically diverse as the inmate population. Most of the team reside in Essex County and have friends and family members who are justice-involved, struggle

[1] Reinhart E, Chen DL. Carceral-community epidemiology, structural racism, and COVID-19 disparities. *Proceedings of the National Academy of Sciences*. 2021;118(21). doi:10.1073/pnas.2026577118
[2] Kang-Brown J, Montagnet C, Heiss J. People in Jail and Prison in 2020. Vera Institute of Justice. Retrieved from: https://www.vera.org/publications/people-in-jail-and-prison-in-2020. Accessed April 29, 2022.
[3] *The Sentencing Project.* Criminal Justice Facts. The Sentencing Project. Retrieved from: https://www.sentencingproject.org/criminal-justice-facts. Accessed April 29, 2022.
[4] Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*. 2017;389(10077):1453-1463. doi:10.1016/s0140-6736(17)30569-x
[5] Brinkley-Rubinstein L, Cloud DH. Mass Incarceration as a Social-Structural Driver of Health Inequities: A Supplement to AJPH. *American Journal of Public Health*. 2020;110(S1): S14-S15. doi:10.2105/ajph.2019.305486
[6] Prison Policy Initiative. Detaining the Poor: How money bail perpetuates an endless cycle of poverty and jail time. Prisonpolicy.org. Published May 10, 2016. Accessed April 29, 2022. https://www.prisonpolicy.org/reports/incomejails.html
[7] Wildeman C, Wang EA. Mass incarceration, public health, and widening inequality in the USA. *The Lancet*. 2017;389(10077):1464-1474. doi:10.1016/s0140-6736(17)30259-3
[8] Hatzenbuehler ML, Keyes K, Hamilton A, Uddin M, Galea S. The collateral damage of mass incarceration: Risk of psychiatric morbidity among nonincarcerated residents of high-incarceration neighborhoods. *American Journal of Public Health*. 2015;105(1):138-143. doi:10.2105/ajph.2014.302184
[9] Valera P, Taylor RJ, Chatters LM. Criminal justice contact and physical and oral health among African Americans. *Research in Race and Ethnic Relations*. 2018; 20:35-52. doi:10.1108/S0195-744920180000020003

with mental health challenges and/or have substance use disorders. Despite access to limited staff and resources, this first-hand experience has shaped how correctional officers implement project activities. For example, one ECCF Medication-Assisted Treatment (MAT) Officer has dedicated his career to helping people with addiction return to their communities with support services because of his friend's negative experience navigating addiction treatment. This MAT Officer is also pursuing a doctoral degree in psychology outside of ECCF. Correctional officers with diverse and specialized backgrounds are a unique strength and asset of ECCF because they give the facility a high degree of scheduling (and program) flexibility.

Challenges within ECCF and the Statewide Jail System

Staffing across all sectors of the jail is spread thin. In the case of mental and behavioral healthcare, it only allows for attention to the most urgent cases. It rarely allows for proactive and ongoing evaluation and treatment of the general jail population for mental health issues past psychotropic interventions. Recidivism is likely to remain for many people in custody because the ability to connect everyone to community programs, jobs, educational opportunities, and medical services continues to be limited unless identified within specialized groups such as those with substance use disorder. ECCF is understaffed and should be re-evaluated on a facility-wide basis as the relative success of the jail relies too heavily upon overworked professionals who exceed their contractual obligations.

At ECCF, the average time served is nearly one month, and inmates are released at unusual time periods with little prior notice, which exacerbates barriers to access and transitions in care. This unpredictability around release has created challenges for the medical staff in treating inmates' health issues and connecting people to care on the outside prior to release. Especially for individuals with highly complex medical and psychiatric conditions, the irregularity around discharge from the facility intensifies their medical and social risks. Efforts should be focused on removing barriers to care delivery behind the wall *and* connecting people to a robust network of primary and specialty care in the community. ECCF, by default, becomes tasked as the primary healthcare provider for all people in custody, but are asked to do so under increasingly shorter and uncertain time frames.

Recommendations for ECCF

Short Term:

1. Increase staffing levels in medical, dental, mental health, and reentry services following the specific recommendations of department leaders based on the current level of needs.

2. Improve training of medical staff on Health Insurance Portability and Accountability Act (HIPAA) and Protected Health Information (PHI) related disclosures for all treating hospitals and ambulatory care settings where inmates are supplied care.

3. Streamline communication and develop protocols with area hospitals and healthcare facilities to minimize instances where inmates are shuttled back and forth during obstetric, medical, and psychiatric cases.

4. Revisit nutrition distribution mechanisms to address inmate complaints of cold food and hunger.

5. Create a nonpartisan committee of experts in various fields that can oversee the jail to make recommendations regularly as a subcommittee of the ECCF Task Force.
6. Establish written policies regarding the Keep on Person Medication Program (KOP) and distribute medical cards with medication information to each participant.
7. Strengthen transitions in care and consider whether there can be a Memorandum of Agreements with area hospitals.
8. Released inmates should be bridged to the date of their appointment in the community (or longer if they will not be able to obtain a new prescription upon their intake appointment), which is often the case.
9. New Jersey should apply for Section 1115 waivers to provide Medicaid coverage while people are incarcerated or in custody at ECCF.

Long Term:

1. Construct additional units meant to house inmates with mental health needs or who are LGBTQ+ identified to maximize psychological and social benefits.
2. Establish female-specific medical and therapeutic services to address this growing jail population.
3. Increase inpatient forensic psychiatric bed capacity where ECCF inmates are presently referred.
4. Construct rooms and spaces where group therapy or individual sessions can be conducted because the current availability of such facilities within the jail is minimal.
5. Prioritize a return to in-person therapy sessions on a jail-wide basis or facilitate telehealth visits with mental health counselors.
6. Establish a Research and Evaluation Unit to show best practices and strategies to promote quality control, enhance tracking and monitoring, and ensure effective management and supervision across the different units within ECCF.
7. Create a *jail dashboard* to help raise awareness and increase transparency with the public about the characteristics of inmates incarcerated in jail and to address the frequent questions about the jail population ECCF receives.

Proposed Model Framework for ECCF Program Development

The challenges that ECCF faces concerning inmate recidivism lie in a grey area where a clear gap in evidence-based practices exists relevant to detainee risk factors. Preventing recidivism is thus too person-dependent on the criminal justice staff at the facility instead of being rooted in a system of robust care. Such a system must have identified community anchors and partners and well-resourced jail staff with quality controls and programs with effectiveness metrics in place. Leadership that is highly skilled in such areas is necessary to ensure program sustainability and effectiveness. Most interventions will require a high degree of adjustment and pivoting, learning, and procedural changes on both an individual and institutional level.

Strong leadership entails a degree of restraint and delegation of much of the actual planning, conceptualization, and structure to the medical staff whose expertise lies in the targeted program for intervention. Criminal justice administration within this context would be better served in providing input to the medical staff regarding the viability and safety of any interventions. Advocacy to obtain the funding necessary for adequate staffing, programming supplies, or materials may also be a crucial area of focus.

These conditions apply equally to the medical staff, as the same degree of apprehension may arise internally amongst providers to changes in protocol or to new initiatives. Strong leadership is thus needed. The correctional officers must ensure that public safety is in place for a program to succeed. It is equally valid that medical staff must make their needs known regarding staffing and resources, as the issue may not otherwise be raised. Thus, executing a pilot program in scope may provide the data and evidence necessary to motivate a more significant investment. When creating a program for ECCF, staff should carefully consider: (1) who they are servicing; (2) what the current systems and facilities are within the jail; (3) where in the community people may come from; (4) what the available reentry resources are upon their release from the facility; (5) and ultimately, how narrow or broad a program should be based on staffing and capacity levels inside the jail and the necessary community connections and support to enable successful reentry.

As mentioned, few meaningful changes can arise within ECCF if there is no broader societal support for these actions to occur. There is a pragmatic concern about the levels of governmental support at the county and state levels on funding and the will to integrate other agencies that provide social and health benefits to ECCF inmates upon release. It is unlikely to expect the government to pay for and support every new initiative using taxpayer dollars. Hence, program-based partnerships with well-established community organizations will be a more inexpensive solution if a degree of mutual benefit can be established. These community relationships can exist on a contractual basis where expectations, including length of partnership and expected reward and benefit, can be negotiated well in advance to ensure that ECCF and its partners have a vested interest in launching a successful program.

A community partnership can be forged with, for example, the Transitions Clinic Network (TCN), a consortium of primary care clinics providing access to health care services to those returning from prison to their communities.[10] TCN began as a pilot initiative at the San Francisco Department of Public Health safety net program and has expanded to other counties located in California, Little Rock, Arkansas, Raleigh, North Carolina, and Puerto Rico.[11] TCN's efforts have been shown to reduce recidivism among people released from prison, supporting the notion that care coordination and care management are essential for community reintegration.[10,11,12]

Because of the many medical issues surrounding incarceration and the incarcerated, it is important that medical professionals, such as public health professionals, doctors, nurses, and dentists, be trained to care for justice-involved populations. These health professionals could develop workshops, gain experiences, and distribute educational materials to inmates during clinical or medical training. Opportunities for such residency training and internships could be developed with ECCF, the Federally Qualified Health Centers, and local academic medical and graduate institutions.[13] These partnerships may provide unique opportunities for ECCF to amplify and publicly promote a new holistic and genuine approach to inmate rehabilitation and release. This may allow more individuals to be diagnosed with an underlying mental or physical health condition and connected to resources upon release. Using community-based resources through a mutually beneficial lens will also allow for an added degree of care coordination and potentially reduce medication nonadherence rates. Creating structured interventions with discrete goals may provide a rich stream of data for government officials to analyze and align with political, policy, and public health goals at the county and state levels.

[10] Shavit S, Aminawung JA, Birnbaum N, et al. Transitions Clinic Network: Challenges and lessons in primary Care for people Released from Prison. Health Affairs. 2017;36(6):1006-1015. doi:10.1377/hlthaff.2017.0089

[11] Transitions Clinic. Transitions Clinic Network Sites – Transitions Clinic. Transitions Clinic Network Sites. Accessed March 31, 2022. https://transitionsclinic.org/locations/

[12] Wang EA, Lin H, Aminawung JA, et al. Propensity-matched study of enhanced primary care on contact with the criminal justice system among individuals recently released from prison to New Haven. BMJ Open. 2019;9(5): e028097. doi:10.1136/bmjopen-2018-028097

[13] Health Resources and Services Administration. Find a Health Center. findahealthcenter.hrsa.gov. Accessed March 31, 2022. https://findahealthcenter.hrsa.gov/

Medication-Assisted Treatment (MAT) Program

The MAT Program of Opioid Use Disorder within ECCF offers a *model* of this comprehensive theoretical framework in action. Director Alfaro Ortiz and Medical Director Dr. Lionel Anicette oversee an addiction treatment program that is strong because of its sensitivity to the security requirements of the jail and the prevention of drug abuse and deviation, administering medication at various timepoints during the day. The program was developed with evidence-based practices at the forefront. Criminal justice safeguards are in place, with dedicated nursing staff administering treatment while a full-time MAT correctional officer is present to ensure safety. This procedure maximizes treatment access without compromising staff or inmate well-being. It demonstrates administrative buy-in through the willingness to pay additional salaries and implement new policies to safeguard all parties involved. A tangible geographic sensibility is present in the MAT program, as care coordination is at the forefront to reduce the likelihood of relapse upon inmates released from jail. This is evidenced in how the staff has been able to name community partners across county lines and within the state to address issues such as transportation and ease of access to treatment, housing, and food.

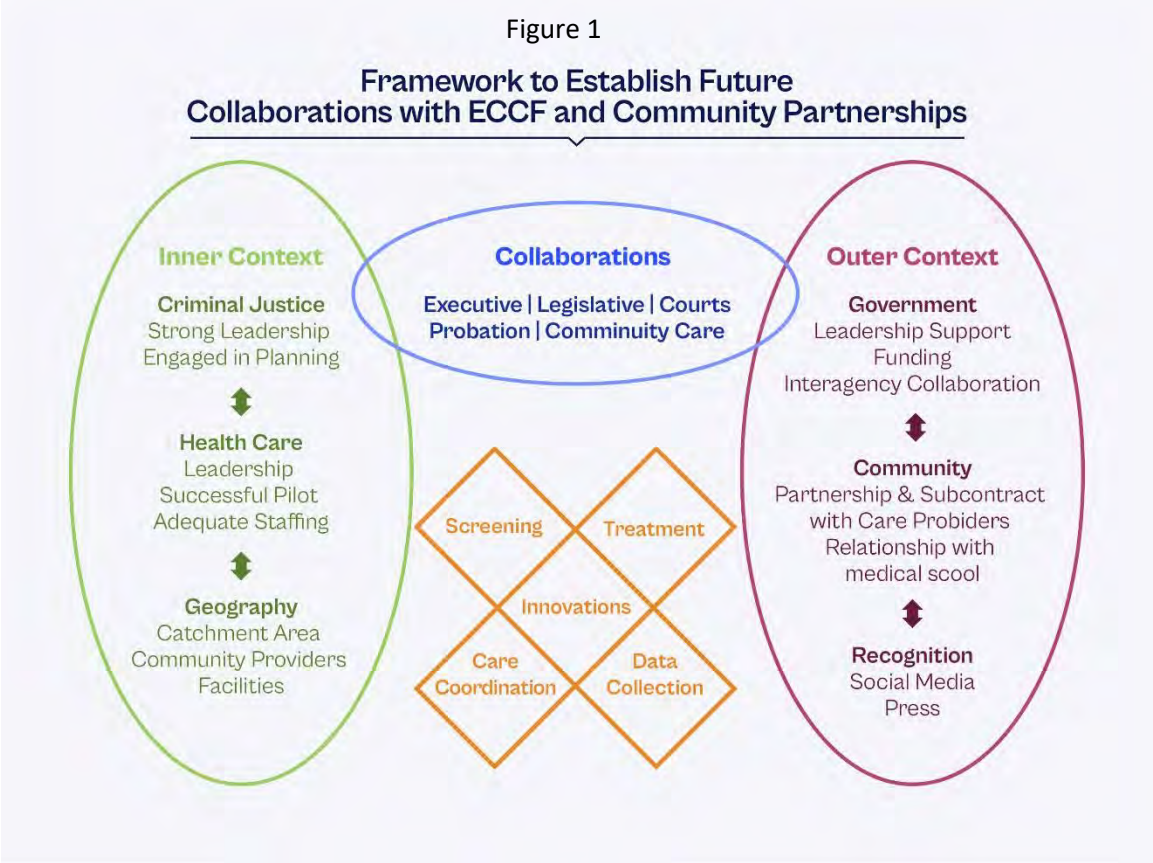
Numerous community centers providing services such as addiction, housing, and nutrition, have forged meaningful relationships with released inmates. Appropriate state and federal grants, giving high priority to the treatment of opioid use disorder, helped create some of these community-based contracts. In them, a financial or volume-based provision of individuals who would seek services and help the bottom line of the community provider was agreed upon. These contracts led to the MAT program. Staff can treat a high volume of inmates and, using longitudinal community care, keep track of their overall success rates upon release with follow-up meetings and survey tools.

Figure 1 displays a working framework to guide ECCF in developing practical solutions for implementing "collaborative relationships" between several entities facilitated by shared principles and values adapted from Aarons, Hurlburt & Horwitz, 2011.[14]

[14] Aarons GA, Hurlburt M, Horwitz SM. Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*. 2010;38(1):4-23. doi:10.1007/s10488-010-0327-7

Framework to Establish Future Collaborations with ECCF

Figure 1



Chapter 1. Overview of the Current State of New Jersey Corrections

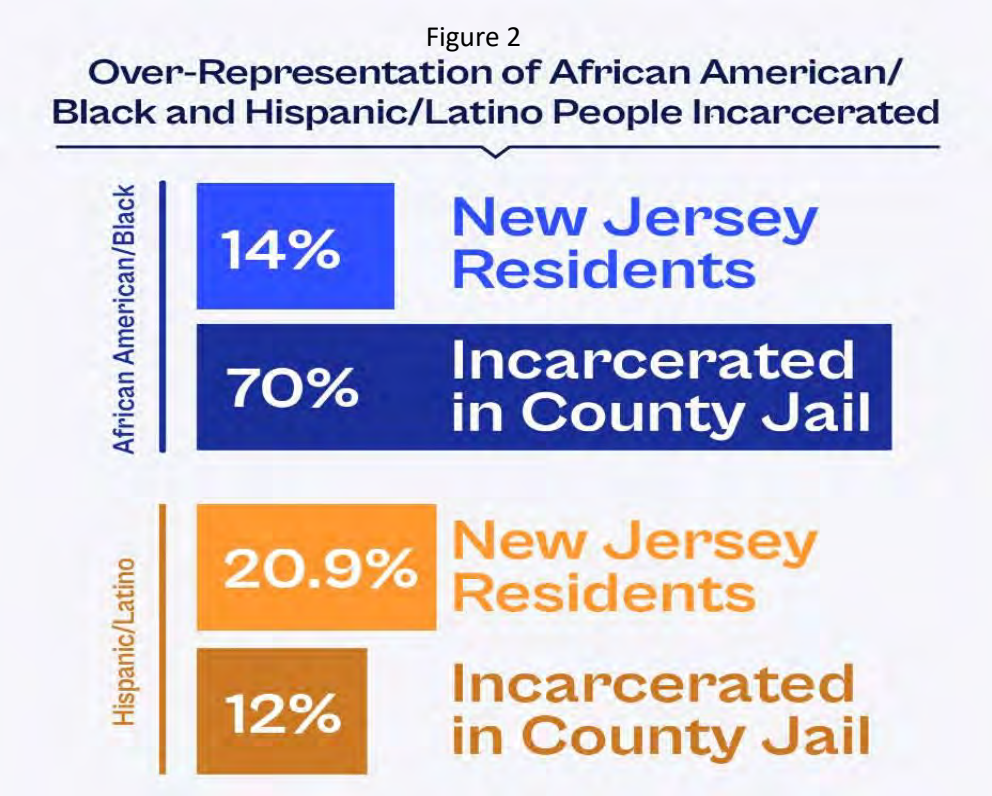
Essex County is one of New Jersey's largest counties, with a population in 2020 of 863,728.[15] It is one of the state's most diverse counties. Among its residents, 41.9% are African American or Black, and 23.8% are Hispanic or Latino, 37% speak and are better served in languages other than English. By comparison, only 22% of the population nationwide are non-native English speakers. In 2019, the most common non-English language spoken in Essex County was Spanish (20%).

In 2019, the percentage of residents living in poverty within Essex County was 14.3%, significantly higher than the national average (11.4%) for that same period, over 1.5 times higher than the state average (9.2%).[16] For reference, the average four-person household in Essex County in 2020 had a poverty threshold of $26,496. The largest racial/ethnic group living in poverty in the county is African American/Black 64,969 ± 1,930, followed by Hispanic 39,167 ± 1,512, and White 32,749 ± 1,377. In Essex County, poverty is disproportionately distributed amongst historically excluded African American/Black people and Hispanic/Latino people, who make up 40.2% and 24.2% of the total share of poverty, respectively. In comparison, White residents make up 20.2%. Nor does the poverty distribution within Essex County fall evenly across age and sex, as the largest demographic group living in poverty were females ages 25 – 34. These higher poverty rates may also account for the higher uninsured rate of residents within the county, which was 11.4%, well above the national average of 8.6 %.

[15] United States Census Bureau. U.S. Census Bureau QuickFacts: Essex County, New Jersey. Retrieved from: https://www.census.gov/quickfacts/essexcountynewjersey. Accessed March 31, 2022.

[16] Data.census.gov. 2022. Explore Census Data: Poverty Status in the Past 12 Months. [online] Available at: https://data.census.gov/cedsci/table?q=poverty%20Essex%20County%20new%20jersey&tid=ACSST5Y2019.S1701. Retrieved February 28, 2022.

Figure 2



The crippling effect of incarceration disproportionately affects poor and historically excluded Black or African American and Hispanic/Latino communities accounting for continued racial disparities and health inequities. The overrepresentation of Black and Hispanic/Latino persons incarcerated in New Jersey is well documented. As displayed in Figure 2, while African American/Black people comprise 14% of New Jersey residents, about 70% percent of the incarcerated population across all county jails are African American/Black.[17] While Hispanics/Latinos comprise 20.9% of the residents in New Jersey,[18] they make up 12% of inmates across all county jails.[17] White residents in New Jersey comprise 71.9%, and about 16% of their population are incarcerated in county jails.[17]

[17] New Jersey State of Department of Corrections. 2020. Offenders in New Jersey Correctional Institutions on January 1, 2020, by race/ethnic identification. Available at: https://www.state.nj.us/corrections/pdf/offender_statistics/2020/2020_Race_Ethnicity.pdf, Retrieved February 28, 2022.

[18] United States Census Bureau. U.S. Census Bureau QuickFacts: New Jersey. www.census.gov. Retrieved April 29, 2022. https://www.census.gov/quickfacts/NJ

The New Jersey Department of Corrections

The New Jersey Department of Corrections (NJDOC), headquartered in Trenton, oversees the operation of 12 main correctional facilities and 11 residential community release programs.[19] Of the 12 main facilities, six are for adult males, three are for youth, one is for sex offenders, one is for adult women, and one is for reception and intake. As the second-largest employer, the NJDOC had approximately 10,000 employees to supervise the care of its 18,477 inmates in 2020.[20,21] Of these inmates, about 61% are Black, 22% are White, 16% are Hispanic, and 1% are Asian.[22]

Approximately 61% of inmates are held for violent offenses, 15% for drug violations, 12% for unlawful weapon passion or operation, 8% for property offenses, and 3% for public policy offenses. Across New Jersey's 21 counties, Essex County (including its jails, prisons, and youth complexes) remains the highest contributor of people in custody, accounting for 2,846 (15%) individuals.

[19] NJDOC. The Official Website for the New Jersey Department of Corrections | About Us - Information. Retrieved from: https://www.nj.gov/corrections/pages/aboutUs.html. Accessed February 25, 2022.
[20]New Jersey Department of Corrections. Dept | Employment Opportunities. Retrieved from: https://www.nj.gov/deptcor/info/employment. Accessed February 25, 2022.
[21] New Jersey Department of Corrections. Total Inmates in New Jersey State Correctional Institutions and satellite units. Retrieve from: https://www.state.nj.us/corrections/pdf/offender_statistics/2020/2020_Total.pdf. Accessed February 25, 2022.
[22] Lanigan G. New Jersey Department of Corrections | Offender Characteristics Report, 2017. Retrieved from: https://www.state.nj.us/corrections/pdf/offender_statistics/2017/Entire%20Offender%20Characteristics%202017. Accessed February 25, 2022.

Demographic Profile of the Jail Population

Essex County Correctional Facility (ECCF) is the largest county jail in New Jersey. It is a medium-security-county-level facility located in Newark.[23] As of November 2021, ECCF has a jail population of 2,707 (2,590 men and 117 women, including people incarcerated at Delaney Hall Detention Facility [Delaney Hall]. **Delaney Hall** is a privately owned facility of the GEO Group, which has a contract to house Essex County inmates. It is a minimum-security reentry and treatment facility predominately housing people serving sentences up to 12 months. The ECCF Classification Unit decides assignment to Delaney Hall following incarceration at the ECCF.

ECCF has 602 correctional police officers and 180 civilian staff (including medical professionals (e.g., physicians, dentists, nurses) and clinical professionals (e.g., social workers) combined across ECCF and its three-alternative-program facilities.[24] As of August 2021, Delaney Hall no longer houses detainees for Immigration and Customs Enforcement (ICE).[25] However, ICE detainees were replaced by Union County inmates and U.S. Marshals through joint-service agreements with ECCF. As of November 2021, approximately 937 U.S. Marshals and 355 Union County inmates are held at ECCF.

[23] Jails & Prisons - Essex County, NJ (Inmate Rosters & Records). www.countyoffice.org. Retrieved February 25, 2022. https://www.countyoffice.org/nj-essex-county-jails-prisons/

[24] Madison County Sheriff. Essex County Correctional Facility. Madison County TN Sheriff's Office - Madison County Jail. Published 2022. https://madisoncounty-sheriff.com/new-jersey/county-jail/essex-county-correctional-facility-2/

[25] Sherman T. Essex jail no longer housing ICE detainees for first time in years, as advocates push Murphy to end detention contracts. Retrieved February 25, 2022. https://www.nj.com/politics/2021/08/essex-jail-no- longer- housing-ice-detainees-for-first-time-in-years-as-advocates-push-murphy-to-end-detention-contracts.html

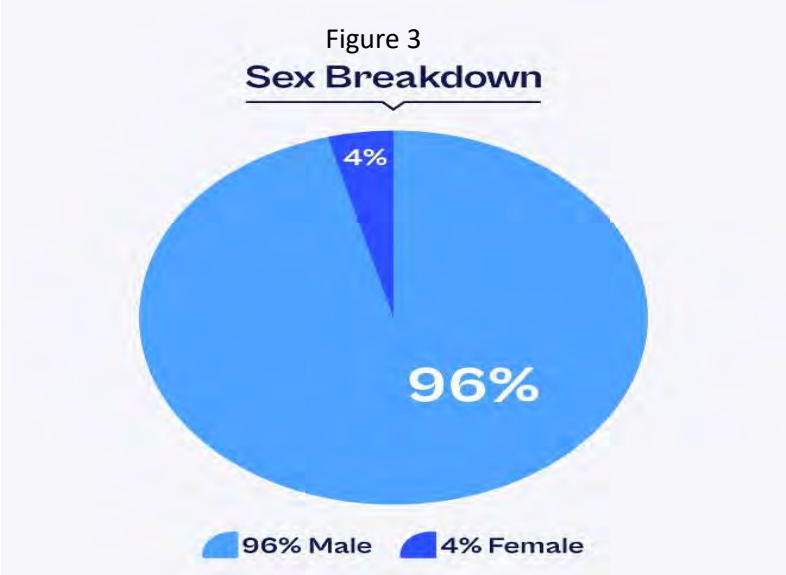


Figure 3 shows the current people in custody; 96% identify as male, 4% as female, and close to 90% (2,390) are single.[26]

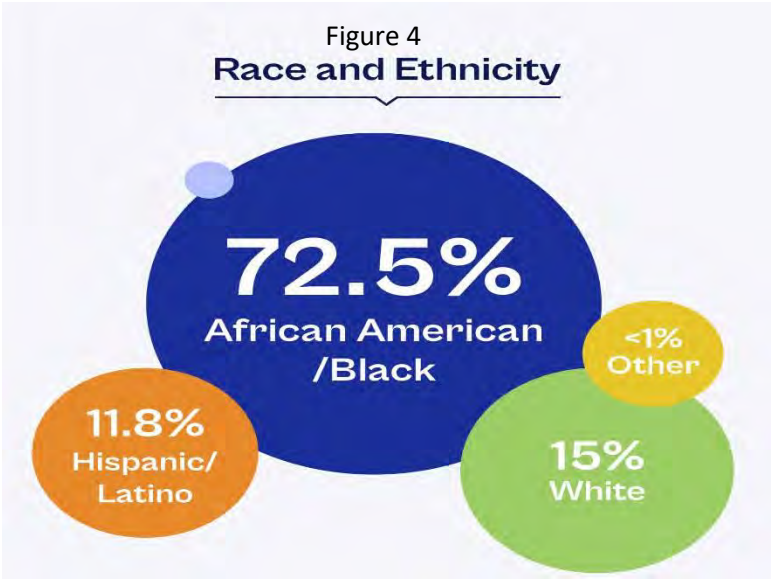


Figure 4 describes the race/ethnicity breakdown of the jail population.[27] From a person's date of first admission to their release, the average time served is 29 days.

[26] Civilian Task Force Requests: September to October 2020.

[27] Demographic Data provided by Offender Management System, 11/4/21.

Figure 5

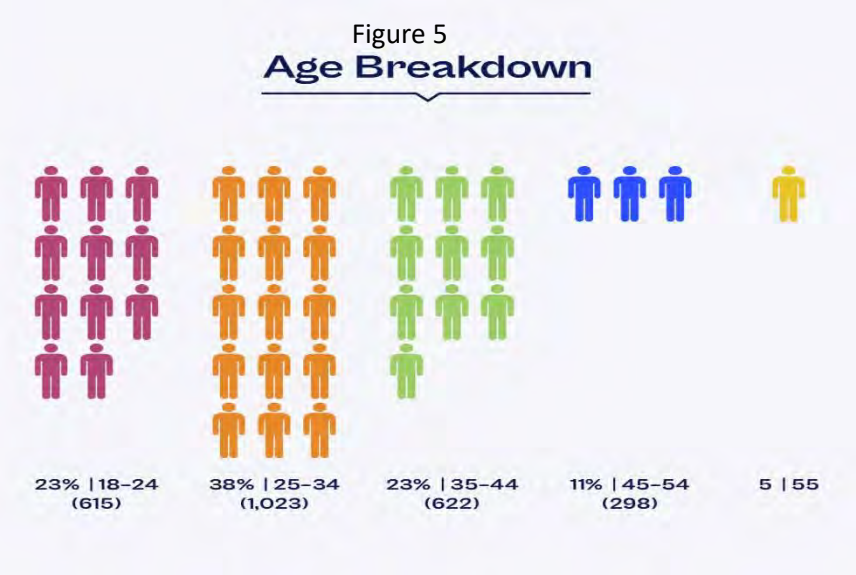


Figure 5 displays a total of 23% (615) of the total people in custody are aged 18-24, 38% (1,023) are 25-34, 23% (622) are 35-44, 11% (298) are 45-54, and 5% (5) are 55 and over.[28]

At least 97% of people in custody at ECCF are awaiting trial and have not been sentenced, compared to 3% who have been convicted and are serving their sentence. (Figure 6).

Figure 6

[28] Demographic Data provided by Offender Management System, Essex County Department of Corrections, 11/4/21.

Chapter 2: ECCF's Organizational Structure

Mission Statement

The purpose of the Essex County Department of Corrections is to provide, in a cost-effective manner, the highest degree of protection for the citizens of Essex County and safety for both the staff and inmates. The institution serves as a place for incarceration for pre-trial detention and the serving of sentences. Essex County Department of Corrections is committed to the preservation of the basic human rights and dignities of the inmate population.

ECCF supplies the care and custody of people awaiting trial or who have been convicted and sentenced to one year or less jail time (custodial management). The organization at ECCF is critical to understand because the institution's structure affects how program activities and objectives are carried out. Navigating the bureaucracy at ECCF requires knowing key players and their roles. ECCF is modeled in a hierarchical formation governed by federal, state, and local policies. Its organizational structure is clearly defined, and staff members address each other as Mr., Ms., Officer [Name], Warden [Name], or Director [Name]. At ECCF, custody officers have a clearly defined chain of command. The operations management handles the inmate population from pre-booking to custody. The officers at ECCF are called 'Correctional Police Officers.' (For examples of the job descriptions of a Correctional Police Officer at ECCF, see Appendix 1).

Correctional police officers are required to follow a rigid command organized in terms of military rankings. For instance, at ECCF, the military order includes Captains, Lieutenants, Sergeants, and Correctional Police Officers. These tables illustrate the number of individuals within each rank and the demographic composition of the custody staff.

Table 1. Staff Breakdown by Demographics

Captains		Lieutenants	
Black Male	*2*	Black Male	*3*
White Male	*3*	White Male	*9*
Hispanic Male	*1*	Hispanic Male	*4*
Other Male	*1*	Other Male	*1*
Black Female	*0*	Black Female	*3*
White Female	*0*	White Female	*0*
Hispanic Female	*0*	Hispanic Female	*0*
Other Female	*0*	Other Female	*0*
Sergeants		**Officers**	
Black Male	*12*	Black Male	*145*
White Male	*16*	White Male	*129*
Hispanic Male	*6*	Hispanic Male	*99*
Other Male	*5*	Other Male	*19*
Black Female	*11*	Black Female	*88*
White Female	*1*	White Female	*25*
Hispanic Female	*1*	Hispanic Female	*32*
Other Female	*0*	Other Female	*4*

Captains = 5

Lieutenants = 23

Sergeants = 52

Correctional Police Officers = 522

This section provides a basic overview of ECCF custody leadership, with details regarding Director Alfaro Ortiz's and Warden Guy Cirillo's professional backgrounds and leadership styles. The Wardens and designated staff are the only members authorized to speak on behalf of ECCF to the media, elected and county officials, and community groups.

Prison Leadership

Administrative Staff

2 Hispanic/Latino Males (Director and Business Administrator)

2 White Males (Warden and Associate Warden)

1 African American/Black Male (Assistant Warden)

Key Points

1. **Strong leadership skills** and **extensive professional experience** in corrections is critical to the overall function and organizational structure at ECCF.

2. A high degree of **self-control** and **emotional regulation** is needed to work in a fast paced and complex system.

3. ECCF operates in **a collaborative and decisive interprofessional practice** that comprises several workers from different professional backgrounds [corrections, medical, mental health, legal, social work, janitorial service, dining, etc.] who work together to deliver high quality custodial care to every inmate.

ECCF Director

Alfaro Ortiz is a retired New Jersey state corrections administrator, having served for over 30 years. He has been the Director of ECCF for 16 years. Director Ortiz has a total of 46 years of experience in corrections. He describes his family roots as central to his leadership style, having been raised in a family with a strong faith tradition. Director Ortiz's father was a minister, and he grew up surrounded by music and the church. Director Ortiz was close to being ordained but met his wife and decided to forgo ministry to marry and raise a family. In high school, he excelled, and despite growing up in humble beginnings, Director Ortiz knew he wanted to serve people and was *called* to the police force. His first professional job was as a police officer, and eventually, he found himself working in corrections.

After 46 years of serving the inmate population, Director Ortiz is still passionate and dedicated to this role. Director Ortiz is on call 24/7 and will often start texting or calling his leadership team at 4am. Each morning, Director Ortiz will check in with Doctor Lionel Anicette regarding any issues related to medical. Director Ortiz works hard every day, managing the inmates, the correctional officers and sometimes serving as a father figure for the many inmates who have experienced adverse childhood events. He is respected by his team of wardens and prison staff, and he tries to instill the same hardworking energy in all his co-workers. Director Ortiz focuses on the humanity of every person who enters the jail.

An issue that weighs heavily on Director Ortiz is the systemic racism within correctional institutions. For example, he is aware that most of his supervisory staff is White, whereas his officers are Black. As the Director, he aspires to develop a culture of inclusivity within ECCF.

Warden

Warden Guy Cirillo is a retired corrections officer who worked for the New Jersey State Department of Corrections for 29 years. Warden Cirillo served as a sergeant for four years, an Assistant Superintendent for two years, and retired as the Academy Director after being in the position for almost two years. Warden Cirillo retired in 2017 and became the Deputy Director at Delaney Hall for approximately one year. In 2019, he became the Warden for ECCF. His skills include policing, public safety, and patrol. Warden Cirillo has the senior-level supervisory experience, a high degree of self-control and emotional regulation, and is dedicated to serving his correctional police officers, jail staff, and incarcerated individuals.

Warden Cirillo became a correctional officer three days after his twentieth birthday to support himself and his younger brother upon the death of his mother. (Cirillo's father had left his family, and he was not present in their lives). Warden Cirillo initially had no interest in law enforcement, but his mom had made him apply for every agency when she was alive, never knowing what a blessing it would be in his life. He did not become a correctional officer because he aspired to help offenders or save the world. Corrections called him when he needed a steady source of income.

Warden Cirillo's most significant concern in managing ECCF is the culture of corrections. The threat of daily violence at the jail causes hypervigilance, anxiety, and stress, perpetuating disrespect among correctional officers and the inmates. Warden Guy Cirillo supervises an Associate Warden (Antonio Pires) and Assistant Warden (Anthony Brown). Together, they manage various aspects of ECCF.

Challenges in Corrections

The roles of the Director of Corrections and the Wardens present challenges, such as exposure to chronic stress-related institutional dangers with mental and physical health risks.[29,30] Along with his wardens and Medical Director Lionel Anicette, Director Ortiz has had to make life-saving decisions, stop jail fights and riots, disrupt hunger strikes, communicate with judges and public defenders, prepare for audits, and act as a liaison for families. Both the Director and the Wardens are concerned about the rise of people in custody who may be perceived as having a mental disorder.

The foremost challenge ECCF faces is the high prevalence of mental disorders among people in custody. Assessing an inmate with a mental disorder is inherently challenging, even in the ideal clinical environment. This is made more difficult due to difficulties obtaining inmate's electronic medical records (EMR) from the community, staff shortages, a lack of outpatient mental health treatment, and disparities in diagnosing and treatment. Unfortunately, ECCF has become the de-facto facility for people with mental disorders due to inadequate community

[29] Finney C, Stergiopoulos E, Hensel J, Bonato S, Dewa CS. Organizational stressors associated with job stress and burnout in correctional officers: a systematic review. *BMC Public Health*. 2013;13(1). doi:10.1186/1471-2458-13-82

[30] Cullen FT, Link BG, Wolfe NT, Frank J. The social dimensions of correctional officer stress. *Justice Quarterly*. 1985;2(4):505-533. doi:10.1080/07418828500088711

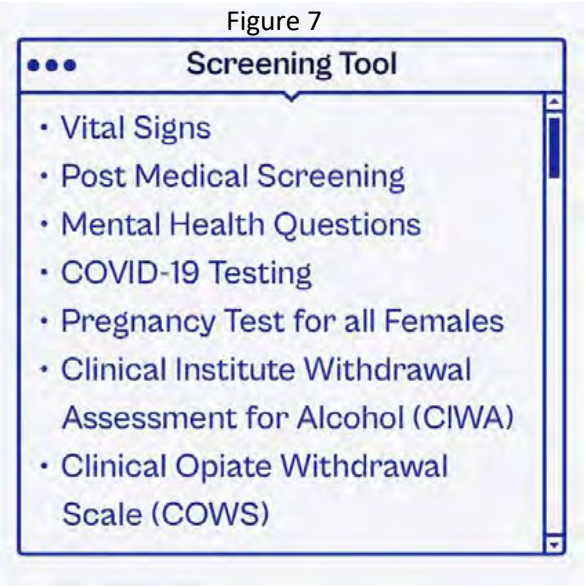
mental health facilities and treatment at other jail facilities. The COVID-19 pandemic has presented added challenges, as discussed below and in the following chapter.

Succession Planning

- ECCF has a strong leadership team, and its correctional police officers have many years of custody experience. However, due to deteriorating public trust, the COVID-9 pandemic, reductions in state and local budgets, and escalating demands of the job, those that can in the next 5-7 years may consider retirement.
- Succession planning, mentoring and training of the next generation of correctional police officers into leadership and administrative roles are equally important. This process is designed to help ECCF recognize future leaders and help lessen the disruption to ECCF.

Chapter 3: The Person in Custody Admission or Pre-Booking Process

Figure 7



The pre-booking or admissions process can take 6-8 hours or more, depending on how busy the jail is, and involves several procedures. Upon arrival, the individual is taken to the pre-booking area for processing by an ECCF correctional police officer. **Women go through a separate intake area.** The pre-booking assessments include: an intake medical screening (see Appendix 2), mental health questions (see Appendix 3), and screening tools (see Figure 7 and Appendix 4) such as Clinical Institute Withdrawal Assessment for Alcohol (CIWA), Clinical Opiate Withdrawal Scale (COWS).

Tuberculosis (TB) (using the Purified Protein Derivative (PPD) tuberculin skin test, the Quantiferon Gold test, and Chest X-rays), which can take up to 12 hours), and COVID-19 testing (utilizing the Abbott Rapid Antigen Test for screening purposes and Abbot Molecular Test for confirmation). After the screening, inmates are given a meal, shower, jail uniform, and an orientation to the jail facility. In addition, every inmate completes a self-report intake form and assessments (including physical health and mental health questionnaires, substance use history, suicide potential, and risk for violence, abuse, or victimization). Everyone is interviewed first by a correctional police officer, followed by medical and mental health staff to figure out classification and housing, medical, physical, and mental health needs. (See Chapter 4 for a description of roles of medical staff and Chapter 5 for a description of functions of mental health staff).

After this intake process, the nursing staff will evaluate the inmate for medical concerns, assess for a mental condition, and confer the responses from the mental health questionnaire (see Appendix 3, mental health screening). A medical team reviews the EMR through Centricity to determine whether the person has prior medical history at the facility.

Inmates with acute needs (e.g., medical, physical, or mental) are placed in specially designated housing units and are monitored accordingly.

Pre-Booking Area or Process and Intake Area (Masks are required)

1. Medical screening upfront following pre-booking includes a TB test using the Purified Protein Derivative (PPD) tuberculin skin test, the Quantiferon Gold test, and Chest X-rays. Additionally, vital signs are collected, including blood pressure, heart rate, oxygen rate, and respiratory rate. Next, the correctional officers will fingerprint the individual and take an official photograph, called a "mugshot," to confirm identity. Verifying identity includes accessing the National Crime Information Center and the Community Corrections Information systems.

2. Biometric authentication technology in the form of finger scanning is used to verify or record an inmate's name and personal information. A biometric fingerprint scanner avoids duplicate entries, eliminates identity fraud, tracks inmate movements throughout the facility, and verifies identity before releasing from jail

Figure 8

3. A search for metal, weapons, and contraband objects – The Body Orifice Security Scanner [BOSS CHAIR] (See Figure 8). As part of the booking process, each inmate is asked to "sit in a Boss Chair" – a non-intrusive, high sensitivity detector designed to detect metal objects in the body cavities (i.e., anal, vaginal, oral, and nasal).

4. Body Imaging Scanning Equipment – Body imaging scanning equipment is used on each inmate to produce an anatomical image capable of detecting contraband objects hidden in the body or clothing, such as ceramic knives or blades. The body scan equipment is solely used for screening inmates who enter ECCF.

5. Pre-booking Bull Pen or Holding Cell – After the custody officer has cleared the inmate, the individual is then taken to a pre-booking bullpen, where they await to be seen by the nurse and medical staff for intake. *Female inmates are taken to a bullpen designated for women, and men are taken to a pre-book bullpen designated for men.* There are generally at least three to four inmates in the pre-booking bullpen awaiting the intake process.

Prison Rape Elimination Act (PREA)

Each inmate is assessed for PREA to determine the risk of victimization (i.e., being sexually abused by other inmates or any prior acts of sexual abuse) (See 77 Fed. Reg. 37106, 37154).[31] Under federal regulations, the PREA objective screening questionnaire should consider the following: (1) whether the person has a mental, physical, or developmental disability; (2) the age of the inmate; (3) the physical build of the inmate; (4) inmate's previous incarceration history; (5) inmate's criminal history; (6) prior convictions for sex offenses against a child or adult; (7) inmate's self-disclosure of either sexual orientation or identity, including transgender, intersex, or gender nonconforming; (8) whether the inmate has previously experienced sexual victimization or abuse; (9) inmate's perception of their vulnerability; and (10) exhibition of certain sexual predator characteristics.

COVID-19 Testing

An inmate is given a COVID PCR Rapid Test with a same-day result during the admission process. Both tests provide results within 15-30 minutes during the admission process. Placement within the jail depends on whether someone tests positive or negative -- inmates are housed in cohorts by their positive or negative test status. When inmates are confirmed positive for COVID-19, they are immediately separated and placed in quarantine. Appropriate medical

[31] Office of the Federal Register, National Archives and Records Administration. 77 FR 37106 - National Standards to Prevent, Detect, and Respond to Prison Rape. Retrieved from: https://www.govinfo.gov/app/details/FR-2012-06-20/2012-12427. Accessed February 24, 2022.

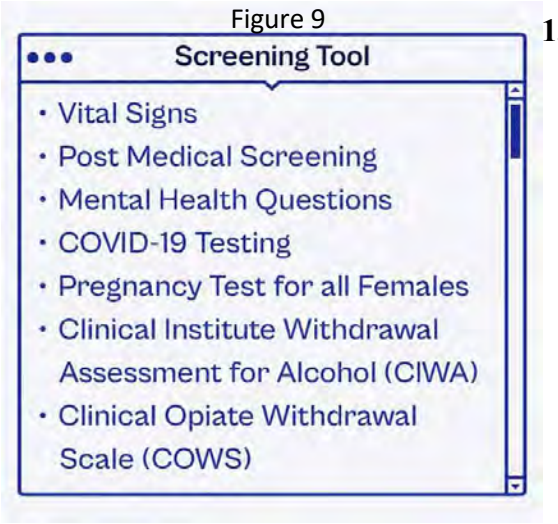
care is provided to an inmate showing symptoms of COVID-19, and they are assessed as to their risk for severe medical complications. Inmates who test negative must quarantine according to the guidelines recommended by the Centers for Disease Control and Prevention [CDC] (see Quarantine section for more information). In the bullpen, inmates are given a mask. They must wear a mask when they are in transit or moving into the facility. Otherwise, masking is not required by the facility because of security concerns.

Quarantine

All inmates are placed in quarantine during pre-booking processing regardless of their COVID-19 test results with a quarantine time period that coincides with the typical incubation period of COVID-19. When an inmate tests positive for COVID-19, they are provided a mask, and they stay in isolation for up to 10 days, as stated by CDC guidelines for Correctional and Detention Facilities. Afterward, they must be cleared by medical staff for admission to the general housing population.

Booking Process

Figure 9



1. **Intake** – The intake process before being housed in the general population is comprised of several steps, as referenced in Figure 9. Immediately after pre-booking, the inmate completes the medical history and mental health screenings. A nurse conducts the first screening intake to ensure that ECCF can meet the inmate's medical and mental health needs. During the intake process, inmates have access to telephones and a shower and are given a meal.

2. **Phone Call –** *People in custody* have access to telephones, are guaranteed one free 15-minute call to contact friends, family, or their attorney, and they are allowed to use the phone for another 10 minutes if needed.

3. **Meal** – Figure 10 describes the meal schedule. Dining and dietary guidelines are further described in Chapter 8.

Figure 10
Meal Schedule

4. **Shower** – A shower is provided to each inmate (10-20 minutes), where they are asked to remove street clothes and replace them with the jail jumpsuit.

5. **Medical Clearance** – The medical staff must clear each inmate to be suitable for incarceration using medical guidelines and policies.

6. **Orientation to ECCF** – An orientation to ECCF is supplied for new inmates. Prior to COVID-19, this orientation was given in person. Since COVID-19, the orientation handbook has been provided entirely on an electronic tablet in a passive manner. Inmates receive a handbook with information on rules of conduct, the daily schedule, sanctions for offenses, the disciplinary process, facilities services, programs, the visiting policy, social services, religious services, grievance policy, information about Essex County Civilian Taskforce, etc. (see Inmate Handbook and Disciplinary Rule Book, revised 2022, available in Spanish and English languages, Appendix 5). The handbook is also uploaded to the tablet for inmates to refer to during incarceration.

Care Package Upon Admission

Figure 11

Bob Barker Company is the vendor that supplies the personal admission kit.

The kit includes a toothbrush, nature mint toothpaste, comb, and wrapped deodorant soap (Figure 11). The personal admission kit does not supply feminine hygiene products (e.g., sanitary napkins, feminine wipes, or tampons). However, female inmates are provided a package (10 **sanitary napkins**) upon request.

Classification of Custody Level

Classification, or deciding an inmate's custody level (minimum, medium, or maximum), includes consideration of several factors. These factors include a propensity toward violence, criminal history, behavioral problems, physical health, mental health, the perceived risk posed by the inmate, history of escape, clinical stability, etc. The objective of classification is to house inmates of a similar status together to minimize risk or conflict between inmates. Housing classification is based on mental health and physical stability [e.g., assigned to University Hospital, Infirmary, forensic unit, or quarantine].

Wardens manage the day-to-day operations of the inmate population. At ECCF, wardens rely on unit managers or Captains. These are corrections police officers who act as "mini-wardens" and oversee the dormitory housing unit. A Captain lead manages each of their housing units. Depending on their classification level, each inmate is then assigned to a housing unit. Often, these housing units are restricted and off-limits to other inmates assigned to different housing units.

A. **Housing Units –** The inmate population at ECCF is currently split up by security status, and exercise and physical activity time depend on classification status. While every unit has a gym in the area and is open from 7am-9pm (7 days a week), access to the gym is site-specific. Count begins at 5:30am each morning, and all the cell lights in the housing units are turned on. There are multiple levels of incarceration: General population, Close watch, Constant Watch, and the Special Housing Units (see Chapter 5 on Mental Health). In addition, Delaney Hall serves as a step-down facility.

B. **Tier Representatives (Tier Rep) –** The Tier Rep is handpicked by the Social Service and Reentry Department to serve as advocates for their housing units. Tier Reps are selected after weighing certain sentencing factors, such as risk level, criminal history, prior convictions, and disciplinary issues. Tier Reps meet with inmates in their housing units to hear concerns

and share information regarding programmatic changes within ECCF. All the Tier Reps meet with Prison Leadership monthly in a conference room. These meetings are twofold to: (1) hear from Tier Reps on issues and concerns that inmates are experiencing in their pods; and (2) for prison leadership to share information about new policies and procedures and/or to provide updates or changes on specific issues. A Jail Advocate generates minutes.

C. **Jail Advocate –** Under the supervision of Director Ortiz, the Jail Advocate, is a jail staff member who meets directly with people in custody at ECCF and serves as a liaison between Tier Reps and Prison Leadership.

Chapter 4: Medical Care and Health Care Services

Key Points

1. Dr. Lionel Anicette, the Medical Director of ECCF, has worked at ECCF for over fourteen years. He is an empathetic leader dedicated to the health of the inmate population.
2. There are significant challenges in transitions to care upon release for those with chronic health conditions.
3. The medical staff is racially and ethnically diverse, and they are representative of the general demographic composition of the people who are housed at ECCF.
4. Consideration of a woman's sex and gender differences specific to their medical and mental health needs in custody should be improved.
5. ECCF is dealing with a critical nursing staff shortage.
6. There are inherent barriers and challenges in treating patients who are incarcerated.
7. There are inherent barriers and challenges in treating incarcerated patients in the area hospitals.

CFG Health Network (Vendor Contract) has a contractual agreement to supply comprehensive medical, behavioral, telemedicine, and mental health services to ECCF. (See Appendix 6 for CFG Contract)

Table 2. Medical Staff Breakdown by Demographics

Advanced Practice Nurse (n=17)		Registered Nurse (RN) n=33	
Asian Female	*1*	Asian Female	*3*
Hispanic/Latina Female	*2*	Hispanic /Latina Female	*1*
White Female	*1*	White Female	*2*
African American/Black Female	*9*	African American/Black Female	*22*
African American/Black Male	*2*	African American/Black Male	*3*
White Male	*2*	White Male	*1*
Hispanic/Latino Male	*0*	Hispanic/Latino Male	*0*
Asian Male	*0*	Asian Male	*1*
Licensed Practical Nurse (LPN) n=45		Ancillary (n=23)	
Asian Female	*0*	Asian Female	*0*
Hispanic/Latina Female	*1*	Hispanic/Latina Female	*3*
White Female	*4*	White Female	*1*
African American/Black Female	*35*	African American/Black Female	*19*
Asian Male	*0*	Asian Male	*0*
Hispanic/Latino Male	*0*	Hispanic/Latino Male	*0*
White Male	*0*	White Male	*0*
African American/Black Male	*5*	African American/Black Male	*0*
Dental (n=6)		Board Certified Physicians (MD) (n=11)	
Asian Female	*0*	Asian Female	*0*
Hispanic/Latina Female	*2*	Hispanic/Latina Female	*0*
White Female	*0*	White Female	*0*
African American/Black Female	*2*	African American/Black Female	*0*
Asian Male	*0*	Asian Indian Male	*2*
Hispanic/Latino Male	*0*	Hispanic/Latino Male	*0*
White Male	*1*	White Male	*4*
African American/Black Male	*1*	African American/Black Male	*5*
Certified Medical Assistant (n=1)			
Asian Female	*0*		
Hispanic/Latina Female	*0*		
White Female	*0*		
African American/Black Female	*0*		
Asian Male	*0*		
Hispanic/Latino Male	*0*		
White Male	*0*		
African American/Black Male	*1*		

Dr. Lionel Anicette is an internist and has been the Medical Director of ECCF for over fourteen years. Dr. Anicette received his medical degree from the Rutgers New Jersey Medical School and completed a three-year Internal Medicine Residency at University Hospital. He is Board in Internal Medicine and Certified through the National Board of Examiners as a Certified Correctional Health Professional. He has been a practicing physician for more than 20 years. Dr. Lionel Anicette has 134 medical staffers that he supervises (Appendix 7 describes CFG Staffing Matrix 2015, 2020)

Figure 12. Dr. Anicette Getting the COVID-19 Vaccine

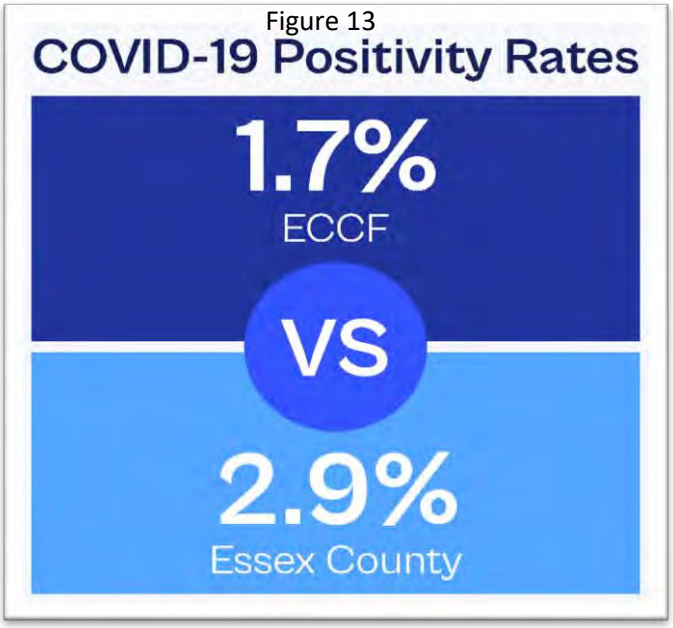
Under the auspices of CFG Health Network, Dr. Lionel Anicette follows the policies of CFG Health Network. These policies are fully integrated into ECCF medical, behavioral, and mental health delivery for inmates housed in the jail. At ECCF, every inmate that enters the facility is medically screened and cleared by the medical team. As a preliminary step to the intake process, inmates are screened during pre-booking by medical staff. The screening includes vital signs (e.g., blood pressure, heart rate, oxygen saturation, and respiratory rate), a TB test, COVID-19 test, and a mental and physical health examination to determine medical stability, including an assessment for suicidality. This process also includes evaluating whether a person can consent to treatment when it is clinically indicated. The medical team works alongside custody staff; this process with each inmate takes about 4-6 hours.

The COVID-19 pandemic has impacted how medical care and healthcare services are provided at ECCF. ECCF has consistently included pandemic planning, including inmate and staff infection prevention protocols and disinfection and cleaning procedures. For example, correctional officers must wear personal protective equipment (PPE) and/or masks in the jail, quarantine and isolate inmates whenever necessary, and provide access to COVID-19 vaccines. While these procedures may seem daunting, curbing the virus, reducing widespread infections, and preventing severe disease and death are top priorities at ECCF.

COVID-19 Protocol and Procedures

As described in the ECCF 2021 Task Force Annual Report, the Task Force conducted the majority of oversight activities amidst the COVID-19 Public Health Emergency and the State of Emergency. (Please see ECCF 2021 Task Force Annual Report for details of COVID-19 protocol and procedures)

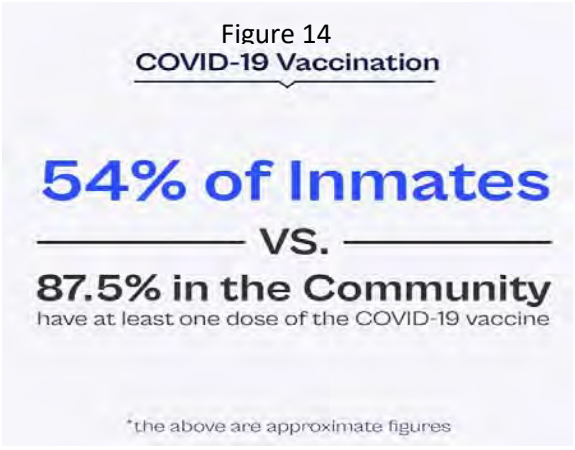
Figure 13



COVID-19 Testing

The medical provider then tests for Sars-CoV-2 using Abbott Rapid Antigen Test for screening purposes and the Abbot Molecular Test for confirmation. As ECCF continues to monitor the impact of COVID-19 within its jail, particularly the Omicron variant, ECCF has seen an increase in the positivity rate. Figure 13 describes the COVID-19 positivity rate in February 2022. In addition, Figure 14 displays the proportion of inmates who have been vaccinated versus those in the community.

Figure 14



PPE (Use of Surgical Masks)

All inmates are provided and have access to PPE; outside of their housing units, wearing PPE is mandatory [e.g., medical, court, law library]; however, within the housing units, PPE is not needed. In other words, due to logistical issues and security concerns, ECCF clarified that individuals within the general population are not always masked. Instead, individuals are housed together based on mutual COVID-19 transmission status. Upon arrival, they are masked when mobile about the facility or outside of their designated cells or pods.

COVID-19 Vaccine

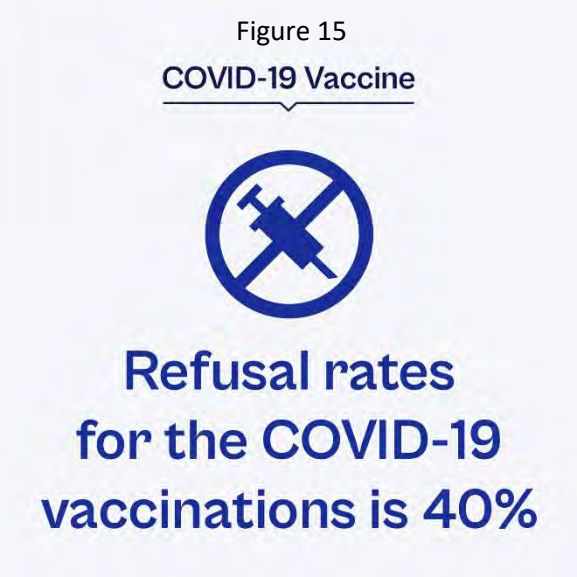
As of February 2022, ECCF has worked with the New Jersey Department of Health to administer 1,637 doses of the COVID-19 vaccines among those incarcerated. ECCF has fully vaccinated 789 individuals with either Moderna, Pfizer, or Johnson & Johnson vaccines and has administered 112 boosters with either Moderna or Pfizer. ECCF continues to administer vaccines to the inmate population on a weekly basis.

The Essex County Department of Health provides the COVID-19 vaccine, and vaccinations began when it was initiated with the public. Maya Lardo, Director of the Essex County Department of Health, is part of the Infection Control Team. ECCF uses the Sheriff's Department to transport and bring the newly created vaccines to ECCF. Public service announcements and digital videos about the COVID-19 vaccine are available daily on TV screens in the housing units, and meetings are held with Tier Representatives (Tier Rep). COVID-19 vaccines are provided to everyone weekly (i.e., Wednesday evenings) through a joint program with the Essex County Department of Health in Newark; at least 10-20 inmates get the COVID vaccine per week. There have been inmates that have requested the COVID-19 vaccine through their tablets, but these numbers are small. ECCF cannot mandate vaccinations [because inmates are awaiting trial and still legally innocent]; all vaccinations are voluntary. The Standard J-I-05 Informed Consent and Right to Refuse Treatment addresses these issues.[32]

[32] National Commission on Correctional Health Care. Right to Refuse Treatment. www.ncchc.org. Accessed March 31, 2022. https://www.ncchc.org/right-to-refuse-treatment

Standard J-105

Any procedure requiring written consent in the community also requires a signed consent from an inmate in a correctional setting. Generally, written consent is required for any treatment or procedure that is invasive and carries some risk of an adverse outcome. Note, though, that not all health encounters require written consent. If the treatment/procedure is neither risky nor invasive, consent may be implied when the patient shows up for the health encounter. That said, if your facility wants to obtain written consent for every health encounter, it may do so.
— From CorrectCare Volume 17, Issue 2, Spring 2003; updated February 2010



As such, people in custody can refuse everything. The refusal rate for COVID-19 vaccination is 40% (Figure 15). Incentives are in place to manage a lack of confidence in the COVID-19 vaccine, including $10 placed in their commissary account, participation in a raffle to win $500, and a pizza party if all members of the housing unit get the COVID-19 vaccine. These incentives and Public Health Service announcements have increased interest in receiving the vaccine. ECCF nurses reported an immediate increase of 10-20% when the incentives were first announced.

To date, there have been eleven COVID-19 admissions to an area hospital from ECCF over the past two years and 1 COVID-19-related death.

Here we describe the essential components of health services within ECCF, which can be summarized under seven headings: (1) Medical Care Services; (2) Keep on Person (KOP) medication; (3) Women's Health; (4) Dental Care; (5) Telemedicine; (6) Medical Monitoring; and (7) Continuity of Care

Medical Care Services

An inmate's clinical stability, including mental and physical stability, is a major factor when deciding placement into a particular housing unit. Housing classifications may include assignment to an outside hospital or infirmary (a dedicated 42 unit), forensic unit, or quarantined. After the nursing intake, all newly processed inmates who are negative for coronavirus infection are quarantined and housed separately from the general population for the recommended time period by the CDC. During that quarantine period, a nurse practitioner evaluates the person within two to three days for additional follow up. Rather, inmates are seen and evaluated at once if an urgent issue or a medical emergency develops. Otherwise, those who are confirmed positive by the two-step testing process during intake are isolated separately from the general population according to CDC guidelines. If there is an urgent issue or acute medical emergency, inmates are seen immediately.

Any inmate exhibiting symptoms of Tuberculosis receives a thorough medical evaluation and quarantine for ten days in a single-occupant cell located in buildings 2e1 2e2, and 4c3, ECCF's quarantine units. An inmate who is actively suicidal is assigned to constant watch status and, depending on severity, may be referred to an area hospital.

Medical Team Structure

ECCF supplies onsite services, including board-certified physicians, dentists, registered nurses, and LPNs who provide medical care and services to inmates. The intake LPNs screen from 15-20 patients per shift on all three work shifts. An RN works at the infirmary 24 hours, seven days a week.

ECCF has a fully equipped infirmary, consultation rooms, treatment rooms, short-stay beds, a nursing waiting area, and an on-site continuity of care clinic that treats various chronic conditions. There is a dedicated specialized medical health care staff for the inmates, including an x-ray technician onsite three days a week. ECCF has ongoing referrals to physicians who specialize in ophthalmology, dialysis, otolaryngology, dermatology, rheumatology, and oncology. An inmate who is sent to ECCF with severe burns is cared for at the local burn center, and patients in need of forensic commitment are sent to an area hospital.

On-site Continuity of Care Clinic

Chronic Care

Physical Therapy

OB/GYN

Podiatry

Orthopedics

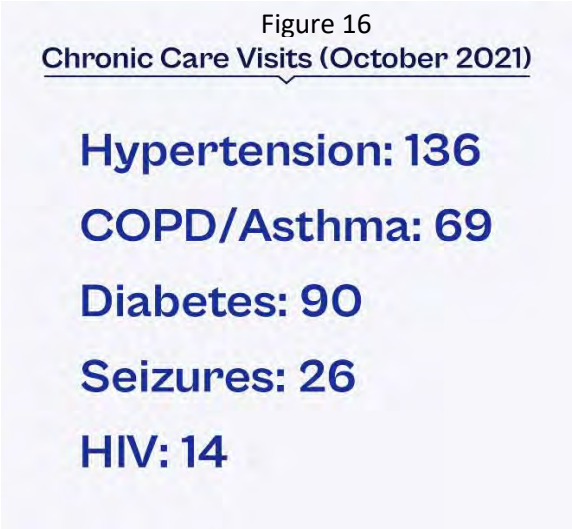
Oral Surgery

Nephrology

Chronic Care Rates within ECCF

Altogether, at least 1,200 inmates of the current population suffer from a chronic condition; most are between the ages of 18-80 and have 1 or 2 comorbidities. ECCF currently has people in custody with hemophilia and geriatric inmates with dementia. The primary chronic conditions that are medically monitored in the facility include Diabetes, Hypertension, COPD, Asthma, Epilepsy, HIV, and Hepatitis C, among other conditions. Prevalence rates for these conditions were not provided as they are not currently being tracked. Chronic care inmate patients such as those with diabetes and hypertension are scheduled for quarterly (every three months) visits for monitoring and management unless their clinical condition and disease management need more frequent checkups. Instead, inmates with cancer, sickle cell disease, and those with multiple chronic conditions, for example, are monitored at more frequent intervals.

Figure 16



In October 2021, there were 1,578 inmate admissions. All inmates were screened for TB (via PPD Skin test); four individuals were sent to the emergency room of an area hospital before jail; 894 physical exams were conducted, and 325 chronic care visits were made.

Figure 16 describes the number of chronic conditions identified and monitored.

While medical screenings are performed on all admissions during intake, based on first evaluation, some persons are deemed in need of urgent care and are immediately referred to a medical provider in the jail. Otherwise, patients typically are referred to on-site medical providers for a thorough physical examination on days 2-3 of incarceration. Since bail reform was enacted, however, most people in custody are sent to physical/virtual court within 24 hours to be considered for immediate release, which may lead to their direct discharge from the facility.

Process of Receiving Medical Care

There are three ways for a person in custody at ECCF to receive medical attention. The process begins in pre-booking and intake when medical staff (e.g., LPNs) conduct a first evaluation. Then inmates are evaluated by medical providers (e.g., MDs and PAs) on day 2 or 3, who perform an extensive physical exam. This includes undergoing a comprehensive mental health assessment done by mental health clinicians (e.g., clinical social workers, psychologists, or psychiatrists), within 72 hours or sooner based on an urgent need identified in the intake process. A second way to receive medical care is to complete a sick call request (either through the tablet or paper form) requesting medical attention. Third, inmates can ask a correctional officer to escort them to the infirmary. Sick calls are read by the medical informatics coordinator and triage staff within 24 hours. The telemate system assigns sick calls. (See Appendix 8 for an example of sick call requests). When necessary, inmates are escalated to Director Ortiz.

Keep on Person Medication Self-Administration (KOP)

A shortage of nurses forced ECCF to re-evaluate their medication administration protocol to ensure that all inmates received their prescribed medications. This process, known as KOP medication, has been administered to 1,600 inmates since February 2022. KOP allows people in custody with a chronic condition to keep a two-week supply of their medication. The KOP medication is incorporated in the electronic medication administration record (EMAR). The individual signs that they have received the prescription and the specific medications provided to the inmate are documented.

The medical team has found that chronic care medications for hypertension or cholesterol are safe for inmates to carry with them. However, ECCF has a class of medications approved for KOP outside of these pathologies, including over-the-counter analgesics such as Motrin. Narcotics for pain management and psychotropic medication (such as Clonidine for anxiety) are not administered through KOP. Such medicines are only administered through Direct Observed Therapy (DOT),[33] where a nurse (primarily an LPN) supplies the medication and watches the

[33] American Academy of Psychiatry and the Law. AAPL Practice Resource for Prescribing in Corrections. *Journal of the American Academy of Psychiatry and the Law Online*. 2018;46(2 Supplement): S2-S50. Retrieved from: http://jaapl.org/content/46/2_Supplement/S2. Accessed March 31, 2022.

person swallow every dose. While KOP is a common practice in correctional settings, it is a relatively new procedure at ECCF. Suggestions for improving KOP at ECCF are discussed in further detail below.

Recommendations for Medical Care

- Active tracking and monitoring of people in custody with chronic conditions is needed to better report prevalence rates and progress toward linkage to appropriate health care services upon release to the community.
- Every inmate on KOP should have a medication card that includes their name, birth date, ID, and list of medication and prescription information. During cell sweeps, medications may be confiscated if no KOP card exists.

Co-Pays within ECCF

To limit or reduce the misuse of sick calls, only direct contact for a sick call visit is charged a fee as part of ECCF policy ((P.L.1995, c. 254). No inmate has been denied health care due to the inability to pay co-pay for service. Co-pays are assessed regardless of insurance status. Medical services initiated by the inmate are subject to $10.00 per visit; there is also a charge for medication at $3.00 cost per medication, which is separate from medications required to address chronic care conditions.

There are no charges made for the following: pre-booking health screening (medical, mental health, and dental care), COVID-19 tests, COVID-19 vaccines, follow-up screenings, health assessments required by ECCF, emergency care and trauma, medical or mental health hospitalizations, infirmary, prenatal care visits, labs, pharmacy medications to address a chronic care condition, staff initiated care visits, follow-up or referral visits, mental health services, and/or treatment for substance use disorders.

Women's Health

- Substance use
- Mental health
- Infectious diseases
- Reproductive health
- Trauma
- Intimate Partner Violence (IPV)

Sex and Gender

Due to sex and gender inequities, female inmates are considered a special population in jail settings.[34] Female inmates are a gender minority at ECCF, accounting for 4% of the total population. Most females who are incarcerated at ECCF have complex needs, particularly concerning their physical, obstetrical/gynecological, and mental health. Many females in custody identify as mothers and grandmothers. They usually are the primary or sole caregivers for their children and/or grandchildren.[35,36]

[34] Van den Bergh B, Plugge E, Yordi Aguirre I. Home. Retrieved from: www.euro.who.int. https://www.euro.who.int/data/assets/pdf_file/0006/249207/Prisons-and-Health, -18-Womens-health-and-the-prison- setting.pdf. Accessed January 15, 2022.

[35] Cecil DK, McHale J, Strozier A, Pietsch J. Female inmates, family caregivers, and young children's adjustment: A research agenda and implications for corrections programming. Journal of Criminal Justice. 2008;36(6):513-521. doi: 10.1016/j.jcrimjus.2008.09.002

[36] Valera P, Chang Y, Hernández D, Cooper J. Exploring kinship and social Support in women with criminal justice backgrounds. Journal of Offender Rehabilitation. 2015;54(4):278-295. doi:10.1080/10509674.2015.1025178

Medical and Social Services

1. Prenatal medical evaluation and care
2. Nutritional supplements and diet as prescribed by the treating physician
3. Non-directive counseling regarding:
   a. family planning
   b. birth Control
   c. termination of pregnancy
   d. child placement services
   e. religious counseling, if desired by the inmate
4. Obstetrical services
5. Abortion services
6. Apropriate postpartum and medical care

N.J. Admin. Code § 10A:31-13.10

Females in custody at ECCF are likely to experience high rates of trauma stemming from IPV (e.g., domestic violence) and substance use disorders.

- CFG should recognize the sex and gender differences specific to incarcerated female's medical and mental health needs. Healthcare services that are personalized and tailored to females should be adopted. Furthermore, evidence-based, individualized counseling and therapy are necessary for every incarcerated female.
- Because of past trauma from their partners, most females entering ECCF may suffer from mental disorders. They may be experiencing psychological distress and post-traumatic stress disorders at the time of incarceration.
- Most custody officers are men, and female inmates may feel uncomfortable sharing essential information about normal female functions and/or issues such as menstruation.
- Due to excessive menstrual blood loss, many reproductive-aged females experience iron deficiencies, multiple vitamin supplements should be provided.

ECCF currently does not supply menstrual products such as sanitary towels or sanitary napkins as part of their care package during the pre-booking process; these products must be solicited. Menstrual products are necessary for women of reproductive age. However, they should be freely available without request.[37] Due to rising incarceration rates for women, increasing numbers of female persons of reproductive age are entering a correctional environment initially designed for men.

[37] National Women's Law Center and Rebecca Project for Human Rights. Mothers behind Bars. The Rebecca Project for Human Rights; 2010. Retrieved from: http://nwlc.org/wp-content/uploads/2015/08/mothersbehindbars2010.pdf. Accessed February 25, 2022.

Pregnancy and Delivery

As the number of women incarcerated in ECCF continues to rise, pregnancy at admission to ECCF has become a significant concern. Alongside meeting the basic needs of women of reproductive age, pregnancy during jail admission requires special consideration. Pregnant women who are incarcerated do not have control of their social environment, which may change sleep, dietary needs, and medication.

Furthermore, there is currently no statute that requires county jails to track or report pregnancy-related data.[38] Consideration should be given to administering routine pregnancy tests upon arrival, as there might be females who do not know they are pregnant during their first trimester. Also, an incarcerated female may become pregnant during her incarceration.

Prenatal Care and Post-partum Care and Treatment

Caring for incarcerated pregnant women is challenging at ECCF. Prenatal care is usually shared among the jail's medical team and a part-time OB/GYN provider. Pregnant patients are transferred to an area medical facility for outpatient and inpatient evaluation and treatment when it is considered clinically indicated, specifically for labor and delivery services. At times, there are logistical challenges to ensuring prompt appointments at an outside facility. There are potential barriers to the efficient transfer of medical information between providers in the jail and the receiving facility, which should be ameliorated to promote prompt and effective evaluation and care.

Under the N.J. Admin. Code § 10A:31-13.10, *"medical staff at an adult correctional facility shall provide pregnant women with medical and social services as soon as possible after the pregnancy is diagnosed.*[39]

[38] Sufrin C, Beal L, Clarke J, Jones R, Mosher WD. Pregnancy outcomes in US prisons, 2016–2017. A*merican Journal of Public Health*. 2019;109(5):799-805. doi:10.2105/ajph.2019.305006

[39] New Jersey Administrative Code. N.J. Admin. Code § 10A:31-13.10. Accessed February 24, 2022. Retrieved from: https://casetext.com/regulation/new-jersey-administrative-code/title-10a-corrections/chapter-31-adult-county- correctional-facilities/subchapter-13-medical-dental-and-health-services/section-10a31-1310-care-of-pregnant-inmate

At ECCF, every woman who either self-reports or is diagnosed with a pregnancy at the time of jail pre-booking is part of a high-risk obstetric group. Some factors that may contribute to poor pregnancy outcomes include experiencing poor social determinants of health, being from socially economically impoverished backgrounds, history of drug abuse, psychiatric disorders, and trauma.[40,41] Additional medical problems (e.g., diabetes mellitus or high blood pressure) could also impact pregnancy-related outcomes.[42]

[40] Terk JV, Martens MG, Williamson MA. Pregnancy Outcomes of Incarcerated Women. *Journal of Maternal-Fetal and Neonatal Medicine*. 1993;2(5):246-250. doi:10.3109/14767059309017243

[41] Terk JV, Martens MG, Williamson MA. Pregnancy Outcomes of Incarcerated Women. *Journal of Maternal-Fetal and Neonatal Medicine*. 1993;2(5):246-250. doi:10.3109/14767059309017243.

[42] Knight M, Plugge E. Risk factors for adverse perinatal outcomes in imprisoned pregnant women: a systematic review. *BMC Public Health*. 2005;5(1). doi:10.1186/1471-2458-5-111.

Recommendations for Improving Pregnancy Outcomes and Childbirth

- ECCF should explore collaborations with area hospitals to strengthen the networks between the jail and receiving facilities. To provide safe and high-quality care along the continuum for incarcerated pregnant patients, efforts to improve inter-facility communication and care coordination between ECCF and area providers and hospitals are necessary to remove barriers to transitions of care and to promote optimal health outcomes.
- Three specific areas of focus for pregnant people as well as for all persons referred for care outside of ECCF: 1) clear protocols for the receiving institution in the care of incarcerated patients; 2) communication around discharge planning between the outside treating facility and the jail; and 3) the relevant transfer of medical information between the treating facility and the jail to ensure continuity of care at ECCF.

Dental Care

Figure 17

Often, dental problems for incarcerated individuals begin long before their incarceration experience because of their lack of access to dentists in their communities. ECCF has been supplying dental care since the facility's opening in 2004. The current dentist has been providing dental care for about seven years. The dental team consists of one full-time dentist, a part-time dental hygienist (about 20 hours per week), a full-time dental assistant who is available to inmates seven days a week, and a dental surgeon who comes in for surgery about two days per week (for a total of four hours per day).

Figure 18

ECCF deals with the increasing demand for dentist consultations for people in custody. Dentist appointments in ECCF for the indigent and justice-involved populations are exceptionally scarce and limited; it can take months for a new patient to be seen for routine cleaning. Figure 18 shows a breakdown of individuals waiting for dental consultations over three months.

Medical Monitoring

The Monitoring and Evaluation Unit performs audits to find areas of concern regarding medical matters at ECCF. It is responsible for using performance indicators and examines trends in reporting. In general, the Monitoring and Evaluation Unit reports on the following: intake, sick calls, chronic care encounters, and mental health.

Telehealth Program

In response to the COVID-19 pandemic, **ECCF has had to implement a telehealth program to enable inmates to receive specialty care via telehealth.** The physician and/or providers have access to the electronic medical record (EMR) and a dedicated laptop with a patient portal for the tele-visit appointment, which allows the inmate to speak with a dedicated physician. There are currently three providers: two physician assistants (PA) and one RN who work to supply telehealth services.

Continuity of Care within ECCF's Medical Unit

The aim of continuity of care ensures that all areas of health – medical, mental health, and dental care – are assessed from admission to discharge. Utilizing a continuity of care approach to healthcare during incarceration ensures that inmates receive services consistent with current community standards (see *2008 Standards for Health Services for jails and prisons, National Commission on Correctional Health Care*).[43] There are, however, barriers to maintaining continuity of care at ECCF, including but not limited to: a shortage of clinical and medical staff, barriers to medication access, treating incarcerated patients once outside of ECCF, and difficulties obtaining medical records from the community. **This report focuses on three prominent issues: (a) shortage of clinical and medical staff, (b) treating incarcerated patients at area hospitals, (c) difficulties obtaining medical records from the community, and (d) the time pressures on supplying care given the brief average stay at the facility and**

[43] National Commission on Correctional Health Care. Standards Explained. Retrieved from: https://www.ncchc.org/standards-explained. Accessed February 24, 2022.

release back into the community at irregular times and without sufficient advance notice for proper medical discharge planning.

(a) Shortage of clinical and medical staff – ECCF reports a clinical staffing crisis, requiring five to six more full-time registered nurses (RNs) and five to six licensed practical nurses (LPNs) to provide staffing for essential services. COVID-19 has worsened shortages of nurse staff. When clinical nurses and medical staff must stay home due to being infected with COVID-19, the remaining health care workers face the burden of caring for over 2,000 inmates. It is nearly impossible to get help from other departments due to limited clinical staffing in general.

(b) Treating incarcerated patients at area hospitals – Area hospitals provide direct patient care and access to complex health care treatment and services for people in custody who cannot be medically treated at the infirmary in ECCF. While best practices in the management and treatment of medical conditions for incarcerated patients hospitalized in an acute setting are limited,[44] it is recommended that clinicians and hospital staff receive dedicated training in caring for patients who are incarcerated "to balance the rights of the patient, responsibilities of the clinician, and safety mandates of the institution and law enforcement."[45]

An inmate patient may arrive at an area hospital for emergency care from pre-booking at ECCF, immediately after arrest in the community or held in custody. However, there are obstacles to the proper navigation of the Health Insurance Portability and Accountability Act (HIPAA) about using and disclosing protected health information (PHI).[46] The treating facility may disclose PHI to ECCF, which is necessary for the provision of health care services and to maintain the health and safety of the inmate patient, including to the officers that are responsible for transporting the inmate patient[47] to law enforcement at ECCF, or to other security personnel to ensure the safety and maintenance of the inmate patient. As such, disclosing PHI exempted under HIPAA should be managed and coordinated with Dr. Anicette at ECCF.

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[44] Peteet T, Tobey M. How should a health care professional respond to an incarcerated patient's request for a particular treatment? *AMA J Ethics*. 2017;19(9):894-902.

[45] Haber LA, Erickson HP, Ranji SR, Ortiz GM, Pratt LA. Acute care for patients who are incarcerated: A Review. *JAMA Intern Med*. 2019;179(11):1561-1567. doi:10.1001/jamainternmed.2019.3881

[46] U.S Department of Health & Human Services. Other Administrative Simplification Rules. HHS.gov. Retrieved from: https://www.hhs.gov/hipaa/for-professionals/other-administration-simplification-rules/index.html. Accessed February 24, 2022

[47] Bednar AL. HIPAA's impact on prisoners' rights to healthcare. Retrieved from: https://law.uh.edu/healthlaw/perspectives/Privacy/030128HIPAAs.pdf. Accessed November 19, 2021.

Another challenge between area medical facilities and ECCF is sharing records between institutions. ECCF's EMR is Centricity, which may differ from the EMR at the receiving institution. The lack of EMR interoperability between the jail and the receiving institution is a specific challenge actively being solved with at least one area hospital. Facilitating continuity of care from ECCF to the receiving healthcare institution is critical. Better coordination and communication between clinicians at an outside treating facility concerning discharge and identifying follow-up need with the receiving Medical Director, Dr. Lionel Anicette at ECCF is needed. An added barrier to continuity of care of ECCF's inmate patients are scheduling medical appointments at area outpatient practices in the community. Medical providers at ECCF report facing many challenges when scheduling appointments for an inmate in need of specialty care - wait times were dangerously long, from a few weeks to several months.

Another barrier to continuity of care of ECCF's inmate patients is scheduling medical appointments at allied hospitals. Medical providers at ECCF report facing many challenges when scheduling appointments for an inmate in need of specialty care; wait times were dangerously long, ranging from a few weeks to several months.

(c) Difficulties obtaining medical records from the community – Medical history is discerned through self-reporting during the initial screening and intake process. The fragmentation of care in jails from community health providers results in disjointed health care services, treatment, and delivery for inmates returning from jail to the community. The jail health providers have little knowledge of their inmates' care in the community and vice versa. There is a need to expand the adoption of a centralized EMR across systems [e.g., hospital to jail, or community provider to jail]. In addition, the development of a health information exchange is urgently needed to ensure continuity of care upon release from jail. Linking information systems across the different medical and health care systems (i.e., hospital, community providers, and the jail) requires addressing technical issues more broadly, and cooperation across all governing agencies and stakeholders is necessary.

(d) Time pressures and negative impacts on care – While bail reform has substantially reduced the number of people held in custody, the shorter incarceration intervals, unintentionally, have complicated care for inmates with chronic medical conditions. While incarceration presents a

unique opportunity to address inmates' medical, physical health, and mental health needs. Upon release, most are discharged without confirmed medical appointments in the community.

Chapter 5 Mental Health

Figure 19

KEY POINTS

1. The current prevalence rates of mental disorders within the jail far exceed the ability of existing staff to provide evidence-based treatment.
2. Only eight mental health staff members provide mental health services to over 2,000 inmates.
3. Structural issues hinder the implementation of improved mental health services within the jail.
4. Those with forensic status and individuals housed in Unit 2B1 are held in different housing units. This creates logistical challenges, such as coordinating different recreation times for this group and hindering constructive social interaction.
5. There is only one forensic mental health facility that accepts mentally ill patients with a history of violent crimes, and wait times for patient transfer from ECCF are long.

6. There are difficulties surrounding the discharge of inmates with mental disorders – mainly due to shorter incarceration periods and the time of day when the the individual is being released, which presents challenges to securing care in the community prior to their release from the facility.
7. There is a need to implement validated, evidence-based screening instruments for most psychiatric disorders.
8. With the current system in place, inmates with the most acute needs are seen regularly, while those in the general population without emergent needs do not receive access to regular therapy sessions.
9. There is an urgent need to construct another mental health unit designed for inmates with mental disorders. A separate mental health unit would allow for creating a therapeutic mental health environment where fewer restrictions are in place in isolating inmates from one another. They would then be able to interact and empathize with one another due to commonly lived experiences.

Table 3. Mental Health Department Staff Composition

Mental Health Department Team

Work Schedule	Professional Type	Race/Ethnicity	Sex
Full-Time	Mental Health Director	Black/African American	Male
Full-Time	Psychiatrist	White	Male
Full-Time	Mental Health Clinician	Black/African American	Male
Full-Time	Mental Health Clinician	White	Male
Full-Time	Mental Health Clinician	Mixed Race	Female
Full-Time	Mental Health Clinician	Hispanic/Latino	Male
Full-Time	Mental Health Clinician	Hispanic/Latina	Female
Full-Time	Advance Psychiatrist Nurse (APN)	White	Male
Part-Time	APN	Asian	Female
Part-Time	**Vacant**		

The Mental Health Department of ECCF consists of eight individuals, including one full-time Mental Health Director who is a licensed Clinical Psychologist. Five Masters-level licensed mental health clinicians; one full-time Psychiatrist; one full-time APN; and two part-time APN's, each work one day per week, with one of these positions being currently vacant. Onsite clinical services are available seven days per week. The Director of the Mental Health Department and Psychiatrist provide coverage 24 hours a day, seven days a week. The Mental Health Department staff responds daily to the various requests for counseling and other treatment needs in the jail population.

Screening and Diagnostics of Mental Disorders

Mental disorders are first documented in the initial self-report intake screening form during the admissions process. The inmate is asked a series of questions concerning their mental health status, suicide risk, substance abuse, and propensity toward violence and aggression (see Appendix 3). When the intake staff decides that an inmate is in acute need, the mental health staff will be called immediately to assess the inmate further. Even where the mental health need is determined not to be acute based on the inmate's behavioral presentation and responses to the mental health questionnaire form, the inmate is still referred to mental health staff for other screening and evaluation by a Masters-level clinician.

In addition to the first mental health screening completed during the custody admissions process, each inmate is seen by another mental health clinician within 72 hours for further mental health assessment. Furthermore, the Mental Health staff reviews the electronic medical records through Centricity to determine whether earlier mental health or medical history records exist. Other health care staff and correctional police officers may also report changes in an inmate's behavior to mental health staff. The inmate may be referred to the Psychologist or Psychiatrist for further assessment based on these outcomes.

Treatments Available for Inmates with Mental Disorders

Inmates with mental disorders are treated with antidepressants, antipsychotic medications, anxiolytics, stimulants, benzodiazepines, etc. In addition to medication provided to the inmates with mental disorders, inmates take part in individual and group treatment, crisis intervention, brief psychotherapy, grief counseling, and occasional family counseling. Counseling sessions are provided to inmates emotionally and behaviorally stable enough to engage in a group format. Group treatment has been limited due to the need to reduce the spread of COVID-19 infections at the facility. Inmates on psychotropic medications are seen by the Psychiatrist or the Mental Health Director within 30 days for evaluation, and most are treated by the psychiatry staff routinely.

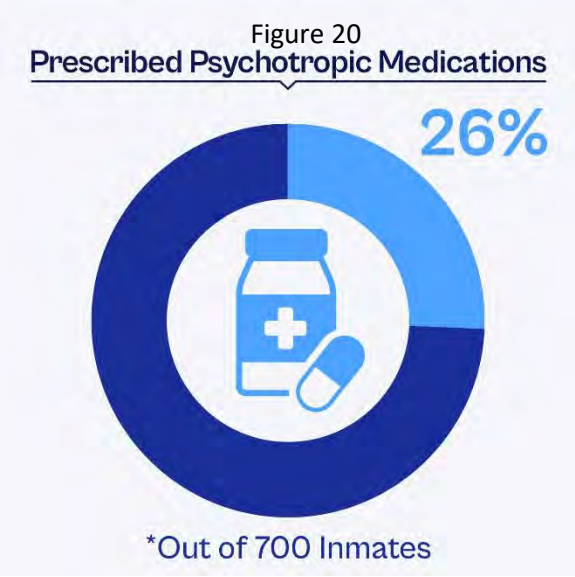
Prescribing sedatives or chemical restraints to any person with acute or severe mental disorders is against ECCF policy and procedures. Instead, inmates with acute or severe mental disorders are seen by the attending Psychologist or Psychiatrist. The inmate will be evaluated to

determine the appropriate mental health diagnosis and are treated with intensive counseling and assessed to determine whether psychotropic medications and treatment are needed.

At ECCF, there is no administrative segregation policy for inmates that pose a danger to themselves. When inmates are in a "mental health crisis" and are considered a potential danger to themselves (i.e., they are suicidal), one of the mental health protocols is to place an inmate on a mental health observation status *(Constant or Close Watch).* Inmates are placed in a single cell; sometimes this includes moving the inmate to another cell by themselves, and other times, their cellmate is moved out. Based on the level of clinical concern about self-harm while an inmate is on observation status, a clinical mental health decision is made regarding (1) what items of clothing an inmate is allowed to have; and (2) whether they are permitted to have eating utensils, as certain articles of clothing and certain eating utensils can both be used to self-harm. Inmates are never forced to be naked in their cells.

While on observation status, inmates deemed a risk to themselves are issued a mattress. If a clinical decision is made that having regular clothing is not safe during the observation status placement, inmates are issued safety gowns and blankets. Inmates on observation status are assessed by mental health staff at least once every day while on that status. Inmates on observation are allowed recreation time where it is deemed to be safe for both inmates and officers. In some cases, there are inmates who are not stable enough to come out of their housing unit for more than one hour for their showers or recreational time.

Prevalence of Mental Disorders at ECCF



Approximately 24% of inmates in U.S. local jails have a mental disorder diagnosis.[48] At ECCF, at least 30% of inmate's self-report and/or show criteria for a mental disorder. Of those, 26% (n=700) have a mental health diagnosis where they are prescribed psychotropic medications by the Psychiatrist and APN staff (Figure 20).

Approximately 75% (n=525) of the inmates with mental health diagnoses have a co-occurring disorder, and most often, the co-occurring diagnosis is related to substance use disorder. In addition, studies have shown that people with substance use disorder are also likely to have co-occurring psychiatric illnesses leading to an overrepresentation of otherwise rare and highly sensitive pathologies, such as schizophrenia, within a jail system.[49,50]

[48] James DJ, Glaze LE. Bureau of Justice Statistics NCJ 213600. Office of Justice Programs. *Mental Health Problems of Prison and Jail Inmates. Published online 2006*.

[49] Ramsay CE, Goulding SM, Broussard B, Cristofaro SL, Abedi GR, Compton MT. Prevalence and psychosocial correlates of prior incarcerations in an urban, predominantly African American sample of hospitalized patients with first-episode psychosis. *J Am Acad Psychiatry Law*. 2011;39(1):57-64. Accessed February 28, 2022.

[50] Munetz MR, Grande TP, Chambers MR. The incarceration of individuals with severe mental disorders. *Community Ment Health J*. 2001;37(4):361-372.

Types of Psychiatric Diagnoses at ECCF

The most prevalent psychiatric diagnoses at ECCF are the following, ranked in order from most frequent to least frequent: Major Depressive Disorder (with anxious features, paranoid features), Schizophrenia, Schizoaffective Disorder, Mood Disorder (with psychotic features, anxiety/depressive features), Anxiety Disorder, Post-traumatic stress disorder, Delusional Disorder, and Various Substance Abuse Disorder.

Forensic Mental Health Units

The Department of Mental Health oversees the Forensic Mental Health Units at ECCF. The jail currently offers Forensic Mental Health Units for inmates with severe mental disorders. Inmates are separated from the general jail population for mental health, medical, disciplinary, and/or protective reasons. Frequently, inmates with disciplinary issues will still be permitted cellmates. A suicide prevention cell can be any cell in the facility.

Typically, inmates are transferred to 2D1 or 2D3 pods for mental health observation when space permits. Otherwise, they stay in their housing units. Those cells are single cells and are all the same size. ECCF has 16 beds and two cell units in the Infirmary used for suicide prevention. Inmates are held in a smaller cell; the cell holds a bed, sink, toilet, and a tinted window, and meals are delivered through a port in the door. There are two types of overhead lights in each cell unit.

One overhead light stays on from 6am-10pm, and the night light is switched on from 10pm-6am. The main light in each tier main hallway is switched off from 10pm-6am. Forensic inmates are in lockdown for 23 hours per day, and they are released from their cells for an hour each day to exercise. The exercise room is another walled area.

Four Level System - Figure 21 describes the four-level system. The jail uses a four-level system that allows the entire facility to be aware of inmates' special needs and circumstances, and these inmates are managed accordingly. At this time, according to a December 14, 2021, communication with Dr. Jason Fleming, there are 67 inmates at ECCF who have Mental Health Forensic Status within the following levels: Level 1: 23; Level 2: 28; Level 3: 13, and Level 4: 4 [Transferred to Unit 2B1 (step up from Level 3, Special Needs general population status)].

Figure 21

Progression up and down the Four Level System is determined by the consensus of clinical reviews made by Dr. Jason Fleming and the Mental Health clinical team.

Inmates who progress up and down this system are closely monitored daily by mental health staff. Any adjustments in inmate level are communicated through clinical evaluations to the custody staff, who coordinate the physical movement of the inmate from one unit to another unit or from cell to another cell. Changes in level also affect the inmate's recreation schedule, with higher levels receiving recreation time with more lenient standards. For example, level 1 inmates receive recreation individually for safety reasons.

Discharge Process Related to Mental Health

The difficulties surrounding mental health carry into discharge requests as well. For example, suppose an inmate with a psychotic disorder is prescribed medication such as lithium which operates within a narrow therapeutic index. In that case, they are given treatment and stabilized within the jail. However, they must: (1) consent to treatment and (2) be detained within the facility to receive treatment. When an inmate is released and has a serious mental health disorder, the mental health team is consulted regarding medication needs or additional considerations that should be made. When an inmate is believed to be at serious risk to themselves at the time of release, the decision can be made to send them to an area hospital for subsequent evaluation.

When an inmate is released within normal business hours, the Mental Health Director, Dr. Jason Fleming is responsible for reviewing certain items related to their discharge. He will check their chart and medication list, attempt to discharge them with three- or four-days' worth of medication and connect them to outside mental health treatment services. This process may be disrupted if the individual is released on the weekend, late at night, or early in the morning when a team member is not available to consult the inmate.

Before COVID-19, upon detention at ECCF, inmates had their Medicaid immediately canceled, making even those with some level of healthcare access before jail time lose medical treatment. Inmates with mental health issues who are uninsured are taken to a hospital when they are (1) at severe risk of hurting themselves or others or (2) acutely psychotic and/or delusional. These factors are the only legal obligation in which a hospital or outside medical unit must see an uninsured patient for mental health services. Hence, the framework for which sensitive psychotropic medications, such as lithium and other mood stabilizers, are required to be effective in preventing lapses in psychiatric illness does not exist for patients outside of jail.

Reflections on the Mental Health Department at ECCF

Treating mental disorders at a county jail is filled with increasing levels of complexity. What is known is that the mental health staff currently working at ECCF is one that is incredibly diverse, passionate, and caring toward the needs of their inmate patients. The reality of the system is that pharmacological treatment for mental disorders can be readily administered to any inmate who requires treatment. ***However, aspects such as group therapy, counseling services for less acute patients, and any therapeutic benefits can under no circumstances be reasonably fulfilled at the current level of staffing and framework of the jail.***

Conclusions and recommendations identified include the following:

1. ECCF is not designed to facilitate a therapeutic environment for varying degrees of mental disorders. In addition, it is not built to support therapy on a scale large enough to service inmates in a group setting. Before COVID-19 restrictions, the mental health director shared limited space in his facility to conduct group therapy.
2. There are inmates scattered throughout the jail who are on a forensic status. This designation is given to those with high profile cases for more serious crimes, such as murder, or those with a severe psychiatric illness. They would not do well psychologically with the general population.
3. This forensic status may extend to inmates identified as LGBTQ+ who may not do well amongst the general population for safety reasons and require specialized care, and more staffing resources may be needed.
4. A unique housing unit that houses only those with mental health needs does not exist with the current restrictions.
5. Inmates with mental health needs are being placed in cells throughout the jail, which becomes a logistical challenge. They may often require their own break time, be separated from other inmates, and require correctional officers to manage inmates with severe mental disorders within the general population.

6. Jails are increasingly housing people with severe mental disorders with minor criminal offenses. This change has forced correctional officers to attempt to identify someone experiencing a mental health crisis despite lacking proper training.
7. If space and resources were not a problem, one therapeutic intervention that would be ideal for the jail would be building another mental health unit explicitly designed for inmates with mental disorders.
8. A mental health designated unit would create a therapeutic environment where fewer restrictions need to be made in isolating inmates from one another.
9. **Current screening tools designed by the facility present a limitation. They are not subject to rigorous reliability and validity studies and, therefore, may create poor measurement accuracy, which has treatment and care management implications.**

Challenges and Barriers to Treating Inmates with Mental Disorders

Dr. Jason Fleming states that his biggest challenge surrounding providing mental health services at ECCF is that his team currently deals with inmates with acute mental health cases (including psychotic, suicidal, or chronically mentally ill). Additionally, he supervises only eight mental health staff members. They are responsible for providing mental health treatment services to over 2000 inmates, at least half of whom have a mental health diagnosis. Of those diagnosed with a mental health issue, 800 are on psychotropic medications. About 100 inmates have a severe mental disorder that is not well managed, with some of these inmates refusing to take psychiatric treatment medications. Therefore, it is impossible to stabilize, manage, and supply time-intensive services, such as counseling, to the general population of inmates who do not have mental disorders.

Specifically, there are only four state-run psychiatric hospitals in New Jersey due to earlier deinstitutionalization policies. Only one accepts severely mentally ill patients with a history of violent crimes. Bottom-line, there are numerous procedural challenges with linking forensic patients to the appropriate level of care, and there is essentially one 200-bed hospital to which the jail can transfer these patients, especially the most complex among them.

As mentioned before, inmates at ECCF are under no legal obligation to follow medication suggestions made by medical professionals. Where inmates are considered too mentally ill to stand trial or where they are pleading insanity, then these inmates are civilly committed to treatment. They constantly go back and forth between the jail and a forensic psychiatric facility. The procedure to be civilly committed is a lengthy process. It takes about six months for motions to be filed with the appropriate medical documentation and a judge hearing. It then takes an additional two months for the psychiatric director of the primary psychiatric facility to which ECCF patients are transferred to review all the documents and reach a resolution. Most cases that require transfer to this facility, therefore, remain in ECCF because there are no beds available at the 200-bed hospital.

At any given time, about 60-70 of these beds are occupied by ECCF. When transferred, the inmate is evaluated for competency for thirty days. This forensic hospital is not a long-term mental health housing facility. Instead, people who stay there are supposed to be stabilized enough to stand trial and taken to court. A patient being transported to such a forensic hospital is not synonymous with someone receiving crucial mental health treatment. As mentioned earlier – it may be a way for their lawyer to attempt to test their competency for court hearings.

Summary

ECCF has a high prevalence of inmates who are acutely psychotic, noncompliant with medications, and unable to be transferred to psychiatric hospitals due to capacity issues. This has created circumstances where socially uncanny behaviors such as smearing feces have been popularized in headlines as signs of inhumane conditions that inmates with mental disorders are being housed in within the jail. The pathophysiology of mental health processes are not ones that typically present with someone displaying such acts, however. Those who are severely psychotic are more likely to be starving, quiet, and talking to themselves rather than engaging in acts of gross insubordination due to the very nature of their severe psychosis.

IMMEDIATE RECOMMENDATIONS

Increase the number of mental health staff members to a minimum of five more mental health clinicians (such as licensed social workers, PhD forensic psychologists, etc.) to effectively manage the need for care and treatment of inmates with severe mental disorders. It takes the burden away from the four psychiatric hospitals that are not equipped to handle this large number of people in custody with severe mental disorders.

Chapter 6 Medication Assisted Treatment Program – Medication for Opioid Use Disorder (MOUD)

Key Points

1. Prior to the MAT program, overdoses occurred 2 to 3 times per week; the current overdose rate is 0.
2. MAT treatment includes: suboxone oral/injectable, Vivitrol oral/injectable, Gabapentin and long-acting opioid antagonists via injection.
3. One full-time nurse and MAT officer in charge of distribution of medication on daily rounds in the jail.
4. Recidivism rate in jails and prisons in New Jersey is 30% vs. only 18% among those in the ECCF MAT Program.
5. A single instance of recidivism can cost a taxpayer $31,286 per year.

Figure 22

Before the MAT program, the inmate overdose rate for opioids was two to three times per week. Since implementing the MAT Program at ECCF in April 2020, ECCF has had zero inmate overdoses. The State of New Jersey funds the MAT program, **and CFG is the vendor providing medical and treatment services to inmates with MOUD.**

Overall Structure of the MAT Program

The MAT program aims to provide treatment to people in custody identified through pre-booking and intake to have an Opiate Use Disorder or Alcohol Use Disorder. This section will describe department staff composition and the MAT program at ECCF, briefly described below.

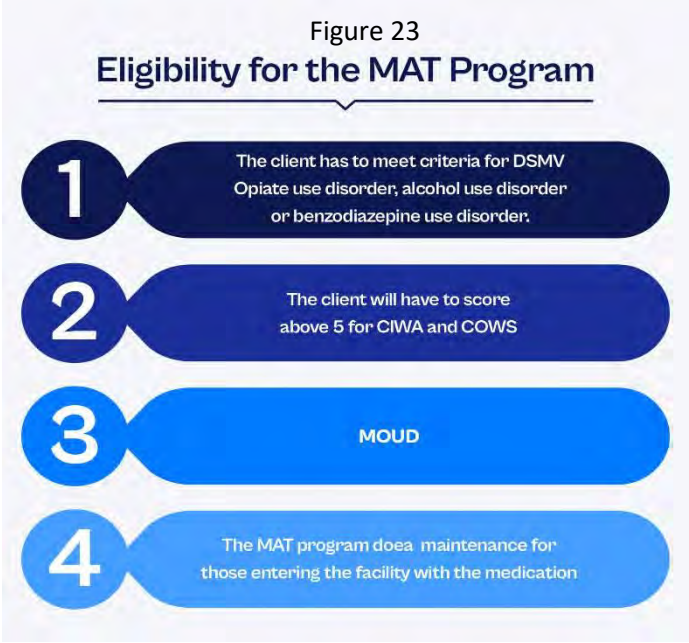
Table 4. MAT Department Staff Composition

Work Schedule	Professional Type	Race/Ethnicity	Sex
Full-Time	MAT Coordinator	African American/Black	Female
Full-Time	MAT Officer/Patient Navigator	White	Male
Full-Time	Discharge Counselor	African American/Black	Female
Full-Time	Registered Nurse (RN)	African American/Black	Female
Full-Time	Peer Recovery Specialist	African American/Black	Female
Full-Time	Case Manager	Hispanic/Latina	Female
Full-Time	Substance abuse counselor	African American/Black	Female

The MAT team includes: one full-time MAT Officer (who is also the Patient Navigator stationed within the team); one full-time discharge counselor; one full-time RN nurse; one certified peer recovery specialist; one full-time Case Manager; one full-time MAT Coordinator (who oversees the program); and one substance abuse counselor. In the coming months, a full-time addiction-based psychologist will be added to the team to promote treatment groups and therapy for participants of the program. The roles within the MAT program are fluid, and its success hinges upon the benevolent calling many of its staff feel toward the cause of addiction treatment.

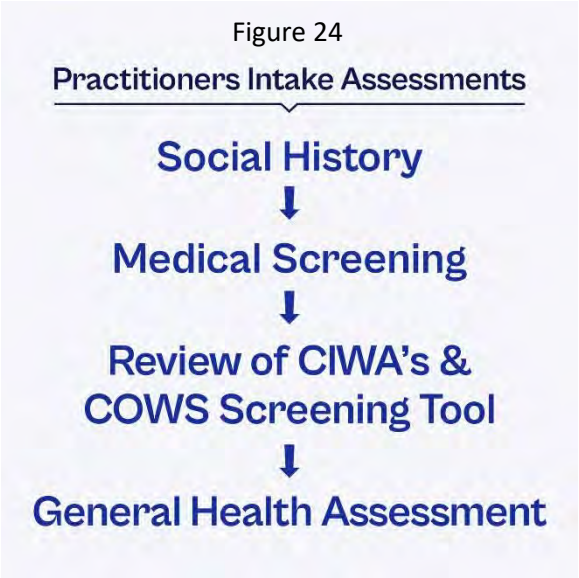
The MAT program is a new, grant-funded initiative that began in 2020, and its capacity has expanded substantially – ultimately serving 120 patients as of 02/01/22. Recently, the program has grown to include more funding from the Comprehensive Opioid, Stimulant and Substance Use Program (COSSAP), funded by the U.S. Department of Justice. The COSSAP grant will hire two peer recovery experts, one substance-abuse counselor, and one assistant nurse practitioner. Although hiring and onboarding are still pending, the capacity for the program will be 250 inmates once the new system is established.

Figure 23



Eligibility Criteria - Inmates who meet eligibility criteria for the MAT/MOUD program will be referred to the medical practitioner for medication consultation (*see Figure 23*). The medical practitioner discusses the MAT/MOUD medications, side effects of the prescribing medication, and dosage.

Figure 24



MAT Intake Procedures

Intake for the MAT program is conducted during intake upon admission to the jail. Before meeting with the inmate, the MAT Team reviews the inmate's Nurse Assessment and the Practitioner's Intake Assessment (*see Figure 24)* and meets with the inmate to complete other questionnaires. Consent forms are included within this form. The MAT Team has up to three days to meet with the inmate and decide program eligibility for either MAT/MOUD program. When an inmate is identified during the intake and release process to have Opioid Use Disorder, they meet with staff at the MAT program. They are asked questions well beyond their medical condition and into the territory of social work – specifically, inmates are asked for contact information for follow up when they are released.

Admission Office

Figure 25

The discharge coordinator begins developing a discharge plan when the inmate is admitted to the program, typically on the same day. The discharge plan includes community resources for housing, therapy, treatment groups, and resources to help fulfill their medication requirements. It also consists of the phone number for the Officer/Patient Navigator in case of urgent needs.

Distribution of MAT on Daily Rounds

One full-time nurse leads the staff in charge of distributing the medication on daily rounds across the various housing units in the jail, including the special housing units. This process is necessary because it is logistically impossible to transport inmates with different security levels to one centralized location for medication administration.

Administering Naloxone/Narcan - Naloxone is a medication approved by the Food and Drug Administration (FDA) designed to reverse opioid overdose. Certain prison staff members carry Narcan on their person, including the Medical Director, Dr. Anicette, Lieutenant Camacho, the MAT Officer/Patient Navigator, and the nurses.

Figure 26

Ensuring Compliance

MAT inmates are administered medication at their bedsides in their housing units. Special procedures are in place to control deviation, including marking the medication cups with a different label every day, observing that the patient has placed the pill underneath their tongue, and confirming that it has been swallowed. After that, staff will stay for a few minutes longer to verify that no immediate attempts are made to deviate from treatment. As shown in Figure 26, despite this, the program has a 65-70% compliance rate with noted cases of deviation, including hiding the medication in a tooth abscess, inducing vomiting, and scraping residue from the tongue. These attempts are conducted to sell the medication in a jail market to inmates who do not use substances yet desire any semblance of a high.

Options for MAT

Options for medication administration are extensive. Various options for treatment include buprenorphine, suboxone, the long-acting injectable antagonist Vivitrol (naltrexone), and Methadone. While Gabapentin is not an MAT treatment, it is one of the added treatment options provided. The MAT Program has a designated provider who delivers Methadone, and an

addiction's specialist handles the consults. The once-monthly injectable Vivitrol is notable for its cost, with the list price exceeding $1,000 per month.

It should be noted that although long-acting injectable antagonist Vivitrol is offered to anyone eligible, only about two or three inmates choose this option due to fears of needles. Furthermore, this choice is rarely taken, as individuals have purposely avoided compliance with MAT treatment when they know they are close to being released pending a court hearing. Special efforts within the program have been developed to reduce these instances and promote linkage to step-down care facilities when inmates are released and on the MAT program. This system has the pharmaceutical treatments necessary to treat whatever level of addiction an inmate may present with; even if an inmate has an addiction that extends beyond opioids, it is still managed by the MAT team.

The most significant barrier to care in this setting is the lack of incentives or motivation to administer a monthly injectable due to bail reform potentially letting inmates with Opioid Use Disorder out sooner rather than later. The inability to release inmates with a long-acting medication opens a considerably smaller margin for error given the previous discussion on the limited prescription of opioids to inmates for 3-4 days upon release.

Counseling – Due to COVID-19, group therapy has been temporarily discontinued. Inmates, however, are given the opportunity of speaking with a peer counseling service for 45 minutes in addition to their usual phone call and recreation time; any other factor does not affect the amount of phone time. According to the MAT officer, inmates can request this service during the hours they have access to the tablets, from 7 am to 9 pm.

Discharge and Jail Release Procedures for MAT

The Discharge Planner. Each inmate on MAT completes a MAT Discharge Plan, and linkage to care is created before release. The Discharge Planner will contact the community provider to assess whether the released patient kept their appointment. Since the medication is a controlled substance, only a 3-4 days' supply is given upon release from jail to hold patients over until they can connect with treatment outside the facility. There have been instances where up to 7 days of prescriptions can be prescribed in exceptional circumstances. A script is faxed over to the

pharmacy from the facility.

As such, the released inmate should be bridged to the date of their appointment in the community. Before release, inmates are also asked questions about their ability to receive treatment, such as their housing location, transportation, and access to goods and services. The inmate release form from MAT is given with specific discharge instructions, including information for community partners, pharmacies, and other support programs that can supply things like housing, food, and peer support convenient to their needs. This discharge plan takes time to formulate. The goal is to have this completed the same day or within 24 hours of an inmate being sent to ECCF.

However, because of the shortened jail stay times due to bail reform, inmates are released at odd hours in the morning or during the night, which affects the creation time periods of discharge plans. In worst-case scenarios, inmates on MAT released without a discharge plan completed by their time of release are discharged with a sheet of paper that lists all the community partners.

Several Barriers

1. Inmates must be released from jail and have access to a mobile device of their own to contact staff at the MAT program or connect with a community resource.

2. Once an inmate is released, s/he needs to have the motivation and the desire to stay off the substance for long enough to begin seeking care outside of the jail.

3. ECCF should not rely on one person (the MAT Officer/Patient Navigator) to manage calls after hours; added support for this coverage is needed.

Patient Navigation of MAT Participants

The MAT Officer/Patient Navigator has personal experience and is currently pursuing a doctoral psychology degree. This unique experience has empowered him to advocate for a role within the jail as a patient advocate.

After release, he contacts each inmate to check up on them; he has taken on this responsibility outside of his regular position and responsibilities and is not compensated for this effort. He will stay late at work at other times and has gone as far as to purchase a previously mentioned work phone. To combat the problem of patients on MAT being released without support, there is a public database with case information for inmates. Specifically, the MAT Officer/Patient Navigator checks public domain websites with details on inmate release times. He tracks whether someone is scheduled for release or supposed to have a court hearing outside of business hours and tries to work from outside of the jail to ensure they have services. By keeping track of the inmate's court hearings dates, the staff has begun checking for potential release information and planning accordingly to prevent lapses in treatment.

The MAT Officer/Patient Navigator has been tracking the released patients from the MAT program since 2020. His work phone is shared alongside the discharge instructions for program participants. Upon release, they are instructed to contact the MAT Officer/Patient Navigator if they need support, need to be connected to a resource center, or have relapsed. Inmates in the MAT program has a stellar rapport with the MAT Officer/Patient Navigator, so they know his daily work schedule, sleep habits, and lifestyle. He reports he has not received a phone call late at night due to the respect that inmates have for him – they will opt instead to call in the morning if they need help.

Figure 27

Figure 27 describes MAT follow-up intervals. The combination of the trust provided, and the team members' dedication contribute to the stellar record of the program. To date, the program has released 301 people. Of those, 56 have returned. Inmates are contacted through a personal phone number or a relative's number where they can be reached. There is a high rate of patient follow-up. In January 2022, which was reportedly a slower month for the

program: 13 inmates were released, and only one person had relapsed. An average of about 20 people are released every month. The relapse rate for the MAT program is less than 20% (see Figure 28).

Figure 28

Establishing Community Partners

Connecting with community partners includes a zoom call with staff to discuss MAT program participants' needs, characteristics of the population being served, and the expected size and scope of services to be provided. *Special attention during these calls is paid to how organizations treat uninsured patients, which is concluded by a site visit where staff sees the facility's conditions*. Once approved, a memorandum of agreement is signed, and that provider is added to the list of partners.

ECCF plays an interesting role within this framework. Often, inmates spend more time in treatment in the jail than they do with the community partners. After being released, and when an inmate is found to have treatment lapses, a community provider will often call someone at the MAT program and ask them to follow up with that individual. The success of the MAT program is primarily due to the rapport that the MAT team has developed with inmates before release. MAT also can address inmate complaints about community partners through audits.

Challenges to Effectively Adopting an MAT Program in the Correctional Setting

1. The sole nurse in the MAT Program is a female who poses a safety and security risk when distributing MAT medication in the housing units. She has been verbally harassed and defended by the MAT Officer/Patient Navigator on multiple occasions as they enter each pod to administer treatment.
2. Group therapy has been suspended following the onset of COVID-19 restrictions.
3. The sheer need for treatment coupled with a small staff makes for a higher risk for employee burnout – the MAT team, like most other medical units at the jail, is in desperate need of more staffing as they navigate the present reality.
4. MAT staff does not have VPN access to the medical record system once outside the jail. This lack of access to crucial information through a secure link, phone, or tablet device makes it difficult to know when an inmate is released outside of business hours. It is even harder to coordinate a treatment plan specific to them should this happen.
5. MAT inmates discharged late at night are released with a bus ticket and a script sent directly to a pharmacy near the jail. For many, this scenario sets them up for relapse, as they are released without access to the MAT team and oftentimes after hours when pharmacies are not open for them to pick up their medicine. If they can pick up the script, it should be noted that as a controlled substance, only a three to four days' supply is given upon release from the jail to hold patients over until they can connect with treatment facilities outside of ECCF. There have been instances where inmates were prescribed up to 7 days of medicine; these are exceptional circumstances, however.
6. Inmates are released at irregular hours. Staff and funding requirements do not allow an overnight member to work the third shift. Some discussion has

been made about introducing a phone in the lobby of the jail for inmates to be able to call MAT Officer/Patient Navigator.

ECCF was not built to provide services like a well-funded outpatient addiction clinic, but they are being tasked to do so with limited funding, staffing and a strict set of laws and regulations which medical staff must constantly navigate to be able to administer treatment for safety reasons.

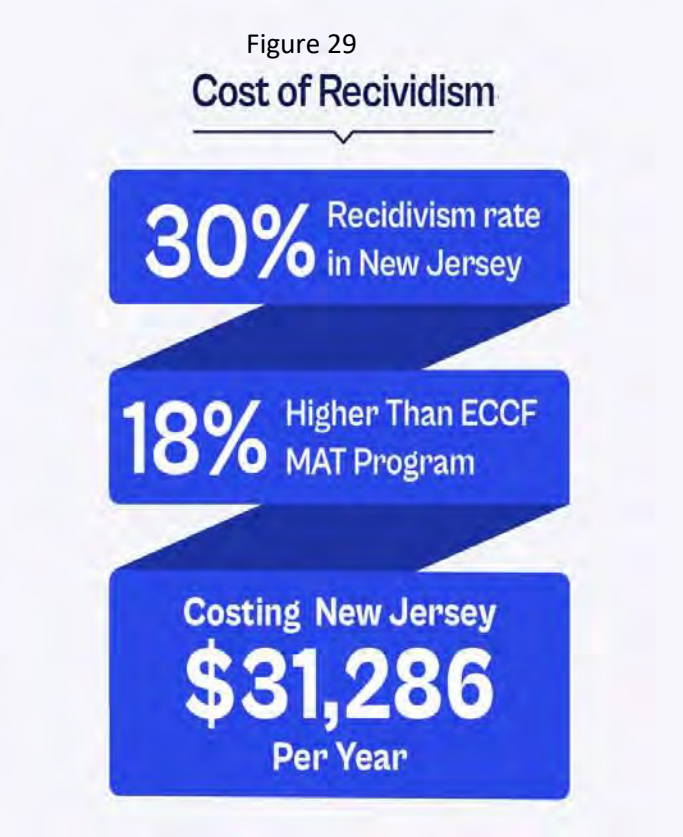
Return on Investment of MAT

This program has significant financial cost-saving effects on the state. For example, an ambulance ride to a local medical facility was around $22,000. Before the program was established, the trafficking of illicit substances into jail was more widespread, and overdoses occurred 2 to 3 times per week. Moreover, each time a person in custody would present with withdrawal symptoms, they would need to be transported to an area hospital as the treatment could not be administered in the jail.

The Cost of Recidivism

The recidivism rate in New Jersey is 30% higher than ECCF's MAT program recidivism rate of about 18%.[51] Each case of recidivism costs New Jersey taxpayers, on average, $31,286 per year (Figure 29). However, a study conducted in Illinois noted that the actual cost of single recidivism could cost taxpayers more than $150,000.[52]

Figure 29



[51] Recidivism rates by state 2022. Worldpopulationreview.com. Accessed March 1, 2022. https://worldpopulationreview.com/state-rankings/recidivism-rates-by-state

[52] Illinois Sentencing Policy Advisory Council. The High Cost of Recidivism.; 2018. Accessed March 1, 2022. https://spac.icjia-api.cloud/uploads/Illinois_Result_First-The_High_Cost_of_Recidivism_2018-20191106T18123262.pdf

IMMEDIATE RECOMMENDATIONS

1. Supply secure, program-sponsored mobile devices for the staff and create an official, paid, on-call schedule for staff to be at home and monitor non-conventional inmate release times using VPN.
2. Access should be given via remote chart review to see whether a patient's discharge status has changed pending a court hearing.
3. Standardize the activity of jail programs to adopt inmate court monitoring and systems for contact following release to improve rehabilitation and success rates from substance use.
4. Address the suspension of Medicaid-related benefits following incarceration, as this poses a risk to the success of the MAT program should pre-COVID restrictions be reinstated.

Chapter 7 Social Services and Reentry

As stated in the Inmate Handbook, The Department of Social Services and Reentry *"responds to requests such as access to religious, counseling, probation and parole consideration, employment training, educational resources, and community housing, an alternative to incarceration programs, family assistance, hospital visits to critically ill family members, and court orders to provide for viewing and funerals. Attention is also given to ensuring inmates have access to the law library, recreation and resources, and spiritual and religious services and materials"* (page. 47).

The programs offered to inmates are the following: Rehabilitation Services; Alternative to Incarceration; Educational and Programming Services; and Referral Service.

Key Points

Partnerships with stakeholders are urgently needed to build a continuity of care framework beyond incarceration to prevent homeless, re-arrest, and overdose.

A request for "reentry services" should begin at intake to increase and promote continuity of care.

Vocational schools and universities/college partners are needed to provide education beyond basic skills remediation. What online programs can inmates take part in during their incarceration to gain skills and training?

Initiate programming services and counseling through video conferencing when the facility is experiencing lockdowns.

Create a Continuity of Care Unit where its sole focus is discharge, building partnerships, creating linkages, updating discharge resource guides, and ensuring that discharge paperwork is in place prior to release.

The Social Services and Reentry Staff Composition

The Department of Social Services and Reentry oversees six full-time staff (including ombudspersons and social workers) and two part-time staff members (group facilitators). Social Workers/ombudspersons are assigned to each housing unit and the Infirmary.

Table 5 Social Services and Reentry Team

Work Schedule	Professional Type	Race/Ethnicity	Sex
Full-Time	Director of Social Services/Reentry	African American/Black	Female
Full-Time	Assistant Director	African American/Black	Female
Full-Time	Ombudsman	African American/Black	Male
Full-Time	Social Worker	African American/Black	Female
Full-Time	Social Worker	Hispanic/Latina	Female
Full-Time	Group Facilitator	Hispanic/Latina	Female
Full-Time	Group Facilitator	Black/African American	Female
Full-Time	Group Facilitator	Black/African American	Female
Full-Time	Education Instructor	Hispanic/Latino	Male

Rehabilitation Services

Rehabilitation Services includes counseling, support, and recreational services and includes the following programs: (1) Religious Services, (2) Law Library and library books, and (3) Daily Recreation. A description of religious services is provided below.

Religious Services

Table 6. Religious Services Staff Member

Work Schedule	Professional Type	Race/Ethnicity	Sex
Part-Time	Spiritual Services	African American/Black	Female

Dr. Carrie Washington coordinates the religious services program and works part-time at ECCF (see Table 6). Dr. Washington is at the facility twice a week. Due to COVID-19, all worship and prayer services and multi-pods bible studies were suspended to minimize the spread of COVID-19. All individual pastoral care visits, confessions, and spiritual consultations conducted by the community clergy or lay volunteers were also suspended. One exception was made for the gatherings of Islamic adherents within the housing pods for the iftar celebrations during the April 23 – May 2020 and April 12 – May 12, 2021, Ramadan Observances.

As voiced on an unannounced tour of the facility to specific Task Force members and by Tier Reps, this has caused considerable hardship for persons who identify with certain faiths and desire communal worship activities. The facility should communicate with the inmates more regularly when group religious activities can safely resume in the manner, they had been conducted pre-pandemic. *ECCF should assess whether interim considerations can be made for small group activities with a volunteer clergy member present conducted safely and equitably*. The Office of Spiritual Services facilitates telephone calls and exchanges letters for inmates to talk with religious leaders. Bibles, Korans, Torahs, Bhagavad Gitas, materials in Santeria, Wicca, Satanists, Buddhists, Rastafarians, and other religions and spiritual beliefs are distributed throughout the facility.

Special Holidays and Special Feasts

Prior to the pandemic, approximately two holidays were celebrated each month so that all faiths and housing pods were included. With permission of the Offices of the Director and Wardens, the various ministry teams distribute cookies, candies, and ethnic treats to commemorate all inmates' religious and cultural holidays. In 2020 and 2021, all activities were curtailed. The

Islamic Society of Staten Island ministry team distributed special iftar meals throughout the facility during the April 12 – May 12, 2021, Ramadan observances, and the Liberty Church of Jersey City volunteers provided gifts for children of female inmates and cookies and candies for all the female inmates on December 18, 2021.

Special Events

In addition to weekly service, bible studies, and prayer meetings, the ministry team also conducts special sacraments for all faith groups according to inmates' requests.

Religious Attire

Persons who want to wear kufis or head coverings are given access to these items though they are not available in unlimited amounts. The facility staff exercises accountability and integrity in engaging respectfully around the distribution of such religious articles of clothing.

Religious Videos

As of January 24, 2022, various religious videos (Catholic, Baptist, Jewish, Muslim – Jumar) are being displayed on the housing units in continuous loops on Channel 49.

Second Chance Programs

Second Chance programs are provided at Delaney Hall. A community-based program designed to earn work credits, life skills, and reintegration. Delaney Hall is a privately-run facility designed to address the issues of substance abuse, criminogenic behavior, life skills, education, employment, and reintegration.

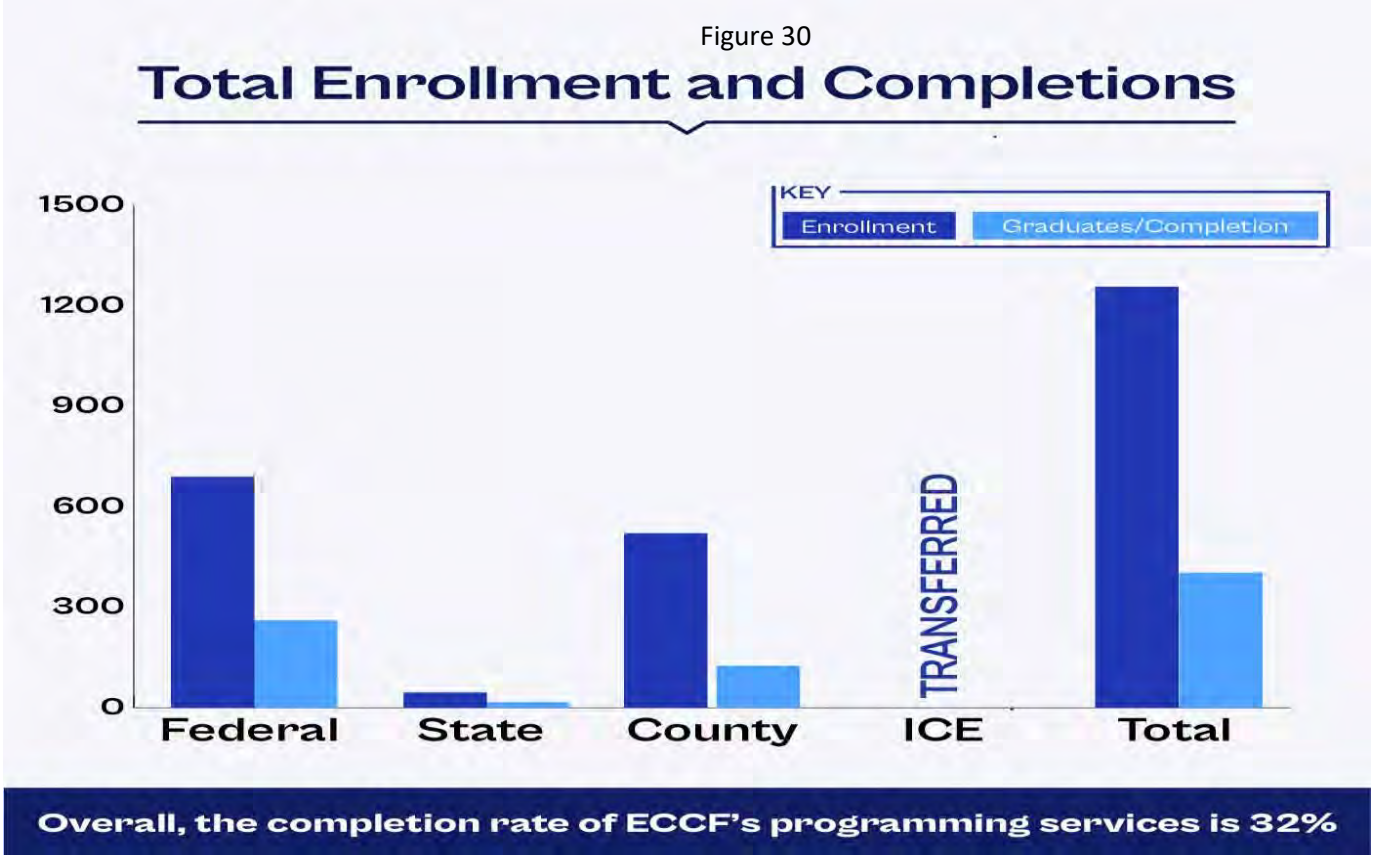
Educational and Programming Services

Educational opportunities are available at ECCF, including basic skills remediation, English as a Second Language, and GED preparation and testing. For those persons who successfully pass the exam, GED certificates are provided.

Programming pre-COVID-19 was group-facilitated, and classes were held five days a week, in the mornings, afternoons, and evenings. Examples of classes include Life Skills, Adult Basic Education/GED, Recovery, Anger Management, Women's Group, Trauma, etc. Each class includes 8-10 inmates, and groups are held at the housing units in the classroom. There are no groups or classes offered on Saturdays and Sundays. Below describes the population, enrollment, and graduation or completions in 2021:

Overall, the completion rate of ECCF's programming services is 32%.

Figure 30



The in-person groups that were started from October 2021– to December 2021 is described in Figure 31.

Figure 31

COVID-19 and the Omicron variant have changed how ECCF provides social services. All materials are given individually and are focused on independent learning.

Cancellations also affected social service programming. Reasons for canceling, suspending, or delaying groups in 2021 are described in Figure 32.

Figure 32

Referral Services

An Ombudsperson handles referral services, but the inmate must request that they need services before releasing from the facility. This is a missed opportunity. **From October 2021 – to December 2021, the number of inmates that requested reentry services were 8.**

Effective discharge planning can significantly prevent re-arrest, homelessness, and overdose. Similar to the MAT program, discharge planning activities should begin at intake. The data gleaned from the nurse and practitioner's intake should supply the basis for developing a discharge plan, particularly among inmates in ECCF for at least 30 days. At the very least, inmates should be given resources on housing, mental health, and other available community resources. A resource guide is provided to an inmate requesting it, but this policy is not based on best practices for preventing re-arrest, homelessness, injury, or overdose.

Access and social resources are critical factors in influencing released inmates from returning to jail.[53] These social resources include interpersonal networks, including family, friends, workplace, and community anchors crucial to reentry. A strong social support network promotes mental health and mitigates the burden of poor social ties and adverse experiences.[54] **An immediate solution is to set up a linkage-to-care vendor agreement with an established reentry organization to enhance continuity of care and ensure that inmates released at ECCF have practical opportunities outside the facility.** As inmates from ECCF return to the community daily, ECCF staff should immediately connect inmates to the community, religious, social, and medical services before release. Increasing social support, community support, and institutional support have been shown to lower the odds of psychological morbidity, overdose, homicide, homelessness, and suicide.[55]

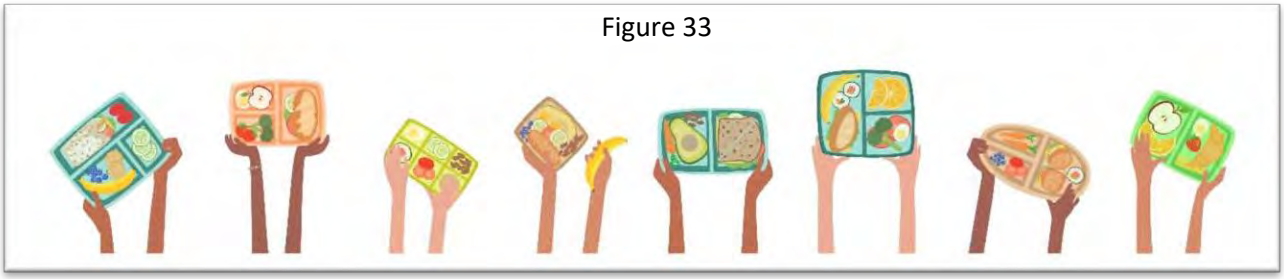
[53] Muñoz-Laboy M, Severson N, Perry A, Guilamo-Ramos V. Differential impact of types of social support in the mental health of formerly incarcerated Latino men. *American Journal of Men's Health.* 2013;8(3):226-239. doi:10.1177/1557988313508303

[54] Valera P, Boyas JF. Perceived Social Ties and Mental Health Among Formerly Incarcerated Men in New York City. *International Journal of Offender Therapy and Comparative Criminology.* 2019;63(10):1843-1860. doi:10.1177/0306624x19832239

[55] Maschi T, Viola D, Koskinen L. Trauma, stress, and coping among older adults in prison: Towards a human rights and intergenerational family justice action agenda. *Traumatology.* 2015; 21(3), 188–200. https://doi.org/10.1037/trm0000021

Chapter 8 Dining, Dietary Guidelines and Drinking Water

Figure 33



People in custody are concerned about access to quality and nutritious food, including fresh vegetables, fruits, and enough protein. At ECCF, one type of meal does not fit the entire inmate community. Some inmates require medical diets for chronic health conditions (e.g., renal diet, soft diet, liquid diet, low cholesterol diet, low salt diet, diets for persons living with diabetes are usually lower in carbohydrates and simple sugar, and a diet that is higher in calories and certain vitamins such as folic acid, iron, etc. for pregnant women, dairy-free or gluten-free diets) and on religious grounds (i.e., kosher or halal). ECCF does accommodate these requests. For example, a pregnancy diet includes a boost and milk with each meal. Lastly, ECCF does not have a specialized kitchen to prepare kosher meals, but it does include a kosher meal plan upon request. However, concerns have been raised around the availability of halal meals consistently.

Religious Diet Program

A certified religious food menu (e.g., Kosher, Halal) is provided. For example, during Ramadan, inmates taking part in the religious diet program receive approved lunch and dinner after sundown. In addition, during the eight days of Passover, inmates identified by religious services are given Kosher meals for Passover. (See Appendix 10)

Medical Diets

Medical diets are ordered by the medical team and are in place of the regular meal menu, and a registered dietician certifies all medical diet menus (see Appendix 11).

Meals

As a general policy (except for those on medical or religious programs), all inmates are served the same meals in their housing units. Meals are brought to the inmates in their housing units because ECCF does not have a cafeteria to feed the inmates. As a procedure, cold items and trays are placed into a refrigerator. The hot trays are removed about two hours before the meal, heated into a warming oven, and then served. **While procedures are in place to ensure food safety is maintained throughout the preparation, delivery, and service, inmates have complained their meals served are too cold. Some indicated that they are not getting enough food.** *ECCF may need to reexamine the best way to deliver meals to its housing units by considering the number of inmates served, the amount of food, the distance to transport the meals, and budget priorities.*

Dining Services

Gourmet Dining (Vendor Contract) has a contractual agreement to supply dining and nutritional services to ECCF staff, correctional officers, and inmates**.** Gourmet Dining is a food service company serving New Jersey, New York, and Pennsylvania.

All inmates are given three meals: Figure 34 displays the meal schedule. A jail commissary where inmates may purchase items such as snacks, food, clothing, and hygiene products is available to inmates (for a listing of items in the commissary, see Commissary List, Appendix 12). Individuals can use the money in their accounts to buy items from the commissary.

Dietary Guidelines

Federal guidelines on the dietary needs of Americans stem from the U.S. Department of Agriculture report on *Dietary Guidelines for Americans, 2020-2025.*[56] The predominant factors influencing dietary guidelines include sex, age, and physical activity. Averages are derived from aggregate estimates of the different body habitus seen in each age group, including sex, pregnancy, and individual needs will vary widely depending on a person's height and individual resting metabolic rate. For example, the general guideline for an adult (age 18-59) estimates 1,600 to 2,400 calories per day for females and 2,000 to 3,000 calories per day for males.

Figure 35

[56] Phillips JA. Dietary Guidelines for Americans, 2020–2025. *Workplace Health & Safety.* 2021;69(8):395-395. doi:10.1177/21650799211026980

Males need more calories than females simply due to larger body habitus and higher muscle mass on average. Due to reductions in basal metabolic rate that occur with aging, calorie needs decrease for adults as they age. Physical activity may also alter this range by a significant amount. For example, an 18-year-old male who is sedentary should only consume 2,400 calories per day, while a highly active individual of the same age can intake as much as 3,200 calories per day.

Race and ethnicity do not directly factor into the caloric recommendation, but it is known to affect nutritional status due to cultural diets, which are centered around calorically dense foods rich in carbohydrates or saturated fats. In addition, pregnant females may need added caloric intake due to increased metabolic demands, but most critically require an influx of varied vitamins and minerals to promote the healthy development of the fetus. These findings, when taken together, make noticeably clear the need to support inmates with sustainable access to rich and varied food sources.

For people in custody at ECCF, inmates are provided a diet of approximately 3,600 calories per day, well above the federal dietary guidelines of 1,600 to 2,400 calories per day for adult females and 2,000 to 3,000 calories per day for adult males.[57] The Essex County Commissioners mandated that ECCF provide an additional 1,200 calories to provide snacks and other comfort foods to prevent subjective complaints from the inmates of hunger.

Uber Streets

Inmates can order packaged meals or a food dish through the tablets, and the kitchen will prepare it for them. Examples of cooked meals from the ECCF kitchen that have been delivered to inmates have included hamburgers, pizza, and milkshakes.

[57] Phillips JA. Dietary Guidelines for Americans, 2020–2025. *Workplace Health & Safety.* 2021;69(8):395-395. doi:10.1177/21650799211026980

Figure 36

Water Quality

The water in ECCF is assessed annually, and ECCF water quality meets all federal, state, and local water quality standards. Water filters are replaced every six months. In addition, all water entering the facility is filtered and then filtered again at the housing unit. Unlimited bottled water is available to all housing units upon request.

Chapter 9 Technology

Key Points

1. Inmates are given two free 10-minute phone calls for 20 minutes per day.
2. Inmates have complained that they cannot make phone calls between 6pm-7pm.
3. Since the COVID-19 pandemic has resulted in suspending in-person visitations at ECCF, there is a need to expand video booths to include video visitation.
4. Wi-Fi signal is a problem in the housing units. Tablets are unable to connect to the internet, or the connection is slow. GTL is the technology vendor with a contractual agreement to supply phone service to ECCF inmates and the Tablets. Fusion is ECCF's WIFI vendor. Inmates are supplied two 10 free minute phone calls for a total of 20 minutes per day.

The COVID-19 pandemic has suspended in-person visitations at ECCF, causing increased frustration and anxiety among the inmates. Communicating with families, friends and attorneys is tremendously important and benefits everyone involved. However, inmates at ECCF have found it nearly impossible to maintain communication with people they care about. **Inmates have complained that they cannot make phone calls between 6pm-7pm. This has caused increased frustration and anxiety among the inmates. These issues have been raised with GTL and the Director, but the problem should be escalated further.**

Consistent phone calls sustain and improve family relationships, particularly among inmates with young children. With in-person visitations suspended, alternative forms of contact with family are critical to reducing the likelihood of anxiety and depression during incarceration.

Tablets

Tablets are provided to each inmate from 7am-9pm. The tablet have preloaded educational content. Added services available through the tablets include the Inmate Handbook, grievance filing, and the

placement of commissary orders. Inmates can buy music, e-books, and videos. They can connect to a secure email system to communicate with family and friends as approved by ECCF. While tablets are provided for free, the Wi-Fi signal is a major issue with using them. An unstable internet connection is severely problematic and restricts inmates from using the tablet. Another major problem is that inmates are destroying the tablets and headphones. For example, there was a recent case where an inmate wrapped a bedsheet around their neck and was transported to the hospital despite not being suicidal, but because they broke their tablet and wanted a new one. Inmates are responsible for replacing their tablets at cost if they break the previous one, further widening the gap between technology and access.

Video Conferencing

COVID-19 created obstacles for inmates to appear in court. ECCF is currently installing 40 video booths that are soundproof to enable inmates to appear in court virtually to lessen the potential spread of the virus within the court system. Video booths reduce the need to shuttle inmates for court appearances, allow witnesses or experts to appear readily, and reduce travel time. These video booths could also provide telehealth services and video visits.

Immediate Recommendations

ECCF receives plenty of questions about the jail population. By creating a jail dashboard, ECCF will help raise awareness and increase transparency with the public about the characteristics of inmates and the medical and social services provided in jail. A jail dashboard is an interactive tool that pulls data from ECCF's Offender Management System and provides updated general information about the jail inmates, length of stay, reasons for incarceration, gender, race/ethnicity, age, etc. A jail dashboard could also be used to include COVID-19 prevalence data or vaccination rates.

Conclusions

This Determinants of Health Report is a comprehensive overview and background of the status of ECCF as it relates to the health, safety, and wellbeing of the inmates, staff, and correctional police officers. This report includes over 200 contact hours (September 2021 through March 2022) of on-site jail visits, ethnographic observations, including a third shift visit (9pm-5am) at the facility, interviewing both female and male individuals in custody at ECCF, participating in unannounced visits, participating in public meetings, a tour of Delaney Hall, and reviews of testimonies and correspondences and public meetings between the ECCF and the ECCF Civilian Task Force,

People released from jail and returning to the community experience adverse health outcomes and are sicker than the general population. Upon reentry, people released from jail face barriers to accessing medical and social services, securing employment, housing, and other much-needed support. Because high prevalence rates of mental health challenges, chronic diseases, and substance use disorders have increasingly affected incarcerated people at ECCF, preparing for release should be a process that begins in pre-booking.

Despite the medical and mental health risks of incarceration, ECCF does show promising approaches to supporting the health and well-being of their jail population. However, the intensity and complexity of imprisonment require a paradigm shift toward increasing state and local support for county jails and expanding medical and mental health programs with wraparound services that allow for re-entrant inmates to be served at one location. New Jersey should apply for Section 1115 waivers to provide Medicaid coverage while people are incarcerated or in custody at ECCF.[58] Investing in care coordination and care management in jails is critical, particularly for inmates with chronic diseases.

[58] Kaiser Family Foundation. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. Retrieved from: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and- pending-section-1115-waivers-by-state

Appendix 1

New Jersey State Correctional Police Officer

(https://www.state.nj.us/corrections/pages/careers.shtml)

Responsibilities
The New Jersey State Correctional Police Officer is responsible, during an assigned tour of duty, to ensure the custody, safety and care of criminal offenders confined in State correctional facilities.

Goals

- To provide public safety and security through the custody and management of those individuals incarcerated within the Criminal Justice system.
- To ensure the safety and welfare of the staff and inmate population.
- To assist in the rehabilitative efforts for those incarcerated individuals returning to the community.
- To promote public support for the operation and objectives of the Department of Corrections.

Requirements

- Education: High school diploma or its equivalent. Candidates must read and write English sufficiently to perform duties of the position;
- Age: Minimum of 18 years of age;
- Citizenship: Must be a citizen of the United States and a resident of the State of New Jersey. Additionally, institutions located in certain municipalities have residency requirements, which require candidates to provide proof of such residency beginning six months prior to the closing date of written examination for the position;
- License: Candidates will be required to possess a valid New Jersey driver's license. Candidates for this position must be eligible to possess a firearm in accordance with State and Federal laws;
- Background: Investigation of candidates' employment history, driving history, domestic violence history, and criminal history are conducted; and
- Medical: Candidates will be given a thorough medical and psychological examination. They must provide urine samples for analysis to determine drug use.

Please review our questionnaire before applying to determine if Correctional Police Officer is the job for you

Pre-Employment Processing
Based on the candidate's score and ranking on the written examination, as well as available vacancies, a candidate will receive notice from the Department of Corrections to report for pre-employment processing, which consists of the following:

Phase 1 & 2 - Completion of employment application, computer background check, written psychological examination, fingerprinting for background investigation and urinalysis testing for drug screening.

Phase 3 - Background investigation that includes personal interviews and visits to your residence and/or place of work.

Phase 4 - When vacancies occur, those candidates who have successfully completed Phases 1,2 and 3 will be notified to report for Phase 4 processing which includes the following: A medical exam (e.g.

blood, vision, hearing test, chest x-ray and EKG). An interview conducted by a psychologist based on the written examination completed during Phase 2.

Candidates who pass the previously noted requirements will be appointed as Correctional Police Officer Apprentice and will be required to satisfactorily complete a 14-week, in-residence NJ Police Training Commission course, at the Correctional Staff Training Academy. While in training, candidates will be paid bi-weekly based upon an annual salary of $34,000. Those who successfully complete the training program will be appointed as a Correctional Police Officer and will serve a one-year working test period. Upon satisfactory completion of the working test period, candidates will be promoted to Senior Correctional Police Officer and serve a four month working test period. The academy training is comprised of three areas of training.

Physical Fitness
The Physical Education and Self-Defense Program emphasizes physical conditioning which includes running and various strength building exercises.

The current Police Training Commission (PTV) minimum requirements
24 pushups in 1 minute
28 sit ups in one minute
15 inch vertical jump
300 meter run in 70.1 seconds
1.5 mile run in 15 minutes 55 seconds

Academics
The Academic portion of the Academy training will include a college level course of studies such as psychological and sociological issues, Language and Communications skills, Criminal Law, Constitutional Issues, Correctional and Police Practice procedures, etc. There will be comprehensive examinations and written assignments.

The Basic Course for State Correctional Police Officer can offer up to 24 college credits.

Firearms Training
Firearms Training includes firearms safety and weapon qualifications.

Salary Compensation
Correctional Police Officer Salary is $40,000
Senior Correctional Police Officer Salary range is $46,276.36 to $88,542.89

In addition to staffing 12 facilities throughout the state, the following positions are some of the career opportunities available to Senior Correctional Police Officers within the Department of Corrections:

- Central Transportation
- Central Medical
- Ceremonial Teams (Pipe Band/Honor Guard)
- Correction Staff Training Academy
- Critical Incident Negotiation Team
- Custody Recruitment Unit
- Interstate Transportation
- K-9 Unit
- Special Investigation Division
- Special Operations

Additional career opportunities for custody officers within the NJDOC

Firearms Unit (Range)

Cobra Applications

Applications
The Civil Service Commission announces the Law Enforcement Examination approximately every two years, at which time applications for State Correctional Police Officer are available online through the New Jersey Civil Service Commission website: www.state.nj.us/csc

Appendix 2

2020 Clinical Care Guidelines

[redacted]

[redacted]

[redacted]

Table of Contents

INTRODUCTION

The clinical guidelines discussed herein are presented with the intention of ensuring the delivery of appropriate, consistent healthcare for inmate patients housed in correctional facilities. This manual has been created by licensed and credentialed CFG practitioners with ample experience in correctional healthcare, who are also certified in basic life support (BLS) and are intimately familiar with community-based standards of care. As conditions of their employment, these professionals are also subject to on-going education and training.

CFG clinicians review the material contained herein on an annual basis, making amendments and/or revisions as needed or stipulated by Federal, State and accrediting bodies. This manual shall also be reviewed quarterly by the Corporate Medical Director and at least annually by each facility's individual Medical Director. Written attestations of compliance are kept on file with each facility's Health Services Administrator (HSA).

This manual has been reviewed by corporate medical administration and the Medical Directors at:

- Albany County Correctional Facility
- Atlantic County Justice Facility
- Burlington County Correctional Facilities
- Camden County Correctional Facility
- Camden Youth Detention Center
- Cape May County Corrections Center
- Cumberland County Department of Corrections
- Essex County Correctional Facility
- Mercer County Correction Center
- Monmouth County Corrections Institution
- Ocean County Department of Corrections
- Schenectady County Correctional Facility
- Somerset County Jail
- Union County Jail (the Ralph Oriscello Correctional Facility)
- Warren County Correctional Center

PURPOSE

This manual has been created for the express purpose of:

- Developing and promulgating standards of care designed to ensure the uniform delivery of healthcare services across all contracted correctional facilities
- Ensuring that inmates with chronic diseases are promptly identified and appropriately managed
- Delineating procedures for the documentation of all service rendered
- Establishing clinical norms of care

These guidelines are **NOT** intended to restrict the delivery of appropriate care by licensed clinicians to individual inmates.

An individual practitioner's failure to achieve the standards of care advocated by these guidelines may result in focused peer review and professional critical analysis by the Medical Director.

All healthcare staff members must sign an attestation form upon receiving a copy of the Clinical Guidelines Manual.

The Medical Director at each facility shall develop an annual curriculum for educational in-services for all staff members involved in providing healthcare services to inmates. This curriculum shall include review of the Clinical Care Guidelines Manual.

PRACTICE PRINCIPLES

DOCUMENTATION

The Health Record memorializes the full scope of clinical interaction between the provider and the patient. Through consistent documentation methodology quality performance measures codify all facets of the health program, including timely diagnostics, appropriate clinical decision making, continuity, effectiveness, efficiency and safety.

Health Records systems, both paper and electronic, are similarly formatted to allow for the documentation of each clinical encounter. CFG subscribes to this standard.

CONTENT

The record should not be populated with automatic checks or responses when there is no clinical correlation. Normal should not be selected to respond to an inquiry if the question is not asked or the examination is not completed.

LEGIBILITY OF MEDICAL RECORD

The medical record serves as official documentation of all patient interaction with health professionals; as such, it represents a legal document that must be able to withstand scrutiny. The medical record also serves as the care plan, enabling the health team to provide treatments both timely and appropriate according to directives entered therein. If the medical record cannot be easily read or understood, it becomes a liability; as such, CFG policies B-08 and A-08 (in conjunction with NCCHC guidelines/standards) address this concern and the issue of patient safety. Risks associated with illegible entries include:

- Treatment errors
- Medication errors
- Duplications

(The use of Electronic Medical Records mitigates problems related to legibility)

ENDORSEMENTS

A clinical entry is not considered complete until the note has been endorsed by the author. Endorsement includes recording the date and time of notation and the signature of the notation's author. After signing their name, the practitioner needs to stamp the chart. Documentation of actual date and time of entry are critical to notation and are of immeasurable value when conducting retrospective chart reviews.

Facilities with electronic medical records must also comply with standard operating practices and procedures. Completed entries must be closed and endorsed by the actual provider. Providers are **NOT** permitted to post-date entries.

The fundamental principles of documentation listed below represent benchmarks of care for CFG Health Systems' healthcare providers:

- proper content
- proper format

- legibility
- endorsement
- diagnostics

PEER REVIEW/CLINICAL PERFORMANCE ENHANCEMENT

The Medical Director serves as the principle professional authority, monitoring and assuring the quality and the appropriateness of health services afforded all patients. The National Commission on Correctional Health Care (NCCHC)suggests maintenance of quality carebe achieved through the implementation of concurrent objective reviews of the clinical skills of each practitioner. These reviews are conducted by the Medical Director or a designee with at least equal training in the same general discipline as the practitioner being reviewed. Subject to this process are all licensed practitioners that provide care within a facility, including medical physicians, psychiatrists, dentists, mid-level practitioners (nurse practitioners and physician assistants) and PhD–level psychologists.

All clinical performance reviews are kept confidential and are filed by the Health Services Administrator (HSA) in employees' individual personnel files. Each review conducted shall include the following:

- the name of the individual being reviewed
- the date of the review
- the name and credentials of the reviewer
- confirmation that the review has been shared with the clinician
- a summary of findings
- corrective actions, if necessary

CFG's peer review program focuses on evaluating clinicians' delivery systems - such as chronic care evaluations, infirmary care plans and discharge planning. At the time of review, the Medical Director will determine the number of chartsneeded (selected through random sampling) in order to ascertain a reasonable and accurate picture of a provider's practices. Sample audit tools to be used by the Director (or his/her designee)are included in the Forms section of this manual.

MANAGEMENT OF PHARMACEUTICALS

A precipitous rise in pharmaceutical costs has fomented the need for conscientious monitoring by the CFG clinician. Historically, though medications new to the marketplace were always more costly, cheaper alternatives were usually available using similar older or generic drugs. However, with recent changes in manufacturing, most notably sole-source designation/contracts, the cost of older drugs has also risen significantly. Of greatest concern is the fact that, in many cases, drugs subject to incredible increases in cost are recognized as the standard and are sometimes the only treatment available. For instance, isoniazid (INH) has historically been a component of primary treatment protocols for mycobacterium tuberculosis and is the standard of care for the management of latent tuberculosis infection (LTBI). Colchicine is used to blunt the acute immunologic cascade seen in gouty arthritis and is also used in patients who present with unilateral joint inflammation, both diagnostic and therapeutic. These two widely utilized medications have been subject to steep increases in cost in recent years, taking them from less than fifty cents to more than six dollars per pill.

As at least 1/3 of the incarcerated population is on medication at any given time, it is crucial that healthcare providers remain vigilant in monitoring medication orders for each of their patients, ensuring treatment regimens are clearly defined and appropriate, and that unnecessary medications are discontinued promptly.

DRUG FORMULARY

As a means of managing pharmaceutical costs, CFG and other healthcare providers have created drug formularies. On an annual basis, CFG's Site Medical Directors are expected to jointly prepare and approve a list of all primary medications to be included on the formulary. The drugs listed within should represent the majority of pharmaceutical classes commonly used in CFG's correctional healthcare services programs, at the best value. In addition to listing available drugs, the formulary must also include the formulations available and recommended dosages.

Once a formulary is approved, it is then distributed among all providers to be used as a guide for ordering medications. In most cases, providers may prescribe from the formulary, with the order filled directly using on-site stock; however, in some instances a medication must be ordered "patient-specific"(see further below).

The drug formulary provides clinicians with a listing of all preferred drugs from each pharmacologic classification, in an effort to manage care in the most cost-effective manner. To fully accomplish this, CFG's Site Medical Directors, in conjunction with CFG's pharmacy provider, must review monthly pharmacy utilization reports, changes in pricing, new product launch materials, drug efficacy and safety claims, and CFG policy on regular bases. On a monthly basis,Site and Corporate Medical Directors receive advisories of drugs that have been reclassified, along with information on alternative medications with similar clinical outcomes are available for substitution. With the increasing number of sole-source medications flooding the marketplace, it is of vital importance that the formulary be consistently reviewed and updated.

Medical Directors must routinely monitor treatment practices of their individual site teams, encouraging the use of medications listed on the formulary.

PATIENT-SPECIFIC DRUG ORDERS

Certain medications included in the formulary must be closely monitored and; therefore, ordered as "patient-specific." In general, these are drugs that have been approved for the formulary, but that are not routinely kept in stock in large quantities for a variety of reasons (for instance, all of the HAART medications used in the treatment of HIV infection are examples of drugs that fall into this group). Each facility's Site Medical Director is responsible for closely monitoring patients taking these drugs. It is incumbent upon the Medical Director to ensure the full compliance of patients taking these medications – regularly evaluating patient use, drug efficacy and patient safety.

All vaccines must be ordered "patient-specific" to avoid maintaining a costly stock supply of vaccines on-site, especially since vaccines kept on-site typically expire before actually being needed.In addition, there are few clinical indications for an immunization to be given immediately, meaning there is little risk associated with waiting for an immunization to be delivered.

Protocol for ordering patient-specific medications can be found in the Forms Appendix at the back of this manual.

NON-FORMULARY DRUGS

Medical Directors must work with their teams to encourage the use of medications listed on the formulary. The use of therapeutic substitutions with comparable drugs should be encouraged when there is no perceived impact to drug efficacy or patient safety. However, as the scope of clinical conditions managed in correctional facilities encompasses a wide and vast array, there will be patients who require specific medications, as ordered, that are not a part of the drug formulary. In these circumstances, protocols concerning the use and request of non-formulary drugs must be strictly adhered to and properly documented, as delineated further below.

The ordering of drugs not listed on the formulary is subject to a review process, with requests sent to the Medical Director for approval. As part of the review process, **the Non-Formulary Medical Request form** must be completed in its entirety by appropriate staff – inclusive of proper verification and justification for use - before being submitted to the Corporate Medical Director/Corporate Director of Psychiatry for review. Corporate Medical Directors, in making the final decision to allow or deny the ordering of a non-formulary drug, must consider a drug's efficacy, safety and appropriateness, as well as the availability of alternative supplies (e.g., - the use of the patient's own prescriptions from home, the availability of drug funding through FQCHs and grants, etc.). In this way, medical staff is able to exercise control over the healthcare program and ensure the delivery of appropriate care, while mitigating costs, when possible.

When presented with patient medications of exorbitant cost or that are on the formulary, but not readily available, the Medical Directors must determine whether the patient can be treated with recommended alternatives/substitutions. Each case must be evaluated independently in consultation with the Corporate Medical Director or the Chief Medical Officer, to ensure patient safety and to determine drug efficacy.

NON-FORMULARY REQUEST FORM

(Please see the Forms Appendix for a sample copy of this document.)

The non-formulary request form should, ideally, be completed by the provider at the time an order is written. This allows for pertinent information, such as "Formulary Medications Used Previously," to be noted on the form.

The provider should make sure the Non-Formulary Medication Request form being completed bears the correct facility name.

Critical to form disposition is the designation of the request as either a **"New Order"** or a **"Pre-Incarceration Order."It is of vital importance that the "Pre-Existing Order Approval" section of each request marked as a "Pre-Incarceration Order" be completed.**Failure to complete this section of the form results in delays in order processing. This information, usually obtained by nursing staff, involves contacting the dispensing pharmacy to confirm the prescription and to determine patient compliance. Other means of confirming medications include direct conversation with the provider who prescribed the medication prior to patient incarceration or inclusion of a printed report, such as a hospital discharge summary or a transfer summary, as received from state institutions/municipalities. The completed Non-Formulary Request form must be endorsed, and both date and time-stamped.

Non-Formulary Medication Request forms marked as a "Pre-Existing Order," but absent of patient compliance confirmation should precipitate a provider's re-evaluation of a patient prior to starting treatment.

Patients found to be non-complaint with pre-existing prescriptions/treatment regimens also need to be re-evaluated prior to restarting treatment to prevent the emergence of issues involving drug tolerance,drug resistance and drugsafety related to lapses in medication.

Non-Formulary Request forms for psychotropic medications must be evaluated by the Chief Medical Officer or this person's designee. The Corporate Medical Director evaluates requests for all other non-formulary medications. Forms approved by the Chief Medical Officer or Corporate Medical Director must be endorsed before being faxed to both the pharmacy and the facility housing the patient.

When a request for non-formulary medication is denied, Corporate Directors may list an alternative order on the bottom of the form before endorsing and returning it to the facility.

Please note, non-formulary medications are always patient-specific.

NON-FORMULARY REQUEST PROCEDURES

1. Medication Verification and Confirmation	Nursing staff is responsible for verifying and confirming a patient's medication(s) with the dispensing pharmacy and/or the prescribing practitioner. The Medication Verification Form must be completed by Nursing staff at the time of intake. All requests for non-formulary drugs require completion of a Non-Formulary Request form, as indicated. **(Both of these forms can be found in the Forms Appendix.)**
2. Documentation of Patient Compliance	Nursing staff is responsible for obtaining a record of patient compliance with drug orders by verifying such with the dispensing pharmacy and the prescribing practitioner.
3. Justification for Use	The Medical Director and prescribing clinician must consider the patient's diagnosis, any contraindications for use, and any risky/compromising behavior demonstrated by the patient (e.g., - active substance abuse).
4. Completion of the Non-Formulary Request Form	Both the Medical Director and Nursing staff are responsible for completing this form accurately and in its entirety, as indicated, EACH TIME a non-formulary drug is ordered.
5. Internal Consultation	As needed, the Medical Director and prescribing clinician should consult available sub-specialists.
6. Other Available Sources	Both the Medical Director and Nursing staff are responsible for researching other available sources for a non-formulary medication – e.g., - Does the patient already have a supply of the drug at home (existing prescriptions)? Was the patient being seen at a FQCH (Federally-Qualified Health Center)? Was the prescribing physician obtaining the medication for the patient through a grant or other similar program?
7. Off-Site Treatment	The Medical Director and facility administration need to determine if the patient can continue to be seen outside the facility by the prescribing physician for continued treatment.
8. Classification Review	The Medical Director and jail administration must determine if a patient is eligible to participate in an at-home incarceration program, is eligible for early release, or is going to be transferred to another facility.
9. Ordering Buprenorphines	Confirm which clinician has the DEA waiver
10. Ordering Naltrexone	A licensed clinician
11. Ordering Methadone	Clinician from the prescribing Methadone clinic

It is the responsibility of all members of the facility management team (the Medical Director, the Director of Nursing, and the Health Services Administrator) to ensure that each of the components listed above are completed for any patient requiringa non-formulary medication.

It is important to note that a Non-Formulary Request form needs to be completed EACH TIME an order is placed. For instance, a patient receiving Factor VIII infusions for the treatment of hemophilia must have a new form completed EACH TIME the prescription is ordered.

The patient chart must reflect consistency and must document all times when a facility team is able to procure medication from alternative sources, such as from the patient's home or through a hospital grant.

Regional Managers must work with facility HSAs to monitor and track patients taking non-formulary medications over time. The common goal for all is ensuring the delivery of care that is both appropriate *and* cost-effective.

NON-FORMULARY APPROVALS

A non-formulary approval is valid for one year or the duration of the current incarceration period, whichever occurs first. Clinicians should write the order to include refills and then new non-formulary requests will not have to be endorsed. Should the patient be discharged and return as a recidivist, a new non-formulary request would need to be endorsed and submitted to the pharmacy.

CONTINUITY OF CARE AND ALTERNATE DRUG FUNDING

In an effort to ensure continuity of care while a patient is incarcerated and beyond release, CFG has begun to partner with community-based Federally Qualified Health Centers (FQHCs) throughout New Jersey. These community-based clinics provide much of the comprehensive healthcare afforded incarcerated Medicaid enrollees outside of the emergency room, including perinatal care and mental health support. Most FQHCs are also involved with 340B drug pricing programs that enable healthcare organizations caring for underserved populations to purchase drugs at discounted prices.

In addition, current corrections policy identifies detainees eligible for house arrest. Patients on Medicaid under house arrest are able to retain their Medicaid benefits (whereas, incarcerated individuals lose all Medicaid benefits with the exception of reimbursement for inpatient hospitalization). As such, CFG works collaboratively with custody staff to identify detainees eligible for house arrest and also works with FQHCs to ensure care is available and accessible for this cohort of offenders.

COST CONTAINMENT

All Medical Directors receive monthly invoice reports for their particular facility that provide cost analysis from a variety of perspectives **(Please see the Forms Appendix at the back of this manual for sample reports)**. Medical Directors are responsible for reviewing these reports on a monthly basis to closely monitor prescription drug use and attendant costs. Goals include finding means to reduce expenditures and discerning any discrepancies and/or areas of concern. Please note, to accurately determine a facility's true total

population, Medical Directors should use the following formula versus merely looking at average daily population (ADP) quotes.

Formula for Calculating Population Census: Inmate Census on Day One of the Month + Total Admissions for the Month = The Total # of Individuals Potentially Served.

In reviewing these reports, Medical Directors should:

1. Check the total charge for the month and compare it to previous months.
2. Check the total costs for non-formulary medications (Medical Directors should be knowledgeable of those patients requiring non-formulary medications).
3. Review the number of patients being treated each month using the formula provided above, NOT the ADP (average daily population).
4. Closely review the column marked "RX's PER I/M" (the # of prescriptions per inmate – the average percentage of inmates on medication is usually 30% – percentages exceeding this number require further investigation).
5. Review charges by category (for instance, one patient on treatment for HCV [hepatitis C] can skew monthly totals for overall cost).
6. Closely review the column marked "CREDITS."
7. Review the report with the Health Services Administrator and the Director of Nursing to address outliers, cost variances, and pending credits.
8. Complete Non-Formulary Tracking reports for all costly medications ordered (see further below).
9. Schedule a monthly Pharmacy Review with clinical staff to review all findings.

Costly Medication Tracking Procedures

Detainees are prescribed a full range of medications, including immune modulators, biogenetically engineered products, and semisynthetic analogs, among others. Many of these medications are sole-sourced by a specific manufacturer and are, therefore, extremely expensive. Access to these medications oftentimes requires an order from an authorized clinician prescriber.

When faced with prescribing costly non-formulary medications, CFG's Medical Directors and clinical staff need to adhere to the following protocol:

1. Confirm the existence of an active prescription order. NOTE: The DON may assist in locating sources for medications supplied by non-traditional pharmacies.
2. Complete a Non-Formulary Request form.
3. Establish all available resources for such medications.
4. Confer with Custody staff to obtain clearance for delivery of such medications to the jail. NOTE: The DON must facilitate and document receipt of such medication by nursing staff, while nursing staff must prepare MAR records and tracking inventory forms, as determined by the DON and the HSA.
5. The HSA must report all information mentioned above to the Correctional Health Administrative Assistant for inclusion in a system-wide, annualized report of all non-formulary costs. This report is given to corporate administration for the purpose of preparing accurate annual budgets.

MEDICATION RECONCILIATION PROCEDURES

All medications prescribed for a detainee during the period of incarceration must be transcribed on the Medication Reconciliation Form (MRF) kept within the medical record (please see the Forms Appendix for a copy of this form). Medications must be documented as ordered by the provider and must also be endorsed by either the Chief Medical Officer (for psychotropic medications) or the Corporate Medical Director (for all other meds). **It is imperative that each adjustment to a medication order be reflected upon the MRF.** Upon a detainee's release, these drugs must be provided to the detainee in quantities as specified by the facility/contract.

MEDICATION RECONCILIATION FORM

This document is a master physician's order form, which identifies those medical and mental health drugs which will be made available to the patient at the time of discharge from the facility. Each drug order will reflect the most current prescription for administration to the patient. As such, medications which are under qualitative or quantitative dose titration should not be included on the form. Over the counter medications will not be included on the reconciliation form. All medications listed on the reconciliation form will be approved by a responsible clinician.

Upon release from the facility, nursing staff will transmit the reconciliation form to the back-up pharmacy for medication pick up by the patient. Patients who receive discharge medications packaged by the primary pharmacy will not receive additional medication via the reconciliation process.

The patient will be instructed at Receiving Screening by nursing on how to obtain medications upon release.

AT THE TIME OF RELEASE

Upon notification of release from a facility, Nursing staff are responsible for faxing the MRF to the designated 24-hour community pharmacy for processing. The designated pharmacy is responsible for filling all orders with the contracted allotment of discharge medications. Substitutions and refills are not permitted. The dispensing pharmacy is required to provide detainees with all packaging and patient education materials, along with the medications given.

Upon release, detainees have forty-eight (48) hours from the time an order is faxed to retrieve meds from the dispensing pharmacy before the order will expire. Detainees are informed of medication reconciliation procedures during Receiving Screening. No monetary fees are assessed detainees for medications dispensed at the time of release.

Recidivist detainees on medication who return to the facility must be reprocessed as outlined herein.

INITIAL HEALTH ASSESSMENT (HISTORICAL FINDINGS)

REVIEW OF RECEIVING SCREENING DOCUMENTATION

Initiation of the Initial Health Assessment begins with thorough clinician review of Receiving Screening documents completed by nursing staff during Intake. Clinicians must make note of all reported health

conditions – both medical and mental – as well as all medications prescribed, past hospitalizations, documentation of concurrent chronic diseaseand reports of substance abuse (including tobacco).

HIGHLIGHTS OF IN-DEPTH INQUIRY INTO PATIENT MEDICAL HISTORY

Clinicians are expected to make further inquiry regarding the following issues and conditions:

- **Recent Injuries(with emergency room clearance)** – For any recent injuries, the clinician must ask about any diagnostic tests completed – including laboratory testing, x-rays and scans/imaging. Based on findings, the clinician must determine whether any follow-up intervention is necessary.
- **Substance Abuse History**– The clinician must challenge and delve deeper into information provided, probing the patient for additional detail. For instance:
    - As pharmacologic accommodation often occurs with chronic opioid use, the clinician must inquire about additional substances a patient might use in order to sustain the desired euphoric effects. With further questioning, chronic opioid users will often admit to taking oral benzodiazepines (known as "blues," "rods," "sticks," or "street Xanax"), too.
    - Patients who report only drinking occasionally should be questioned regarding the time of day the patient "occasionally" drinks, the type of alcohol consumed, and the quantity.
    - Clinicians should also ask detainees if they understand what "withdrawal" means or looks like. It is often only when using this line of questioning that a patient might report having had seizures or black-outs in the past, experiencing tremors, or relating that theydrink continuously in an effort to forestall the onset of these symptoms.
    - Are detainees enrolled in substance abuse treatment programs and are these Medication Assisted Therapy facilities.
- **Tobacco Use** – As numerous health conditions are negatively impacted by the use of tobacco and nicotine products – especially cigarette smoking – clinicians must document patient use in terms of the amount of product used daily/weekly over xx number of years –for instance: "Mr. Smith reports smoking one pack of cigarettes per day for the past 17 years" or "Mr. Jones reports smoking E-cigarettes approximately 12 times per day for the past year and a half" or "Mr. Johnson reports using a can of dipping tobacco per day for the past five years".
- Inquiry into all prior **Surgeries and Hospitalizations**noted
- **Review of Systems and Chronic Diseases** –
    - **Asthma** – The clinician must remember that wheezing may be caused by a number of different conditions – not just asthma.Inquiry should be made regarding any asthma-induced ER visits, type of medication(s) taken, frequency of use, environmental triggers (e.g. – exercise, cold weather, dust, pet dander), history of cigarette smoking, and the inhalation of abused substances (such as marijuana and heroin). This information, coupled with physical exam findings, serve to confirm diagnosis, determine condition classification (mild, moderate, moderately severe or severe), and inform treatment planning **(please see "Asthma" under"Initial Health Assessment of Chronic Conditions" and also the section labeled "Asthma" under "Pulmonary" for additional information).**

- **Depression and Anxiety** – The clinician will need to record any patient report of depression or anxiety in the progress notes, along with any evidence of on-going follow-up for such within the community, and<u>issue a referral to Mental Health</u>.
  NOTE: Official mental health diagnoses, as reported in the Master Problem List, can only be entered by Mental Health professionals.
  Detainees reporting use of medications associated with the treatment of mental health disorders must be referred to Mental Health for further evaluation and appropriate management. Of particular note are detainees requesting or reporting use of medications such as Sinequan (doxepin), Seroquel (quetiapine) or Neurontin (gabapentin), as these medications have a strong potential for abuse among detainees.
- **Diabetes** – Upon completion of the examination, the clinician will need to classify the condition on the Problem List as Type 1 or Type 2, insulin dependent. The clinician will also need to target specific "end-organs" to determine the extent of involvement. These "end-organs" include the eyes, heart, kidneys, peripheral nerves, reproductive system, integumentary system, and musculoskeletal system. The clinician must also ascertain the detainee's understanding of the disease in terms of compliance with diet, exercise and medication regimens. Questions posed during the taking of the patient's medical history in reference to these issues will inform the care plan.
- **Hypertension** – Clinicians should make further inquiry regarding current and prior cigarette smoking, family history, prior hospitalizations and concurrent chronic conditions. In conjunction with examination, inclusive of assessment of "end-organs" (eyes, heart and kidneys), the clinician can use historical information reviewed to classify the condition as essential or secondary on the Master Problem List.
- **Seizures** - The clinician will need to ask several questions to ascertain if a patient was placed on anti-seizure medication secondary to withdrawal or in response to an early diagnosis of epilepsy. As part of medical history, the clinician must find out the name of the prescriber, the frequency of follow-up visits, and what diagnostic testing has been conducted. This information, coupled with examination findings, will determine classification of the condition on the Master Problem List asepilepsy, related to substance abuse or secondary to trauma.
- **Sexually Transmitted Diseases (STDs (**– Clinicians must obtain a sexual history from each detainee, prior to visual examination, asking about and recording a wide range of clinical information that includes:
  - Patient report of STDs (both past and present - note severity and chronicity)
  - Known infections of sexual partners
  - The number of sexual partners
  - Instances of unprotected intercourse
  - Presence of genital discharge - note odor, color, consistency and the presence or absence of pain or blood
  - Information regarding menses (abnormal pain, change in flow)
  - Past and present episodes of pediculosis pubis

- Presence of lesions, sores or growths
- Suspected or previously diagnosed hernias
- Hydrocele testis (fluid accumulation around the testicles)
- Cystocele (bladder herniation into the vagina in women; bladder prolapse in men)
- Genital injury/trauma (past and present)
- Phimosis (inability of the foreskin or clitoral hood to fully retract)
- Past treatment (ask what treatment was recommended and whether it was provided by a clinician, in a clinic, in an ER, using over-the-counter medications or using medications given to the patient by a friend or acquaintance)
- Presence or absence of ornamental hardware (note patient reports of pain and/or discharge at piercing sites and any patient reports of restricted urine flow)

Clinicians must question detainees in a professional, non-threatening and non-judgmental manner. Detainees should be made to understand that some findings might require referral to a sub-specialist for definitive diagnosis and treatment. The thoroughness of the clinician's questions can serve todecrease patient embarrassment and stress associated with subsequent visual examination of the genitalia.

NOTE: Clinicians who are unable to perform visual inspection of a detainee's genitalia must inform the Medical Director prior to housing assignment. Clinicians must also mark patient progress notes with either of these two notations:

- **Genital Examination Deferred** – examination to be conducted at a different location or by a different physician within fourteen (14) days
- **Genital Examination Refused** – examination was declined by the patient

- **Chest Pain and Cardiac Disease** – Clinicians often hear patient reports of chest pain.Non-cardiac chest pain (e.g. - chest pains associated with respiration or chest wall tenderness upon palpation) may often be determined via the taking of a thorough patient history. As part of questioning, clinicians must identify an individual's**Cardiac Risk Factors(see the section marked Cardiovascular for a breakdown of these factors)**and must also ask the following questions:
  - Does the patient now or has the patient ever smoked? If so, how often and for how long?
  - Does the patient have a history positive for diabetes or hypertension?
  - Does the detainee note lipid abnormalities, such as hypercholesterolemia?
  - Has the detainee ever had an electrocardiogram performed?
  - Has the detainee ever been given nitroglycerin sublingually?
  - Has the detainee been told to monitor his/her diet or to restrict sodium intake?
  - Has the patient ever been diagnosed with a heart murmur?
  - Does chest pain resolve with over-the-counter medication?
  - Is there a history of substance abuse? Were any of the drugs used taken intravenously?
  - Has the patient ever been hospitalized for chest pain?
  - Has the patient ever been treated for endocarditis?
  - Was the patient compliant with treatment regimens?

- **Renal Disease** – As clinical history aids greatly in determining the care plan, the clinician should ascertain the following:
  - Is the patient on dialysis? If yes, note the history of treatment compliance(**NOTE: dialysis patients presenting with complaints of respiratory insufficiency, pleuritic chest pains and non-descript illness should be transferred to a hospital immediately for dialysis treatment).**
  - Evidence of concomitant substance abuse
  - Existence of any co-morbid conditions and/or chronic infections
  - Vascular competency
  - Medications taken

REVIEW HEALTH ASSESSMENT (PHYSICAL EXAMINATION FINDINGS)

VISUAL INSPECTION

Inspect the patient with every contact/visit. Observe the skin to see if it is dry and/or flaky or if there are blisters or wounds with drainage. Look at the patient's face and eyes. Are the conjunctivas moist? Is there a discharge? Are the pupils sunken? Is there exophthalmos (bulging of the eye)? Are the sclera pale? Is the patient's hair dry or brittle? During the oral exam (which can even be done during an interview) do you notice a dry, whitish film on the tongue (leukoplakia)? Do the gums appear healthy and luminous?Does the patient hold his/her head erect while seated? Is there a visible goiter? Is the trachea along the midline? Is chest wall splinting noted upon respiration? Are there ecchymotic lesions to the trunk? Is the abdomen protuberant? Areperiumbilical venous dilatation or blanching spider hemorrhages detected? Are the genitalia intact? Have the testicles descended? Are hydroceles, hernias, lesions or visible signs of apediculosis pubis infestation noted? Is there asymmetry or aberrancy to the patient's gait or to the musculoskeletal system? In addition to physical characteristics, note the patient's demeanor – is he or she tense, anxious, unfocused, drowsy, obtunded, stressed, relaxed?

PHYSICAL EXAMINATION

A basic physical examination should be performed for all newly arriving detainees, even those who lack a significant clinical history and who appear without injury upon visual inspection.

The clinician must maintain a professional demeanor throughout the entire examination process. Prior to beginning the physical exam, the clinician must inform the detainee of the examination's scope and purpose. The detainee must understand that the examination is done to identify any health conditions requiring immediate attention, intervention and treatment. The detainee must understand that clinical staff will address urgent and/or emergent conditions, while assessing the status of chronic diseases. However, elective and or cosmetic interventions requested by the detainee will not be addressed. Finally, the clinician must seek approval from the detainee to begin the physical examination before actually doing so.Detainees that refuse the physical examination may be isolated/segregated according to facility policy and procedures.

Vital Signs

Obtaining vital signs is fundamental for acquiring critical diagnostic information. Clinicians should assess not just the values themselves, but the character of the vitals. For instance, is the pulse weak or thready versus

bounding and strong? Is there an orthostatic change in blood pressure? Is jugular venous distension noted or are neck veins absent? Are there peripheral pulses? Is the skin warm, cool, dry, ashen, scaly ...? Are skin changes chronic (stasis dermatitis)?

During the examination, the clinician should note the following (those detainees with chronic conditions may require additional screening and/or evaluations during the initial health assessment):

- CRANIUM –Note symmetry, lesions, visible vascularization, hair texture, signs of pediculosis.
- EYE –Using a penlight, observe the sclera and conjunctiva. Evaluate the third cranial nerve (the oculomotor nerve), the fourth cranial nerve (the trochlear nerve) and the sixth cranial nerve (the abducens nerve). While performing an assessment of the eyes,evaluate the size and shape of the pupils (are they equal and round?), the pupils' reaction to light, and their ability to accommodate. If all findings are normal, use the acronym "PERRLA"to indicate such in the medical record.
- NECK – Note range of motion, ease of motion (supple, spastic), jugular venous distention, goiters, a palpable thyroid, bruits, and adenopathy.
- CHEST – Note symmetry, splinting, retraction, flailing. Upon auscultation, assess for wheezes, rales and rhonchi.
- CARDIAC – Palpate for a cardiac "lift" or "thrill." Upon auscultation, assess for heart sounds (S1, S2 with +/- S3 or S4) and hemodynamic sounds or murmurs.
- ABDOMEN– Note abdominal girth. Provide additional commentary regarding a protuberant abdomen (Is the protuberance associated with shifting dullness and a fluid wave [ascites] or a ridged, firm abdomen with bounding percussive sounds and/or rebound pain?). Feel for palpable masses and auscultate for bowel sounds in at least four quarters of the abdomen.
- GENITALIA – **NOTE: This examination is done by initially asking the detainee about specific problems or conditions. Male detainees should be asked if they are circumcised, have any lesions or discharges. Female detainees must be asked about lesions or discharges. Female detainees must have a comprehensive birth history, including the number of times pregnant, the number of children, any miscarriages or abortions. If the interview identifies problems warranting examination, the clinician must organize the examination in the presence of a chaperone. This part of the physical examination entails visual inspection of the patient's genitalia under conditions that must ensure the patient's personal privacy. Before initiation of this portion of the exam,patients must be advised of the scope and intent of the examination. The detainee's permission must be obtained again in order to continue. Should the detainee decline this portion of the examination, the clinician must ascertain the patient's rationale for doing so. If this portion of the examination is NOT performed, the Medical Director must be immediately located and the clinician must notate the medical record using one of the following delineations:**
  - **DEFFERRED** – Note "deferred" in the genitalia examination results field for those detainees requesting a same sex clinician or whenever the location where the physical is being performed is not conducive to ensuring a patient's privacy. The clinician must make a notation in the progress note offering justification for the deferment and must also issue an order toreschedulethis portion of the initial health evaluation within mandated timeframes.

- **REFUSED**– Note "refused" in the genitalia examination results field for those detainees who decline visual examination of the genitalia for any other reason.
  Examination of patient genitalia must include comment on the observation ofphimosis, lesions, hydrocele, cystocele, hernia, sores, discharge andpediculosis.

All visual and physical examinations of urogenitalia must be with an appropriate chaperone. It is recommended that all female detainees at facilities with on-site Gynecology staff be referred at intake for a comprehensive examination, as indicated by age and comorbidity.

- MUSCULOSKELETAL – Witness the patient's gait. Does the patient limp? Can the patient ambulate without assistance? Is there symmetry or is there evidence of muscle wasting? Does the patient have a prosthetic or use support braces? Observe the patient's musculature and report on anyfasciculation observed.
- PULSES –Note the absence or presence of peripheral pulses.

Detainees who present with signs or symptoms of active infection or infestation must have the issue(s) addressed expeditiously and in a manner that provides personal treatment, while ensuring environmental containment. The clinician must contact the Charge Nurse to retrieve any specimens collected, to put the patient in isolation and to initiate treatment. The setting of the initial health evaluation and the number of detainees to be seen will influence management strategy.

Dehydration

Though specific findings are stressed in each diagnostic section of this manual, in relation to dehydration, physicians should look for dependent bruises (indicative of early muscle injury) in patients presenting with acute intoxication that are unable to provide a reliable history. In patients with clubbing of the nails and a quiet auscultatory examination, clinicians should consider the possibility of pulmonary disease underlying dehydration.

Tests Associated with Dehydration

Clinicians are responsible for ordering and interpreting any testing deemed necessary following examination; however, **at a minimum, the following tests should be done when a patient is dehydrated:**

- Urinalysis – check:
  - Osmolality
  - Glucose levels
  - The presence of ketones (indicative of starvation)
  - The presence of lactic acid (indicative of hypoperfusion)
  - The presence of sediment (granular casts)
- Electrolytes – BUN: creatinine ratio in dehydration > 20:1.
- Is there an increase in the anion gap?

Treatment Initiation for Dehydration

The underlying state of hydration is a fundamental aspect of basic care. As such, the treatment interventions initiated by clinical staff must take into accountfactors that contribute to dehydration, such as hyperglycemia, hyperthermia, hemorrhage, tachypnea and trauma.Nursing staff members who assess new detainees for signs and symptoms of substance abuse must consider the multiple causes of volume contraction and begin immediate replacement therapy as an initial treatment intervention **(please see the subsection of "Substance Abuse Withdrawal" entitled "Treatment Protocols for Withdrawing Inmates with Elevated Blood Pressure" for additional information).**

The Hydration Therapy Table on the following pageserves as a model for clinicians to follow.

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS (1 liter = 33.81 oz. or 1000 cc/mL)	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

IV Fluids – Normal saline (0.9 NS) will treat shock, but physicians should note that the use of normal saline will push a fragile patient with underlying cardiac deficiency into congestive heart failure. Physicians must make careful considerations regarding when to use normal saline versus half-normal saline (0.45 NS). Remember to give the vitamins thiamine, folate and magnesium orally as hydration progresses and the patient begins to take in nutrition.

Oral Hydration – Electrolyte replacement fluids are available at CFG contracted-facilities. These fluids may be used, but should be balanced with water. Clinicians should consider the glucose content of electrolyte replacement fluids and remember to order thiamine, folate and magnesium, dosing at the earliest opportunity. **See the Physicians' Orders and Withdrawal Monitoring Form in the Forms Section of this Manual.**

MANAGEMENT OF GENDER NON-CONFORMING DETAINEES

This section has been created to inform and assist health professionals in caring for gender non-conforming detaineeswithin the correctional environment. Gender non-conformingindividuals may not identify with or present as the gender assigned to them at birth, though the extent to which a person's gender identity, role or

expression differs from cultural norms associated with a particular sex can represent a broad range of phenotypes.

Stigma associated with gender non-conformity can often lead to targeted prejudice and discrimination, giving rise to the potential for mental health problems, such as anxiety and depression, in transgender individuals. Gender dysphoria (discomfort or distress caused by a discrepancy between the gender a person self-identifies with and that person's sex as assigned at birth) can, in large part, be alleviated through treatment – both mental and medical (via medication and/or surgery); however, care plans must be individualized to meet each patient's express clinical needs.

To protect the right to privacy afforded all patients and to uphold the inviolability of the doctor-patient relationship, health providers must ensure care is rendered in a private and confidential area. Clinicians must also maintain a professional demeanor, withholding personal judgment.

CONSENT TO TREAT

The New Jersey Department of Education directs licensed prescribing clinicians caring for transgender patients already on exogenous hormone regimens at the time of presentation to maintain hormone treatment therapy. Exogenous hormonal therapy, given in pharmacologic dosages sufficient to blunt the effects of intrinsic gonadal production, is used to alter a person's external appearance. Estrogens given to males lead to changes in the hair line, reduction in laryngeal prominence, changes to the timber of the voice, development of pendulous mammary glands, widening of the hips, and softening of the skin. Likewise, exogenous testosterone given to females may alter the hair line and cause an increase in facial and body hair, changes in body hair distribution, changes to the voice, and cessation of the menstrual cycle. These phenotypic changes may sometimes be associated with dysplasia of the gonads in both sexes, manifesting as breakthrough menses, hemangiomas of the liver, and malignancies of the male and female reproductive tracts.In addition to increased incidence of hemangiomas, pharmacologic ingestion of estrogens in males can lead to other vascular malformations. Dysplastic changes to the morphology of the epithelial cells of the cervix and other tissues, resulting in abnormal PAP smears, may be noted in females taking testosterone.

The Consent Form for Hormone Therapy **(please see the Forms Appendix)** must be reviewed in detail with patients requesting continuation of exogenous hormone therapy. Review of this form should be conducted by nursing staff during Receiving Screening. Upon completion of the Consent Form for Hormone Therapy, Nursing staff must complete the Medication Verification process **(see Management of Pharmaceuticals for further detail)**.

ALTERNATIVE PHARMACEUTICAL SUPPLY SOURCES

Detainees undergoing gender reassignment often acquire hormones from non-traditional sources, such as internet drug store mail order suppliers, or illicitly within the community. In these circumstances, the prescribed medication verification process cannot be completed bynursing staff.As such, the clinician performing the Initial Health Assessment must make a determination as to whether exogenous hormone therapy will be continued. This decision must be based upon:

- Patient reported history of treatment and the duration of therapy
- Phenotypic presentation of the patient

- Documented history of prior mental and medical intervention

Detainees exhibiting outward signs of prolonged exogenous hormone therapy, such as males with pendulous breast tissue or females with facial hair and deep voices, will be prescribed hormone replacement as reported during intake.

Detainees lacking visible changes to appearance, but for whom pre-incarceration treatment plans can be confirmed with either a treatment center or valid provider will also be maintained on hormone therapy.

Treatment will **not** be continued or initiated for detainees lacking phenotypic changes and for who no consistent or credible past history of treatment can be confirmed.

Mental Health Evaluation

Gender dysphoric patients with active care plans require on-going support from mental health specialists. Throughout the process of gender reassignment, counseling should parallel the stages of transition. All detainees requesting exogenous hormone therapy will be referred to Mental Health for an initial evaluation and care plan, as needed. In addition, special needs treatment plans must be developed that encompass input from Mental Health, medical consultants, and the on-site healthcare team.

Patients who have undergone gender reassignment surgery prior to incarceration may need to continue to be seen for follow-up by surgical and mental health specialists outside the correctional facility. Post-op patients may also require support pertaining to prosthetic devices.

Special Garments, Prosthetic Devices and Housing

Sports bras will be provided to detainees, as needed and approved.

The Medical Director must confer with the surgeon or specialist of record regarding any prescriptions for post-op prosthetic devices. The Medical Team will then develop a plan of care considerate of prescribed usage, security issues and the cleaning of said prosthetics. At case conferences and patient safety meetings (as allowed under NCCHC standard J-B-08) convened with the Warden, key designees and the Medical and Mental Health teams, management protocols will be reviewed and submitted for approval, as will recommendations regarding appropriate housing and patient access to prosthetic devices. In consideration of therapy plans, health staff must seek to identify the most appropriate setting for detainee use of approved devices, ensuring patient privacy, while meeting all custody directives pertaining to safety issues and contraband.

Special Needs housing may be recommended as part of a care plan; however, gender non-conformingdetainees should have access to the general population (in order to partake of recreation services, use telephones andtelevisions, and enjoy outside visits).

Annual Health Evaluations

It should be noted that females transitioning to males (FTMs)who are on testosterone therapy will still need to undergo regular gynecologic examinations and PAP smears. These detainees must also be advised to promptly report any instances of excessive pelvic cramping or pain and any abnormal menses or bleeding to clinical staff. Likewise, males on estrogen therapy must be told to report any instances of urogenital pain or changes in the stream of urine to the clinician (changes in the urine stream may be related to prostatic hyperplasia). In

addition, the testicles of males transitioning to females (MTFs) must be monitored for any growths or deformities. Detainees on exogenous hormone replacement therapy – both those who have and those who have not undergone gender reassignment surgery – may require additional monitoring by sub-specialists.

SMOKING CESSATION PROGRAM

Cigarette smoking is the most common type of nicotine addiction. During incarceration, inmates are forced to undergo abrupt nicotine withdrawal. All clinical staffmembers are required to provide ***firm*** and ***focused*** counseling for inmates, inclusive of the benefits to be gained with smoking cessation, outlined below.

Smoking cessation leads to:

- A reduction in the progression of coronary artery disease within one (1) year
- A reduction in hypertension levels
- A reduction in myocardial infarction rates
- A reduction in symptomatology related to peripheral vascular disease
- A reduction in cardiovascular complications in those persons with underlying diabetes
- A reduction in cases of COPD and improved pulmonary function in those persons with reversible airways disease
- A reduction in the risk of thromboembolic events related to hormone replacement therapy
- A reduction in perinatal morbidity and mortality
- A reduction in rates of macular degeneration and the new onset of cataracts

Medications are not routinely prescribed as part of a smoking cessation program;however, medical staff will assist those inmates interested in smoking cessation via patient education, behavioral modification techniques, and if needed, non-prescription nicotine suppression lozenges.

Medical staff shall **NOT** prescribe:

- Polacrilex gum
- Nicotrol inhalers
- Varenicline (Chantix) (Chantix has been associated with increased risk of depression, suicidal ideation and suicide attempts)

Literature on smoking cessation is available in all medical clinics as part of nursing and medical education.

INITIAL HEALTH ASSESSMENT OF CHRONIC CONDITIONS

Patients with specific long-term healthcare conditions must be identified and enrolled in a chronic disease management clinic. Employing the healthcare models implemented in community-based ambulatory clinics in New Jersey, the CFG healthcare team will develop interdisciplinary physician, mid-level and nursing care teams for each subspecialty. Key subspecialty clinics are addressed individually farther below and include:

- Asthma
- Cardiovascular Disorders
- Diabetes
- Dyslipidemias, Hyperlipidemias
- HIV/AIDS
- Hypertension
- Seizure Disorders (including relation to Withdrawal Syndrome)
- Major Mental Illness

The patient will be identified as "Chronic Care" in the progress notes. Nursing staff will maintain concurrent Chronic Care Rosters for patients at each facility. The Problem List is to be used to identify the Chronic Care condition(s). The Medical Director will establish the frequency of medical follow-up based on clinical and laboratory information available at the time of enrollment. Patients requiring special housing accommodations will be identified to custody staff. Nursing staff are to provide pertinent educational materials for the patients.

ASTHMA

(Also, please see the section devoted to Asthma under Pulmonary)

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - History of asthma diagnosis
    - Last emergency room visit for the treatment of asthma
    - Last hospitalization for the treatment of asthma
    - Current medications for the treatment of asthma and frequency of use
    - Current primary medical provider for the treatment of asthma
    - Presence or absence of auscultatory findings, such as wheezes, rhonchi, etc.
    - History of smoking
    - History of inhaled substance abuse and its relationship to asthmatic exacerbation
    - Environmental triggers (e.g. – exercise, cold weather, dust, pet dander, etc.)
2. The Problem List must be completed and the diagnosis of asthma must be characterized as Mild, Moderate, Moderately Severe or Severe (see Asthma section).
3. The written clinician's orders are to include:
    - Enrollment in chronic care
    - Smoking cessation education
    - Documentation of peak flow at baseline and at every nursing sick-call visit for assessment of respiratory problems

- Documentation of pulse oximeter at baseline and at every nursing sick-call visit for assessment of respiratory problems
- The RN is to auscultate the lungs and make notation in the medical record prior to each nebulizer treatment.

4. Asthmatic patients are offered the annual influenza vaccine.

CARDIOVASCULAR DISORDERS

(Also, please see the Cardiovascular section under System Disorders and Specific Conditions)

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
   - Review of medical history, including primary care
   - Jugular venous distension
   - Neck bruits
   - Lung field
   - Auscultation for gallops, murmurs
   - Akinesis
   - Mitral valve prolapse
   - Abdominal bruits
   - Hepatojugular reflux
   - Dependent edema
   - Pulse
   - Concurrently occurring conditions (i.e., - diabetes, kidney disease, etc.)
   - Electrocardiogram (ECG/EKG)
   - Echocardiogram with ejection fraction (EF)

2. The Problem List must be completed with the diagnosis, cardiac risk factors and functional level documented.
3. The written clinician's orders are to include:
   - Nursing Care Plan
   - Diagnostic testing
   - Sub-specialty support and cardiac work-up
   - Level of monitoring required through:
     - Chronic Care
     - Infirmary Care
   - Identification of treatment goals
   - Initiation of smoking cessation program (as necessary)
4. The information obtained in items 1 - 3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

DIABETES

(Also, please see the section devoted to Diabetes under Endocrinology)

Clinicians will determine at the Initial Health Assessment whether the patient is insulin deficient (Type 1) or insulin resistant (Type 2). Patients thought to have Metabolic Syndrome (Syndrome X) will be noted.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - Level of control of diabetes
    - Past hospitalizations or emergency room evaluations for diabetes management
    - Methods of home monitoring of blood sugar levels and home treatment regimens
    - Discussion with the current primary medical provider regarding management of the patient's diabetes
    - Last electrocardiogram
    - Last chest x-ray
    - Last eye examination (Optometry or Ophthalmology) - NOTE: The Snellen Eye Test is performed by nursing staff
    - Knowledge of comorbid conditions, such as hyperlipidemia, hypertension, gout
    - Physical examination of critical "end-organs" with notation of pertinent negative findings (for example - "No neovascularizations seen on funduscopic exam"):
        - Eye
        - Lungs (check for rales, rhonchi, wheezes)
        - Cardiac (check for gallops or murmurs)
        - Abdominal bruits
        - Renal (BUN, creatinine, urine microalbuminuria [dipstick], urinalysis [dipstick])
        - Pulses
        - Peripheral nerves
        - Integumentary system (check for stasis dermatitis, hair loss, dependent edema)
        - Reproductive system
        - Musculoskeletal system
2. The Problem List must be completed with Insulin deficiency (Type 1), Insulin resistance (Type 2) or Metabolic Syndrome noted.
3. The initial written clinician's orders should include:
    - Enrollment in Chronic Care Clinic
    - Smoking cessation education
    - ADA diet – specifying daily caloric intake
    - Sodium restrictions for Insulin resistant and Metabolic Syndrome patients
    - Urinalysis/Urine dipstick testing for ketones, leucocyte esterase, RBCs, sediment
    - Assessment of urine chemistry, osmolality and specific gravity
    - Daily FBS (fasting blood sugar) and pre-prandial blood glucose determinations for insulin deficient (Type 1) patients
    - Determination of glycosylated hemoglobin (HbA1c) at intake to determine the level of control needed and the frequency of clinic visits
    - Baseline weight

- Baseline abdominal girth (should be <40inches for males and <35inches for females – abdominal girth greater than the numbers indicated is indicative of Metabolic Syndrome)**NOTE:** This test may be deferred until the initial chronic care visit
- Urinalysis for microalbuminuria
- Microfilament testing of the feet - NOTE: This test may be deferred until the initial chronic care visit
- Baseline Snellen Test

4. Clinicians are to make notation of identified Cardiac Risk Factors
5. The information obtained in items 1 - 4 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

   NOTE: Diabetic patients found to have significant microalbuminuria are at increased risk for cardiovascular sequelae and vascular compromise. Early introduction of angiotensin converting enzyme inhibitor therapy [ACE] or Angiotensin receptor blockers [ARB] for those with intolerance will clinically slow the progression and delay the onset of vascular compromise.

DYSLIPIDEMIA, HYPERLIPIDEMIA

(Also, please see the section of this manual entitled Hypercholesterolemia)

The clinician must determine if the lipid dyscrasia is part of a clinical syndrome (i.e., - Metabolic Syndrome characterized by diabetes, hypertension, lipid dyscrasia, truncal obesity) or is a finding associated with a particular illness (such as Hypertriglyceridemia in diabetic ketoacidosis [DKA]). In the latter circumstance the treatment is targeted at correcting the DKA.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
   - Past medical history pertaining to dyslipidemia or hyperlipidemia
   - Where was the diagnosis made?....pre-admission, ER visit, emergency response in the jail?
   - Did the patient fast prior to having a blood sample taken?
   - Are there any comorbid conditions, such as diabetes, renal disease, cardiac disease?
   - Who is the primary care clinician?
   - Look for signs of lipid overload, such as xanthomas
   - Is the cardiac examination within normal limits – are there gallops, murmurs, etc., present?
2. The Problem List must be completed to include hyperlipidemia and/or other information, as provided.
3. The written clinician's orders should include:
   - A request for old records
   - Pharmacy verification of medications
   - Fasting lipid profile specimen. NOTE: Call the laboratory for special handling requirements.
   - Dietary recommendations (the ADA [American Diabetic Association] diet is most appropriate)
   - ECG/EKG (electrocardiogram)
4. Clinician must make note of identified **Cardiac Risk Factors**.
5. The information obtained in items 1 – 4 above will be reviewed by the clinician and be used to support the development of a patient-specific treatment plan.

HIV/AIDS

(Also, please see HIV/AIDS under the Infectious Diseases section of this manual)

Additional information is provided in the Infection Control Manual regarding the management of HIV.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - Requests for old records
    - Identification of primary medical provider for treatment of HIV
    - Pharmacy verification of medications
    - Information on current laboratory values from the clinic, physician or order including:
        - CD4
        - viral load
        - CBC with differential
        - CMP (comprehensive metabolic panel)
        - urinalysis
2. The Problem List must be completed and include HIV, AIDS
3. The initial written clinician orders should include:
    - Enroll in chronic care clinic – Infectious Diseases
    - Requests for existing laboratory and testing data
    - Orders for CD4 and viral load titers to be drawn after Week Three, with results available for the initial chronic care visit after 30 days (unless recent counts have already been provided)
    - Primary prevention review for current immunizations, including:
        - Influenza vaccine
        - Pneumovax (should be within eight[8] yrs.)
        - Hepatitis immunity (A and B), plus screening for HCV+
        - PPD
        - Females with +STDs will have HPV testing completed through community health clinics
    - Referral to gynecology for PAP smear (females)
    - Medication verification report – **NOTE**: Patients compliant with pre-incarceration medication regimens inclusive of HAART will have all associated drugs initiated upon admission
    - Dietary orders, including the ordering of supplementation for asthenic and cachectic patients
4. The information obtained in items 1 –3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

HIV EVALUATIONS IN FEMALES

- Annual PAP smear evaluations is not recommended for general female population.
- Annual PAP smear evaluations are recommended for HIV+ patients.

HYPERTENSION

(Also, please see the section devoted to Hypertension)

During the Initial Health Assessment, the clinician must determine whether the hypertension is acute or chronic; essential or secondary; controlled, uncontrolled, accelerated or malignant. Patients who present with acute or new onset hypertension must be assessed for signs or symptoms of volume contraction.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
    - Contact information for the patient's primary medical provider
    - Clinical events related to hypertension, including emergency room visits and prior hospitalizations
    - History of tobacco use
    - Family history
    - Concurrent chronic conditions
    - The physical examination must document all pertinent negative findings (such as: "no jugular venous distention," "no rales or rhonchi," "no cardiac heaves, gallops or murmurs," "no abdominal bruits," "no dependent edema," etc.)
    - Critical "end-organs" need to be assessed to determine the extent of damage to the:
        - Eyes (funduscopic assessment)
        - Heart
        - Kidneys
    - The results of diagnostic testing completed in the past, including:
        - CXR
        - ECG/EKG
        - echocardiogram
        - urinalysis
        - stress test
    - Review of all current and prior medications
2. The Problem List must be completed and must characterize the type of hypertension:
    - Essential – must indicate controlled, uncontrolled, benign, accelerated or malignant (See the Hypertension Section of this manual)
    - Secondary (causes include anxiety and dehydration, which should be "resolved")
    - **Comorbid conditions and cardiac risk factors must be delineated**.
3. The initial written clinician orders should include:
    - A written diet order (recommendation for a low sodium diet is most common)
    - CMP (comprehensive metabolic panel) must be obtained and should include:
        - BUN
        - creatinine
        - urinalysis
        - glucose
        - calcium

- An ECG must be obtained within two(2) weeks of the inmate's arrival, sooner if there are cardiac complaints or a cardiac history
- A chest x-ray should be obtained within thirty(30) days for patients with ECG evidence of ventricular hypertrophy or for those with rales, gallops, murmurs or dependent edema
- Smoking cessation education (if applicable)
- Enrollment in Chronic Care Clinic

4. The information obtained in items 1 – 3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

SEIZURE DISORDER

(Also, please see Seizures located under the Neurology section of this manual)

Review of clinical practice outcomes over several years has provided justification and support for early classification of reported seizures among inmates. The clinician must determine if the seizures are associated with substance abuse/substance withdrawal. Seizures occurring after significant head trauma represent a different cohort. Patients with new onset, unprovoked seizure activity represent a clinical emergency and must be sent for immediate CT scan or MRI.Patients with a history of epilepsy or an underlying seizure disorder of several years' duration represent yet another cohort.

1. The clinician must complete a comprehensive history and physical examination during the Initial Health Assessment and address the following:
   - History of seizures, nature of seizures and last hospitalization for seizures
   - Possible relationship between substance abuse withdrawal and onset of seizures
   - Emergency room management of seizures (especially as related to substance abuse)
   - Age at onset
   - History of significant head trauma
   - Comorbid conditions, such as diabetes, ischemic heart disease, chronic renal failure
   - Documentation of all medications (especially insulin, levothyroxine, Keppra, and phenobarbital and other anti-seizure medications)
   - HIV/AIDS status
   - Malignancies
   - Clinician will note pertinent negatives on examination including: "no carotid bruits," "no cardiac ectopy, gallops, murmurs"
2. The Problem List must be completed and must characterize the seizure type as one of the following:
   - Related to substance abuse withdrawal
   - Epilepsy
   - Secondary to trauma
   - New onset
3. Clinician's written orders should include:
   - Review of old records
   - Seizure precautions
   - CMP, CBC with differential, urinalysis
   - ECG

- CXR

4. The information obtained in items 1 – 3 above will be reviewed by the clinician and used to support the development of a patient-specific treatment plan.

MAJOR MENTAL ILLNESS

The nursing staff will make referrals for all patients diagnosed with mental illness at the time of Receiving Screening (NCCHC standard E-02). The clinicians must review mental health assessments, when available, during the Initial Health Assessment (NCCHC standard E-04), and amend treatment plans accordingly.

The clinician will evaluate all substance abuse withdrawal patients during the Initial Health Assessment for associated Axis I and Axis II diagnoses. These **M**entally-**I**ll **C**hemically **A**ddicted (**MICA**) patients must be carefully monitored throughout the periods of withdrawal and adjustment to living within a correctional facility. Special procedures for caring for these patients are delineated under the Substance Abuse Withdrawal section of this manual.

LABORATORY STUDIES AND DIAGNOSTIC TESTING

Laboratory forms are available to practitioners. Diagnostic profiles (groupings of laboratory tests) afford the clinician needed information in the most cost-effective manner. The Medical Director will collaborate with practitioners to ensure that only appropriate tests are ordered. **NOTE**: Single tests usually require special assays and are generally more costly.

ASSESSMENTS

- **Lifestyle modifications (see chart)**
- **Standardized diagnostic tests (facility-initiated)**
  - Ultrasound
  - X-ray
  - EKG/ECG
  - Spirometry
  - Echocardiogram
  - CT scans/MRI
- **Standardized diagnostic tests (consultant-initiated)**
  - Bronchoscopy
  - Cardiac catheterization
  - Paracentesis
  - ERCP (endoscopic retrograde cholangiopancreatography)
  - Biopsy
    - Diagnostic
    - Therapeutic

- Ultrasound
  - Transesophageal echocardiography
  - Transrectal
- D&C (dilation and curettage)

- **Diagnostic Testing**
  - On-Site
    - Urinalysis
    - Microalbumin 2-1Combo Strips
    - Electrocardiogram (ECG/EKG)
    - Immunizations
    - X-ray
    - Ultrasound
  - Off-Site
    - CT scan
    - MRI (magnetic resonance imaging)
    - MRA (magnetic resonance angiography)
    - Ambulatory electrocardiogram/Holter monitoring
    - Cardiac stress test

CONSULTATIONS AND THE USE OF SUB-SPECIALISTS

1. Establish a working diagnosis or a tentative care plan.
2. Record in progress notes what diagnostic tests, consultants or sub-specialty services are required and what information you expect to obtain. Please see the following examples:
   - Ultrasound of kidneys for hematuria – R/O nephrolithiasis, renal cysts, mass lesion
   - Echocardiogram with ejection fraction for dyspnea and orthopnea – Ejection fraction <35% versus >60%
   - Thyroid ultrasound for goiter – cystic or solid lesion
3. Issue a written order using the Physicians' Order Sheet.
4. Staff clinicians **MUST** submit all requests for diagnostic testing, consultations and sub-specialty services to the Medical Director for approval.
5. The Medical Director reserves the right to not concur with the proposed operating differential diagnosis, to not support the current clinical care plan and to deny any requests. In these instances, an alternative plan must be entered in the progress notes. Consult requests are filed in the medical record and not forwarded to the Corporate Medical Director.
6. Diagnostic testing, consultation and sub-specialty service requests approved by the Medical Director are forwarded to the Corporate Medical Director for review and final approval (this process is usually

completed within 24 hours). The Medical Director may circumvent standard procedures in the event of urgent or emergency requests by calling the Corporate Medical Director directly to discuss a case.

7. The Corporate Medical Director reserves the right to not concur with the proposed operating differential diagnosis, to not support the current clinical care plan or to deny a request. In these instances, an alternative plan must be outlined on the Consultation Request form. This form must be placed in the medical record and the clinician must complete a new progress note.
8. Upon completion of diagnostic testing, consultation or sub-specialty services, the official report must be reviewed and endorsed. Endorsement must include the clinician's name/initials, name stamp and date. A corresponding note must also be included in the progress notes. See examples below:
    - CXR reveals infiltrate with a 20mm PPD skin test. Plan: Order CT scan of chest.
    - Endoscopy completed by Gastroenterology. Polyps removed from colon. Patient informed will follow-up with pathology report.

See Forms for:

- Consultation Request Form
- Consultation Response Form
- Consult Return Review

INFORMATIVE DOCUMENTS

PAIN MANAGEMENT PRINCIPLES

NOCICEPTIVE PAIN			
	CAUSE	**CHARACTER**	**TREATMENT**
SOMATIC	**Musculoskeletal:** – Skin – Muscle – Joints – Ligaments	– Sharp – Localized – Reproducible – Positional	– NSAIDs – Injectable NSAIDs – Ketorolac (Toradol)
VISCERAL	**Internal Organs:** **Thorax** – Heart – Lung **Abdomen** – Liver – Kidney – Spleen – Bowel **Pelvis** – Bladder – Uterus – Ovaries	– Ache (dull, deep) – Stretching – Heaviness – May refer (e.g., backache)	***Opioids:** – Mild – Codeine – Strong – Morphine Ultram (Tramadol)

*** When prescribing opioids, please note the following:**

- Opioids may interact with anti-depressants and migraine medications, leaving the patient at risk for serotonin syndrome. Serotonin syndrome is characterized by an increase in serum levels of serotonin and can cause agitation, hallucinations, rapid heart rate, fever, sweating, shivering, shaking, muscle twitching, muscle stiffness, nausea, vomiting and diarrhea. Symptoms may develop within several hours or several days.
- According to the FDA's Adverse Event Reporting System (FAERS) database, serotonin syndrome is more likely to occur with fentanyl and methadone, even when used at recommended dosages.

- Use of opioids can also result in adrenal insufficiency and decreases in cortisol production. Symptoms to be on alert for include nausea, vomiting, loss of appetite, fatigue, weakness, dizziness and low blood pressure. If adrenal insufficiency is suspected, the healthcare professional should order appropriate diagnostic testing and treat the patient with corticosteroids, tapering the patient off of the opioid, as appropriate.
- Opioid medications can also decrease the level of sex hormones, leading to changes in libido, impotence, amenorrhea and infertility. As appropriate, the health professional should order laboratory testing to assess this adverse reaction.

NON-NOCICEPTIVE PAIN			
	CAUSE	**CHARACTER**	**TREATMENT**
NEUROPATHIC	**Primary Neurologic:** – CVA (cerebral vascular accident) – Multiple sclerosis – Disc herniation – Compression fracture	– Hypesthesias – Highly variable – Variable temperature (hot/cold) – Localized or referred – Treat the primary cause	**Anticonvulsants** – Gabapentin (Neurontin) – Pregabalin (Lyrica) **Antidepressants** – Amitriptyline (Elavil) **Ultram**(Tramadol) **Lidocaine** – Patches – Creams
SYMPATHETIC	– Acute fracture or soft tissue injury – CRPS (complex regional pain syndrome)	– Severe pain – Disuse secondary to pain – Diaphoresis – Swelling – Sudden and debilitating	– Anti-convulsants – Anti-anxiety – Anti-depressants – Anti-inflammatory – Surgery

LIFESTYLE MODIFICATIONS

Lifestyle Modifications

This information is provided with the intention of assisting the practitioner in the development of care plans for:-

- Hypertension
- Diabetes
- Dyslipidemia/Hyperlipidemia
- Smoking cessation

MODIFICATION	RECOMMENDATION	SYSTOLIC BP REDUCTION
WEIGHT REDUCTION	Body Mass Index = 18.5 to 24.9 kg/M2	5 to 20 mmHg for each 10 kg of weight loss
DIET MODIFICATION	Increased fruits and vegetables, low saturated fats, low-fat dairy	8 to 14 mmHg
SODIUM REDUCTION	<100 mmol per day 2.4 Na+ or 6 gm NaCl	2 to 8 mmHg
PHYSICAL ACTIVITY PLAN	Aerobic exercise for 30 minutes per day, most days	4 to 9 mmHg
ALCOHOL CONSUMPTION MODERATION	<2 drinks (1 oz. ethanol) – e.g., - 24 oz. of beer or 10 oz. of wine or 3 oz. 80 proof per day	2 to 4 mmHg

PHYSICIAN ORDER SHEET for DIABETIC PATIENTS

1. Admit to Chronic Care Clinic
2. Prescribe 1800 calorie diet recommended by the ADA (American Diabetes Association)
3. Instruct Nursing to provide educational materials on Healthy Lifestyle Management
4. No added salt

DEHYDRATION PRINCIPLES AND STANDARDS OF CARE

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS **(1 liter = 33.81 oz. or 1000 cc/mL)**	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

Dehydration is one of the most common clinical conditions encountered within correctional facilities, and yet it is frequently unaddressed, leading to protracted morbidity and negative outcomes.

- **underdiagnosed**
- **partially-treated**
- **often recurrent**

There are numerous clinical causes associated with dehydration. Some are subtle in presentation and require intensive observation and thorough examination. Increased insensible water loss can be due to tachypnea (as part of upper respiratory conditions like influenza and pneumonia), increased core temperature (as with fever and malignant hyperthermia) and extensive dermatologic pathology (like exfoliations and blisters). Some clinical causes of dehydration are dramatic and acute, such as hemorrhage and shock. In all of these instances stabilizing treatment initiatives discontinued prematurely can lead to dehydration recurrence and relapse.

All clinicians who interact with patients must be able to recognize and effectively treat dehydration. Care plans must be multidisciplinary in approach and iterative in scope of management. Prognosis is oftentimes directly related to:

- **PROMPT INITIATION** of
- **APPROPRIATE CARE** for
- **THE RIGHT DURATION**

Throughout this manual, treatment for dehydration factors into treatment regimens. Outcomes often correlate with the correction of volume deficit. For instance, diabetics who present in ketoacidosis require hydration to correct hyperglycemia, but proper hydration will also counter poor perfusion and ketoneogenesis. Pneumonia patients receiving appropriate antibiotics may not initially respond to treatment if hypovolemic and on physical examination the lungs may sound clear to auscultation; however, once the patient is adequately hydrated, rales and rhonchi may suddenly become audible upon auscultatory examination.

Withdrawing patients will remain confused or obtunded, with hyper- or hypotension, if there is underlying volume contraction due to diaphoresis and/or diarrhea, even though therapeutic doses of Chlordiazepoxide have been administered. Patients seen on admission with CPK elevations in the thousands and prerenal azotemia will progress to rhabdomyolysis and obstructive uropathy if fluid repletion is not aggressive and intensive. Patients with bronchial asthma will remain refractive to respiratory treatment if not euvolemic and if underlying pneumonitis goes undiagnosed. **With each section in this manual, the clinician is asked to assess the volume status of the patient and to implement necessary volume replacement therapy in support of the care plan.**

ANNUAL HEALTH EXAMINATIONS

An annual health examination will be conducted for all inmates housed in the facility for 364 days or more. This applies to all inmates who have been sentenced, as well as those awaiting trial or disposition.

The annual health examination is conducted in two phases. **Phase One** includes the clinician's comprehensive review of the patient's health record to identify any chronic diseases, as well as prior conditions that have already resolved. All significant laboratory tests, diagnostic procedures and consultation reports are evaluated. Medications for chronic conditions are identified. Lastly, the patient level of compliance is determined following review of the objective information obtained. The Problem List is continually reviewed and periodically updated to include new clinical events and outcomes, as well as scheduled interventions, such as the "Annual Physical Examination" (with the date). **Phase Two** is an objective, hands-on evaluation of the inmate-patient. It involves the inspection, palpation, auscultation and percussion of the patient's body to determine the presence or absence of physical signs of disease. The clinician documents all clinically significant findings stemming from the physical examination, along with all "pertinent negative findings" in the medical record.

NCCHC has shifted its position regarding the annual physical examination to recommend that said services be defined by the facility.

The Centers for Medicare & Medicaid Services (**CMS**), previously known as the Health Care Financing Administration (HCFA), is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid,

Affordable Care Act (ACA) has a provision that private insurance plans cover preventive services without any patient cost-sharing. This requirement stems from evidence-based research yielding two pivotal outcomes:

- Impact mortality [save lives]
- Impact morbidity [improve heath]

These outcomes are achieved by:

- Early identification of illnesses
- Effective management strategies
- Effective and definitive treatment interventions prior to complications and/or debilitating illnesses

Full achievement of these stated goals are prevented to some individuals due to cost.

e.g. Colon cancer screening with colonoscopy with mean cost of $1000.00 for the procedure alone, ancillary fees [conscious sedation, medications, professional fees, post op medications] significantly higher.

Yearly "Wellness" visit - The compromise

This plan is designed to help prevent disease and disability based on:

- Current health
- Clinical risk factors.

The visit is based on the completion of a questionnaire, called a "Health Risk Assessment," which stratifies clinical information needed to develop a personalized health maintenance plan:

- A review of your medical and family history.
- Developing or updating a list of current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- Detection of any cognitive impairment.
- Personalized health advice.
- A list of risk factors and treatment options.
- A screening schedule (like a checklist) for appropriate preventive services
    - Vaccines
    - PAP smears
    - PSA determinations
- Advance care planning

COMPONENTS OF THE ANNUAL HEALTH EXAMINATION

NURSING DOCUMENTATION

Intake Screening

- Review of inmate patient history
    - Obtain SIGNED Release of Information form
    - Medication review
    - Confirmation of Medications – FAXED TO ORDERING PHYSICIAN/DISPENSING PHARMACY
- Determination of current level of disease control through review of inmate history
- Ascertain any special needs requirements
- Complete and include all necessary medical documentation in the medical record

COMPONENTS OF THE ANNUAL HEALTH EXAMINATION

Age	Sex	Examination	Factoids
All	M/F	Comprehensive "hands-on" examination	CBE(Clinical Breast Exam)
All	M/F	CBC with differential, CMP, PPD	Systems review for LTBI
All	M/F	Disease-specific testing (such as HA1c, CD4, viral load)	
All	M/F	Primary Prevention Review and Update	All annual vaccines will be documented, along with other immunizations[1] and clinically appropriate screening tests.[2]
All	M/F	Comprehensive dental examination	X-ray studies, as indicated
All	M/F	Disease-specific Diagnostic Testing[3]	See Chronic Disease Management – Clinical Guidelines Manual
50+	M/F	Secondary Prevention [Screening]	
All	M	PSA testing over 50	This test is under review; therefore, recommendations are subject to change.
Adult	F	Pelvic examination and PAP smear	Emancipated juvenile defendants, as well as those with a history of STDs will be included.
All HIV+	M/F	CB4, viral load and CXR	
All	M/F	Ophthalmology	
All	M/F	Podiatry and Microalbuminuria	
HIV+	F	PAP	

EMERGENCY CARE MANAGEMENT

ACUTE CARE MANAGEMENT

[1] Refer to the Infection Control Manual and the Clinical Guidelines Manual for a listing of recommended tests.
[2] HIV screening is offered at intake in some facilities. Private grants operate HIV Testing-on-Demand programs.
[3] Examples of tests include - ECG for hypertensive patients, diabetics, cardiac patients; echocardiogram with ejection fraction for patients in congestive heart failure or renal failure.

Patients presenting to the nursing staff with certain urgent or emergent conditions that DO NOT require immediate transfer to a tertiary care emergency facility shall require management by the clinician on-duty or on-call. Standardization of these orders assures compliance with established treatment guidelines and supports favorable clinical outcomes.

EMERGENCY CONDITION	**TREATMENT ORDERS**
Abdominal Pain	DO NOT GIVE ANALGESICS UNTIL ETIOLOGY IS CONFIRMED Flat plate abdominal x-ray or ultrasound – to discern pancreatic calcifications, gas Ultrasound – for determining cholelithiasis, choledocholithiasis, nephrolithiasis
Acute Asthma [reversible airway disease]	0.083% Albuterol 2.5mg in 3cc of normal saline administered via nebulizer
Allergy – Pruritus [Mild to Moderate]	Benadryl 50mg IM
Allergy – Pruritus [Severe]	Solu-Medrol 125mg IM
Chest Pains	Electrocardiogram Cardiac – nitroglycerin SL Costochondritis – indomethacin [Indocin] – high dose NSAIDs
Dehydration	Urine specific gravity test IV – normal saline or 0.45 normal saline [avoid glucose on first liter until thiamine and folate supplementation have been provided]
Dental Pain	Motrin 800mg BID Monitor vital signs [if fever present, rule out infection] Antibiotics [if necessary]
Diabetic Ketoacidosis	Urine testing - specific gravity, ketone levels Electrocardiogram [to determine silent AMI or ischemia] IV – normal saline or 0.45 normal saline [avoid glucose on first liter until thiamine and folate supplementation have been provided] Regular insulin on sliding scale **[Glucose levels decline rapidly with hydration]**
Falls, sprains, non-displaced fractures	Ice Elevation Immobilization NSAIDS, including Ultram or Toradol
Hematuria with **severe** pain	Ketorolac [Toradol] 60mg IM Abdominal ultrasound **ASAP**
Seizure	Known etiology – Epilepsy or withdrawal Ativan 2mg IM with continual monitoring up to 4mg in 30 minutes **DO NOT MASK NEW ONSET SEIZURES; SEIZURES SECONDARY TO HEAD TRAUMA OR FALLS; OR FEBRILE SEIZURES – REFER PT. TO ER**

System Disorders and Specific Conditions

CARDIOVASCULAR

CARDIOVASCULAR PROTOCOL

Review of Intake Screening/Clinical History (Nursing Documentation)

Enroll in Chronic Care (all necessary documentation must be included in the medical record)

Initial Health Assessment (Physical Examination Findings)

- Review of past medical history, including primary care
- Jugular venous distension
- Neck bruits
- Lung field
- Auscultation for gallops, murmurs
- Akinesis
- Mitral valve prolapse
- Abdominal bruits
- Hepatojugular reflux
- Dependent edema
- Pulse
- Concurrently occurring conditions (i.e., - diabetes, kidney disease, etc.)
- Electrocardiogram (ECG/EKG)
- Echocardiogram with ejection fraction (EF)

CHRONIC CARE FOR CARDIOVASCULAR PATIENTS

- Review inmate's cardiac history and indicate diagnosis using appropriate ICD code(s) – i.e., ischemic heart disease, restrictive cardiac disease, obstructive cardiac disease
- Risk Factors (identify in medical intake notes [baseline] and initial chronic care visit [clinic])

CARDIAC RISK FACTORS
o **Male**
o **Diabetic**
o **Hypertension**
o **Smoker**
o **Dyslipidemia/hypercholesterolemia**
o **History of ischemic heart disease**
o **Diet high in saturated fats and sodium**
o **Angina**
o **Metabolic Syndrome**
o **Neck circumference >20 inches**
o **Waist circumference >40 inches**
o **Gallops and murmurs**

CHRONIC CARE DIAGNOSTIC TESTS

- Electrocardiogram (ECG/EKG)
- Echocardiogram with ejection fraction (EF)
- Ambulatory electrocardiogram/Holter monitoring

MEDICATIONS

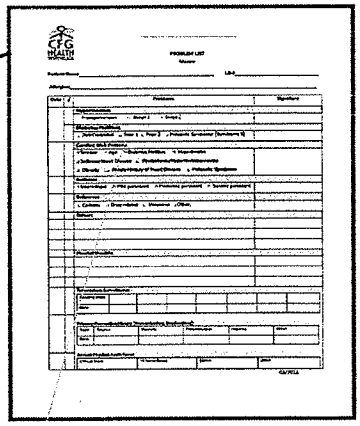
- Beta blocker
- ACE/ARB
- Amiodarone (for ejection fraction <35%; persistent cardiac ectopy)
- ASA (acetylsalicylic acid/aspirin)
  - Low dose (81 mg) - cardioprotective
  - Full dose (325 mg) - antithrombotic for females
  - ASA + dipyridamole (vs. clopidogrel)
- Diuretics (thiazides, loop)
- Aldosterone Antagonist
- Vasodilator Therapy (Hydralazine)
- Digitalis (decreases rates of heart failure hospitalizations)
- LCZ- 696 (Entresto, Ivabradine)
- NTG

Did You Check For?	Did You Do?

Risk factors (assessed at baseline and clinic evaluations)
 	
CARDIAC RISK FACTORS
 	
Male
Diabetic
Hypertension
Smoker
Dyslipidemia/Hypercholesterolemia
History of ischemic heart disease
Diet high in saturated fats and sodium
Angina
Metabolic syndrome
Neck circumference >20 inches
Waist circumference >40 inches
Gallops and murmurs
 	
• Insulin control
• Vegetation
• Mitral valve prolapse
• Akinesis
	• Comprehensive physical exam
	• Chronic Care enrollment
	• Patient education
	  o Comment on cardiac risk factors:
	  o Initiate smoking cessation program (if necessary)
	  o Encourage aerobic exercise (walking)
	• Cardiac work-up (via consultation) to include:
	  o Stress test
	  o Catheterization
	  o MUGA scan (multi gated acquisition scan)
	• Electrocardiogram (ECG/EKG)
	• Echocardiogram with ejection fraction (EF)
	  o 58% - Normal
	  o 45 - 55% - Moderate failure (controlled with medication)
	  o < 35% - Low (administer amiodarone; use defibrillator, if necessary)
	• Write Orders
	  o Nursing Care Plan
	  o Diagnostic testing
	  o Sub-specialty support
	  o Establish level of monitoring through:
	  ▪ Chronic Care
	  ▪ Infirmary Care
	• Identify Treatment Goals
	• Stabilize and improve cardiac reserve by:
	  o Increasing cardiac output (via inotropic medications, afterload reduction, antiarrhythmic drugs)
	• Eliminate pain and discomfort through the use of:
	  o Beta blockers
	  o Nitrates
	• Contain or eliminate hypoxia and/or cardiac ectopy through the use of:
	  o Amiodarone
	  o Oxygen

CARDIOVASCULAR DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Characterize cardiac disease and comment on risk factors (see chart next page)** • **Include ICD code** • **Provide documentation of functional level (e.g., -** *severe congestive cardiomyopathy with EF 34% with defibrillator*)
Orders and Care Plan
Nursing Education
Discharge Planning • **Review all medications and studies** • **Clinic referral**



Cardiac Risk Factors:

□Smoker □Age □Diabetes Mellitus □Hypertension

□Ischemic Heart Disease □Dyslipidemia/Hypercholesterolemia

□Obesity □Family History of Heart Disease □Metabolic Syndrome

HYPERTENSION

HYPERTENSION PROTOCOL

(Treatment of hypertension as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Review of Intake Screening/Clinical History (Nursing Documentation)

- Inmate history of hypertension (obtained from nurse screening)
- Results of prior diagnostic testing including:
  - prior electrocardiograms (ECGs/EKGs) and laboratory studies
- Ascertain any special needs requirements and comorbid conditions (i.e., diabetes, kidney failure, cardiac insufficiency, end organ deficits, etc.)

Initial Health Assessment (Physical/Examination Findings)

- Review of hypertension history with inmate, including medications
- Focused physical examination, with particular emphasis on end organ impact, to include:
  - Cardiovascular examination:
    - presence of heaves, thrills, gallops, murmurs, rubs
    - uncontrolled blood pressure
  - Eye examination:
    - Proptosis
  - Neck examination:

        - jugular venous distension (JVD)
        - bruits
    - Peripheral pulses
    - Renal vascular evaluation
- Temperature
- **IT IS IMPERATIVE THAT THE CLINICIAN MAKE NOTATION OF CRITICAL NEGATIVE FINDINGS (PERTINENT NEGATIVES).**

Diagnostic Tests

- Snellen eye test
- electrocardiogram (ECG/EKG)
- echocardiogram with ejection fraction (EF), as indicated
- Doppler study
- 24-hour urinary free cortisol
- urinalysis, noting:
    - osmolality
    - presence of ketones
    - chem
    - sediment
    - presence of vanillylmandelic acid (VMA)
    - presence of metanephrine
    - evidence of hyponatremia
    - evidence of hematuria
    - increased catecholamines

Referrals

- Cardiology
- Nephrology

TREATMENT STRATEGIES FOR HYPERTENSION

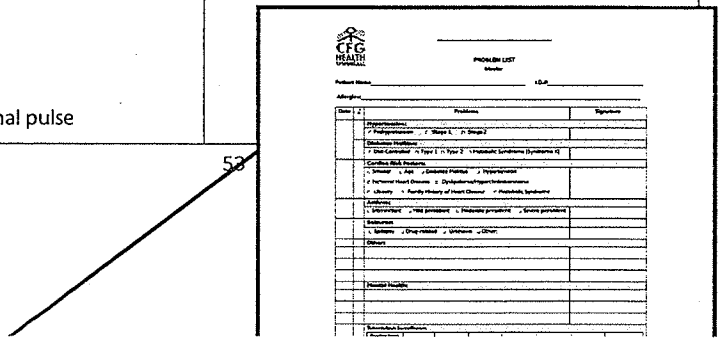
BLOOD PRESSURE	SYSTOLIC mmHg	DIASTOLIC mmHg	LIFESTYLE MODIFICATION	INITIAL CLINICAL INTERVENTION ESSENTIAL HYPERTENSION	INITIAL CLINICAL INTERVENTION HT+DM or CRF
NORMAL	<120	<80	Support		
PRE-HYPERTENSION	120-139	80-89	Yes	No Rx	Start Rx
STAGE 1 HYPERTENSION	140-159	90-99	Yes	Thiazide, then assess and prescribe additional medications (as indicated)	Many Rxs available
STAGE2 HYPERTENSION	>160	>100	Yes	Two Rx combination + diuretic	Many Rxs available

Lifestyle Modifications

This information is provided with the intention of assisting the practitioner in the development of care plans for hypertensive patients.

MODIFICATION	RECOMMENDATION	SYSTOLIC BP REDUCTION
WEIGHT REDUCTION	Body Mass Index = 18.5 to 24.9 kg/M2	5 to 20 mmHg for each 10 kg of weight loss
DIET MODIFICATION	Increased fruits and vegetables, low saturated fats, low-fat dairy	8 to 14 mmHg
SODIUM REDUCTION	<100 mmol per day 2.4 Na+ or 6 gm NaCl	2 to 8 mmHg
PHYSICAL ACTIVITY PLAN	Aerobic exercise for 30 minutes per day, most days	4 to 9 mmHg
MODERATION OF ALCOHOL CONSUMPTION	<2 drinks (1 oz. ethanol) – e.g., - 24 oz. of beer or 10 oz. of wine or 3 oz. 80 proof per day	2 to 4 mmHg

Did You Check For?	Did You Do?
Abnormal pupil reaction	Electrocardiogram (ECG/EKG)
Abnormal heart function	Funduscopic examination
Abnormal kidney function	Electrolyte panel
Peripheral pulses	Urinalysis
Jugular venous distension	Optometry/Ophthalmology referral
Carotid bruit	Doppler study
Gallop rhythms S3 and S4	Echo with ejection fraction (EF)
Murmurs	Lab studies
Heaves	Increase BP with ACE inhibitor for *Renal Art Stenosis*
Hematuria	Special studies
BUN:Creatinine (Cr) ratio of >20:1	Arrange consultations
Abdominal bruits	
Diminished pulse	
Bounding pulse	
Distal pulse lower than proximal pulse	



Hyperkalemia Hypokalemia Metabolic alkalosis	

HYPERTENSION DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Classification via ICD coding** • **Etiology (*e.g. – essential, renal, etc.*)**
Orders and Care Plan • **Note level of control** • **Enroll in Chronic Care**
Nursing Education
Discharge Planning • **Medication review** • **Compliance issues and impotence in males** • **Review of laboratory results and consultations**

Hypertension:

□ Prehypertension □ Stage 1 □ Stage 2

CONGESTIVE CARDIOMYOPATHY

CONGESTIVE HEART FAILURE

BNP (B-type Natriuretic Peptide) is a substance secreted from the ventricles or lower chambers of the heart in response to changes in pressure that occur when heart failure develops and/or worsens. The level of BNP in the blood will increase when heart failure symptoms worsen and will decrease when the heart failure

condition is stable. The BNP level in a person with heart failure is ***always***higher than in a person with normal heart function.

The B-type Natriuretic Peptide laboratory test is used when heart failure is suspected to evaluate and manage problems associated with the ventricles of the heart. The B-type Natriuretic Peptide test is particularly useful for the following clinical situations:

- Differentiating CHF (congestive heart failure) from pulmonary disease
- Screening for CHF in high risk patients
- Determining severity of CHF
- Risk stratification after acute myocardial infarction
- Assessing left ventricular hypertrophy in dialysis patients
- Assessing cardiotoxicity related to chemotherapy

NOTE: The BNP titer increases with age. Basal levels of BNP are consistently higher in females.

MEAN BNP CONCENTRATION BY AGE:

AGE	MALE	FEMALE
45 – 54	14.3	25.2
55 – 64	19.2	33.6
65 – 74	23.3	37.7
75+	46.1	76.5

Measured in pg/mL

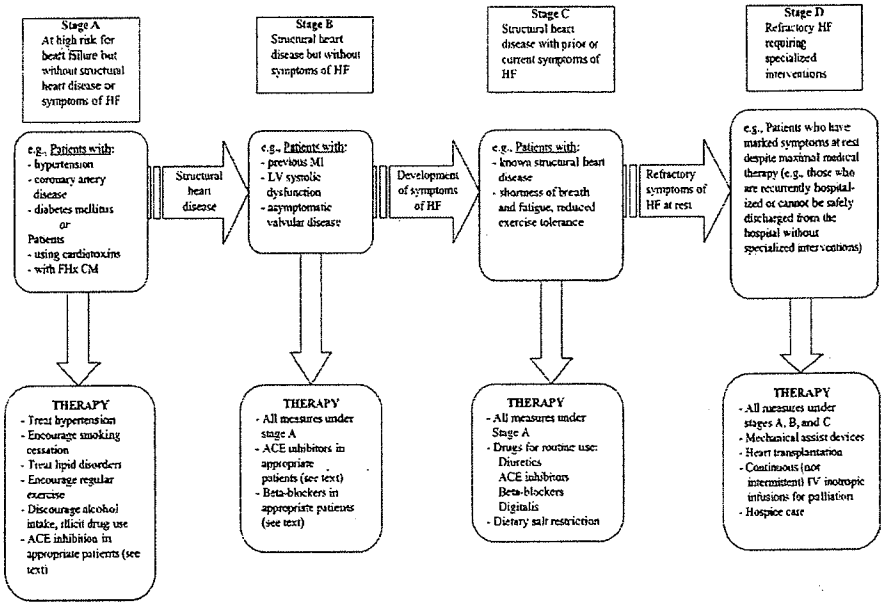
CLASSIFICATION OF HEART FAILURE SEVERITY

NYHA Class I (mild)	**Normal**	**No Symptoms** **Normal Exercise Test** **Normal LV Function**	**71**
NYHA Class II (mild)	**Asymptomatic LV (some dysfunction)**	**No Symptoms** **No Problems Exercising** **Abnormal LV Function**	**204**
NYHA Class III (moderate)	**Compensated CHF**	**Symptoms on Exercise** **Abnormal LV Function**	**349**
NYHA Class	**Refractory CHF**	**Symptoms Present at Rest**	**1022**

IV (severe) **Not Controlled with Treatment**

Measured in pg/mL
LV=left ventricle

HEART FAILURE TREATMENT GUIDE AND RECOMMENDED THERAPY BY STAGE



ACC/AHA Practice Guidelines TableClinical Applications:

1. Patient presents with dyspnea at rest. BNP is < 100 pg/mL. Is the dyspnea cardiac in origin? Should the next diagnostic test performed be a chest CT scan or echocardiogram with ejection fraction?

Answer: Dyspnea is non-cardiac in origin; next test should be a chest CT

2. Breast cancer patient on Adriamycin therapy. Initial BNP is 25 pg/mL when therapy begins, but is now 375 pg/mL. What is the appropriate diagnostic test? What is the anticipated clinical scenario?

Answer: Echocardiogram with ejection fraction; dyspnea on exertion (NYHA III)

3. 38 yo with cocaine cardiomyopathy, chest pains at rest, hypotension and dyspnea is transferred to the ER. Troponins are 3 and the BNP is 900 pg/mL. Patient has audible pulmonary wheezing. Cardiac or asthma?

Answer: Cardiac

Heart Failure with Preserved Ejection Fraction

- Left ventricular ejection fraction is > 50%
- Also known as "Diastolic Heart Failure
- Elderly females
- Diabetes mellitus
- Essential hypertension

Diagnosis is based on left ventricular ejection fraction, preferably with two-dimensional echocardiography.

Treatment

- Tight blood pressure control
- Weight reduction
- Beta blockers
- Anti-arrhythmia medications
- Management of ischemic heart disease

Hypertrophic and Restrictive Cardiomyopathy

Echocardiogram demonstrates the pathology.

Range of presentations from sudden syncopal episodes to chronic debilitating dyspnea and fatigue. Refer to Cardiology for care and treatment.

Acute Coronary Syndromes Unstable Angina, Non-ST Segment Elevation Myocardial Infarction

- Clinical spectrum based on severity of symptoms with a similar underlying pathogenesis
- Risk for death at one year is considerable
- Patients usually with comorbid conditions
- Females have a worse short-term and long-term outcomes and more complications
- Symptoms may occur at rest
- Angina may be prolonged – may have atypical presentation such as jaw pain
- Risk for recurrent events

Check hemodynamic status immediately. Provide oxygen supplementation.

ECG may be normal or Q in lead III only

Transport to tertiary center

ST-Segment Elevation Myocardial Infarction

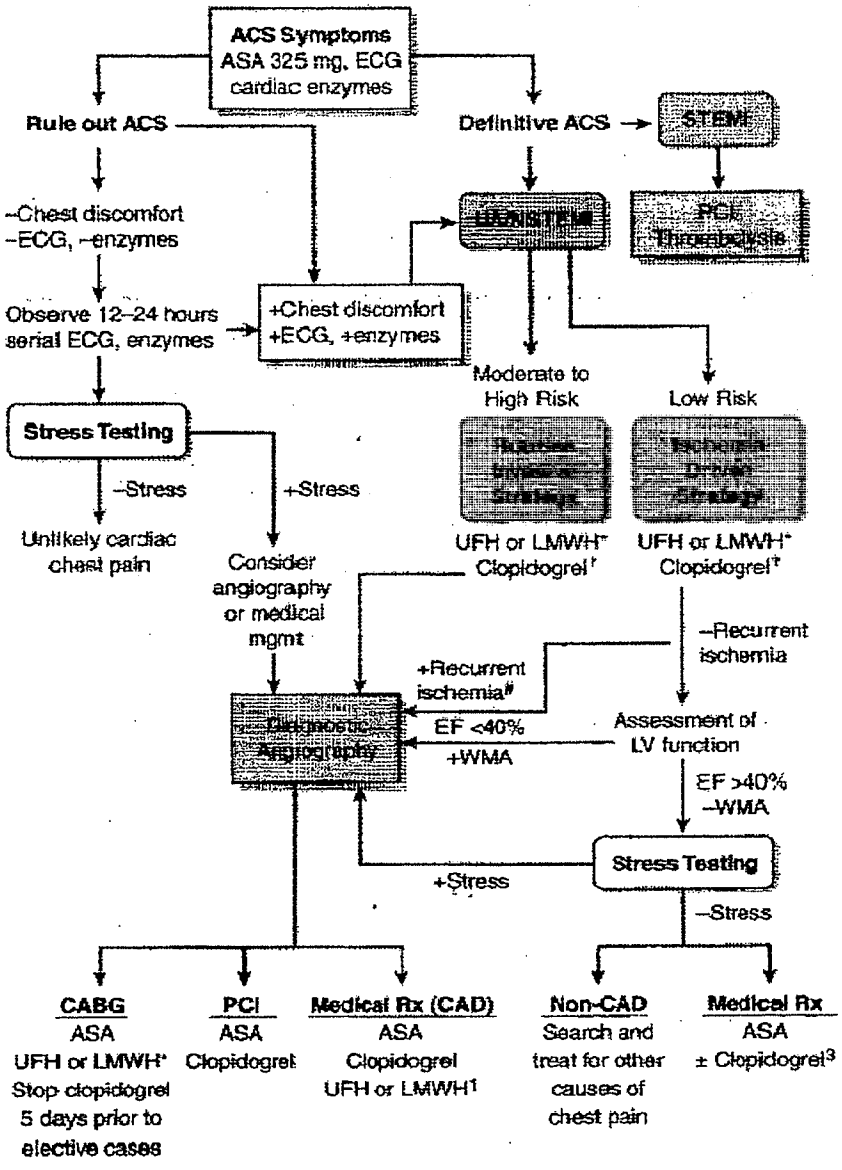
- Persistent ECG ST elevations

- Total occlusion of epicardial coronary artery, most often due to atherosclerotic plaque rupture or erosion and subsequent thrombus formation.
- Severe symptoms lasting for a longer duration
- Diabetics may present with sudden dyspnea with little chest pain
- Hemodynamic compromise is sudden onset, with range from dyspnea to shock
- Assess risk factors for treatment with thrombolytic therapy
- Rule out cocaine-abuse disorder

Check hemodynamic status immediately. Provide oxygen supplementation.

ECG with ST-elevations and Q waves

Transport to tertiary center


ACS Symptoms
ASA 325 mg, ECG
cardiac enzymes
Rule out ACS
Definitive ACS
STEMI
–Chest discomfort
–ECG, –enzymes
Observe 12–24 hours
serial ECG, enzymes
+Chest discomfort
+ECG, +enzymes
PCI
Thrombolysis
Moderate to
High Risk
Low Risk
Stress Testing
–Stress
+Stress
Unlikely cardiac
chest pain
Consider
angiography
or medical
mgmt
UFH or LMWH*
Clopidogrel†
UFH or LMWH*
Clopidogrel†
–Recurrent
ischemia
+Recurrent
ischemia#
EF <40%
+WMA
Assessment of
LV function
EF >40%
–WMA
Stress Testing
+Stress
–Stress
CABG
ASA
UFH or LMWH*
Stop clopidogrel
5 days prior to
elective cases
PCI
ASA
Clopidogrel
Medical Rx (CAD)
ASA
Clopidogrel
UFH or LMWH†
Non-CAD
Search and
treat for other
causes of
chest pain
Medical Rx
ASA
± Clopidogrel‡

HYPERCHOLESTEROLEMIA

HYPERCHOLESTEROLEMIA PROTOCOL

(Treatment of hypercholesterolemia as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Review of Intake Screening/Clinical History (Nursing Documentation)

Initial Health Assessment (Physical/Examination Findings)

- Ascertain and document any comorbid conditions, including, but not limited to:
  - Diabetes
  - Hepatitis
  - Pancreatitis
  - Alcoholism
  - Cholelithiasis
  - Choledocholithiasis

DIAGNOSTIC TESTS

- Ultrasound
- Abdomen
  - Liver
  - Laboratory Studies
- Lipid panel:
  - total cholesterol (TC)
  - triglycerides (TG)
  - HDL
  - LDL
- Liver function tests (LFTs)

MEDICATIONS GUIDELINE

Please visit the following link:

http://www.nhlbi.nih.gov/guidelines/cholesterol/atglance.pdf

- Goal of treatment is LDL cholesterol <70

Did You Check For?	Did You Do?
Xanthomas	Retrieve inmate patient's prior medical records
Skin lesions	Physical examination
Hepatomegaly	Abdominal flat plate x-ray
Positive Murphy's sign	Ultrasound of abdomen
Mid-line calcifications	Fasting specimen
Air-fluid levels	Serum glucose
Cholelithiasis	Amylase
Choledocholithiasis	Lipase
Fatty hepatic infiltrate	Liver function tests (LFTs)
Fatty hepatic degeneration (liver has mottled appearance)	Lipid panel
Comorbid conditions including, but not limited to:	
Diabetes	
Pancreatitis	
Dehydration	
Substance abuse	

HYPERCHOLESTEROLEMIA DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **ICD code(s)** • **Primary or secondary prevention** • **Level of control** • **Risk relationships (such as uncontrolled diabetes, alcohol abuse, etc.)**
Orders and Care Plan • **Abdominal ultrasound**
Nursing Education
Discharge Planning • **Discuss treatment targets** o **LDL <70** • **Behavioral modifications** o **Smoking cessation** o **Alcohol abstinence** • **Medications** • **Follow-up care**

HMG- CoA Reductase inhibitors are effective in lowering total cholesterol, LDL-C and raising HDL-C. These drugs, the statins, now have a FDA box warning.

Cytochrome P450- metabolism

- Rhabdomyolysis
- Ketoconazole
- Fibrates
- Cyclosporins

ENDOCRINOLOGY

DIABETES

(Treatment of diabetes as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Diabetes is a chronic condition whose clinical hallmark is elevation of blood glucose levels. Over 20 million people in the United States (7% of the population) have diabetes, and a significant number of these individuals remain undiagnosed. End-organ vascular damage related to diabetes involves:

- the *micro*-vascular system, including the retinal artery and renal capillaries
- the *macro*-vascular system, including the coronary and cerebral arteries

As such, treatment strategies are designed to forestall progressive cardiac, renal, ophthalmologic and neurologic issues and premature death.

Intrinsic insulin levels among these patients help to differentiate the two types of diabetes:

- Type 1 diabetes - characterized by insulin deficiency
- Type 2 diabetes - characterized by hyperinsulinemia and insulin resistance

MANAGEMENT OF TYPE I DIABETES – INSULIN DEFICIENCY

Insulin therapy is paramount to the treatment of patients diagnosed with Type 1 diabetes. Type 2 diabetes is often included in the clinical presentation of Metabolic Syndrome:

- Atherogenic dyslipidemia
- Abdominal obesity
- Elevated blood pressure
- Insulin resistance; +/- glucose intolerance
- Pro-inflammatory state
- Pro-thrombotic state

MANAGEMENT OF TYPE II DIABETES – INSULIN RESISTANCE

The management of Type 2 diabetes is multifactorial and includes the possible need for:

- Insulin, along with other oral blood glucose-lowering medications
- Antihypertensive preparations
- HMG-CoA reductase inhibitors (such as the "statins")

The evaluation parameters differ between the two diseases -- fasting blood glucose levels are measured for Type 1 diabetics versus HA1c, fasting lipids and blood pressure determinations for Type 2.

TREATMENT INITIATION

- Lifestyle Modifications (see chart in Office Practice Assessments)
- General principles applied to all patients with diabetes include:

- Education
- Nutritional management (education, caloric counts, calorie exchanges)
- Daily exercise
- Blood pressure management
- Weight
- Abdominal girth measurements
- BMI

The Diabetes Prevention Program[4] was a 27 clinical center study involving 3,234 participants followed for over three (3) years to assess the impact of lifestyle intervention (i.e. - exercising 150 minutes weekly, reducing fat and caloric intake, weight loss target of 7%) versus Metformin 850mg twice daily versus placebo tablets. The participants were identified as impaired glucose tolerance (IGT) (also called pre-diabetics). The findings were dramatic in terms of demonstrated prevention or delay in the onset of Type 2 diabetes in both of the groups receiving treatment. The Lifestyle Modification group sharply reduced progression from IGT to Type 2 diabetes and more robustly than the group receiving Metformin.

The HEALTHY Study, a primary prevention trial sponsored by the National Institute of Diabetes and Digestive and Kidney Diseases (a division of the National Institutes of Health) looked at early intervention among the middle school level at risk juveniles to assess the impact of lifestyle modification on the development of IGT, pre-diabetesand Type 2 diabetes. The outcomes,published in 2008, were the same as those in the Diabetes Prevention Program.

NON-MEDICATION TREATMENT PLANS IN THE CORRECTIONAL SETTING

All inmates, residents and/or or detainees identified as IGT, pre-diabetic, having Metabolic Syndrome or having Type 2 diabetes will be placed on the calorie-restrictive American Diabetic Association diet (to be provided by the contracted food services providers). The essential role of dietary regulation will be the cornerstone of treatment and education and will be reinforced by the clinicians and nursing staff during chronic care visits and medication passes.

Facility-adjusted exercise regimens will be required for each inmate, resident and/or detainee identified as IGT, pre-diabetic, as having Metabolic Syndrome or as having Type 2 diabetes. For those individuals with access to a gymnasium or outdoor activities, nursing will assist in the development and management of an activity log. For those inmates confined to their housing units or cells only, marching in place and performing arm swings 4 to 5 times daily will be considered sufficient activity.

The patient must understand that at each clinical visit the provider will monitor both their dietary compliance and exercise activity.

Though smoking is not allowed in correctional facilities, all clinical staff must counsel patients against smoking and document this education in the medical record.

MEDICATIONS

[4]Knowler WC, Barrett-Connor E, Knowler SE et al, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or metformin", NEJM, 2002, Feb 07;346(6):393-403.

Type 1 diabetics require adequate insulin supplementation.

Type 2 diabetics who do NOT have renal insufficiency should receive Metformin, up to the maximum daily dosage, as part of their regimen.

Type 2 diabetics also require a plan that manages any comorbid conditions concomitantly while treating blood glucose elevations. The treatment regimen must address the control of blood pressure and dyscrasia, in addition to blood glucose elevations. **NOTE**: Blood pressure goals in diabetics are BP < 130/80. ACEI/ARBS are first line therapy. LDL goal is less than seventy(70). Medications should be adjusted accordingly to meet these goals.

CATEGORY/MEDICATION	ACTION	OUTCOMES	SIDE EFFECTS
BIGUANIDES • **Metformin**	• decreases hepatic gluconeogenesis (GNG) • blocks intestinal absorption of glucose • secondary increase in glucose sensitivity	• first line Rx • hypoglycemia rare • HA1c down 1.5 • weight OK (possible gain)	• renal failure • cardiac issues • lactic acidosis (more prevalent among the elderly)
SULFONYLUREAS **First Generation:** • **Acetohexamide** • **Chlorpropamide** • **Tolazamide** • **Tolbutamide** **Second Generation:** • **Glipizide** • **Glyburide** • **Glimepiride**	• pancreatic beta-cell stimulation	• HA1c down 1.5	• weight gain • decreased efficacy with time • problems among the elderly
MEGLITINIDES • **Repaglinide** • **Nateglinide**	• pancreatic beta-cell stimulation	• HA1c down 1.5 • must be taken with food	
AMYLIN ANALOG • **Pramlintide**	• injectable Amylin • slows gastric emptying • decreases gluconeogenesis • increased feeling of satiety		• gastroparesis
THIAZOLIDINEDIONES • **Rosiglitazone** • **Pioglitazone**	• increases sensitivity to insulin • increases uptake of glucose into adipose,	• **only works when insulin is present** • HA1c down	• fluid retention • weight gain • secondary

CATEGORY/MEDICATION	ACTION	OUTCOMES	SIDE EFFECTS
	muscle and hepatic cells	1.0	congestive heart failure • bladder cancer (with Pioglitazone)
DIPIPIDYL PEPTIDASE-4 (DPP-4) INHIBITORS • **Sitagliptin**	• enzymatic degradation of incretin hormones: 1. glucagon-like peptide-1 (GLP-1) 2. glucose-dependent insulinotropic polypeptide (GIP)	• HA1c down 0.5 • blocks inhibition of the enzymes	
ALPHA-GLUCOSIDASE INHIBITORS • **Acarbose** • **Miglitol**	• delays digestion of fat, proteins and carbohydrates	• minimal HA1c impact	• gas, diarrhea, cramping
SODIUM-GLUCOSE COTRANSPORTER-2 INHIBITORS •	•	•	•
[illegible]	•	•	•
[illegible]	•	•	•

INSULIN THERAPY

Insulin Coverage – Sliding Scales

Use the total daily coverage figures to determine an appropriate dose of long-acting insulin to prescribe. The goal is to blunt cyclic variations in blood glucose while lowering basal glucose levels to within normal range.

LANTUS INSULIN

LANTUS offers stable basal control of blood glucose levels in both Type1 and Type 2 patients. As control over dyscrasia, blood pressure and excessive caloric intake begin to blunt hyperglycemia in Type 2 diabetics, LANTUS insulin may be tapered and/or discontinued.

FASTING BLOOD GLUCOSE DETERMINATIONS

Fasting blood glucose (FBS) determinations, along with evening preprandial (4:00 PM) or nighttime (8:00 PM or 12:00 AM) glucose monitoring (via finger sticks) are important data points for defining insulin requirements. Blood glucose should be determined prior to each dose of insulin. In patients diagnosed as IGT, pre-diabetic or as having Type 2 diabetes, a single blood glucose level will be helpful in establishing a care plan. FBS and 4:00 PM blood glucose determinations are not indicated in the absence of insulin therapy.

HEMOGLOBIN A1C LEVELS

Glycosylated hemoglobin levels are more appropriate determinants of glucose control in Type 2 diabetics and should be taken to establish a baseline, within thirty(30) days after a medication change or with the addition of LANTUS coverage. Individual therapeutic targets should be developed with each patient. It should be noted that across all correctional facilities CFG serves within New Jersey, the goal is to achieve an average HA1c titer of < 7.0.

ANCILLARY MANAGEMENT OF DIABETES

As part of the Initial Health Assessment (Physical/Examination Findings), the following should be conducted:

OPHTHALMOLOGIC ASSESSMENT:

A baseline Snellen score must be obtained within thirty (30) days of an inmate's arrival at the facility. Annual ophthalmology appointments shall be conducted for all patients designated IGT, pre-diabetic, diabetic or diagnosed with Metabolic Syndrome. The practitioner must request tonometry, visualfields, fundoscopic examination with macular evaluation and vascular review. Laser treatment for neovascularization is considered a community standard of care.

CARDIAC ASSESSMENT:

The clinician must complete a cardiac examination within thirty(30) days of an inmate's admission and must comment on all auscultatory findings. For those individuals with concomitant hypertension or hyperlipidemia, a cardiogram must be performed. Symptomatic patients should be referred for on-site echocardiogram with ejection fraction determination requested. Patients with evidence of "third-spacing" or dependent edema should also have a chest x-ray done.

RENAL ASSESSMENT:

All patients designated as IGT, pre-diabetic, diabetic or as having Metabolic Syndrome must undergo urinalysis and have a urine microalbumin test done within thirty(30) days of admission. Diabetic patients and/or those with evidence of proteinuria must be placed on an ACE-inhibitor. Those patients who cannot tolerate this class of medication and/or in whom measurable proteinuria has been identified will be referred for sub-specialty evaluation and care.

Clinicians must monitor the urine for leucocyte esterase, along with WBCs and sediment. Glycosuria is often associated with colonization that must be differentiated from urinary tract infections. **NOTE:Pregnant**

patients with urinary tract infections, with or without diabetes, must be referred for prompt evaluation and treatment.

GASTROINTESTINAL ASSESSMENT:

Clinicians must inquire about a patient's bowel habits and any perceived bowel issues. As nocturnal diarrhea may be seen in diabetics, clinicians should question patients about frequency and urges. Early satiety with eating, excessive flatus and/or bloating may be indicative of gastroparesis and may need special attention in the jail.

INTEGUMENTARY ASSESSMENT:

Within thirty (30) days of inmate admission an evaluation of the skin, including a podiatry examination, must be completed. Clinicians must assess the pedal pulses and look for pressure ulcers or lesions.

NEUROLOGY ASSESSMENT:

Microfilament units are available on-site to test for gross peripheral neuropathy. Patients with paresthesias may require medication to blunt symptoms. It is reported that control of glucose and lipids will abate symptomatology.

DIABETES PROTOCOL

Review of Intake Screening/Clinical History

LABORATORY STUDIES

- Random glucose testing (finger stick)
- Urinalysis
- Order medications
- Order HA1c test (glycosylated hemoglobin A1 c test) for chronic diabetics every three(3) months unless well controlled and then every six(6) months.
- Enroll in Chronic Care (complete and include all necessary documentation in the inmate's medical record)

DIAGNOSTIC TESTS

- Cardiovascular:
  - examination
  - electrocardiogram (ECG/EKG)
  - echocardiogram with ejection fraction (EF) – as indicated

CARDIAC RISK FACTORS
o **Male**
o **Diabetic**
o **Hypertension**
o **Smoker**
o **dyslipidemia/hypercholesterolemia**
o **history of ischemic heart disease**
o **diet high in saturated fats and sodium**
o **angina**
o **metabolic syndrome**
o **neck circumference >20 inches**
o **waist circumference >40 inches**
o **gallops and murmurs**

CHRONIC CARE:

- HA1c test
  - Eyes:
    - Snellen eye test
    - fundoscopic eye examination
    - optometry/ophthalmology referral
  - Kidney:
    - urinalysis for albuminuria, leukocyte esterase and white blood cell count (WBC)
  - Skin:
    - examination for/of pressure ulcers, stasis dermatitis and other chronic changes
    - microfilament examination

Did You Check For?	Did You Do?
Adequate hydration	Hydration therapy
Orthostatic blood pressure	Medication ordering, including:
Skin turgor	Oral medications
Mucus membranes	Insulin
Urinalysis	ACE/ARB inhibitors (NOTE: All diabetics shall be placed on ACE inhibitors [ARBs]. Patients intolerant of ACE inhibitors due to intractable cough, rashes, etc., should be offered a trial of ARBs.)
Osmolality	
Ketones	
BUN: creatinine (> 20:1)	Beta blockers (for treatment of ischemic heart disease)
Acidosis	
Tachypneaic	Diagnostic testing
Urinalysis	Referrals for consultation
pH	Intake and output measuring
Ketones	Review of nursing orders
Nidus of infection	IV for saline hydration; add glucose if blood sugar is <250mg/dL
Skin – check for abscesses and sores	Administration of insulin using sliding scale
Lungs – cough or rhonchi	Routine urinalysis using:
Urine	DiaScreen 10
WBC – leukocyte esterase	Microalbumin 2-1 Combo Strip
High or low orthostatic blood pressure	Echocardiogram with ejection fraction (EF), when applicable
BUN: Creatinine (Cr) ratio of >20:1	Abdominal ultrasound of liver for NASH
C02 content	Chest x-ray (CXR)
Abnormal respiratory rate	
Ketone breath	
Urinalysis for albuminuria,	
Rhonchus/cough	
Skin changes	
Abnormal lipid profile	
Abnormal liver function tests (LFTs)	
Non-alcoholic steatohepatitis (NASH)	
Abnormal ECG/EKG	

CARDIAC RISK FACTORS

Male

Diabetic

Hypertension

Smoker

dyslipidemia/hypercholesterolemia

history of ischemic heart disease

diet high in saturated fats and sodium

angina

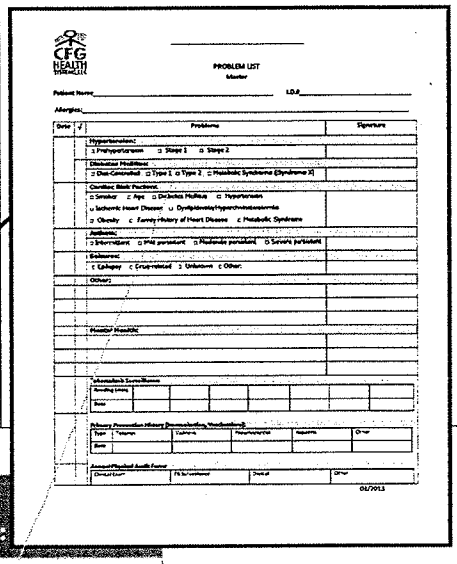
metabolic syndrome

neck circumference >20 inches

waist circumference >40 inches

gallops and murmurs

Need for smoking cessation program



PROBLEM LIST

DIABETES DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:

Problem List

- **Identify inmate as:**
  - **insulin dependent**
  - **taking oral hypoglycemic**
  - **mixed**
- **ICD codes**

Diabetes Mellitus:

□Diet-Controlled □Type 1 □Type 2 □Metabolic Syndrome [Syndrome X]

Orders and Care Plan

- **Enroll in Clinic**
- **Statement of level of control (necessary documentation for the medical record)**

Nursing Education

- **Dispense at intake**

Discharge Planning (site specific)

- **Educational materials**
- **Diagnostic test results**

METABOLIC SYNDROME

Twenty-five percent (25%) of all general, non-obese, non-diabetic people have significant insulin resistance, as seen in Type 2 diabetes.

Indicators associated with Metabolic Syndrome include the following:

- Normal or slightly elevated BMI (Body Mass Index)
- Normal 2-hour postprandial glucose levels
- Abdominal girth >40 inches (for males); >35 inches (for females)
- Neck girth >20 inches (for males only)

Those individuals diagnosed with Metabolic Syndrome are at increased risk for developing:

- Type 2 diabetes
- Hypercholesterolemia (high LDL-C)
- Pro-inflammatory states
- Hyperuricemia

In some populations, there exists underlying insulin resistance or hyperinsulinemic states.

THYROID DISORDERS

DIAGNOSTIC TESTING

- Ultrasound of thyroid
  - Cystic?
  - Solid?
- Thyroid scan and uptake

LABORATORY STUDIES

- Rule out any comorbid conditions, such as diabetes

THYROID ABLATION THERAPY

- Patients with Grave's Disease are often treated with ablation therapy utilizing I^{131}. The facility may not be able to provide post-therapy isolation. The Medical Director will confer with the Warden prior to the initiation of I^{131} to inform them of procedures on segregation.

MEDICATIONS

NOTE: Please refer to Endocrinology Clinic for the initiation of thyroid medication.

DIABETES INSIPIDUS (DI), SYNDROME OF INAPPROPRIATE ANTIDURETIC HORMONE (SIADH) AND PSYCHOGENIC WATER DRINKING (PWP)

Initial Health Assessment (Physical/Examination Findings)

- SIADH (Syndrome of Inappropriate Antidiuretic Syndrome) indicators:
  - Hyponatremia
  - Hyposmolality (<280 mosm/kg)
  - Urinary sodium elevation (>20 mEq/L)
- Psychogenic water drinking
  - Review mental health history
  - Implement water restriction

Laboratory Studies

- Serum electrolytes
- Serum creatinine
- Serum osmolality
- Urinary sodium

PULMONARY

Asthma/COPD

(Treatment of asthma as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Asthma is characterized by reversible airflow obstruction, indicated by FEV I measurements greater than 12% from baseline or an increase of FEV I greater than 10% of predicted results after use of a bronchodilator. Patients often report dyspnea, cough, nocturnal wheezing, difficulty breathing and a feeling of tightness in the chest. Hyperinflation of the lungs is observed during acute episodes and is generally accompanied by diminished breath sounds, high-pitched wheezing and the use of accessory muscles. The condition is usually exacerbated by exercise, viral infections, inhalation of allergens, exposure to irritants, changes in weather, strong emotion, stress and menstruation.

For asymptomatic, non-compliant patients, discontinue medication and complete a Non-Compliance form. Reassess the level of disease in these patients when they have not been exposed to allergens and known irritants, such as cigarette smoke.

Asthma Protocol

Review of Intake Screening/Clinical History

- Management History

Initial Health Assessment (Physical/Examination Findings)

- Vital signs
- Auscultation of lung fields
- Assess peak expiratory flow (PEF)

- Spirometry Assessment

- Make clinical diagnosis

  "All Wheezing is **NOT** Asthma"

  - Primary:
    - Mild
    - Moderate
    - Moderately Severe
    - Severe
  - Secondary:
    - Essential
    - Cardiac
    - Smoking
    - Other
- Assess severity and establish control
  - Self-medication techniques
  - Health plan and community support
  - Enroll in Chronic Care

MEDICATIONS

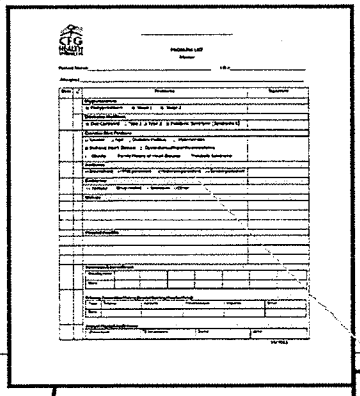
Please visit the following links:

http://www.health.ny.gov/diseases/asthma/pdf/2009_asthma_guidelines.pdf

http://img.medscape.com/fullsize/migrated/editorial/journalcme/2008/17618/fromer.fig2.gif.

- Nebulizer Treatments, PRN
- Steroids
- Selective Beta-agonists
- Leukotriene blockers

Did You Check For?	Did You Do?
Resolution of symptoms Primary prevention (immunizations) Patient compliance with medication	Reduce impairment via control of environmental/external contributing factors (i.e., cleaning, extermination, smoking cessation, etc.) Provide long-term chronic symptom control (proscribed medication) Maintain normal pulmonary function tests (PFTs) Enable the patient to engage in normal activity Stabilize condition through steroid use, reducing short-acting Beta-2 agonist (SABA) use Work toward preventing recurrent ER interventions Optimize medications, minimizing long-term side effects



Asthma:

□Intermittent □Mild persistent □Moderate persistent □Severe persistent

ASTHMA DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Establish primary and secondary diagnoses (i.e. – Primary: moderate-severe; Secondary: exercise-induced** • **ICD codes**
Orders and Care Plan • **Pulse oximeter** • **Peak expiratory flow**
Equipment • **Oxygen Concentrators- provide low flow oxygen therapy in the medical housing unit or infirmary**
Nursing Education • **Printed patient materials**
Discharge Planning

EMBOLISM

DVT (DEEP VEIN THROMBOSIS)

PROBABILITY SCORING

RISK FACTORS OF DEEP VEIN THROMBOSIS (DVT)

DVT can occur in almost anyone. Only about half of all patients with DVT exhibit any symptoms; however, certain individuals may be at increased risk for developing a DVT. Risk factors include, but are not limited to, the following:

- Surgery
- Restricted mobility
- Congestive heart failure
- Cancer
- Respiratory failure
- Infectious disease
- Age >40
- Overweight/obese
- Smoker
- Prior VTE (venous thromboembolism)
- Family history of VTE (venous thromboembolism)
  - Ex: Factor V Leiden Prothrombin gene 620210A, Deficiency Protein C, Protein S and AT
- Homocystinuria
- Acquired Autoantibodies

On the heels of a widely-adopted set of clinical criteria for pulmonary embolism, in 2006 Scarvelis and Wells overviewed a set of clinical prediction rules for DVT (deep vein thrombosis).

Wells Score Criteria

1) Active cancer (treatment within last 6 months or palliative care)	1 point
2) Calf swelling >3 cm compared to other calf (measured 10 cm below tibial tuberosity)	1 point
3) Collateral superficial veins (non-varicose)	1 point
4) Pitting edema (confined to symptomatic leg)	1 point
5) Swelling of entire leg	1 point
6) Localized pain along distribution of deep venous system	1 point
7) Paralysis, paresis or recent cast immobilization of lower extremities	1 point
8) Recently bedridden >3 days or major surgery requiring regional or general anesthetic in past 4 weeks	1 point
9) Alternative diagnosis at least as likely	1 point

- ❖ Plus heart rate ≥ 100 bpm

Interpretation of results:

1) Score of 2 or higher – deep vein thrombosis is likely. Consider imaging the leg or veins.
2) Score of less than 2 – deep vein thrombosis is unlikely. Consider blood testing, such as the D-dimer test to further rule out deep vein thrombosis. If D-dimer is negative, it is highly unlikely the patient has a DVT.

Review of Intake Screening

Initial Health Assessment (Physical Examination Findings)

- Measure the circumference of both limbs (affected and non-affected)

<u>DIAGNOSTIC TESTING</u>

- Doppler study
- CT Scan

Activate emergency transfer to tertiary care center

HOSPITAL TREATMENT

- TPA

ANTICOAGULANT MEDICATIONS
Rivaroxaban
Xarelto
Warfarin
Apixaban
Edoxaban
Dabigatran
Dalteparin
Enoxaparin
Fondaparinux
Tinzaparin
Unfractionated Heparin

TREATMENT INITIATION

- Elevation of affected limb
- Apply warm compresses
- **NOTE:** If aspirin is given, this must be documented in the order form
- Refer to Emergency Room for anticoagulation. **DO NOT INITIATE WARFARIN OR LOVENOX ON-SITE.**

INFECTIOUS DISEASES

(Clinicians must refer to the Infection Control Manual)

INFECTIOUS DISEASE PROTOCOL

Receiving Screening

- Review nursing statements
- History of fever or rash or cough
- Other people affected or sick
- Travel history
- Treatments already taken such as an antibiotic
- Obtain vaccine-specific consents
- Confirm pregnancy

Initial Health Assessment (Physical/Examination Findings)

- Complete the Immunization History
- Obtain vaccine-specific consents
- Confirm pregnancy

If pregnant, **withhold** the following vaccinations:

- MMR
- HPV
- Polio
- H1N1 Mist

Primary preventive vaccines offered:

- Pneumovax
- Influenza
- Tetanus toxoid
- Hepatitis
- Tdap
- Polio
- MMR
- H1N1

CFG does not offer the Varicella vaccine, hyperimmune globulin or the HPV vaccine.

Did You Check For?	**Did You Do?**
Consult Infection Control Manual	Identify any chronic diseases
Disease background information	Identify any comorbid conditions
Additional guidelines	
Care Plans	
Forms for tracking and reporting	

HEPATITIS

BACKGROUND

There are five (5) primary viral hepatitis infections: Hepatitis A (HAV), Hepatitis B (HBV), Hepatitis C (HCV), Hepatitis D (HDV) and Hepatitis E (HEV). These infections vary widely in their:

- communicability
- scope of morbidity
- chronicity

- response to treatment
- long-term consequences and sequelae

Please see the Hepatitis Chart on the following pages for information specific to each type of infection.

Hepatitis Table

	Hepatitis A	**Hepatitis B**	**Hepatitis C**	**Hepatitis D**	**Hepatitis E**
Etiology	RNA virus	DNA virus	Single-strand RNA virus	Sub-viral RNA particle	Single-strand RNA virus
Transmission	Oral-fecal (poor hand-washing)	Blood Mother-to-baby Sexual	Blood Mother-to-baby Tattoos	Found in combination with HBV	Oral-fecal (poor hand-washing) Water contamination
Incubation Period	15 to 50 days (average 30 days)	45 to 160 days (average 120 days)	2 to 25 weeks (3 wks. PCR testing;< 9 wks. HCV-antibody)	2 to 8 weeks (+HBV infection)	2 to 9 weeks (average 40 days)
Symptoms	None Jaundice Dark urine Myalgia Nausea Fatigue	None Flu-like symptoms +/- Jaundice +/- Dark urine Myalgia Nausea Fatigue Fulminant hepatitis	Usually none Co-morbidity with: – Nephrotic syndrome – Thrombocytopenia – Autoimmune disease Cirrhosis Fulminant hepatitis Hepatoma	See HBV	Inflammatory transaminitis outbreak
Diagnostic Examination	– Hepatitis panel – CBC with differential – CMP – Urinalysis – Serial transaminase titers – Albumin, globulin, INR – Abdominal ultrasound (for severe abdominal pain)	– Hepatitis panel – CBC with differential – CMP – Serial transaminase titers – Albumin, globulin, INR – Abdominal ultrasound – Monitor HBeAg, HBeAb, HBcAg, HBcAb and HBsAb	– Hepatitis panel – CBC with differential – CMP – **Abdominal ultrasound (with cirrhosis; hepatoma)**		

	Hepatitis A	Hepatitis B	Hepatitis C	Hepatitis D	Hepatitis E
Treatment	– HBV vaccination – Supportive	– HAV vaccination – Anti-viral medications – Supportive – Enroll in Chronic Care Clinic – Infectious disease consultation for NNRT therapy (as needed)	– HAV, HBV vaccination – Medication, as indicated by established clinical protocols – Anti-viral[5] medications – Enroll in Chronic Care Clinic	– HAV, HBV vaccination – Hospital-based management	Supportive
HIV Surveillance	Primary prevention	Primary prevention	Primary prevention	Primary prevention	
Vaccination	2 dose regimen: – baseline – 6 months	3 dose regimen: – baseline – 1 month – 6 months	Primary prevention (protection from combined A or B + C)	3 dose regimen: – baseline – 1 month – 6 months	

MANAGEMENT AND TREATMENT PROTOCOLS

Hepatitis A (HAV)

Patients, who present with extreme jaundice, diffuse abdominal pains, dark urine and clay-colored feces should be placed in contact isolation until etiology can be determined. A diagnostic hepatitis panel must be ordered to:

1. establish acute diagnosis
2. determine passive immunity to other forms of hepatitis

Patients found to have hepatitis A (HAV) infection with no immunity to hepatitis B are to begin three phase immunization therapy for hepatitis B, with a baseline inoculation administered at the time of diagnosis, a second inoculation given one (1) month later, and a third and final inoculation administered at six (6) months post-testing. As the primary route of infection is fecal/oral, the Infection Control Nurse (ICN) must work closely with Custody staff to determine any possible sources of infection within the jail. Proper hand-washing techniques, plus universal precautions and personal hygiene training should be given to all key staff and especially food service workers. A comprehensive health screening of the facility should be performed under the direction of the ICN to monitor for potential outbreaks. Finally, the Medical Director must monitor the patient's serial transaminase titers (to confirm healing/reduction in titer), as well as albumin, globulin and INR titers (to monitor hepatic reserve). Patients who fail to improve must be referred to a Gastroenterology specialist.

[5] Anti-viral medications blunt the efficacy of anti-HIV protease inhibitors; possible other classifications

HEPATITIS A SYNOPSIS	
Transmission	Oral-fecal
Actions	✓ Contact isolation for patients with diarrhea ✓ ICN surveillance ✓ Supportive care (self-limiting) ✓ Immunization against HBV ✓ Serial transaminase titers to assess injury ✓ Monitor albumin, globulin and INR to assess hepatic function ✓ Abdominal ultrasound for severe abdominal pain

Hepatitis B (HBV)

Hepatitis B is a highly contagious disease and is usually contracted via blood-borne transmission and/or through unprotected sexual activity with an infected partner. As with hepatitis A, a diagnostic hepatitis panel must be ordered to:

1. establish acute diagnosis
2. determine passive immunity to other forms of hepatitis

Patients found lacking in immunity to HAV must begin immunization therapy, with a baseline inoculation administered at the time of diagnosis and a second dose given six (6) months later, in order to confer complete immunity. Medical and jail staff must employ universal precautions. Contact isolation should be used whenever a patient diagnosed with HBV is jaundiced and/or has diarrhea. The Medical Director will monitor serial transaminase titers (to confirm healing/reduction in titer), as well as albumin, globulin and INR titers (to monitor hepatic reserve).

There are several types of chronic hepatitis often associated with HBV infection – chronic, active and persistent. Patients will need to have assays for HBeAg, HBeAb, HBcAg, HBcAb, and HBsAb performed. Patients with progressive hepatitis who fail to improve must be referred to Gastroenterology. An Infectious Disease specialist may be consulted regarding NNRT therapy (this is often the case with patients co-infected with HIV).

HEPATITIS B SYNOPSIS

Transmission	Sexual and blood-borne transmission
Actions	✓ Contact isolation for patients with jaundice and/or diarrhea ✓ Immunization against HAV ✓ Serial transaminase titers to assess injury ✓ Monitor albumin, globulin and INR to assess hepatic function ✓ Monitor HBeAg, HBeAb, HBcAg, HBcAb and HBsAb (persistent "core" or "e" antigenemia) ✓ Abdominal ultrasound for severe abdominal pain ✓ Enroll in Chronic Care Clinic (every 3 to 6 months) ✓ Provide primary prevention immunizations ✓ Screen for HIV ✓ Infectious disease consultation for NNRT therapy

Hepatitis C (HCV)

There are several genotypes of the hepatitis C virus, with type 1 being the most common in the United States. Hepatitis C is usually spread through contact with blood from an infected individual. Increased risk factors for contracting HCV include:

- Having undergone blood transfusion or organ transplant prior to 1992 or receiving blood clotting factor concentrates prior to 1987
- Intravenous drug use
- Being born between 1945-1965
- Long-term hemodialysis
- HIV-infection

CFG policy (based upon NCCHC guidelines) dictates that medical staff only screens patients for HCV infection when clinical conditions or co-morbidities associated with HCV infection exist, as delineated below:

Screening Associated with HCV

1. Patients with acute or uncontrolled HIV infection should be screened for hepatitis A, B and C. Here, the intent is to determine whether immunity exists in the patient and, if not, to implement primary prevention through the administration of vaccines. Since no vaccine exists for HCV, intervention at this stage is to immunize solely against HAV and HBV, as previously indicated.

2. Patients with persistent or increasing hepatic transaminase titers over a ninety (90) day period - with assessment occurring on at least two (2) occasions separated by one (1) month - should undergo hepatitis C screening.

3. Patients who present with moderate to severe anemia, defined as a low MCV and MCHC, and/or those with significant thrombocytopenia (platelet counts less than 25,000) will need to have HCV ruled out.

4. Patients who present with nephrotic syndrome (as determined by massive proteinuria of greater than 3.5 grams per twenty-four [24] hours), or those with kidney biopsy findings of membranous glomerulonephritis should be screened for HCV.

The vast majority of HCV-infected individuals remain asymptomatic, even when chronic disease is present. The literature reports some 25% of those with acute HCV infection (demonstrated by a positive HCV assay and associated elevations of hepatic transaminase titers) will spontaneously clear the virus from the body and will have no long-term sequelae (chronic hepatitis, cirrhosis or hepatic failure). In most cases, progression of HCV is measured in terms of years, with less than one-fifth of HCV infection progressing to cirrhosis; however, one-fifth of those who do develop cirrhosis will develop a hepatoma within 20-30 years post-diagnosis.

A liver biopsy should be performed to determine whether cirrhosis of the liver has developed. In the past, the decision to treat was based on virus genotype and the results of liver biopsy, in conjunction with the presence of co-morbid conditions, such as uncontrolled HIV infection, severe anemia, severe thrombocytopenia and/or nephrotic syndrome. The new nucleotide analog NS5B polymerase inhibitors, which mediate HCV RNA replication, have properties that protect against disease genotypes 1, 2, 3 and 4, with efficacy data in existence for patients with evidence of cirrhosis; however, there is no current firm consensus regarding clinical criteria for beginning such treatment.

Hepatitis C Treatment Paradigm

Detainees with active HCV who will remain in county custody and who present at Receiving Screening already on therapy will be evaluated on an individual basis to determine if hepatitis medication will continue. The Medical Director must confer with the prescribing physician and establish their area of specialty (Hepatologist, Infectious Disease). The Medical Director will contact each treating physician who has prescribed a medication regimen for addressing HCV to arrange for the patient's uninterrupted and continued access to such

medication. Many of these practitioners may make HCV medications available to their patients via treatment grants. CFG shall work in tandem with each of these providers to maintain the patient's medication supply.

NOTE: Detainees who arrive on medication, but for whom no responsible clinician can be identified or who have demonstrated poor compliance with treatment will not have HCV medication regimens continued. Continuity of care is an imperative to minimize risks associated with treatment. Without evidence of proper and consistent follow-up care beyond the treating physician's initial order, HCV medication shall be discontinued.

All patients for whom the initiation of treatment is recommended while incarcerated shall be referred to the Corporate Medical Director, who will work in collaboration with the jail, outside agencies and the Courts to expeditiously relocate the patient to the most appropriate care setting.

Strict adherence to the treatment regimen, along with long-term follow-up, is essential to the care plan. This often presents a problem in county jail settings, where most patients' terms of incarceration are for short periods of time – up to 47% of detainees incarcerated in New Jersey county jails are released within two (2) weeks.

Facility Medical Directors shall not be permitted to initiate medication therapy prior to the receipt of an approved non-formulary request from CFG's Corporate Medical Director. Supportive pharmacies are advised not to ship HCV meds without prior receipt of a CFG Non-Formulary Request form endorsed by the Corporate Medical Director.

Patients who present with symptomatic HCV infection, along with serious co-morbid conditions (as previously reviewed), must be referred to Custody classification for identification of those detainees who will not remain incarcerated for at least eight (8) months (HCV protocol dictates a minimum three [3] months of treatment and two [2] months of follow-up and monitoring). At those facilities where a relationship has been established with a Federally-Qualified Health Centers (FQHCs), CFG shall work to establish a viable care plan for adequate follow-up and treatment. CFG will also work in collaboration with Custody/the Warden to promptly identify detainees who qualify for bracelet monitoring outside the jail. For detainees who will transition to the State penal system, CFG will provide supportive care while the patient remains in county custody, but will let the State provide medication therapy and follow-up care.

HEPATITIS C SYNOPSIS

Transmission

Blood-borne transmission

Symptomatic HCV defined by

- Severe anemia
- Thrombocytopenia
- Nephrotic syndrome
- HCV viral load in the millions

Actions

***Note – CFG will not initiate medication in asymptomatic HCV-infected individuals.**

- ✓ Immunization against HAV and HBV, as indicated
- ✓ Serial transaminase titers to assess injury
- ✓ Abdominal ultrasound
- ✓ Medication therapy – to be ordered only when:
  - clinical documentation exists of patient compliance with treatment as initiated by an external physician
  - case review and endorsement from CFG's Corporate Medical Director has been obtained
- ✓ Anti-viral medications, as needed
- ✓ Enroll in Chronic Care Clinic (every 6 months)

Special Considerations and Actions

CFG will provide supportive care to symptomatic HCV+ patients while appropriate treatment and facilities for long-term management are being identified. Jail administrationmay be informed of symptomatic HCV patients for expedited transfer to the State prison system (as applicable) and when a facility has established a relationship with an FQHC (federally-qualified health center) in order to determine eligibility for release and/or transfer for treatment.

This section shall serve to spotlight key diagnostic and treatment parameters of CFG's clinical pathway for treatment of the Hepatitis C viral infection. Consistent with guidelines from the National Commission on Correctional Health Care (NCCHC), this plan identifies and defines pivotal decision points along the disease continuum for clinical intervention by CFG clinicians.

For Inmates who are HCV+ and on medication at Intake:

1. Nursing must complete a comprehensive initial health assessment, verify all medications and obtain a Release of Information form signed by the patient.
2. The clinician must complete a comprehensive history and physical examination, inclusive of assessment for active infection or intercurrent disease (such as cryoglobulinemia, nephrotic syndrome, anemia, thrombocytopenia, HIV or depression).
3. The clinician shall review all verified medications and contact the primary prescribing clinician in order to obtain a history that includes the following information:
    - Date of diagnosis
    - Clinical presentation at time of diagnosis (i.e., - cryoglobulinemia, renal failure, thrombocytopenia, cirrhosis)
    - Known HCV risk factors and patient's level of compliance in demonstrating restraint
    - Primary prevention intervention via vaccinations
    - Secondary prevention intervention, including prophylaxes such as isonicotinic acid hydrazide INH for latent tuberculosis infection (LTBI)
    - HIV serology
    - Serologic laboratory testing, inclusive of liver function tests (LFTs), blood chemistry, hemograms and platelet counts
    - Hepatitis C viral RNA titers
    - Liver biopsy results and histopathology
    - Specific findings, recommendations and the treatment plan from the patient's last office visit
4. Enroll the patient in Chronic Care Clinic
5. Provide Primary and Secondary prevention, accordingly (or confirm prior treatment)
    - Vaccination for Hepatitis A and B, if no evidence of immunity exists
    - HIV testing (if patient status is unknown or unconfirmed)
    - Monitoring and evaluation of the PPD skin test site, with INH prophylaxis for LTBI
    - Tetanus vaccination
    - Pneumococcus vaccination
6. **Medications:**
    - **Continue with patient's previously prescribed medications if:**
        - Continuation of care with necessary specialist(s) is possible
        - The patient's compliance with medications has been confirmed
        - A positive clinical response to treatment has been confirmed through:
            - Reduction of present HCV RNA titers when compared to baseline
            - Rise in total platelet count
            - Rise in hemoglobin/hematocrit

        - Improved renal function (diminished proteinuria)
- **Discontinue a patient's medications if:**
    - No Gastroenterologist or Infectious Disease Specialist managing care
    - No evidence of follow-up care beyond initial order or evidence of missed appointments with specialist(s)
    - Patient resumption or continuance of risky behaviors
    - Patient has failed to respond to treatment as evidenced by the following (must discuss in collaboration with specialist[s]):
        - Persistent elevation of HCV RNA titer
        - Continued thrombocytopenia
        - Presence of hemolytic, persistent or refractory anemia
        - Diagnosis of nephrotic syndrome
    - Clinical evidence or prior diagnosis of major depression

For patients who are HCV+ and NOT on medications at intake:

1. Nursing must complete a comprehensive initial health assessment, verify all medications and obtain a Release of Information form signed by the patient
2. The clinician must complete a comprehensive history and physical examination inclusive of assessment for signs of active infection and intercurrent disease (i.e., - cryoglobulinemia, nephrotic syndrome, anemia, thrombocytopenia, HIV or depression)
3. Enroll patient in Chronic Care Clinic
4. Provide Primary and Secondary prevention, accordingly (or confirm prior treatment)
    - Vaccination for Hepatitis A and B, if no evidence of immunity exists
    - HIV testing (if patient status is unknown or unconfirmed)
    - Monitoring and evaluation of the PPD skin test site, with INH prophylaxis for LTBI
    - Tetanus vaccination
    - Pneumococcus vaccination
5. **The following laboratory tests should be ordered – baseline LFTs, CBC with differential, blood chemistry - with the applicable steps listed below followed:**
    - If LFTs are abnormal, CBC is normal and there is no evidence of thrombocytopenia, GO TO NUMBER 6 (below)
    - If LFTs are normal and CBC is normal, PROCEED TO NUMBER 6 (below)
    - If LFTs are abnormal, CBC is abnormal and the patient has thrombocytopenia, then order HCV RNA titers:
        - If LFTs are abnormal, CBC is abnormal and HCV RNA titers are elevated, refer the patient for consultation with the specialist
        - If LFTs are abnormal, CBC is abnormal, but HCV RNA titers are normal or only mildly elevated, PROCEED TO NUMBER 6 (below)
        - If LFTs are abnormal, but CBC is normal, PROCEED TO NUMBER 6 (below)
6. Repeat LFTs, CBC with differential and blood chemistry in four (4) months

Hepatitis D (HDV)

Hepatitis D is a co-morbid viral infection only associated with active HBV infection. Patients with hepatitis D will be referred promptly to a tertiary care setting for proper management under a Hepatologist, as significant rates of mortality are associated with fulminant HBV+HDV infection.

HEPATITIS D SYNOPSIS	
Transmission	Incidental finding in clinically-compromised HBV+ patients
Actions	Hospital-based management

Hepatitis E (HEV)

Like HAV, Hepatitis E is transmitted via the fecal-oral route and presents in a similar manner. HEV is extremely rare in United States patient populations, but may nevertheless be seen at jail facilities housing INS detainees. Though this condition is self-limiting and is not associated with chronic disease, universal precautions should be taken and supportive care given when the condition is detected.

HEPATITIS E SYNOPSIS	
Transmission	Oral-fecal
Actions	Supportive (disease is self-limiting)

SEXUALLY TRANSMITTED DISEASES (STDS)

Multiple studies, as reported by the CDC (Centers for Disease Control), indicate correctional facility populations have high rates of STDs (sexually transmitted diseases) – including HIV and viral hepatitis – especially among persons aged 35 and younger. Risk factors for contracting STDs (having unprotected sex; having multiple partners; using drugs and alcohol; and engaging in commercial, survival and/or coerced sex) are also more

prevalent among incarcerated populations. Compounding the problem further, prior to incarceration, many detainees have limited access to medical care, especially community-based clinical prevention services.

In its approach to both detection and treatment of STDs, CFG utilizes recommendations released by the CDC in its Morbidity and Mortality Weekly Report (MMWR) as part of treatment paradigms. The MMWR contains important data on current prevalent infections, including information on susceptibility, resistance patterns and recommendations for treatment. As such, the MMWR represents a clinical mean, helping to establish standards of care for public health providers, with local health departments assisting in the dissemination of MMWR publications throughout the community.

It should be noted that all sexually transmitted diseases (STDs) have subclinical (latent) phases during which time patients appear asymptomatic. Screening for asymptomatic infections allows for identification and early treatment of STDs that might otherwise go undetected; thereby, eliminating potential complications and reducing the prevalence of infection both inside and outside the jail. Please note, patients may also present with several co-occurring infections (or multiple organisms) at the time of screening.

Screening

Patients testing positive for syphilis must be screened for HIV, as syphilis is considered an "AIDS-defining illness." Similarly, patients found to have oral thrush infections of the tongue and oral cavity must also undergo HIV testing. Patients testing positive for gonorrhea should also be screened for chlamydia and ureaplasma. Those patients with a history of substance abuse should be screened for the following:

- Lesions/anomalies of the skin and soft tissue
- Aspiration pneumonias
- Hepatitis A, B and C
- HIV/AIDS
- HPV
- Syphilis
- Endocarditis
- Septic arthritis

Referrals

- Consult a specialist for any of the following:
    - New case of HIV
    - Persistent or relapsing infection
    - Endocarditis
    - Osteomyelitis

Treatment Guidelines for Sexually Transmitted Diseases

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
SYPHILIS		
ADULTS Primary, secondary or early latent (< 1 year)	• Benzathine penicillin G 2.4 million units IM once	**(For penicillin-allergic non-pregnant patients only)** • Doxycycline 100 mg orally 2 times per day for 14 days ***OR*** • Tetracycline 500 mg orally 4 times per day for 14 days
ADULTS Late latent (> 1 year) or latent of unknown duration	• Benzathine penicillin G 2.4 million units IM for 3 doses at 1 week intervals (total 7.2 million units)	**(For penicillin-allergic non-pregnant patients only)** • Doxycycline 100 mg orally 2 times per day for 28 days ***OR*** • Tetracycline 500 mg orally 4 times a day for 28 days
NEUROSYPHILLIS	• Aqueous crystalline penicillinG 18 - 24 million units per day, administered as 3 - 4 million units IV every 4 hours or continuous infusion for 10 - 14 days	❖ Procaine penicillin 2.4 million units IM once daily PLUS Probenecid500 mg orally 4 times per day, both for 10 - 14 days
CONGENITAL SYPHILIS	**See CDC guidelines – www.cdc.gov/std/treatment**	
HIV INFECTION	**Same stage-specific recommendations as for HIV-negative persons.**	
PREGNANT	**Penicillin is the only recommended treatment for syphilis during pregnancy. Women who are allergic should be desensitized and treated with penicillin. Treatment is the same as in non-pregnant patients for each stage of syphilis.**	
GONOCOCCAL INFECTIONS		
ADULTS AND ADOLESCENTS (aged 12-19) Urogenital, pharyngeal and rectal	❖ Ceftriaxone 250 mg IM once* PLUS Azithromycin 1 g orally once (preferred) ***OR**** Doxycycline 100 mg orally 2 times per day for 7 days **(doxycycline NOT recommended for pregnant or lactating women)** ***Because data is limited concerning the efficacy of ceftriaxone and azithromycin regimes in HIV-infected persons, these regimens should be used for such patients	***Note*: Use of any alternative regimens for gonorrhea should be followed by a test-of-cure one week after treatment ends. *** **For urogenital or rectal infections ONLY (and ONLY if ceftriaxone is not available):** ❖ Cefixime 400 mg orally, once PLUS Azithromycin 1 g orally once (preferred) ***OR*** Doxycycline 100 mg orally 2 times per day for 7 days **For severe cephalosporin allergy:**

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	only if follow-up care can be ensured.	• Azithromycin 2 g orally in a single dose
ADULTS AND ADOLESCENTS (aged 12-19) Conjunctival	❖ Ceftriaxone 1 g IM once PLUS lavage the infected eye with saline solution once	*Test-of-cure for gonorrhea should be performed with culture or with nucleic acid amplification (NAAT), if culture is not available. If NAAT positive, confirmatory culture is recommended. If treatment failure after recommended regimen use, perform anti-microbial susceptibility testing, then notify and consult with the State Health Department and/or an infectious disease specialist, an STD/HIV Prevention Training Center or the CDC. If treatment failure after alternative regimen use, treat using ceftriaxone 250 mg IM, PLUSazithromycin 2 g orally once and perform test-of-cure one week later.
CHLAMYDIAL INFECTIONS		
ADULTS AND ADOLESCENTS (aged 12-19)	• Azithromycin 1 g orally once *OR* • Doxycycline 100 mg orally 2 times per day for 7 days	• Erythromycin base 500 mg orally 4 times per day for 7 days *OR** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days *OR** • Levofloxacin 500 mg orally once per day for 7 days *OR*** • Ofloxacin 300 mg orally 2 times per day for 7 days** *If the patient cannot tolerate high dose erythromycin schedules, change to a lower dose over a longer period of time (see alternatives for Pregnant patients - below) **Quinolones (such as levofloxacin and ofloxacin) not recommended for use in patients under 18 years of age. Also contraindicated in pregnant patients.
PREGNANT	• Azithromycin 1 g orally once *OR* • Amoxicillin 500 mg orally 3 times per day for 7 days	• Erythromycin base 500 mg orally 4 times per day for 7 days *OR* • Erythromycin base 250 mg orally 4 times per day for 14 days *OR* • Erythromycin ethylsuccinate 800 mg orally 4 times per day for 7 days *OR* • Erythromycin ethylsuccinate400 mg orally 4 times per day for 14 days
NON-GONOCOCCAL URETHRITIS		
ADULT AND ADOLESCENT MALES (aged 12-19)	• Azithromycin 1 g orally once *OR* • Doxycycline 100 mg orally 2 times per day for 7 days Infections with *M. genitalium* may respond better to azithromycin.	• Erythromycin base 500 mg orally 4 times per day for 7 days *OR** • Erythromycin ethylsuccinate 800 mg orally 4 times a day for 7 days *OR** • Levofloxacin 500 mg orally once per day for 7 days *OR*** • Ofloxacin 300 mg orally 2 times per day for 7 days**

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
		*If the patient cannot tolerate high dose erythromycin schedules, change to a lower dose over a longer period of time (see alternatives for Pregnant patients - above) **Quinolones (such as levofloxacin and ofloxacin) not recommended for use in patients under 18 years of age.
EPIDIDYMITIS		
ADULT AND ADOLESCENT MALES (aged 12-19)	❖ Ceftriaxone 250 mg IM once PLUS Doxycycline 100 mg orally 2 times per day for 10 days The recommended regimen of ceftriaxone and doxycycline is for epididymitis most likely caused by gonococcal and/or chlamydial infection. Given the increase in quinolone-resistant gonorrhea, an alternative regimen of ofloxacin or levofloxacin is recommended only if epididymitis is not found to be caused by gonorrhea or if infection is most likely caused by enteric gram-negative organisms.	• Levofloxacin 500 mg orally once per day for 10 days *OR** • Ofloxacin 300 mg orally 2 times per day for 10 days* *Quinolones (such as levofloxacin and ofloxacin) not recommended for use in patients under 18 years of age.
PELVIC INFLAMMATORY DISEASE		
ADULT FEMALES	• Ceftriaxone 250 mg IM once *OR* ❖ Cefoxitin 2 g IM once PLUS Probenecid 1 g orally once *OR* ❖ Other third generation cephalosporin PLUS Doxycycline 100 mg orally 2 times per day for 14 days WITH OR WITHOUT Metronidazole 500 mg orally 2 times per day for 14 days	See complete CDC guidelines for alternatives - www.cdc.gov/std/treatment
PREGNANT	**Patients should be hospitalized and treated with the appropriate recommended parenteral IV therapy (see CDC guidelines - www.cdc.gov/std/treatment)**	
CHANCROID		
ADULTS	• Azithromycin 1 g orally once *OR** • Ceftriaxone 250 mg IM once	

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	OR* • **Cipfofloxacin** 500 mg orally 2 times per day for 3 days ***OR**** • **Erythromycin base** 500 mg orally 3 times per day for 7 days ***Because data is limited concerning the efficacy of ceftriaxone and azithromycin regimes in HIV-infected persons, these regimens should be used for such patients only if follow-up care can be ensured.** ****Quinolones (such as ciprofloxacin) not recommended for use in patients under 18 years of age. Also contraindicated in pregnant patients.**	
BACTERIAL VAGINOSIS (BV)		
ADULT FEMALES	• **Metroniazole** 500 mg orally 2 times per day for 7 days ***OR**** • **Metronidazole** gel 0.75%, 5 g intra-vaginally once per day for 5 days ***OR*** • **Clindamycin cream** 2%, 5 g intra-vaginally at bedtime for 7 days ***Multiple studies and meta-analyses have *not* demonstrated an association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole.**	• **Tinidazole** 2 g orally once daily for 3 days ***OR**** • **Tinidazole** 1 g orally once daily for 5 days ***OR**** • **Clindamycin** 300 mg orally 2 times per day for 7 days ***OR*** • **Clindamycin ovules** 100 mg intra-vaginally at bedtime for 3 days ***Tinidazole safety during pregnancy has NOT been established. Interruption of breastfeeding is recommended during treatment and for 3 days following the last dose.**
PREGNANT	**Oral therapy is the preferred treatment for pregnant women with BV due to the possibility of sub-clinical upper genital tract infections.** • **Metronidazole** 500 mg orally 2 times for 7 days ***OR**** • **Metronidazole** 250 mg orally 3 times per day for 7 days ***OR**** • **Clindamycin** 300 mg orally 2 times per day for 7 days ***Multiple studies and meta-analyses have *not* demonstrated an association between**	

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole.	
TRICHOMONIASIS		
ADULTS	• Metronidazole 2 g orally once ***OR**** • Tinidazole 2 g orally once** *Multiple studies and meta-analyses have *not* demonstrated an association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole. **Tinidazole safety during pregnancy has NOT been established. Interruption of breastfeeding is recommended during treatment and for 3 days following the last dose.	• Metronidazole 500 mg orally 2 times per day for 7 days Multiple studies and meta-analyses have *not* demonstrated an association between metronidazole use during pregnancy and teratogenic or mutagenic effects in newborns. In lactating women given metronidazole, withholding breastfeeding during treatment and for 12-24 hours after the last dose will reduce infant exposure to metronidazole. The 7-day metronidazole regimen may be more effective than single dose metronidazole in women co-infected with trichomoniasis and HIV.
PEDICULOSIS PUBIS		
ALL (pregnant detainees should be treated using the recommended treatments only and *NOT* the alternative treatments listed)	• Permethrin 1% cream rinse applied to the affected area and washed off after 10 minutes ***OR*** • Pyrethrins with piperonylbutoxide applied to the affected area and washed off after 10 minutes	• Malathion 0.5% lotion applied for 8 - 12 hours and washed off ***OR*** • Ivermectin 250 mcg/kg orally once – repeated in 2 weeks* *Ivermectin not recommended for pregnant or lactating women.
SCABIES		
ALL	• Permethrin 5% cream applied to all areas of the body from the neck down and washed off after 24 hours ***OR*** • Ivermectin 200 mcg/kg orally, repeated in 2 weeks* *Ivermectin not recommended for pregnant or lactating women.	• Lindane 1% 1 oz. lotion or 30 g of cream applied thinly to all areas of the body from the neck down and washed off after 8 hours* *Lindane is no longer recommended as the first line of treatment due to its toxicity. Lindane should not be used immediately after a bath, for persons with extensive dermatitis or for women who are pregnant or lactating.
GENITAL HERPES SIMPLEX		

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
ADULTS AND ADOLESCENTS (aged 12-19) First clinical episode	• Acyclovir 400 mg orally 3 times per day for 7 - 10 days ***OR*** • Acyclovir 200 mg orally 5 times per day for 7 - 10 days ***OR*** • Famciclovir 250 mg orally 3 times per day for 7 - 10 days ***OR**** • Valacyclovir 1 g orally 2 times per day for 7 - 10 days ***The efficacy and safety of famciclovir has not been established for patients younger than 18.**	
ADULTS AND ADOLESCENTS (aged 12-19) Episodic therapy for recurrence	• Acyclovir 800 mg orally 2 times per day for 5 days ***OR*** • Acyclovir 400 mg orally 3 times per day for 5 days ***OR*** • Acyclovir 800 mg orally 3 times per day for 2 days ***OR*** • Famciclovir 125 mg orally 2 times per day for 5 days ***OR**** • Famciclovir 1000 mg orally 2 times per day for 1 day ***OR**** • Famciclovir 500 mg orally once, followed by 250 mg orally 2 times per day for 2 days ***OR**** • Valacyclovir 500 mg orally 2 times per day for 3 days ***OR*** • Valacyclovir 1 g orally once per day for 5 days ***The efficacy and safety of famciclovir has not been established for patients younger than 18.**	
ADULTS AND ADOLESCENTS (aged 12-19) Suppressive therapy for recurrence	• Acyclovir 400 mg orally 2 times per day for 1 day ***OR*** • Famciclovir 250 mg orally 2 times per day for 1 day ***OR**** • Valacyclovir 500 mg orally once ***OR*** • Valacyclovir 1 g orally once	

DISEASE	RECOMMENDED TREATMENT	ALTERNATIVES (use only if recommended regimens are contraindicated)
	*The efficacy and safety of famciclovir has not been established for patients younger than 18.	
HIV INFECTION	Higher dosages for longer periods of time are recommended. See the CDC's complete guidelines - www.cdc.gov/std/treatment	
PREGNANT	See the CDC's complete guidelines for the management of herpes in pregnant women - www.cdc.gov/std/treatment	

GENITAL WARTS

ALL	RECOMMENDED TREATMENT			
	External or Perianal	Urethral Meatus	Vaginal	Anal
	• Cryotherapy using liquid nitrogen or cryoprobe. Repeat applications every 1 – 2 weeks, if necessary ***OR*** • Podophyllin resin 10% – 25% in a compound tincture of benzoin. Limit application to < 10 cm^2 and< 0.5 ml. Do not apply to open wounds or lesions. Allow to air dry. Wash off 1 - 4 hours after application. Repeat weekly, if necessary ***OR****	• Cryotherapy using liquid nitrogen***OR*** • Podophyllin 10% - 25% in a compound tincture of benzoin. The treatment area must be dry before allowing contact with normal mucosa. Repeat weekly, if necessary* *Podophyllin, podofilox, imiquimod andsinecatechins should not be used on pregnant patients.	• Cryotherapy using liquid nitrogen.Cryoprobe not recommended due to risk of perforation and fistula formation ***OR*** • TCA or BCA 80% - 90%. Apply a small amount to warts only. Allow to dry. If an excessive amount is inadvertently applied, cover with baby powder, talc, baking soda or liquid soap. Repeat weekly, if necessary.	• Cryotherapy with liquid nitrogen***OR*** • TCA or BCA 80% - 90%. Apply a small amount to warts only. If an excessive amount is inadvertently applied, cover with baby powder, talk, baking soda or liquid soap. Repeat weekly, if necessary ***OR*** • Surgical removal Many people with anal warts may also have them in the rectal mucosa. Inspect rectal mucosa via digital examination or anoscopy. Warts on the rectal mucosa should be managed in consultation with a specialist.

- **Trichloroacetic acid (TCA) or bichloroacetic acid (BCA)** 80% - 90%. Apply a small amount to warts only. Allow to dry. If an excessive amount is inadvertently applied, cover with baby powder, talc, baking soda or liquid soap. Repeat weekly, if necessary ***OR***
- **Surgical removal**

***Podophyllin, podofilox, imiquimod and sinecatechins should not be used on pregnant patients.**

MRSA [Methicillin-Resistant Staphylococcus Aureus]

Methicillin-Resistant Staphylococcus Aureus (MRSA) is an infection caused by a strain of staphylococcus bacteria that has become resistant to antibiotics commonly used in the treatment of ordinary staph infections.

Colonies of staphylococcus can be found in the nostrils of 25-35% of all healthy, asymptomatic individuals. Other common infection sites within asymptomatic individuals include the axillae (armpits) and groin.

The Infection Control Nurse (ICN) works in collaboration with the clinician in the management of cases of MRSA. Information on the source of the staph bacteria (i.e., pre-existing wound or animal bite vs. perirectal boil) are to be obtained and documented by the ICN. Open or weeping lesions need to be cultured prior to the initiation of any antibiotic therapy.

Nursing staff are to begin symptomatic treatment, including the application of warm compresses and irrigation with wet-to-dry dressings (or mechanical wound debridement). Clinicians are not encouraged to routinely forcibly or surgically culture lesions.

Treatment Initiation

- Oral, single-antibiotic therapy is NOT encouraged in this cohort population.

- Bactrim DS and Clindamycin are an effective drug therapy regimen.

Referrals

- Patients requiring intravenous therapy must be seen by the specialist.

Skin, Soft Tissue, and Bone Infections

- Community-associated methicillin-resistant Staphylococcus aureus [CA-MRSA]
- Toxic Shock Syndrome [TSS] caused by exotoxin superantigens from Staphylococcus aureus or group A Beta-hemolytic Streptococcus [GABHS]

Toxic Shock Syndrome

Clinical Risk Settings:

- Surgical wounds
- Burns
- Vaginitis
- Tampon use in younger females
- Nasal packing for epitaxies

The clinical presentation is dramatic with fever, hypotension, macular desquamating erythroderma of the palms and soles. There may be generalized symptoms of emesis, diarrhea, severe myalgia's, weakness, dyspnea and altered mental status.

This is a medical emergency and the patient must be moved to a tertiary care setting for immediate diagnosis and treatment.

Purulent Skin and Soft Tissue Infections [Furuncles, Carbuncles, and Abscesses]

- Nursing protocols activated of warm compresses
- Avoid forcibly expressing the wound
- Incision and drainage [I&D] under control conditions in the clinic should be scheduled
- Send wound cultures for C&S studies
- Schedule nursing daily wound care and dressing changes
- Empiric antibiotics, especially if there is evidence of surrounding cellulitis 5 to 7 days
    - Clindamycin 150mg BID
    - Bactrim DS po BID

Non-purulent Skin and Soft Tissue Infections [Erysipelas and Cellulitis]

- Sharply demarcated lesions
- Superficial
- Painful
- Blanching
- Treatment options include:
    - Clindamycin
    - Bactrim DS

- Macrolides
- Penicillin remains an option

TUBERCULOSIS

Tuberculosis Protocol and Screening

At the time of intake screening, PPD skin tests must be administered by nursing staff for all newly admitted inmates, unless documentation of a negative chest x-ray or negative test results not more than three (3) months old exist and have been verified.

Returning inmates with previously documented positive PPD tests (LTBI) will receive a chest x-ray **ONLY** if positive responses are noted with use of the TB surveillance-screening tool.

In addition to PPD testing, chest x-rays must be ordered for all new detainees who meet the following criteria:

- +PPD test
- HIV+
- Foreign-born inmates in the United States for less than one year's time or for whom documentation of a chest x-ray performed in the United States within the past three (3) months does not exist
- Inmates who have been out of the United States or Canada for six months or more prior to incarceration

Once a baseline chest x-ray is on record, annual and additional follow-up surveys, as appropriate, should be performed.

QuantiFERON-TB Gold

This is a blood test that aids in the detection of Mycobacterium tuberculosis, the organism which is the cause of tuberculosis disease. QuantiFERON-TB Gold [QFT] is an interferon-gamma release assay, commonly known as an IGRA and is a modern alternative to the tuberculin skin test [TST, PPD or Mantoux]

The assay establishes both T-cell lymphocyte function and past exposure to the TB antigen. Patients with immune suppression of T cell function may not respond to testing. They may be Anergic, a state of immune unresponsiveness. The QFT tests the subject's T cells against standard mitogens, which in a non-anergic patient will elicit a reaction. A second aliquot of blood is tested against specific tuberculosis antigens. Thus, when a patient successfully completes a QFT and the report is negative for tuberculosis exposure, the patient is known not to be anergic. If the QFT is reported as positive, then the due to the sensitivity of the test, a chest x-ray will need to be completed to rule out pulmonary tuberculosis disease.

Conditions presenting with Anergy include:

- AIDS
- T-cell leukemia
- T-cell lymphomas, such as Hodgins's Disease
- Sarcoidosis

PLEASE CONSULT THE INFECTION CONTROL MANUAL AND THE POLICIES AND PROCEDURES MANUAL (POLICIES B-02 AND E-02) FOR ADDITIONAL INFORMATION REGARDING TUBERCULOSIS

Latent TB Infection (LTBI) Flow Chart

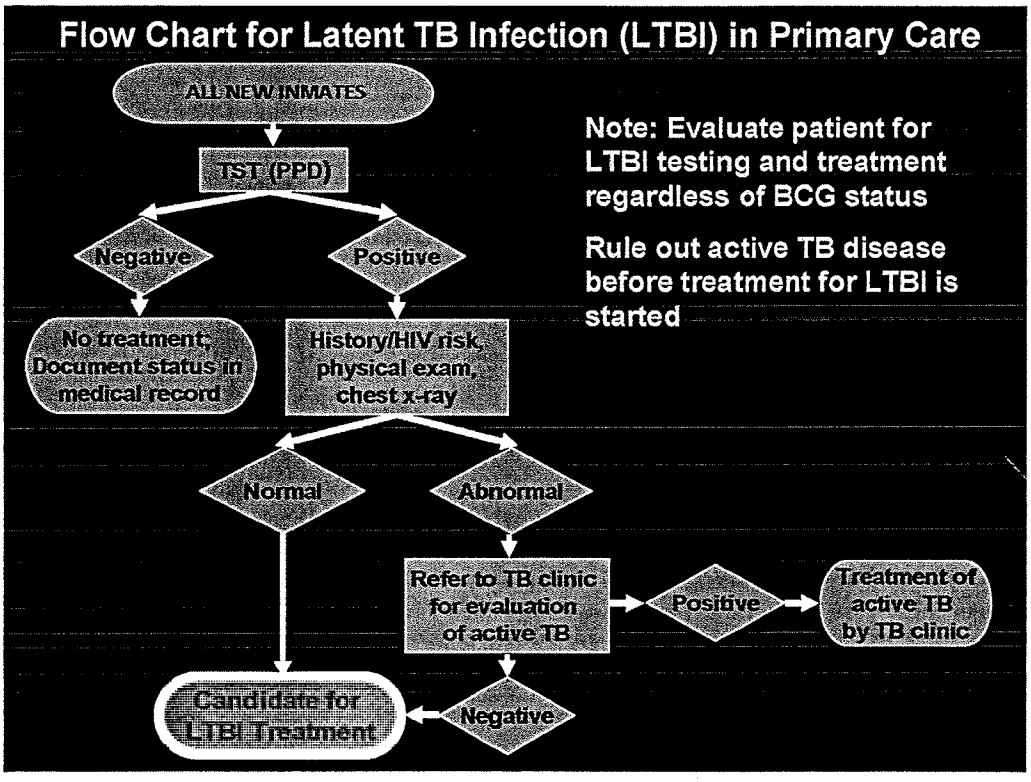


Table 1. Candidates for the Treatment of Latent TB Infection

Groups Who Should be Given High Priority for Latent TB Infection Treatment	
People who have a positive IGRA result *or* a TST reaction of 5 or more millimeters (TST = Tuberculin Skin Test)	**People who have a positive IGRA result *or* a TST reaction of 10 or more millimeters (IGRA= interferon gamma release assay)**
• HIV-infected persons • Persons in recent contact with a TB case • Persons with fibrotic changes on chest radiograph consistent with old TB • Organ transplant recipients • Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer; taking TNF-α antagonists)	• Recent immigrants from countries with a high prevalence of TB cases (in the USA < 5 years) • Injection drug users • Residents and employees of high-risk congregate settings (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other healthcare facilities) • Mycobacteriology laboratory personnel • Children under 4 years of age; children and adolescents exposed to adults in high-risk categories

Persons with no known risk factors for TB may be considered for treatment of LTBI if they have either a positive IGRA result **or** if their reaction to the TST is 15 mm or larger. However, targeted TB testing programs should only be conducted among high-risk groups. All testing activities should be accompanied by a plan for follow-up care.

Treatment for latent TB infection should reflect the most current CDC guidelines. Please see www.cdc.gov/tb

Table 1 is from:

http://www.cdc.gov/tb/publications/factsheets/treatment/LTBItreatmentoptions.htm

Mycobacterium Tuberculosis (MTB) and Latent Tuberculosis Infection (LTBI)

Did You Check For?	Did You Do?
Past history of tuberculosis/consumption	Confirm patient history
HIV/AIDS	Chest x-ray (CXR)
Severe anemia	CT scan
Elevated LDH (lactate dehydrogenase)	Chest
Steroid treatment of six (6) months' duration or more	Abdomen
Autoimmune disorders	Risk Stratification (based on size of swelling at PPD injection site):
Bacillus Calmette-Guerin (BCG) immunization	**5 mm** is considered positive for individuals with: • HIV • Autoimmune disorders • On Prednisone therapy • Recent contact with confirmed or suspected cases of TB • Fibrotic changes on a chest x-ray consistent with old/healed TB • On TNF alpha antagonists
Prior chest x-ray (CXR)	**10 mm** is considered positive for individuals who are: • In prison/jail • Current or past injection drug-users • Diabetes • Silicosis • Cancer of the head and neck • Hematologic and reticuloendothelial diseases • End-stage renal disease • Intestinal bypass or gastrectomy • Chronic malabsorption syndrome • Low body weight (10% or more below the ideal) • On immunosuppressive therapy
Prior CT scan	**16 mm** is considered positive in all individuals with no known risks
Chest	
Abdomen	

Tuberculosis Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:

Problem List

- **ICD code (Mycobacterium tuberculosis [MTB] or Latent tuberculosis infection [LTBI])**
- **Ensure TB findings are documented in the record**
- **Ensure PPD was administered and read**
- **Ensure CXR report was endorsed**

Orders and Care Plan

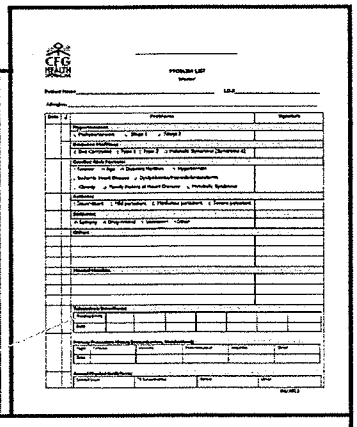
- **Prophylaxis offered**
- **6-month course of INH (isonicotinylhydrazine) offered:**
  - **Initiated**
  - **Refused**

Nursing Education

- **Printed patient materials - chart**

Discharge Planning

- **Provide patient with:**
  - **Department of Health (Tuberculosis Bureau) contact and referral information**
  - **Facilitate and document follow-up care**
  - **Related hand-outs and brochures**



Tuberculosis Surveillance:

Reading (mm)						
Date						

HIV/AIDS

(Treatment of HIV/AIDS as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Treatment Initiation

- Provide Primary Prevention Support
- Annual influenza vaccination
- Pneumovax vaccination
- Tetanus toxoid to be administered if last vaccination was >10 years
- Hepatitis vaccines (Hepatitis A, Hepatitis B, Twinrix)

Medications

- Discuss medication options (HAART – highly active anti-retroviral therapy) and contract for patient compliance with a goal >95%
- For MICA and substance-abusing patients, treat mental health issues and addictions as primary diagnoses before initiation of HAART to ensure patient commitment to treatment.

AIDSMEDS Drug Chart

Antiretroviral options abound for both those who are HIV treatment naive and those who are experienced. This quick-reference chart compares available medication options, including dosing and dietary restrictions. To learn more about these medications, including possible side effects and drug interactions, log on to AIDSmeds.com.

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NRTIs)			
Combivir (zidovudine + lamivudine)		One Combivir tablet twice a day. Contains two NRTIs in one tablet.	Take with or without food.
Emtriva (emtricitabine)		One 200 mg Emtriva capsule once a day	Take with or without food.
Epivir (lamivudine)		One 300 mg Epivir tablet once a day, or one 150 mg Epivir tablet twice a day	Take with or without food. Also approved for the treatment of hepatitis B virus (HBV), but at a lower dose. People living with both viruses should use HIV dose.
Epzicom* (abacavir + lamivudine) *Sold as Kivexa in some countries		One Epzicom tablet once a day. Contains two NRTIs in one tablet.	Take with or without food. Get tested for an inherited gene (HLA-B*5701) before starting this medication to reduce the risk of a severe allergic reaction to abacavir.
Retrovir (zidovudine)		One 300 mg Retrovir tablet twice a day	Take with or without food.
Trizivir (abacavir + zidovudine + lamivudine)		One Trizivir tablet twice a day. Contains three NRTIs in one tablet.	Take with or without food. Get tested for an inherited gene (HLA-B*5701) before starting this medication to reduce the risk of a severe allergic reaction to abacavir.
Truvada (tenofovir + emtricitabine)		One Truvada tablet once a day. Contains two NRTIs in one tablet.	Take with or without food.
Videx EC* (didanosine) *Also available generically in the U.S.		One 400 mg Videx EC capsule enema day (or one 250 mg capsule once a day for those who weighs less than 130 lbs.)	Take on an empty stomach. Rest to avoid alcohol with this drug.
Viread (tenofovir)		One 300 mg Viread tablet once a day	Also approved for the treatment of hepatitis B virus (HBV). Take with or without food.
Zerit (stavudine)		One 40 mg Zerit capsule twice a day (or one 30 mg Zerit capsule twice a day for those who weighs less than 130 lbs.)	Take with or without food.
Ziagen (abacavir)		Two 300 mg Ziagen tablets once a day, or one 300 mg Ziagen tablet twice a day	Take with or without food. Get tested for an inherited gene (HLA-B*5701) before starting this medication to reduce the risk of a severe allergic reaction to abacavir.
Protease Inhibitors (PIs)			
Aptivus (tipranavir)		Two 250 mg Aptivus capsules plus two 100 mg Norvir tablets twice a day	Take with food. Approved only for treatment-experienced patients. Aptivus should not be taken with other PIs, with the exception of Norvir.
Crixivan (indinavir)		Two 400 mg Crixivan capsules three times a day, or two 400 mg Crixivan capsules plus one or two 100 mg Norvir tablets twice a day (preferred dosing)	Take on an empty stomach or with a light, low-fat snack if used without Norvir. If Norvir is used, take with or without food. Drink six glasses of water a day to help prevent kidney stones.
Invirase (saquinavir)		Two 500 mg Invirase tablets plus one 100 mg Norvir tablet twice a day	Invirase must be used with Norvir and should be taken with food.
Kaletra* (lopinavir + ritonavir) *Sold as Aluvia in some countries		Two tablets twice a day or four tablets once a day, depending on nature of HIV drug resistance. Contains two PIs in one tablet.	Take with or without food.
Lexiva* (fosamprenavir) *Sold as Telzir in some countries		Two 700 mg Lexiva tablets twice a day, or two 700 mg Lexiva tablets plus one Norvir tablet once a day, or one 700 mg Lexiva tablet plus one Norvir tablet twice a day (recommended dose for those who have used other PIs in the past)	Take with or without food. People who have used other PIs in the past should only use twice-daily Norvir-boosted Lexiva.

Norvir (ritonavir)		Six 100 mg Norvir tablets twice a day	The full dose of Norvir is rarely used. It is most often used at much lower doses to "boost" the levels of other PIs in the blood. Take with food
Prezista (darunavir)		Two 400 mg Prezista tablets plus one 100 mg Norvir tablet once a day, or one 600 mg Prezista tablet plus one 100 mg Norvir tablet, twice a day, depending on extent of HIV drug resistance	Prezista must be used with Norvir and should be taken with food.
Reyataz (atazanavir)		Two 200 mg Reyataz capsules once a day, or one 300 mg Reyataz capsule plus one 100 mg Norvir tablet once a day	Take with food.
Viracept (nelfinavir)		Two 625 mg Viracept tablets twice a day, or five 250 mg Viracept tablets twice a day, or three 250 mg Viracept tablets three times a day	Take with food. If you have trouble swallowing the pills, you can dissolve a powder formulation in water for easy drinking.
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)			
Edurant (rilpivirine)		One 25 mg Edurant tablet once a day	Should be taken with a meal containing fat (eg., breakfast or dinner).
Intelence (etravirine)		One 200 mg Intelence tablet twice a day	Take with food.
Rescriptor (delavirdine)		Two 200 mg Rescriptor tablets three times a day	Take with or without food.
Sustiva® (efavirenz) *Sold as Stocrin in some countries		One 600 mg Sustiva tablet once a day	Take on an empty stomach and at bedtime to minimize dizziness, drowsiness and impaired concentration.
Viramune XR (nevirapine)		One 200 mg Viramune tablet once a day for the first 14 days, then one 400 mg Viramune XR tablet once a day	Take with or without food.
Integrase Inhibitors			
Isentress (raltegravir)		One 400 mg Isentress tablet twice a day	Take with or without food.
Fusion and Entry Inhibitors			
Fuzeon (enfuvirtide)		One 90 mg Fuzeon injection twice a day	Fuzeon comes as a white powder that must be carefully mixed with sterile water in a vial each day before being injected—a process called "reconstitution."
Selzentry® (maraviroc) *Sold as Celsentri in some countries		One 150 mg Selzentry tablet, one 300 mg Selzentry tablet, or two 300 mg Selzentry tablets twice a day (Because Selzentry interacts with many HIV drugs, the dose will depend on other medications being used)	Take with or without food. Selzentry is only effective against CCR5-tropic HIV (virus that uses the CCR5 receptor on CD4 cells). A tropism assay, such as Monogram Biosciences's Trofile, will determine whether treatment with Selzentry will be useful.
Single Tablet Regimens			
Atripla (efavirenz + tenofovir + emtricitabine)		One tablet once a day. Contains one HIV-1 and one HIV-2 virus tablet	Can be used with or without other HIV medications. Take on an empty stomach and at bedtime to minimize dizziness, drowsiness and impaired concentration (possible side effects of efavirenz).
Complera (rilpivirine + tenofovir + emtricitabine)		One Complera tablet once a day. Contains brand TDs and are HIV-1 in one tablet	Should be taken with a meal containing fat (eg., breakfast or dinner).

Drugs not shown actual size. Please refer to the complete prescribing information for each medication for details.

April 2012

HIV/AIDS Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List
Orders and Care Plan
Nursing Education
Discharge Planning • Establish medical and pharmaceutical community and local connections for discharge planning and follow-up care • Community mental health support

VARICELLA (CHICKEN POX)

PLEASE REFER TO THE INFECTION CONTROL MANUAL FOR STANDARD PROCEDURES.

Notify the Health Services Administrator (HSA) and the Infection Control Nurse. Facilities with County Department of Health liaisons require the DOH be informed of any cases of varicella. **The Corporate Medical Director *MUST* be notified.**

PEDICULOSIS (HEAD AND BODY LICE)

SEE THE INFECTION CONTROL MANUAL AND FACILITY CONTAINMENT PROTOCOLS.

OTIC INFECTIONS

Initial Health Assessment (Physical Examination Findings)

- External otitis
  - Painful ear canal with pain exacerbated by manipulation of the auricle
  - Erythema
  - Edema
  - Purulent exudate ("crusty" residue may be evident)

Treatment Initiation

- Patient must avoid using cotton swabs (i.e., - Q-Tips) or placing any foreign objects within the ear
- Administration of drying agents isopropyl alcohol/white vinegar (acetic acid) in a 50:50 solution
- Antibiotic drops
  - Fluoroquinolones
  - Aminoglycosides
  - Steroids

NOTE: Monitor diabetic patients closely and refer patients with persistent and/or recurrent otic infections to the ENT (ear-nose-throat specialist).

OPHTHALMOLOGIC INFECTIONS

BLEPHARITIS

Common purulent infection of eyelids and margins (may affect one eye or both)

Treatment Initiation

- Warm compresses

- Establish cleanliness of lid margins

Hordeolum

Initial Health Assessment (Physical Examination Findings)

- Staphylococcal abscess is common
- Swollen upper or lower eyelid with localized tenderness
- May be involvement of the meibomian gland

Treatment Initiation

- Application of warm compresses
- Instruct patient to avoid rubbing the area in an effort to thwart seeding

Acute Suppurative Bacterial Conjunctivitis

Causative organisms:

- Staphylococcus aureus
- Streptococcus pneumoniae
- Hemophilus
- Moraxella catarrhalis
- Neisseria gonorrhoeae

Treatment Initiation

- Standard universal precautions
- Tobramycin optic
- Polymyxin optic
- Neomycin/bacitracin ointment

Chalazion

Initial Health Assessment (Physical Examination Findings)

- Granulomatous infection of the meibomian gland

Treatment Initiation

- Application of warm compresses for small lesions

Referrals

- Complaints of compromised vision or visual deficits must be referred to the specialist

Pterygium

Initial Health Assessment (Physical Examination Findings)

- Fleshy, triangular growth on the nasal side of the cornea

Treatment Initiation

- No treatment, unless patient complains of visual deficit

Referrals

- Refer to specialist if patient complains of visual deficit

NEUROLOGY

SEIZURES

(Treatment of seizures as a key subspecialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Seizure Disorders Protocol

Initial Health Assessment (Physical/Examination Findings)

- Document clinical history (obtained during nursing screening) and review prior records and medications. Include:
  - Type of seizures
  - Age at onset
  - Date of last known seizure
  - Prior medical provider(s)
  - Substance abuse history
  - Verify Phenobarbital management
- Establish relationship between withdrawal and seizures *(see Withdrawal section under Multisystem Disorders)*
- Emergency if:
  - New onset
  - Head trauma- NOTE: Alcoholic with a history of a fall may present with a seizure. There is an increased propensity to develop subdural hematomas.
  - Febrile
  - Sepsis, e.g. HIV
- Urgent if:
  - Known history of seizures with acute withdrawal
  - Patient has long-term disease and has been on a "medication holiday"
- Evaluate for "pseudo-seizures"
  - If no secondary findings, (e.g. incontinence, confusion) consider pseudo-seizures
- Enroll in Chronic Care
  - Confirm primary care provider

- Indicate any concomitant conditions, such as:
  - Epilepsy
  - Secondary seizures
  - Diabetes
  - Cancer
  - HIV
  - Transient ischemic attacks (TIAs)
  - Cerebrovascular accidents (CVAs)
  - Thyroiditis
  - Sepsis
  - Ketoacidosis
  - Hyponatremia
  - Hypercalcemia
  - Hypomagnesemia
  - Hemoglobinopathy
  - Other metabolic disorders
- Access for cardiac ectopy or arrhythmia

- Establish working diagnosis (all three diagnoses listed below require initiation of an immediate care plan; management plan is dictated by diagnosis)
  - Epilepsy
  - Withdrawal seizures
  - Seizures, unknown

DIAGNOSTIC TESTING

- CT scan (MUST be ordered for head trauma with seizure)

MEDICATIONS

- Contact all prior and present treating physicians
- Transition from Phenobarbital

LABORATORY STUDIES

- Use laboratory studies to determine any primary causes, such as sepsis or hypoglycemia

Did You Check For?	Did You Do?
Evidence of seizure disorder	Request prior records
Prior attending physician, hospital or clinic sources	Identify comorbid conditions
Prior hospitalizations and ER transfers	Diagnostic testing
Prior electroencephalograms (EEGs) – note where and when performed	Confirm present medications (noting prescription and date of last order), including:
Prior CT scan (computed tomography)	Benzodiazepines
History of substance abuse	Phenobarbital
Potential relationship of seizures to substance abuse withdrawal	Selective serotonin reuptake inhibitors (SSRIs)
	Atypicals
	Prescribe any necessary medications

SEIZURE DISORDER DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:

Problem List

- **ICD code**
- **Provide diagnosis (epilepsy, withdrawal seizures, etc.)**

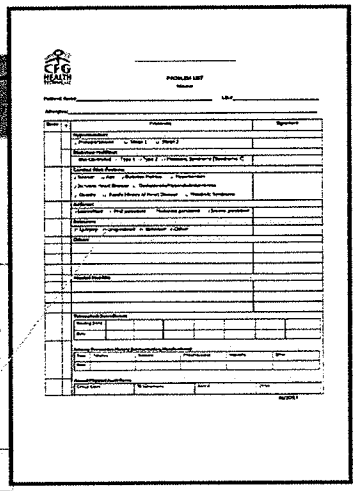
Orders and Care Plan

- **New onset seizures, febrile seizures, head trauma with seizures and undiagnosed seizures MUST be evaluated as an emergency**
- **Head trauma with seizure MUST have head CT scan**

Nursing Education

Discharge Planning

- **Discuss all diagnostic test results**
- **Organize post-release follow-up**



Seizures:

□Epilepsy □Drug-Related □Unknown □Other:

GASTROENTEROLOGY

GASTROINTESTINAL DISORDERS

Review of Nursing Intake Screening/Clinical History

- Scope of symptoms
  - Association with food
  - Accompanied by fever
  - Coughing up blood
  - Bloating and gas
  - Diarrhea (loose stools are NOT considered diarrhea)
    - Watery
    - Bloody
- Document any concomitant conditions
- Note use of medications associated with gastrointestinal issues, such as NSAIDs (non-steroidal anti-inflammatory drugs)
- Past history of surgery, irradiation

Initial Health Assessment (Physical/Examination Findings)

- Abdominal pain
- Fever
- Ascites
- Dyspepsia
- Stool color, consistency (Melena, watery, bloody red)

Diagnostic Testing

- CBC
- Coagulation parameters (INR), PTT
- CMP (including liver function and transaminase

Treatment Initiation

- H2 blocker (Zantac)
- If the patient finds relief with Zantac (or another H2 blocker), then counsel the patient regarding dietary changes
- If the patient fails to find relief with the use of H2 blockers, the clinician must consider other diagnoses
- Trial HMG Co-reductase inhibitors, e.g. Omeprazole

Endoscopy

- High diagnostic accuracy
- Upper GI Pathology
- Therapeutic capability

ROCKALL SCORE FOR RISK STRATIFICATION OF ACUTE UPPER GASTROINTESTINAL (GI) BLEEDING	
VARIABLE	**POINTS**
AGE	
<60 YR.	0
60-70 YR.	1
≥ 80 YR.	2
SHOCK	
HEART RATE >100 BPM	1
SYSTOLIC BLOOD PRESSURE < 100 MM HG	2
COEXISTING ILLNESS	
CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE, OTHER MAJOR ILLNESSES	2
RENAL FAILURE, HEPATIC FAILURE, METASTATIC CANCER	3
ENDOSCOPIC DIAGNOSIS	
NO FINDING, MALLORY-WEISS TEAR	0
PEPTIC ULCER, EROSIVE DISEASE, ESOPHAGITIS	1
CANCER OF THE UPPER GI TRACT	2
ENDOSCOPIC STIGMATA OF RECENT BLEEDING	
CLEAN BASED ULCER, FLAT PIGMENTED SPOT	0
BLOOD IN UPPER GI TRACT, ACTIVE BLEEDING, VISIBLE VESSEL, CLOT	2

GASTROINTESTINAL DISORDERS DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Include medication start and stop dates** • **ICD codes (Note – Gastritis is often omitted)**
Orders and Care Plan • **Ensure that Nursing Protocol Rx are endorsed (e.g. – Zantac)**
Nursing Education • **Include printed patient education materials**
Discharge Planning • **Comment on issues surrounding gastrointestinal symptomatology and NSAID usage**

Dysphagia and Odynophagia

- Detailed history – identification of lev

Oropharyngeal dysphagia	Difficulty in transferring liquids from mouth to esophagus	Nasopharyngeal regurgitation Aspiration	Neuromuscular Irradiation	ENT GI referral Neurology
Esophageal	Food stuck in transit down esophagus			
Odynophagia	Pain on swallowing food or liquids	Mucosal inflammation – esophagitis	Infectious Pill esophagitis	GI
Dysphagia [GERD]	Epigastric Burning Fullness post prandial 30 to 60 minutes	H2 blockers Proton Pump inhibitors	Gastritis Hiatal hernia	Patient education – chewing fully, dietary changes -Post prandial posture

Diarrhea

- Confirm the diagnosis prior to work up or treatment. A single loose stool is not diarrhea [>240 cc/24 hrs.]
- Often self-limiting
- Detailed history –
    - related to diet? e.g. malabsorption or explosive related to dairy products
    - associated bloating
    - abdominal pain
    - fever or chills
    - extreme odor
- Other cases reported from the same area? Same day
- Vital signs – tachycardia, fever
- Quantify – medical housing

Treatment if persists for over 24 hours or for evidence of volume depletion

- CBC with differential
- Stool analysis – E.coli 0157, bacterial overgrowth secondary to antibiotic therapy,
- Volume replacement, osmotic diarrhea replace with balanced fluid supplements
- Bulk resin agents, if tolerated
- Non-specific agents: Loperamide, opiates, Lomotil, bismuth subsalicylate
- Antibiotics – Metronidazole with confirmed bacteriologic diagnosis.

Severe persistent diarrhea refer to Gastroenterology

Constipation

- Confirm diagnosis – change from daily routine does not mean constipation
- Stress exercise
- Increase fluid intake
- Complete diet history which may differ from that of home and contribute to the change in bowel habits.
- Offer psyllium natural products with hydration prior to initiation of medications.
- Laxatives should be reserved until all other measures have failed.

The following disorders are reviewed below (in alphabetical order), followed by a section dedicated to the treatment of other possible causes of abdominal pain:

- Appendicitis
- Barrett's Esophagus (carcinoma)
- Choledocholithiasis/Acute Cholecystitis
- Crohn's Disease
- Diverticulitis
- GERD (gastroesophageal reflux disease)
- Pancreatitis

- Peptic Ulcer Disease
- Perforated Ulcer

APPENDICITIS

Initial Health Assessment (Physical/Examination Findings)

- Anorexia
- Periumbilical pain that becomes localized to the RLQ (right lower quadrant)
- Nausea and/or vomiting
- Low-grade fever
- RLQ tenderness
- Abdominal rebound
- Abdominal rigidity (often associated with perforation of the appendix)

The **Alvarado Score** is a clinical scoring system used in the diagnosis of appendicitis. The mnemonic for this score is:

MANTRELS

SYMPTOM	EXAMINATION FINDINGS	SCORE
1. Migration	Painful symptoms are migratory and localize to the right of the iliac fossa	2
2. Anorexia	History of loss of appetite	1
3.Nausea/vomiting	Patients often report emesis	1
4. Tenderness	Abdominal tenderness to abdominal distension	1
5. Rebound	Abdominal rebound is often seen	1
6. Elevated Temp	Fever	1
7. Leukocytosis	WBC elevation [10,000+]	2
8. Shift	WBC elevation with left shift	1

MANTRELS Scoring:

Inconsistent with acute appendicitis	0 - 4
Compatible with acute appendicitis diagnosis	5 – 6
Probable acute appendicitis	7 – 8
Very probable acute appendicitis	9 – 10

For Clinicians:

Treatment

No CT scan	< 3
Order an abdominal CT scan[6]	4 – 6
ER referral and Surgical Consultation	> 7

[6] McKay, R. Sheppard, J, The Use of the Clinical Scoring System by Alvarado in the Decision to Perform CT for diagnosis of Acute Appendicitis in the ED, American Journal of Emergency Medicine 2007, June 25(5):489-93

Barrett's Esophagus (carcinoma)

Initial Health Assessment (Physical Examination Findings)

- Persistent symptoms of GERD (gastroesophageal reflux disease) with no response to omeprazole coupled with antibiotics

Treatment Initiation

- Endoscopy with biopsy
- Surgery consultation

Choledocholithiasis/Acute Cholecystitis

Initial Health Assessment (Physical/Examination Findings)

- Positive for "4 Fs"
  - Female
  - Fat
  - Forty
  - Fertile
- RUQ (right upper quadrant) pain
- Diabetic
- Indigestion
- Diabetic ketoacidosis
- Positive Murphy's sign- A test for gallbladder inflammation- examiner's fingers at right costal margin (right hypochrondrium) patient is asked to inhale. Inflamed gallbladder taps the finger during the maneuver and the patient experiences pain. Positive sign order: Abdominal ultrasound onsite
- Occasional jaundice

Crohn's Disease

Initial Health Assessment (Physical/Examination Findings)

- Anemia
- Arthritis
- RLQ (right lower quadrant) pain
- Fever
- Diarrhea
- Melena
- Cramping
- Skip lesions

- Presence of cobblestones on endoscopy

Treatment Initiation

- Dietary modifications (possibly NPO [nil per os – nil by mouth])
- Volume and electrolytes replacement
- Medication
- Surgical consultation (for abscesses and fistulas)

DIVERTICULITIS

Initial Health Assessment (Physical/Examination Findings)

- Crampy abdominal pain
- Melena
- Hematohezia
- Diarrhea
- Constipation
- Fever
- LLQ (lower left quadrant) tenderness
- Palpable mass
- Positive stool guiac test
- +/- Peritoneal signs

GERD (GASTROESOPHAGEAL REFLUX DISEASE)

Initial Health Assessment (Physical Examination Findings)

- Dyspepsia
- Abdominal pain
- Negative rebound
- Anemia
- Positive stool guaiac test

Treatment Initiation

- Dietary modifications
- Behavioral adjustments
- Initiate two-week trial of Proton pump inhibitor (omeprazole)
- If patient finds relief with omeprazole, then continue to monitor and counsel patient regarding dietary changes
- If no relief is obtained with the use of omeprazole, the clinician must persist in finding the correct diagnosis

PANCREATITIS

Initial Health Assessment (Physical/Examination Findings)

- Clinical history of alcohol (ETOH) abuse
- Abdominal flat plate calcifications
- Deep epigastric pain radiating to the back that is relieved with the patient in the upright position
- Nausea and/or vomiting
- Dehydration- may require IV hydration
- Abdominal ultrasound- rule out Pseudocyst formation

Treatment Initiation

- Monitor
  - Glucose
  - Calcium
  - Potassium
- Begin narcotic analgesics

PEPTIC ULCER DISEASE

Initial Health Assessment (Physical Examination Findings)

- Persistent dyspepsia
- Abdominal pain (periumbilical)
- Weight loss
- Anemia
- Positive stool guaiac test

Treatment Initiation

- Initiate two-week trial of omeprazole
- If no relief or if symptoms return, perform the urea/H. pylori breath test; if positive, begin a two-week trial of omeprazole, plus clarithromycin and amoxicillin
- If symptoms still persist, refer patient for endoscopy

PERFORATED ULCER

Initial Health Assessment (Physical/Examination Findings)

- Sudden onset of severe abdominal pain
- History of PUD
- History of long-term NSAID use
- History of crack use

- Rigid abdomen
- Decreased bowel sounds
- Detection of free air with abdominal flat plate x-ray
- Dehydration

Treatment Initiation

- Emergency volume replacement with normal saline (to prevent shock)
- Emergency surgical consultation/referral to ER

OTHER CAUSES OF ABDOMINAL PAIN

- Ectopic Pregnancy
- Hiatal Hernia
- Nephrolithiasis
- Perforation
- PID (pelvic inflammatory disease)
- Renal Colic
- Ruptured Abdominal Aneurysm

ABDOMINAL PAIN PROTOCOLS

Know the Diagnosis BEFORE you mask the pain with analgesics

Review of Intake Screening/Clinical History

- Assess and document risk factors:
  - HBeAg + (hepatitis B e antigen positive)
  - HBsAB – (hepatitis B surface antibody negative)
  - 4 F's of gallbladder disease:
    - Female
    - Forty
    - Fat
    - Fertile

Initial Health Assessment (Physical/Examination Findings)

- Shifting dullness
- Bruits
- Masses

Diagnostic Testing and Referrals

- Abdominal ultrasound

- Spiral CT
- ERCP (endoscopic retrograde cholangiopancreatography)

Did You Check For?	Did You Do?
Concurrent Medications	Review current medication orders
Over-the-counter (OTC)	*Know the Diagnosis BEFORE you mask the pain with analgesics*
Prescribed NSAIDs	Trial of omeprazole
Bisphosphonates	Prescribe beta blockers **(propranolol)** for patients with a history of varices or prior bleeds
Antibiotics	Screen for H. pylori
Alcohol abuse	
Past treatment/Medical history	
ER visits	
Surgery	
Endoscopy	
Hemorrhage	
Varices	

ABDOMINAL PAIN DOCUMENTATION

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **ICD codes, for example:** o **Chronic hepatitis** o **Pancreatitis** o **Cholelithiasis** o **Alcohol abuse**
Orders and Care Plan • **Progress notes – "Case Review"**
Nursing Education • **Provide patient with appropriate printed educational and follow-up materials**
Discharge Planning • **Review all diagnostic tests** • **Facilitate outpatient follow-up**

Ectopic Pregnancy

Initial Health Assessment (Physical/Examination Findings)

- Amenorrhea
- Pelvic pain, worse in the lower quadrants
- +HCG with predicted rising titer

Treatment Initiation

- ER referral

Hiatal Hernia

Incarceration/Strangulation
Initial Health Assessment (Physical/Examination findings)

- History of prior surgery
- Adhesions
- Hernia
- Sudden, acute, localized pain
- Erythema
- Fever
- Diminished bowel sounds

Treatment Initiation

- Injectable Toradol (ketorolac), then reassess

NASH (Non-Alcoholic Steatohepatitis)

This finding is of clinical significance given the propensity of patients diagnosed with NASH to progress to cirrhosis.

NASH is marked by the following laboratory studies:

- Rising/falling titers
- Elevated alanine and aspartate aminotransferase (ALT and AST)
- Elevated alkaline phosphatase (alk pho)
- Elevated PO4 (serum phosphorus)
- Definitively diagnose via GI referral and liver biopsy

Treatment Initiation

- Refer to specialist

Nephrolithiasis

Initial Health Assessment (Physical/Examination Findings)

- Referred abdominal pain

- Hematuria
- Dramatic relief with Toradol IM

PERFORATION

Initial Health Assessment (Physical/Examination Findings)

- Anorexia
- Periumbilical pain that migrates
- Nausea and vomiting
- Low-grade fever
- RLQ tenderness
- Rebound or rigidity

Treatment Initiation

- Refer to ER for surgical evaluation

PID (PELVIC INFLAMMATORY DISEASE)

Initial Health Assessment (Physical/Examination Findings)

- Fever
- Pelvic pain
- Cervical discharge (or history of recent treatment for cervical discharge)
- Pelvic fullness
- Positive Chandelier sign

Treatment Initiation

- Rocephin(+ Zithromax 1gm PO x1 or Doxycycline 100mg PO BID x 7 days for Chlamydia)

RENAL COLIC

Initial Health Assessment (Physical/Examination Findings):

- Hematuria
- Nausea
- Emesis
- +/- Fever
- Diaphoresis
- Tachycardia during bouts of colic
- U/A sedimentation

Treatment Initiation

- IV hydration with either normal saline or half normal saline
- Toradol IM

RUPTURED ABDOMINAL ANEURYSM

Initial Health Assessment (Physical/Examination Findings)

- History of smoking
- Vasculopathy (common causes: hyperlipidemia, HTN (hypertension), atherosclerosis and autoimmune disorders)
- Palpate for pulsatile abdominal mass greater than 3cm
- If mass detected upon palpation, refer patient for abdominal vascular ultrasound
- Abdominal pain
- Altered mentation
- Peripheral pulse gradient
- Patient may be hypotensive – in shock

Treatment Initiation

- **CALL 911 IMMEDIATELY**

WOMEN'S HEALTH

According to the Federal Bureau of Prisons, as of January 2016, women represent approximately 6.6% of the correctional population in the United States. The NCCHC recognizes the unique and specific needs of incarcerated women and views them as a distinct and special population. To address women's gender-specific health needs, including reproductive health issues and pregnancy, as well as issues pertaining to alcohol and drug abuse, sexually transmitted disease, sexual and physical abuse, and mental illness in women, CFG follows the NCCHC's *Standards for Health Services in Jails* (2018). Specific guidelines and recommendations directly impacting women's healthcare have been outlined below:

- As a Compliance Indicator of Standard J-E-02 (Receiving Screening), women reporting current opiate use are to be offered a pregnancy test immediately (to avoid risks to the fetus associated with opiate withdrawal). Selective means of early detection of and treatment for sexually transmitted diseases (STDs) also needs to be initiated, as well as establishing an inmate's pregnancy status, following inquiry into medicaland sexual history. Current STD screenings allow for the detection of some diseases/infections within hours of admission. The NCCHC's intent is to offer solutions to problems that might otherwise develop without early intervention. For example, infected and untreated females of childbearing age may develop complications that are both painful and costly, and can lead to adverse outcomes related to pregnancy.
- Standard J-E-04 (Initial Health Assessment) states that both age- and gender-specific clinical practice guidelines should be followed, to include clinical preventive services such as pelvic examinations and Pap smears.
- Standard J-F-05 (Counseling and Care of the Pregnant Inmate) acknowledges the special management of pregnant inmates with opioid-use disorders.

- Standard J-B-06 (Contraception) recommends that women inmates be provided with non-directive counseling concerning pregnancy prevention, as well as access to emergency contraception, as needed. The Standard also counsels consideration of the continuation of contraception for those women who enter the facility on some form of birth control (for both medical stability and as a means of preventing pregnancy). Compliance Indicators of this Standard stress that written information about various contraception methods and community resources should also be made available.
- Standard J-F-05 (Counseling and Care of the Pregnant Inmate) specifies that pregnant inmates receive timely and appropriate pre-natal care, specialized obstetrical services (as needed), pre-natal vitamins and post-partum care (including mental health services). Pregnant inmates should also be provided counseling and assistance supportive of a woman's expressed desire to either maintain or terminate a pregnancy. During active labor and delivery, the Standard cautions that restraints should not be used (unless absolutely necessary to prevent serious harm to the patient, staff and/or others). Because fetal exposure to alcohol and drugs can be detrimental, pregnant inmates should be counseled on the dangers of alcohol use while pregnant, with opiate substitution therapy and counseling made available for pregnant women who are opiate-dependent. The Standard's intention is that the health of the pregnant inmate and the fetus are protected, with pregnant inmates receiving services as they would within the community.
- Breast Feeding – Detainees who are actively breast feeding at the time of arrest will be assisted in the daily collection of milk for retrieval for administration to the baby. The nursing staff will provide for storage of the patient's breast pump in the clinic. The staff will coordinate with custody who will retrieve the milk, from what location and the time of day. NOTE: If the detainee is an active substance abuser or if she exhibits signs and symptoms of intoxication and would otherwise be evaluated for withdrawal management, the clinician will meet with the mother to discuss the safety and risks of continued breast feeding for the infant. If urine drug testing is performed at the facility in association with withdrawal management, the mother will be informed of the findings. Urine testing positive for buprenorphines must be determined to be from Subutex. The mother will be asked to sign a consent form that clearly states that she has been fully informed of the risks but wishes to continue to breast-feed her baby.

Review of Intake Screening/Clinical History
(see Initial Health Assessment [Historical Findings])

- Identification of chronic conditions (e.g., heart disease, hypertension, diabetes mellitus)
- Gynecological history
- Pregnancy status
- Review of appropriate immunizations (adolescents)

Initial Health Assessment (Physical/Examination Findings)
(see Initial Health Assessment [Physical Examination Findings])

- Should be comparable to the general assessment performed for male detainees, with the addition of:
    - Pelvic examination
    - Pap smear

- Breast exam/mammogram

Clinical Breast Exam

The clinical breast exam should be performed by either the APN or OB/GYN, either at Intake or within several days of a female inmate's admission to the correctional facility. It should be conducted with the patient either in the prone position or sitting. The patient should raise their arms over their heads. Breasts should be inspected for differences and changes in size and shape, puckering, dimples and redness of the skin. Breasts and axillae should be palpated to detect any changes or anomalies. The nipples may be gently squeezed to check for discharge. Clinical breast exams should be performed according to the following schedule, as recommended by the American Congress of Obstetricians and Gynecologists (ACOG) and the American College of Obstetricians and Gynecologists (April 2015):

- Women aged 29-39 – every 1-3 years
- Women aged 40 and older – performed annually

Mammography

- Mammography screening should be performed annually for all women aged 40-49
- Per the US Preventative Services Task Force (USPSTF), mammography screening should be performed bi-annually for all women aged 50-74

Cervical Cancer Screening (PAP Smear) and HPV Testing

Current cervical cancer screening guidelines have been prepared byThe American College of Obstetricians and Gynecologists (March 2016) and have been developed to maximize the benefits of screening while minimizing any potential harm:

- Screening should begin for all females at the age of 21
- For women aged 21-65, cytology should be performed every three years
- Women aged 30-35 at high-risk should also have HPV (human papilloma virus) testing performed every five years
- Screening is not recommended for women beyond age 65 or for women who have undergone hysterectomy with removal of the cervix

Intoxication and Withdrawal

Please see the section entitled Substance Abuse Withdrawal for additional information.

Pregnant, opiate-abusing females are considered "high risk," priority patients and require specialized OB/GYN and Maternal/Fetal Medicine care. Depending on the substance(s) being used, pregnant women may be managed on methadone. Hydration therapy should be initiated as indicated below:

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS **(1 liter = 33.81 oz. or 1000 cc/mL)**	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

- IV Hydration - IV 0.45% or NS x two (2) liters, administered over 12 hours. May repeat in 12 hours, as needed.
- Intake and output assessments
- 8-Day Nursing Plan (see Flow Sheet for Alcohol/Poly-Substance Withdrawal)

CONTRACEPTION

Continuation of contraception (birth control pills, shots, etc.) is advised, especially for detainees with short-term stays/sentences. Stopping birth control medications, especially for individuals who might return to the community in a few days may significantly increase the risk of unwanted pregnancy upon release. Removal of intrauterine devices simply because a woman is incarcerated is neither necessary nor advisable. Hormonal medications taken for medical reasons other than or in addition to contraception should be reviewed with regard to a patient's medical health conditions and other concurrent treatment(s).

TREATING THE PREGNANT INMATE

In the correctional setting, all pregnancies are considered high risk. Consultations for pre-natal care are ordered by the clinician, with special attention afforded those inmates whose pregnancies are complicated by substance abuse. A multidisciplinary approach works best to optimize care of the pregnant inmate.

- Pregnant inmates may be referred to the gynecology nurse practitioner in those facilities with such staff; however, all patients must be referred for management by a"high-risk" pregnancy team.
- Hydration therapy should be started.
- All pregnant females should be prescribed pre-natal vitamins.
- Specialized laboratory tests (such as cystic fibrosis genotyping assay) and diagnostic evaluations (such as genetic counseling) are to be provided by the consultant gynecology team.
- Pregnant and opioid-addicted patients are to be referred for initial evaluation and initiation of a treatment regimen. Each facility should have a designated methadone provider for routine medication

administration and scheduled counseling. Newly admitted opioid-addicted mothers shall be sent to the emergency room for initial management, pending enrollment in the methadone treatment program.

- Termination of pregnancy shall be facilitated upon request of the mother; however, in these circumstances, it is imperative that the provider make a referral to mental health and that the mother confirms that the decision to terminate the pregnancy has been made of her own volition and not under duress or pressure from clinical staff.

Sexually Transmitted Disease (STD) Screening for Pregnant Women

- VDRL (Venereal Disease Research Laboratory test)
- Chlamydia test
- Ureaplasmaurealyticum test

Did You Check For?	Did You Do?
Pregnancy status	Hydration therapy (for pregnant inmates)
Sexually Transmitted Diseases (STDs)	Pre-natal care (including pre-natal vitamins)
Current status	Fetal monitoring (completed by nursing)
History	Obstetrical care
Substance abuse	Mental health referral
Physical abuse	Gynecological evaluation
Primary healthcare history	PAP smear
PAP smear/HPV immunization	Clinical breast exam
Mammography, as appropriate	Mammography referral, as indicated

Women's Health Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • **Notations from sub-specialists** • **ICD codes**
Orders and Care Plan
Nursing Education • **Include materials from sub-specialists**
Discharge Planning

BREASTFEEDING

Background

Breastfeeding has well-established physical and psychological benefits for newborns and mothers, and enhances long-term bonding. Breast milk supply relies heavily on being able to continue to produce milk, either through direct feeding or expressing milk. Fair Labor Standards Act (29 U.S. Code 207) now requires employers in community workplaces to provide reasonable break-time and clean, private space (excluding a bathroom) for an employee to express breast milk for her nursing child for one year after the child's birth each time the employee needs to express milk. These laws also apply to employees working in correctional facilities. This accepted community and legal standard for employees highlights the importance of making accommodations for postpartum detainees and inmates who wish to breastfeed. The Agency for Healthcare Research and Quality conducted a comprehensive analysis of scientific literature that concluded that compared to infants fed commercial formula, breastfed infants have fewer incidents of respiratory tract, infections, ear infections, GI tract infections, necrotizing enterocolitis, sudden infant death syndrome, infant mortality, allergic disease, celiac disease, obesity, diabetes, childhood leukemia, and lymphoma (Breastfeeding and Matemal and Infant Health Outcomes, 2007). For the mothers, improved health outcomes include less postpartum blood loss, less postpartum depression, and greater postpartum weight loss (American College of Obstetricians and Gynecologists [ACOG], 2013). Breastfeeding is also protective against later development of breast and ovarian cancer, cardiovascular disease, diabetes, and other conditions (acog, 2013). Psychological benefits include improved bonding between mother and child, which is particularly important when the mother is incarcerated (ACOG, 2013).

Many women in custody have substance use disorders. Breastfeeding is safe and encouraged for women who are taking methadone or buprenorphine as there are benefits to their infants. However, breastfeeding is discouraged among women who are actively using illicit substances. Breastfeeding is also safe for women with hepatitis C, but is not recommended for HIV-positive women (American Academy of Pediatrics, 2013). Most common medications are safe with breastfeeding. Smoking is known to reduce a mother's milk supply. Exposure to tobacco smoke is harmful to children.

Position and Practices

1. Clinical staff will screen women on entry to determine if they are postpartum and breastfeeding.
2. Clinical staff will counsel pregnant women on the benefits and nutritional needs of breastfeeding and inform them of the systems and supports in place at the facility.
3. Clinical staff will provide breastfeeding women with a special diet with appropriate caloric, fluid, calcium, and vitamin D intake. Prenatal vitamins offer a convenient way to provide essential nutrients that are often missing from correctional diets.
4. Clinical staff will provide personal education support in assessment of breast pain, Let-down reflex and Oxytocin release, use of the breast pump, milk collection and storage procedures.
5. Clinical staff will coordinate with custody to allow for daily retrieval of breast milk by a designated family member.
6. Clinical staff will identify the appropriate storage procedures at each facility.

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SUBSTANCE ABUSE MANAGEMENT IN THE PREGNANT DETAINEE

Procedure:

1. Confirm pregnancy with urine testing and/or phenotypic presentation
2. Confirm substance abuse disorder with urine drug test.
3. Rule out ketosis and urosepsis with urinalysis and dipstick
4. Oral hydration with water is appropriate
5. Determine if the patient is already receiving MAT [Subutex, Methadone] and confirm the program participation.
6. Notify the designated facility treatment who provides services for the clinic. NOTE: Patients registered in other programs may be registered as a "guest" and their therapy continued.
7. Confirm that ALL HIV infected detainees receive a referral to Infectious Diseases.

MULTISYSTEM DISORDERS

PHYSICAL MEDICINE

Initial Health Assessment (Physical Examination Findings – see the table below and on the following pages)

SITE	PHYSICAL EXAM	DIAGNOSTIC	TREATMENT
HAND	– Visual alignment – Deformities – Swelling – Erythema	– Neurovascular assessment – Grip – X-ray	– Splint – NSAIDs – Orthopedic hand specialist referral
SHOULDER	– Drooping – Spontaneous movement – Splinting	– A/PROM testing – Focal point tenderness to palpation – Abduction to 90° – Thumb extension – Pronation – MRI	– NSAIDs – Splint sprains – Orthopedic referral for rotator cuff surgery
HIP	– Pain lying on hip – Pain to groin – Hx of arthritis/steroid injections	– Leg extension – Straight leg raise – Trochanteric or sacroiliac – X-ray – MRI	– NSAIDs vs. Steroids
KNEE	– Crushing pain day of injury – Locking or popping after injury – Swelling – Warmth	CRUCIATE – Crushing – urgent care warranted – Drawer test – Squatting OK MINISCUS – Popping or locking – + McMurray test – Unable to squat ARTHROCENTESIS – Crystals – Cultures – Fluid exam FOR ALL – X-ray – MRI	– Birefringence – Allopurinol (though *NOT during acute phase)* – NSAIDs – Antibiotics – Orthopedic referral

ANKLE	– Visual exam – Achilles' tendon – Swelling – Alignment	– Drawer test – Pronation – Supination – Point tenderness – Spring ligament rupture – Possible x-ray	– Immobilization (splinting or casting)
SPINE	– Kyphosis – Scoliosis – Fluid gait – Involvement – Illness or disease	– Waddell's sign (with axial loading) – Trunk rotation – Heel-toe walking – Squatting – X-ray	– Physical therapy – Orthopedics vs. Rheumatology

- Chronic Musculoskeletal Pain
- Chronic Back Pain
- Old Gun Shot Injuries

DIAGNOSTICS

- Repeat physical exam
- X-ray – DON'T MISS SIGNS OF SECONDARY INFECTION

MEDICATIONS

Therapeutic doses of NSAIDs

- Motrin 2400 – 3200mg/daily
- Naproxen 1000 – 2000mg/daily

CUSTODY SURVEILLANCE

- Seen playing basketball
- Free ambulation

IDENTIFICATION AND TREATMENT OF PSYCHOTIC DISORDERS AND MOOD DISORDERS

PSYCHOTIC DISORDERS

(Treatment of major mental illness as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

Psychotic Disorders can be an acute or chronic condition, depending on the nature and course of the condition. Psychotic symptoms can be the result of acute intoxication (e.g., amphetamines, hallucinogens), symptoms of schizophrenia, an overwhelming traumatic event, or an aspect of a severe manic episode. Mental health disorders, with respect to diagnosis and treatment, are not as cleanly differentiated as medical conditions, so careful assessment to rule out medical reasons for change in mental status is always the first differential diagnosis. Many times what appears to be a formal mental health disorder is actually a disruption in mental status related to the ingestion of substances, or a physical condition. Please refer to the table below for the differential assessment of formal vs. cannabis-induced psychosis.

TABLE. **A comparison of the clinical features of idiopathic versus cannabis-induced psychosis**

Primary psychosis (eg, schizophrenia)	Cannabis-induced psychosis
Cannabis urine toxicology sometimes positive	Positive cannabis urine toxicology
Variable reported cannabis use (25% prevalence of positive cannabis urine toxicology in schizophrenia)	Heavy cannabis use within past month
Symptoms appear before heavy substance use	Symptoms appear only during periods of heavy substance use/sudden increase in potency
Symptoms persist despite drug abstinence	Symptoms abate or are reduced with drug abstinence
Antipsychotics markedly improve symptoms	Antipsychotics may/may not improve symptoms
Most often presents with delusions, hallucinations, and thought disorder	Often associated with visual hallucinations and paranoid ideation (eg, features of an "organic" psychosis)
Less insight about psychotic state	More aware of symptoms/insight about disease
Disorganized thought form (eg, loose associations, tangential or circumstantial speech)	Thought form more organized and sequential

Source: Psychiatric Times. Cannabis-Induced Psychosis: A Review. Ruby S. Grewal, MDTony P. George, MD, FRCPC July 2017

Symptoms of schizophrenia include psychotic symptoms such as hallucinations, delusions, and thought disorder (unusual ways of thinking), as well as reduced expression of emotions, reduced motivation to accomplish goals, difficulty in social relationships, motor impairment, and cognitive impairment. Precise prevalence estimates of schizophrenia are difficult to obtain due to clinical and methodological factors such as the complexity of schizophrenia diagnosis, its overlap with other disorders, and varying methods for determining diagnoses. Given these complexities, schizophrenia and other psychotic disorders are often combined in prevalence estimation studies. A summary of currently available data is presented here.

- Across studies that use household-based survey samples, clinical diagnostic interviews, and medical records, estimates of the prevalence of schizophrenia and related psychotic disorders in the U.S. range between 0.25% and 0.64%.[1,2,3]
- Estimates of the international prevalence of schizophrenia among non-institutionalized persons is 0.33% to 0.75%.[4,5]
- Co-occurring medical conditions, such as heart disease, liver disease, and diabetes, contribute to the higher premature mortality rate among individuals with schizophrenia.10 Possible reasons for this excess early mortality are increased rates of these medical conditions and under-detection and under-treatment of them.[6]
- Approximately half of individuals with schizophrenia have co-occurring mental and/or behavioral health disorders.[7]

Despite its relatively low prevalence, schizophrenia is associated with significant health, social, and economic concerns.

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MANAGEMENT OF ACUTE PSYCHOSIS

Intense symptom reduction and behavioral control are of paramount importance in managing acute psychotic symptoms in a correctional setting. Typically, individuals suffering from these symptoms are non-compliant with treatment and unable to house safely with other inmates. It is imperative that all mental health and healthcare staff participate in encouraging treatment compliance, particularly with proffered medication. Individuals with acute psychosis can show the following signs and symptoms:

- Agitation
- Intense crying or laughing

- Nonsensical, disorganized speech
- Attending to internal stimuli (auditory and/or visual hallucinations)
- Intense paranoia and/or delusions
- Withdrawn from interaction, not speaking
- Rigid posturing (catatonia)
- Extremely poor hygiene
- Unable to follow commands or directions
- Aggressive behavior

It is important that all healthcare staff interacting with the person project a therapeutic attitude to encourage treatment compliance. Mental health staff should take the lead in therapeutic interactions with the person and determine the necessary housing level/watch status to manage the behavior. Should the person's symptoms and behavior escalate to a psychiatric emergency, psychiatric staff can employ the policy for emergency forced medication, which requires a referral and transfer to the local acute psychiatric emergency service. Alternatively, psychotic patients requiring a higher level of psychiatric care can be transferred to the local psychiatric emergency service without receiving emergency forced medication. If the patient's mental health problems can be managed on-site, all staff interactions with the patient should be documented in the medical record.

MANAGEMENT OF CHRONIC PSYCHOSIS

Symptom management and treatment compliance are of primary importance to treat chronic psychotic symptoms in a correctional setting. Often, individuals suffering from these symptoms are frequent residents of the facility and are intermittently involved with mental health treatment in the community. They may have co-morbid substance abuse problems, but their primary clinical issue is an ongoing, serious and persistent mental illness that interferes with their ability to meet the daily demands of living, and as a result, often run afoul of the legal system. Typically, individuals with this problem will comply with treatment when it is offered, and show improvement when regularly taking psychotropic medication. Often, these individuals require special housing in a facility, and may have difficulty in general population. Depending on the facility, and the management of a housing unit, some treatment compliant individuals can be housed in a general population unit. It is imperative that mental health staff monitors the person regularly and follows them on a mental health roster. Individuals with chronic psychosis can show the following signs and symptoms:

- Poor hygiene
- Difficulty communicating needs
- Repeat incarcerations for minor offenses
- Disorganized thinking
- Hallucinations and delusions to a moderate degree
- Peculiar thought pattern
- Poor judgment, lack of insight
- Receive some form of disability income in the community
- Respond to therapeutic efforts to treat and manage them

TREATMENT INITIATION

- General principles applied to all patients with psychosis include:
  - Medication Education (psychiatry and nursing staff)
  - Nutritional management (education)
  - Daily exercise (time out of cell)
  - Special housing (if indicated)
  - Regular contacts with mental health staff while housed in the facility
  - Discharge planning arrangements for return to the community
  - Education and referral for any co-morbid medical and/or substance abuse problems

ANTIPSYCHOTIC MEDICATIONS

Following the first psychotic episode, antipsychotic medication is usually stopped by the patient after 1-2 years, although long-term therapy is the rule for patients with recurrent illness. Antipsychotic medications prevent relapse in patients with remitted positive and mood symptoms, and maintenance treatment helps to reduce symptoms in patients with chronic illness. These drugs enable many patients who previously would have been institutionalized to live in the community.

The most commonly used conventional antipsychotics in the long-term treatment of psychoses are high-potency oral antipsychotics, such as haloperidol or depot formulations, such as fluphenazine. The major drawback with conventional antipsychotics is their tendency to produce extrapyramidal adverse effects at effective doses. These include dystonias, parkinsonism, akathisia and tardive dyskinesia, a disfiguring, stigmatizing and often irreversible neurological disorder.

Atypical antipsychotics are a diverse group of drugs with a lower risk of extrapyramidal adverse effects at therapeutically effective doses. Some atypicals may be more effective than conventional antipsychotics in long-term treatment. Clozapine is particularly effective for treatment resistant cases. While its toxicity restricts initiation of treatment to specialist centers, increasingly general practitioners are involved in long-term care and monitoring of patients on clozapine therapy. Risperidone has shown superior efficacy to haloperidol in long-term prevention of relapse.3Recently, high-dose olanzapine was shown to have greater effectiveness than conventional and other atypical antipsychotics (apart from clozapine) in terms of discontinuation rates over an 18-month period.

While reducing problems with extrapyramidal adverse effects, atypicals have caused other problems such as postural hypotension, weight gain and hyperglycemia. Each drug seems to have adverse effects which are particular problems, for example, clozapine can cause neutropenia, agranulocytosis and myocarditis. Olanzapine frequently causes considerable weight gain and increases glucose and lipids which can lead to hyperlipidemia and diabetes. Although weight gain is less of a problem with risperidone, it may cause sexual dysfunction and amenorrhoea due to hyperprolactinaemia. Quetiapine may cause mild weight gain, while amisulpride and aripiprazole are generally well tolerated in long-term treatment (although aripiprazole can initially cause troubling nausea and restlessness).

Medication Guidelines and Associated Laboratory Studies for Patients with Psychotic Symptoms

ANTIPSYCHOTICS

If an atypical is needed then a trial of Abilify or Risperdal, should be tried first and used to its maximum dosage (except if side effects limit dosage). Zyprexa (olanzapine) has the largest weight gain so this should be utilized less in our populations, who are sedentary. Clinicians should follow appropriate laboratory protocols for use of antipsychotics.

Medication	Monitor	Recommendation
Antipsychotics	AIMS	Performaclinicalassessmentforabnormalvoluntarymovementsevery6monthsfor generationantipsychoticsandevery12monthsforpatientstakingsecondgeneration Forpatientsatincreasedrisk,such astheelderly,assessmentsshouldbemadeevery3monthsforfirstgenerationantips generationantipsychotics
	FastingglucoseorHgA1C&lipidsortriglycerides	Baseline,atfourmonthsandthenannually
	Electrolytes,Renal,Liver,TSH	Annuallyoras clinicallyindicated
	Medicationreview-mitigatingrisk	Documentedrationaleformorethanoneantipsychoticmedication.Everyprescriptic
	WeightandBMI	Baselineandevery 3months BMICalculation:weight(kg)/[height(M)]2
(Clozaril,FazaClo) (inadditiontoaboveguidelines for"Antipsychotics")	Neutrophil Count(ANC)	Ifnormalresults:weeklyduringfirst6monthsoftreatment;every2weeksduringse y FollowClozapineREMSprotocolforabnormalANCresults[2]

NOTE: Please consult the CFG Health Systems formulary for available atypical and typical antipsychotic medication.

General Prescribing Guidelines and Monitoring for Psychiatry

Use ONE DRUG at a time unless there is clear indication to do otherwise, such as in a major psychiatric crisis (as in clearly manic or psychotic individuals). FOR EXAMPLE: inmates out of the facility for months who are not on medications but ask to be started back on medications in the facility, often two etc., because they "were on them last time". Question the need multiple for medications if they were not on them in the community. Also, treat the anxiety/dysphoria first with an SSRI and inform them that the medicine will take a few weeks, but will eventually help with sleep, anxiety, irritability. Many of the inmate patients are substance abusers that want, even demand, quick relief from their feelings, etc. and need to learn to live without substances. We need to support them in this by NOT prescribing meds to cover up their true emotions, worries, etc. In select cases, non-formulary medication will be initiated or continued when clinical need is apparent and other medications have failed to effectively treat the problem. Practicing in a correctional environment is unique, especially with the threats of intentional diversion of medication by inmate patients. That problem notwithstanding, we must show that we consider the clinical needs of the inmate patients and ensure that our practice does not fall outside of the community standard of clinical care.

As a general practice,we do not treat with medication

- Sleep, unless part of a major active psychiatric disorder (mania or psychosis); (this is a federal guideline that we take very seriously). This includes not treating complaints of "my mind is racing, doc, and so I can't get to sleep"—I start an SSRI and tell them it will get better in a couple weeks.
- Erectile Dysfunction
- ADHD unless impacting functioning at jail, and then only Bupropion XL.
- "Stressing"
- Anxiety with benzodiazepines, gabapentin, or antipsychotics

Psychiatric personnel are **NOT** to treat chronic pain with TCA'S or gabapentin; refer these patients to Medical.

If a medication such as Seroquel is used outside of the facility for sleep, anxiety, or anger issues, **this will not be continued**. We markedly limit use of Seroquel, as inmates often abuse it, and there are many better medications. If a patient is on Seroquel, then you need to cross taper to a formulary antipsychotic or mood stabilizer over no more than TWO weeks.If there is clinical evidence or documented information that Seroquel effectively manages mental health symptoms, and no other medication does so, then it will be continued as a non-formulary medication.

If an inmate has been inconsistently on medications or off medications for MORE than TWO weeks prior to incarceration then the formulary needs to be adhered to strictly.

Equivalent medications will be utilized instead of brand names when possibleand provide similar treatment benefits.

- Citalopram for Lexapro
- Venlafaxine XR for Pristiq

Bupropion has the potential to be abused by patients in a correctional setting. The use of bupropion should be limited. Only the long acting form of bupropion in on the formulary.

Neurontin, (gabapentin) has limited usage in psychiatric treatment and is abused by inmates. It is not a mood stabilizer and there are many other medications for anxiety (SSRI). Correctional Psychiatric Professionals should not prescribe it, except to rapidly taper it off.

ADDRESSING ADHERENCE TO TREATMENT

The mental health treatment team is responsible for monitoring the patients with psychotic disorders, providing adjunctive therapeutic contact, make appropriate housing recommendations, and interact on behalf of the patient with custody staff. Compliance with treatment efforts, particularly medication, is very important with patient with psychotic disorders.

MANAGEMENT IN THE COMMUNITY AFTER DISCHARGE

All Mental Health staff will work with available resources within the facility to plan for the eventual discharge of patients into the community.

MOOD DISORDERS

(Treatment of major mental illness as a key sub-specialty clinic can be found under Initial Health Assessment of Chronic Conditions)

OVERVIEW

Amood disorder is a mental health classification that health professionals use to broadly describe all types of depression and bipolar disorders.Therapy, antidepressants, and support and self-care can help treat mood disorders.Many factors contribute to mood disorders. They are likely caused by an imbalance of brain chemicals. Life events (such as stressful life changes) may also contribute to a depressed mood. Mood disorders also tend to transmitted genetically.

The most common types of mood disorders are:

- **Major depression.** Having less interest in usual activities, feeling sad or hopeless, and other symptoms for at least 2 weeks may indicate depression.
- **Dysthymia.** This chronic, low-grade, depressed, or irritable mood lasts for at least 2 years.
- **Bipolar disorder.** This is a condition in which a person has periods of depression alternating with periods of mania or elevated mood.
- **Mood disorder related to another health condition.** Many medical illnesses (including cancer, injuries, infections, and chronic illnesses) can trigger symptoms of depression.
- **Substance-induced mood disorder.** Symptoms of depression that are due to the effects of medicine, drug abuse, alcoholism, exposure to toxins, or other forms of treatment.

Depending on age and the type of mood disorder, a person may have different symptoms of depression. The following are the most common symptoms of a mood disorder:

- Ongoing sad, anxious, or "empty" mood
- Feeling hopeless or helpless
- Having low self-esteem
- Feeling inadequate or worthless
- Excessive guilt
- Repeating thoughts of death or suicide, wishing to die, or attempting suicide (**Note:** People with this symptom should get treatment right away!)
- Loss of interest in usual activities or activities that were once enjoyed, including sex
- Relationship problems
- Trouble sleeping or sleeping too much
- Changes in appetite and/or weight

- Decreased energy
- Trouble concentrating
- A decrease in the ability to make decisions
- Frequent physical complaints (for example, headache, stomachache, or tiredness) that don't get better with treatment
- Running away or threats of running away from home
- Very sensitive to failure or rejection
- Irritability, hostility, or aggression

In mood disorders, these feelings are more intense than what a person may normally feel from time to time. It is also of concern if these feelings continue over time, or interfere with one's interest in family, friends, community, or work. The risk of suicide is higher in patients with mood disorders.

Mood disorders can often be treated with success in a correctional facility. Treatment may include:

- **Antidepressant and mood stabilizing medicines**—especially when combined with psychotherapy have shown to work very well in the treatment of depression
- **Psychotherapy**—most often cognitive-behavioral and/or interpersonal therapy. This therapy is focused on changing the person's distorted views of himself or herself and the environment around him or her. It also helps to improve interpersonal relationship skills, and identifying stressors in the environment and how to avoid them

Depression (major or clinical depression)

Depression is a common mental disorder. Grief or sadness is a typical response to a traumatic life event or crisis, such as the death of a spouse or family member, loss of a job, or a major illness. However, when the depression continues to be present even when stressful events are over or there is no apparent cause, physicians would then classify the depression as clinical or major depression. For a person to be diagnosed with clinical depression, symptoms must last for at least two weeks.

Bipolar disorder (manic-depressive disorder)

Bipolar disorder is defined by swings in mood from periods of depression to mania. When someone experiences a low mood, symptoms may resemble those of a clinical depression. Depressive episodes alternate with manic episodes or mania. During a manic episode, a person may feel elated or can also feel irritable or have increased levels of activity.

- **Bipolar I** - This is the most severe form. Manic episodes last at least seven days or may be severe enough to require hospitalization. Depressive episodes will also occur, often lasting for at least two weeks. Sometimes symptoms of both mania and depression are present at the same time.
- **Bipolar II disorder** - This disorder causes cycles of depression similar to those of bipolar I. A person with this illness also experiences hypomania, which is a less severe form of mania. Hypomanic periods

are not as intense or disruptive as manic episodes. Someone with bipolar II disorder is usually able to handle daily responsibilities and does not require hospitalization.

Intermittent explosive disorder

This is a lesser-known mood disorder marked by episodes of unwarranted anger. It is commonly referred to as "flying into a rage for no reason." In an individual with intermittent explosive disorder, the behavioral outbursts are out of proportion to the situation. This diagnostic category is frequently seen in a correctional setting.

What causes mood disorders?

There may be several underlying factors, depending on the type of the disorder. Various genetic, biological, environmental, and other factors have been associated with mood disorders.

Risk factors include:

- Family history
- Previous diagnosis of a mood disorder
- Trauma, stress or major life changes in the case of depression
- Physical illness or use of certain medications. Depression has been linked to major diseases such as cancer, diabetes, Parkinson's disease and heart disease.
- Brain structure and function in the case of bipolar disorder

What are the symptoms of common mood disorders?

Symptoms depend on the type of mood disorder that is present.Symptoms of major depression may include:

- Feeling sad most of the time or nearly every day
- Lack of energy or feeling sluggish
- Feeling worthless or hopeless
- Loss of appetite or overeating
- Gaining weight or losing weight
- Loss of interest in activities that formerly brought enjoyment
- Sleeping too much or not enough
- Frequent thoughts about death or suicide
- Difficulty concentrating or focusing

Symptoms of bipolar disorder may include both depression and mania. Symptoms of hypomanic or manic episodes include:

- Feeling extremely energized or elated
- Rapid speech or movement

- Agitation, restlessness, or irritability
- Risk-taking behavior, such as spending too much money or driving recklessly
- Unusual increase in activity or trying to do too many things at once
- Racing thoughts
- Insomnia or trouble sleeping
- Feeling jumpy or on edge for no apparent reason

MEDICATION GUIDELINES AND ASSOCIATED LABORATORY STUDIES FOR PATIENTS WITH MOOD DISORDERS

The correctional psychiatric clinician must have the wellbeing of the individual patient in mind, but also the wellbeing of the community of inmates. Our goal is to eliminate emotional pain and reduce psychiatric symptoms, but also to avoid misuse of medication by inmates, as well as medication diversion in the correctional facility. We need to conform to evidence based management and be consistent with the on-label usage of psychiatric medication.

ANTIDEPRESANTS

SSRI'S serve as both first and second line treatments for depression and anxiety. We treat only if symptoms IMPAIR functioning. TIME LIMITED use of Vistaril/Benadryl (about ten days) while SSRI'S are "kicking in" is acceptable. Use of Vistaril, etc. should be the exception rather than the rule, and only for individuals that YOU see as in CLEAR distress, such as individuals that have never been in jail before or are accused of a major crime.

Do not use tricyclic antidepressants or Remeron, as we are not providing antidepressant medication as a sleep aid. Duloxetine and venlafaxine are formulary. Use Bupropion XL sparingly as there is a risk of abuse in correctional environments. The shorter acting forms of Bupropion are off the formulary to prevent abuse and diversion.

MOOD STABILIZERS

Use mood stabilizers as first line for bipolar disorder, and to adequately evaluate for TRUE symptoms of mood cycling vs "moodiness", and/or mood shifts while involved in drug/alcohol abuse. We are all aware of the over diagnosis of Bipolar Disorder. The diagnosis of Bipolar Disorder, in adults, has doubled in the last ten years and increased 40 times in children! Also, there is the over diagnosis of bipolar in individuals with impulsivity driven by adult ADHD. Which is highly represented in the correctional "community". Frequently patients come from substance abuse rehabs with a bipolar diagnosis, but there is no clear systems of cycling. As you are aware, "MOODINESS" or "mad one minute and then okay the next" is NOT bipolar, though frequently individuals erroneously carry this DX. We do not have to agree, nor treat the DX. Treat the patient based on the symptoms at hand, and treat most conservatively. Lastly, gabapentin studies have demonstrated it is NOT a mood stabilizer, and should not be used for this purpose.

Medication	Monitoring	Recommendation	ChartReviewMinimum
Lithium (Eskalith,Lithobid)	Pregnancytest	Baselineinwomenof childbearingageandwhen clinicallyindicated	Same
	BUN/Cr	Baseline;every2-3monthsinfirst6monthsand every6-12monthsinstablepatientsorwhen clinicalstatus changes	Baselineandevery6months
	TSH	Baseline;1-2timesinfirst6monthsandevery 6-12monthsinstablepatientsorwhenclinical statuschanges	Baselineandevery6months
	Liblood level	Monthlyuntilbaselinereached,and after baseline,Minimumevery6monthsandwhen clinicalstatuschanges(includingdosage changes)	Baselineandevery6months,after dosagechanges
ValproicAcid (Depakote, Depakene)	Pregnancytest	Baselineinwomenofchildbearingageandwhen clinicallyindicated	Same
	Liverfunction test	Baselineandaminimumofevery6months	Baselineandevery6months
	CBC,Diff	Baselineandaminimumofevery6months	Baselineandevery6months
	VPAblood level	Weeklyuntiltherapeuticandafter dosage changes, minimum every 6 months or when clinical status changes	Same
	Amylase/lipase	ObtainonlyifsuspectValproateinduced pancreatitis(rare)	Same
	Ammonia	Obtainonlyifsuspectvalproateinduced hyperammonemia/hyperammonemic encephalopathy	Same
Carbamazepine (Tegretol}	Pregnancytest	Baselineinwomenofchildbearingage andwhenclinicallyindicated	Same
	CBC/diff &platelets	Baseline; every2 weeksduringfirst2weeksoftreatment thenevery3months	
	Liverfunction tests(CMP}	Baseline;every2weeksduringfirst2 monthsoftreatmentthenevery3months	Baseline,after2weeksandevery6months
	BUN/Cr(CMP)	Baselineandifclinicallyindicated	Same
	CBZblood level	1weekand1monthafterstart, 1 weekafterdosagechangeorwithnew	Baseline,1monthandthenevery6months,andafterdosage changes

		sideeffects;every6monthsinstablep atients	
	Electrol ytes(C MP)	Ifhighriskforhyponatremia(elderly)	Same
	HLAB*1 502	PriortostartinginAsianpatients	Same

ACUTE SUBSTANCE INTOXICATION AND SUBSTANCE ABUSE DISORDERS

Substance Use Disorder

Within the jail setting, practitioners encounter a broad spectrum of clinical diagnoses arising from acute intoxication and/or withdrawal. Most clinical presentations are complex and multi-faceted due to polysubstance use or use of multiple difference substances including alcohol.

The intent of this protocol is to initiate specific clinical support that forestalls or completely avoids the debilitating and potentially life-threatening consequences associated with the abrupt cessation of specific substances. Healthcare staff aims to identify those inmates with the potential for significant withdrawal morbidity or mortality in order to effect pre-emptive interventions. Identification of these patients occurs through focused questioning at intake and the gathering of critical historical information through patient self-report, as well as clinical evaluation.

Inmates often attempt to minimize their degree of intoxication, deny or downplay their history of substance use or dependence, and make false claims of being in full control. Practitioners must therefore remain focused and constant in helping individuals admit to and recognize the full extent of their illness, especially since significant morbidity and mortality are often associated with acute intoxication and withdrawal syndromes. Bearing all this in mind, clinicians must be attuned to patients' presenting problems, vigilant and thorough in conducting initial evaluations, and expedient and assertive in the initiation of interventions and treatments. Face-to-face evaluations with patients must occur on a daily basis. Those patients refusing key aspects of withdrawal care, such as hydration therapy or medications, must be fully assessed and referred to the clinician for intervention *at the earliest signs of decompensation* (please see the 8-Day Nursing Form and the Nursing Withdrawal Handbook for additional detail).

It is the policy of CFG Health Systems to ***proactively*** and ***aggressively*** treat all inmates who exhibit signs of physical dependence, intoxication, and/or symptoms of withdrawal at intake. Treatment is considered preventative, begun in an attempt to avoid the onset of symptoms/conditions associated with substance dependence such as Korsakoff's syndrome, Wernicke's encephalopathy and delirium tremens.

COMMONLY USED SUBSTANCES

- Opioids/Opiates

    - Percocet, Vicodin, Hydrocodone, Oxycodone, etc.
    - Heroin
    - Buprenorphine (Suboxone/Subutex)
    - Methadone
- Alcohol
- Sedative Hypnotics: (Benzodiazepines and Barbiturates)
    - Xanax ("footballs or bars")
    - Klonopin
    - Phenobarbital
    - Gamma-Hydrobutyric acid (GHB) and GHB derivatives
- Synthetic Marijuana (a.k.a. K2, Spice)
- Stimulants:
    - Cathinones (a.k.a. "Bath Salts")
    - Cocaine ("Powder" or "Crack")
    - Amphetamine/Methamphetamine

MEDICATION ASSISTED TREATMENT [MAT]

There are two clinical objectives facing the clinician treating a patient with substance use disorder [SUD]. The first goal is to manage their symptoms, the ranging from the intoxication caused by an unknown cocktail of substances to that of withdrawal with incapacitating depression, intense drug cravings and a myriad of somatic complaints. The second objective is targeted intervention to prevent overdose death.

Medication therapy is available to target classes of commonly abused substances prescribed to mitigate withdrawal symptoms or to prevent death. Buprenorphine hydrochloride, as a single agent, and in combination with naloxone hydrochloride, methadone, and naloxone hydrochloride all provide therapeutic support for opioid use disorders [OUD]. Intermediate and short-acting benzodiazepines are prescribed for both alcohol and benzodiazepine use disorders. Naltrexone provides long-term support for alcohol and opioid use disorders. Vitamin and mineral replacement therapy are essential to a sustained response to therapy. With the broad-based problem of poly-pharmacy, the physiologic principles of dilution and renal elimination take on pivotal importance in the management of patients with substance use disorders.

Patients under treatment for substance use disorder [SUD] receive behavioral counseling along with FDA-approved medications in an effort to provide a comprehensive approach to the management of their illness.

Medications such as methadone, buprenorphine, naltrexone and naloxone could be prescribed in different situations and in a responsible manner to someone with an opioid addiction. These

medications are used to manage dependence and addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone.

Disulfiram, Acamprosate and naltrexone are often used to help treat someone with an alcohol addiction.

Methadone used in the treatment of opioid addiction can be prescribed and dispensed only through a SAMHSA-certified OTP. Buprenorphine-containing drugs, such as Suboxone can be prescribed by physicians who obtain a waiver from the DEA after taking specified training in the use of these drugs. Naltrexone, oral or injectable, can be prescribed by any licensed physician.

POPULATION SPECIFIC INFORMATION

Pregnancy:

Pregnant females are considered "high risk," priority patients and require specialized OB/GYN and Maternal/Fetal Medicine care. Opioid-dependent pregnant women should be stabilized on either buprenorphine or methadone, and may require hospital or ED admission for stabilization. Pregnant women with alcohol or sedative dependence may require inpatient detoxification for safety. Pregnant women with acute, severe stimulant intoxication may require inpatient evaluation for fetal monitoring.

The ever-present consequence to continued substance use in the pregnant female is fetal viability. It is recommended that early during first trimester, determinations of fetal viability must be obtained preferably prior to housing at the facility. Level Two Ultrasound studies may be obtained from community emergency room facilities, which will inform the clinical staff at baseline.

Prompt consultative follow up with neonatology or high-risk pregnancy is essential to sustainable fetal viability. Buprenorphine and methadone management is important for opioid use disorder. Gravid patients with active benzodiazepine use may need frequent obstetrical evaluations, along with continued maintenance of a benzodiazepine.

Termination of Pregnancy [TOP] is an option available to all pregnant female detainees in our system. Working with community providers, such as Planned Parenthood, services are made available in a timely manner to all who are eligible. Especially with this population, close collaboration with Mental Health staff is imperative to assure that all decisions made by the detainee are informed.

Finally, detainees with active substance use disorders who are maintained on Buprenorphine or Methadone to assure fetal viability may be re-evaluated after TOP for voluntary enrollment in MAT.

Medical Co-morbidities:

Substance use disorders often are the harbingers of chronic progressive end-organ deterioration and failure. Screening assessment tools, such as CIWA-Ar and PAWSS focus on neurologic consequences of alcohol abuse. Patients who report adult onset seizure disorders often attribute them to withdrawal and absence from alcohol. Black outs, drop attacks, confabulations, and Werneke's encephalopathy, along with tremors and paresthesia are all extreme neurologic consequences of long-standing alcohol use disorder.

Cardiac arrhythmias, congestive heart failure, endocarditis, acute myocardial infarctions may all be the endpoint of poly-substance use disorders, including alcohol. Some conditions progress to a stage not amenable to medical management, such as congestive heart failure due to alcohol or cocaine abuse.

Hepatic transaminitis due to substance abuse are commonplace, with 3-4 fold elevations hampering the use of treatment medications.

Renal disease may appear as toxic with a sediment or obstructive with acute renal failure, such as seen with Rhabdomyolysis.

Cellulitis and abscess formation must be aggressively treated, oftentimes with parenteral antibiotics.

Severe Psychiatric Co-morbidities:

The proliferation of synthetic stimulants, alone and in combination with fentanyl opioid products lead to a myriad of psychologic presentations. Wildly aggressive behaviors, paranoias, to catatonic states have all been attributed to substance use disorders. Patient management must include mental health staff early on in the development of a care plan.

With the wide-use of MAT for opioid use disorder in the facility, medical staff may prescribe low-dose buprenorphine – naloxone to patients identified by mental health as impulse, labile, willful. These patients often make verbal gestures of impending self-harm as a ploy to control and manipulate their circumstances surrounding incarceration. These medications often assist mental health in stabilizing and redirecting these patients.

Traumatized Patients:

Screening for PTSD is done in order to initiate trauma-informed care. Highly traumatized patients may react disproportionately to routine interactions, verbal assessments, clinical evaluations, or incarceration itself.

TRIAGE

WHICH PATIENTS NEED IMMEDIATE TREATMENT?

- Pregnant Patients
    - Pregnant patients with opioid dependence require immediate stabilization on opioid treatment (methadone or buprenorphine)
    - Pregnant patients are recommended to be cleared for fetal viability at the time of incarceration
    - Pregnant patients with sedative or alcohol dependence require inpatient detoxification
    - Pregnant patients with acute stimulant intoxication require immediate assessment and may require fetal monitoring
- Sedative Dependence: patients with sedative dependence, acute sedative intoxication, or exhibiting signs/symptoms sedative withdrawal:
    - It is important to assess frequency, quantity, and duration of sedative use, history of sedative withdrawal symptoms, and history of withdrawal severity (i.e. delirium or seizures). Like alcohol, sedative withdrawal can be life threatening.
        - The abrupt cessation of sedatives can lead to severe neurologic events. Symptoms may range from labile mood swings, severe anxiety, diaphoresis and insomnia to frank delirium, myoclonus, grand mal seizures and death.

  Note: Sedative use should be assessed even when it is not primary drug used or drug of choice. Some patients use sedatives regularly to enhance other substances (i.e. heroin). These patients will require monitoring and potential treatment of sedative withdrawal if they use daily and/or have signs and symptoms of physical dependence.
- Alcohol Use: Patients with reported or suspected alcohol use:
    - Assessment must include how often the patient uses alcohol (frequency), how much alcohol is consumed (quantity), how long (days, weeks, months, years) they have been consuming alcohol (duration), if alcohol consumption is supplemented with other sedative use, and the last time they had alcohol prior to their arrest.
    - Assessment must also include history of alcohol withdrawal and severity of withdrawal (history of seizures or delirium tremens).
    - Patients often underreport drinking. A patient's report of having "just a couple of drinks a day" must be explored further, as this can result in dependence and withdrawal. Reports of "the occasional cocktail" or "social drinking" or "only with friends" also need further evaluation to rule out possibility of physical dependence.
    - All patients with reported or suspected alcohol use should undergo screening with ***PAWSS*** and ***CIWA-AR*** to stratify risk and to initiate treatment when needed.
- Patients exhibiting clinical signs or symptoms of stimulant, PCP, or synthetic marijuana intoxication
    - Acute stimulant intoxication can result in cardiovascular events, stroke, rhabdomyolysis, and self-injurious behavior.

- Stimulant withdrawal can induce severe depression or suicidal behavior, but is not typically physically dangerous. Mood should be monitored.
- Patients exhibiting signs of dehydration (abnormal urine specific gravity, no urine, dry mucosal membranes)
- Patients with a positive history for substance use and elevated blood pressure, advanced age, or significant medical or psychiatric co-morbidities (i.e. CHF, severe renal disease, history of stroke, history of suicide attempt).

All inmates presenting with signs and symptoms of intoxication and/or withdrawal shall be subject to comprehensive treatment protocols and will be monitored by nursing staff for a minimum of eight (8) days for signs and symptoms of persistent withdrawal.

Treatment strategies, involving both clinicians and nursing staff, are designed to mitigate neurologic and physical risks of acute withdrawal or intoxication, correct aberrations in fluid volume and electrolyte levels, and to also address infectious and comorbid conditions.

SUBSTANCE WITHDRAWAL PROTOCOLS

Screening, Clinical Assessment, and Diagnostic Testing

The following screening tools are used at time of Intake:

Diagnostic information is obtained by nursing staff during Receiving Screening (NCCHC standard E-02), evaluated by the RN during the initial clinical assessment, and used to corroborate the decision to initiate withdrawal treatment. Diagnostic and screening tools used as part of substance withdrawal protocols may include:

- Substance(s) identification by history
- NIDA Drug Use Screening Tool: https://www.drugabuse.gov/nmassist/
- CAGE (a screening test used to identify alcohol dependence)
- T-ACE (a screening test used to identify alcohol dependence)
- CIWA-Ar (an assessment for monitoring withdrawal symptoms)
- CIWA-B (withdrawal assessment for sedatives/benzodiazepines)
- PAWSS (a screening test used to identify alcohol dependence)
- Vital signs
- Random glucose testing (finger stick)
- Urinalysis (checking for the presence of ketones, abnormal osmolality, glucose, rhabdomyolysis [dark-colored urine], clinical signs of dehydration, leukocyte esterase)
- Point of Care (POC) urine drug screen
- Primary Care-Post Traumatic Stress Disorder Screen (PC-PTSD) Screen

NURSING TREATMENT PARADIGM

	Information Obtained During Receiving Screening	Next Step	Nursing Action
Self-Report at Intake	Female of reproductive age with recent (past 30 day) substance use	Urine pregnancy test (UPT)	• +Pregnancy Test –assess for need for acute stabilization and/or hospitalization • Level 2 Ultrasound fetal viability • Sedative, alcohol, or opioid dependence or withdrawal or acute stimulant intoxication
	Male/Female - visibly intoxicated	Clinical assessment • Females: UPT • vital signs, urinalysis, *urine drug screen • physical exam for substance assessment • substance history intake (if possible)	Nursing should initiate substance specific treatment(s)
	History of "social drinking" or "occasional drinker" and not intoxicated at intake or exhibiting signs of withdrawal: complete the CIWA-Ar; if score is <8 **THEN** completeCAGE or T-ACE	**CAGE** and **T-ACE, PAWSS** are screening tools that quantify the potential risk for underlying alcoholism. If a patient's history is benign, but the CAGE or T-ACE scores are >2, there exists the likelihood that the patient may be underestimating their consumption of alcohol.	Nursing should initiate treatment when: • **CAGE score = >2 OR** • **PAWSS score =>4 OR** • **T-ACE score = >2**
	History of chronic/daily substance use	Inquire as to time/date of last intake and the amount consumed [e.g. - pt. consumes 1 pint daily of vodka; last drink - day of arrest]	Nursing should initiate substance specific treatment(s)
CIWA-Ar	RN assessment	CIWA-Ar score = 8 or more PAWSS score =4 or more	Nursing should initiate treatment
Modified Treatment if:	• Occasional Substance Use (i.e., intermittent use, social drinker) • No s/sx physical dependence • No history of withdrawal symptoms • No s/sx acute intoxication	**Clinical Screening Tools:** • COWS: score < 6 • CIWA-Ar: score = <8 • CAGE or T-ACE score = <2	Refer to the clinician for non-urgent further assessment.

See Physician's Orders for Withdrawal and the Flow Sheet for Alcohol/Poly-Substance Withdrawal; orders must be patient-specific and signed by the clinician

Hydration Therapy:

Hydration therapy should be initiated as indicated below:

- Oral Hydration

HYDRATION THERAPY TABLE	
GOAL: 4 LITERS (135.24 OUNCES; 4000 cc/mL) CONSUMED WITHIN 24 HOURS **(1 liter = 33.81 oz. or 1000 cc/mL)**	
Using 8 oz. cups	16.9 servings over 24 hours
Using 10 oz. cups	13.5 servings over 24 hours
Using 16 oz. cups	8.5 servings over 24 hours

- IV Hydration - IV 0.45% or NS x two (2) liters, administered over 12 hours. May repeat in 12 hours, as needed.
- Intake and output assessments
- Caution with fluid resuscitation and call care provider if:
  - PMH Congestive Heart Failure
  - PMH Renal disease on dialysis
  - Patient exhibiting edema or shortness of breath
- 8-Day Nursing Plan (see Flow Sheet for Alcohol/Poly-Substance Withdrawal)

THE CLINICIAN MUST REVIEW AND ENDORSE RECEIVING SCREENING, ESTABLISHED BASELINES AND TREATMENT DATA AS PROOF OF REVIEW.

Treatment is to be initiated by Clinicians

MISSED SUBSTANCE DEPENDENCE AT RECEIVING SCREENING

Oftentimes patients divulge information regarding substance use and/or dependence to the clinician during the Initial Health Assessment (NCCHC standard E-04) that they did not reveal at Receiving Screening. The onset of signs or symptoms of clinical withdrawal might be the patient's motivation for full disclosure to the clinician at this time. The clinician will need to review all information obtained during the nursing intake (Receiving Screening E-02), and perform screening for alcohol and drug use and clinical diagnostic withdrawal tools as needed.

Alcohol Use: Patients who denied alcohol use and who were not subjected to screening with CAGE or T-ACE or PAWSS will need to have screening and assessment with CIWA-AR performed by the clinician now. Once treatment has been initiated, serial CIWA-Ar evaluations with objective quantification scores may be used as an indicator of response to treatment.

Opioid Use: Patients who denied opioid use and had negative NIDA drug use screens upon Receiving Screening, but who are now complaining of opioid withdrawal should have the Clinical Opioid Withdrawal Scale (COWS) performed by the clinician now. If patient exhibiting moderate to severe opioid withdrawal, initiate opioid withdrawal treatment pathway. If treatment is initiated, serial COWS evaluations with objective quantification scores may be used as an indicator of response to treatment. [See Opioid use Disorder plan].

Sedative Use: Patients who denied sedative use and who had negative NIDA drug use screening at Receiving, but who are now complaining of or exhibiting s/sx sedative withdrawal will need to have assessment with CIWA-Ar or PAWSS performed by the clinician now. NIDA drug use screening can be re-done at this time by the clinician as well. If treatment is initiated, serial CIWA-Ar or PAWSS evaluations with objective quantification scores may be used as an indicator of response to treatment.

CONTINUATION OF SUBSTANCE USE DISORDERMANAGEMENT

Patients started on substance use disorder treatment by the nursing staff will need to be assessed by the clinician at the Initial Health Assessment to determine the adequacy of intervention. Severe, multifaceted dehydration due to heroin withdrawal, with diaphoresis, emesis and diarrhea all exacerbating underlying volume contraction may require the clinician to order intravenous fluid replacement administered via a PICC line (peripherally inserted central catheter). Patients with a history of seizure or abuse of multiple sedatives may need the initial dose of chlordiazepoxide increased or the titration scheme revised in order to provide extended support for long-term withdrawal. Patients taking methadone* or Suboxone* for opioid-dependence will transfer and enrollment into the facility's MAT program to assure needed counseling.

Please see individual substance withdrawal pathways for more detail for screening, diagnosis, and treatment of withdrawal for each substance.

There will be individuals referred by nursing staff to the clinician for evaluation based solely on the Receiving Screening interview (NCCHC standard J-E-02). These individuals will have positive findings related to potential alcohol use disorder based on the intake screening questionnaire, but final scores of "0" or "1" on the CAGE and T-ACE assessments and/or CIWA-Ar scores of 7 or less and/or PAWSS scores of 3 or less. The clinician will determine the need for treatment in these cases. Patients with visible stigmata of long-

standing opioid use disorder, even with a negative urine drug screen MUST be offered MAT to prevent discharge reuse and death.

SPECIAL POPULATIONS

I. Treatment of Withdrawing Inmates with Elevated Blood Pressure

As a normal physiologic response to dehydration, patients with underlying volume depletion disorder may demonstrate secondary blood pressure elevations, wide pulse pressure readings and/or tachycardia. These patients must be treated with aggressive volume repletion therapy and be reassessed within twenty-four (24) hours of baseline evaluation. The same holds for withdrawing patients with known underlying hypertension – baselines must be established during the initial clinical evaluation and the patient must undergo aggressive hydration therapy as medications are reinstated.

Hydration therapy must be initiated for any patient meeting any two of the criteria in List A and any one of the criteria in List B:

List A

- Diastolic blood pressure >100
- Blood pressure reading >160/>100
- Pulse >92
- Urine specific gravity >1.025
- Strongly concentrated urine
- Urinalysis positive for ketones
- Urinalysis positive for sediment
- Urinalysis positive for abnormal cells
- Lack of urine
- Dry skin and/or dry mucus membranes (no tears, no axillary moisture)

List B

- Obtunded or confusion
- Unsteady gait
- Recent emesis
- Recent diarrhea

Effective hydration treatment intervention shall be defined as:

- a ten percent (10%) reduction in pulse rate,
- narrowing of pulse pressures,

- decline in high blood pressure

Patients who remain hypertensive following hydration intervention must be referred for anti-hypertensive therapy.

Patients with post-hydration therapy blood pressure elevations who present without prior anti-hypertension treatment regimens should be placed on a beta-blocker, unless clinically contraindicated.

- **NOTE:** Patients with underlying reactive airways disease may be sensitive to beta-blockers; as such, antihypertensive therapy using an ACE or ARB in place of a beta-blocker should be initiated instead.
- **NOTE:** CFG Medical Directors strongly caution against the use of alpha-adrenergic therapy, such as Catepres/Clonidine, in an attempt to lower a patient's blood pressure quickly. **The goal of treatment is to *slowly* lower the patient's blood pressure under continuous monitoring.**

Patients with evidence of end-organ impact and any of the following symptoms (indicative of accelerated hypertension) MUST BE REFERRED TO A TERTIARY CARE FACILITY:

- altered mental status
- complaints of angina or chest pain
- new onset hematuria
- new onset severe headache
- new onset visual impairment
- new focal neurologic impairments

II. Patients Requiring Opioid Medications:

*** When prescribing opioids, please note the following:**

- Opioids may interact with anti-depressants and migraine medications, leaving the patient at risk for serotonin syndrome. Serotonin syndrome is characterized by an increase in serum levels of serotonin and can cause agitation, hallucinations, rapid heart rate, fever, sweating, shivering, shaking, muscle twitching, muscle stiffness, nausea, vomiting and diarrhea. Symptoms may develop within several hours or several days.
- According to the FDA's Adverse Event Reporting System (FAERS) database, serotonin syndrome is more likely to occur with fentanyl and methadone, even when used at recommended dosages.
- Use of opioids can also result in adrenal insufficiency and decreases in cortisol production. Symptoms to be on alert for include nausea, vomiting, loss of appetite, fatigue, weakness, dizziness and low blood pressure. If adrenal insufficiency is

suspected, the healthcare professional should order appropriate diagnostic testing and treat the patient with corticosteroids, tapering the patient off the opioid, as appropriate.

- Opioid medications can also decrease the level of sex hormones, leading to changes in libido, impotence, amenorrhea and infertility. As appropriate, the health professional should order laboratory testing to assess this adverse reaction.

ON-GOING TREATMENT BY THE CLINICIAN

Day-4 Evaluation

- Mental health referral needs to be completed if not already done
- Patients with eventful Day 4 evaluations must be seen for follow-up by the clinician until there is objective evidence of a favorable response to the withdrawal protocol.
- Patients who continue to deteriorate, in spite of aggressive withdrawal treatment, must be placed on an infirmary level of care.
- Clinician will need to determine when a patient's withdrawal is life threatening and warrants admission to the hospital for additional stabilization and treatment
- **Medical office visit –**
  - On Day 4 of the treatment regimen,
    - Clinician must examine the patient and determine if a reduction in chlordiazepoxide is indicated.
    - Clinician must complete a comprehensive review of the appropriateness and efficacy of treatment.
    - Objective data, beyond the history and physical examination, should include a review of the 4-Day Nursing logs, which provide intake and output data, vital signs and pertinent information regarding mood and affect.
    - Clinician should complete a new CIWA-Ar evaluation as objective criteria of response. Patients that arrived at the jail intoxicated, but with a low CIWA-Ar score (less than 8) at intake, may have a higher score on Day 4.
    - Clinician will need to provide a clinical assessment and will need to amend the treatment plan as directed by findings.
    - Day 4 orders may call for an increase in chlordiazepoxide dosing or extended treatment at entry level dosing prior to beginning tapering of treatment.
    - Clinician must also certify that adequate hydration has been restored.
    - Clinician is to note the use of Ativan for seizures and adjust Librium levels accordingly.
      - Nursing staff must inform the clinician whenever Ativan is to be administered

- Patients started on buprenorphine-naloxone or methadone regimen may be deemed stable at Day 4 by the clinician.
- Continued counseling will be provided by the MAT provider protocol.

Clinician Review and Treatment Titration

Did You Check?	Did You?
• Substance history • Time and type of last substance ingestion • Symptoms of withdrawal • Comorbid conditions • Pregnancy status • Inconsistencies between patient self-report of alcohol use and CAGE scores • Alcohol hallucinations occurring without shakes • Visible intoxication • Kidney stones • Prior visits to the ER for intoxication and/or withdrawal • Seizures • Seizures with pregnancy • Pancreatitis • Diabetes • Hepatitis • Opioid addiction • Mental status • Completed Day-4 syndrome	• Aggressively hydrate (see Order Sheets) o Two (2) liters every twelve (12) hours for eight (8) days *(even if inmate is eating)* • Assess intake and output • Provide essential vitamin supplementation • Complete critical evaluations • Complete necessary referrals and consultations • Order o Thiamine o Folate o Magnesium oxide o Serum glucose testing o Urinalysis • Check ketones • Check leucocyte esterase • Check glucose • Observe for rhabdomyolysis • Check for clinical signs of dehydration • Complete Day-4 screening

Withdrawal Documentation

DOCUMENTATION TO INCLUDE THE FOLLOWING:
Problem List • ICD code • Identify substance(s) of intoxication, dependence, and/or withdrawal.
Orders and Care Plan • Physicians' Orders • Flow Sheet for Alcohol • Single Substance or Poly-substance Withdrawal and Care Plan o **For Alcohol or sedative withdrawal:** ▪ Review Chlordiazepoxide treatment ▪ Note the use of Ativan for seizures and adjust Librium levels accordingly o **For Alcohol or sedative withdrawal:** ▪ Review Chlordiazepoxide treatment ▪ Note the use of Ativan for seizures and adjust Librium levels accordingly • Prolong treatment with chronic patients • Urine Drug Screen • MAT referral • MAT bridge orders
Nursing Education
Discharge Planning

OUD TREATMENT

Background: There are two clinical objectives facing the clinician treating a patient with OUD. The first goal is to manage their symptoms, ranging from the intoxication caused by an unknown cocktail of substances to that of withdrawal with incapacitating depression, intense drug cravings, generalized pain and a myriad of somatic complaints. The second objective is targeted behavioral modification to prevent overdose death.

A consequence of bail-reform, is the rapid transit through the justice system of patients at various stages of acute intoxication and chronic OUD disease. Drug tolerance is maximally impacted by the activities of the clinical staff through aggressive hydration and dilution, vitamin and mineral replacement therapy and nutritional supplementation, as tolerated. OUD patients, who then return to substance abuse 48 to 72 hours later, at the pre-incarceration doses, are at higher risk for overdose. Information provided by the New Jersey State Department of Correction[7] reports that 75% of the incarcerated population have a substance use disorder with 25% of that group suffering from OUD. Nearly 75% of those with OUD relapse with three months of release from incarceration. Fewer than 10% enter a substance abuse treatment program, post-release. National statistics have reported the risk of overdose death for the previously incarcerated is approximately 130 times greater than the general public, with many of the deaths occurring the first week of release.

This protocol is intended to afford guidance to the clinical team in the initial stratification of patients with underlying OUD for immediate support therapy, integration to Medication Assisted Treatment [MAT] or more extensive psycho-social behavioral management.

Receiving Screening:

Nursing

1. Comprehensive history of SUD, including OUD, alcohol, chemicals or stimulants.
   Use of the Opioid Risk Tool – Dash 100 [Table 1. Opioid Risk Tool]
   Developed to screen potential patients prescribed chronic narcotic analgesic medications, Dash 100 provides an objective evaluation

[7]Adam Bacon LSW, NJ Stater Opioid Treatment Authority, Office of the Medical Director, Division of Mental Health and Addiction Services.

instrument to determine the risk of male and female patients with the likelihood to future abusive drug-related behaviors. This survey will be completed and scored initially for all detainees who report OUD.

2. Duration of abuse history, including the type of past medical treatment interventions:
    a. Emergency room treatment,
    b. Naloxone hydrochloride [Narcan] administration,
    c. IV fluids with "banana bags"
    d. Treatment for seizures
    e. Past overdose history
3. Has the patient ever received medication assisted treatment [MAT] in the community? Obtain all contacts and confirm past participation.
4. What SUD does the patient admit to?
5. What treatment, if any, does the patient request. **NOTE:** Many of the detainees seen at our facilities are informed of MAT services being offered and will request treatment.
6. Overall evaluation of the patient
    a. Grossly intoxicated
    b. Aggressive behavior, paranoid ideations, hallucinations
    c. Physically ill – pain, fever, diarrhea
7. Assessment: Vital signs, including wide pulse pressure, diastolic hypertension, tachycardia, tachypnea, nystagmus, pupillary dilatation, bounding pulse, epistasis, track marks to skin.
8. CAGE, CIWAr, Dash-100 score, COWs score
9. Urine drug screen **NOTE:** The point of service urine drug test kits employed at most of the facilities do not consistently identify synthetic opioid chemicals, such as fentanyl. Most urine test kits will measure for benzodiazepines. Alcohol is not tested. **NOTE:** A negative UDS for opioids with physical track marks must be counted as a positive OUD.

Urgent Treatment Interventions: **Nursing** [See Withdrawal Protocols]

1. Calculate the Dash-100 and COWs scores and activate the appropriate withdrawal management protocols.
    a. Group 1. Score 0 – 3
    b. Group 2. Score 4 – 7
    c. Group 3. Score 8 or higher
2. Aggressive hydration as tolerated, intravenous supplementation if needed.
3. Treatment of withdrawal symptoms, such as antiemetics, analgesics
4. Confirm MAT treatment information

5. Confirm treatment medications with pharmacy, including last dose filled.
6. House in the clinical area which will allow access for treatment intervention.

Discussion: The nursing staff has sufficient information at this juncture to refer to the clinician for a care plan and treatment. Facilities with 24-hour clinician staff will receive the patient for the intake evaluation. When clinician staff are unavailable and the patient is deemed to be unstable, the nurse will page the clinician on call for directions.

The two treatment goals are to Prevent Death and to Link to MAT.

OUD with No past MAT and no consent for MAT on this Admission

1. Clinician reviews the reported pharmacology – What is the patient taking?
2. The vital signs and the presentation of the patient is assessed. Does the patient require emergency room intervention?
3. Urine drug screen [UDS] – **NOTE**: Negative for opioids would not rule out fentanyl. Ask the patient if there is an OUD history. Negative for benzodiazepines would suggest no need for STAT chlordiazepoxide [Librium] versus observation.
4. Dash-100 [Group 1, 2, 3] and COWs score Less than 11, 11 or greater
5. **Use of SuboxoneHCl Taper to prevent withdrawal**

Dash -100 Group 3	COWs 11 or greater
• Day 1	SuboxoneHCl 8mg/2mg 2 q day
• Day 2	SuboxoneHCl 8mg/2mg 2 q day
• Day 3	SuboxoneHCl 8mg/2mg 1 q day
• Day 4	Clinician reassessment - o Continue daily 8mg/2mg, OR o Increase 8mg/2mg 2 day, OR o Discontinue Suboxone

NOTE: Discuss need for MAT with the patient

Dash -100 Group 2	COWs Less than 11
• Day 1 -3	SuboxoneHCl 8mg/2mg 1 q day
• Day 4	Clinician reassessment o Continue daily 8mg/2mg

OR

- Discontinue Suboxone

NOTE: Discuss need for MAT with the patient

Dash -100 Group 1 COWs Less than 11

- Aggressive hydration
- Symptomatic support

OUD with history of MAT

For patients with a history of ongoing treatment, efforts will be made to assure continuity of care. Methadone maintenance programs are highly regulated by Federal Law and documentation necessary for patients to receive guest dosing at a local facility are exacting. Patients may be transported back to their original facility for treatment until a chain of custody is established with the correctional facility for Methadone pick up and administration by nursing.

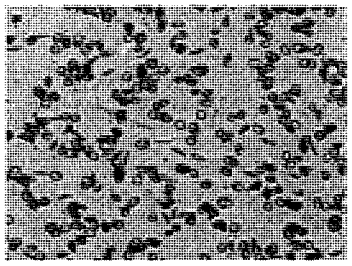
Patients enrolled in buprenorphine programs may be dosed at the facility, while awaiting an initial evaluation and care plan from the facility-based and/or collaborating MAT provider. Under these circumstances, the clinician with the DEA-X certification at the facility will write a bridge order for: SuboxoneHCl 8mg/2mg daily [3 - 7 days] for "continuity of care pending evaluation and treatment plan from the MAT provider". Once evaluated by the MAT provider, the facility clinician will write an order directing nursing staff to administer medication as ordered by the MAT provider.

Because of bail-reform, detainees are often lost to follow up throughout the treatment process. To assure that patient care plans are maintained, consent forms are signed at intake which allow for a bi-directional sharing of clinical information with the clinic and the community-based MAT provider. The patient knows from intake where follow up care will be available.

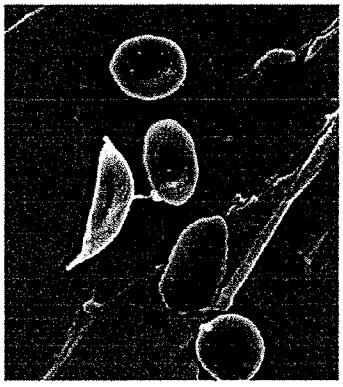
SICKLE CELL ANEMIA

Sickle-cell disease (SCD), also known as sickle-cell anemia (SCA) or drepanocytosis, is a hereditary blood disordercharacterized by red blood cellsthat assume an abnormal, rigid, sickleshape. This change in red blood cells, or sickling, decreases the cell's flexibility, resulting in significant risk for various acute and chronic complications, several of which have a high mortality rate.

The sickling is the result of a mutation in the hemoglobingene. individuals with one copy of the mutant gene will produce a mixture of both normal and abnormal hemoglobin.



Sickle cells in human blood: both normal red blood cells and sickle-shaped cells are present in this slide



Normal blood cells (round) next to a sickle blood cell (colored image from a scanning electron microscope)

Sickle Cell Crisis

The terms "sickle cell crisis" or "sickling crisis" are used to describe several independent acute conditions occurring in patients with sickle cell disease and include anemia, vaso-occlusive crisis, aplastic crisis, sequestration crisis, hemolytic crisis, as well as others. Most episodes of sickle cell crisis last between five and seven days. Although infection, dehydration, and acidosis (all of which favor sickling) can act as triggers, in most instances no predisposing cause can be identified.

Vaso-Occlusive Crisis

Vaso-occlusive crisis is seen when sickle-shaped red blood cells obstruct capillaries and restrict blood flow to an organ, resulting in ischemia, pain, necrosis and, often, organ damage. The frequency, severity and duration of vaso-occlusive crises vary considerably. Painful crises are treated with hydration, analgesics and blood transfusion, plus the administration of opioids at regular intervals until the crisis has settled. For milder crises, sub-groups of patients may manage pain through the use ofNSAIDs (such as diclofenac or naproxen). For more severe crises, most patients require inpatient management, so opioids* may be administered intravenously - patient-controlled analgesia (PCA) devices are commonly used in the hospital setting. Vaso-occlusive crises

involving organs such as the penis or lungs are considered emergent and must be treated with red-blood cell transfusions. Incentive spirometry, a technique to encourage deep breathing, is recommended to minimize the development of atelectasis.

*** When prescribing opioids, please note the following:**

- Opioids may interact with anti-depressants and migraine medications, leaving the patient at risk for serotonin syndrome. Serotonin syndrome is characterized by an increase in serum levels of serotonin and can cause agitation, hallucinations, rapid heart rate, fever, sweating, shivering, shaking, muscle twitching, muscle stiffness, nausea, vomiting and diarrhea. Symptoms may develop within several hours or several days.
- According to the FDA's Adverse Event Reporting System (FAERS) database, serotonin syndrome is more likely to occur with fentanyl and methadone, even when used at recommended dosages.
- Use of opioids can also result in adrenal insufficiency and decreases in cortisol production. Symptoms to be on alert for include nausea, vomiting, loss of appetite, fatigue, weakness, dizziness and low blood pressure. If adrenal insufficiency is suspected, the healthcare professional should order appropriate diagnostic testing and treat the patient with corticosteroids, tapering the patient off of the opioid, as appropriate.
- Opioid medications can also decrease the level of sex hormones, leading to changes in libido, impotence, amenorrhea and infertility. As appropriate, the health professional should order laboratory testing to assess this adverse reaction.

Splenic Sequestration Crisis

Because of its narrow vessels and function in clearing defective red blood cells, the spleen is frequently affected in patients with sickle cell disease, with the spleen generallyinfarcted before the end of childhood. This auto-splenectomy increases the risk of infection from encapsulated organisms. Preventive antibiotics and vaccinations are recommended for those patients withasplenia.

Splenic sequestration crises are characterized by acute, painful enlargements of the spleen, caused by intrasplenic trapping of red cells, resulting in a precipitous fall in hemoglobin levels. In these instances, the potential for hypovolemic shock exists, thereby rendering sequestration crises emergency situations - if not treated, patients may die within 1–2 hours, due to circulatory failure.

Management is supportive, but will sometimes necessitate blood transfusion.

Instances of splenic sequestration crises are transient, generally lasting between 3–4 hours to one day.

Acute Chest Syndrome (ACS)

Acute chest syndrome (ACS) is defined by evidence of new pulmonary infiltrate upon chest x-ray, with the manifestation of pulmonary symptoms such as tachypnea and dyspnea, as well as fever. As both pneumonia and sickling in the lung can produce these symptoms, patients should be treated for both conditions. ACS can be triggered by trauma, respiratory infection, bone-marrow embolization, and possibly by atelectasis, opiate administration and surgery.

ACS is the second most common complication of sickle cell disease and accounts for about 25% of deaths in patients with SCD. The majority of ACS cases present as vaso-occlusive crises that develop into ACS. In

addition, according to Dessap et al., in a 2007 study, about 80% of patients experience vaso-occlusive crises during ACS.

Aplastic Crisis

Aplastic crises are characterized by an acute worsening of the SCD patient's baseline anemia - producing pallor, tachycardia and fatigue. This crisis is normally triggered by Parvovirus B19, which directly affects theproduction of red blood cells by invading red blood cell pre-cursors, multiplying within them and then destroying them.

Parvovirus infection nearly completely prevents the production of red blood cells for two to three days in all individuals. In normal individuals, this is of little consequence, but in combination with the shortened life of red blood cells in sickle-cell patients, Parvovirus results in an abrupt, life-threatening situation for this cohort. Reticulocyte counts drop dramatically, causing reticulocytopenia, with the rapid turnover of red cells leading to a drop in hemoglobin.

Aplastic crises can take anywhere from four days to one week to resolve. Most patients can be managed supportively, though some may require a blood transfusion.

Hemolytic Crisis

Hemolytic crises are characterized by acute, accelerated drops in hemoglobin levels, with red blood cells breaking down at a faster rate. This is particularly common in patients with co-existent G6PD deficiency. Management is primarily supportive, though sometimes necessitates blood transfusion.

Other

One of the earliest clinical manifestations of SCD is dactylitis, or sausage digit, a condition that causes extreme swelling of digits, both fingers and toes. In patients with SCD, dactylitis arises as a result of vaso-occlusive crisis with bone infarct and may present in patients as early as six months of age. Episodes of dactylitis can last up to a month.

Assessment and Treatment

- **Initial Health Assessment (Physical Examination Findings)**
  - Vital signs
  - Sclera – may be icteric, bone-white or show signs of conjunctivitis
  - HEENT
  - Lungs
  - Cardiac – precordial heave, thrills, S3, murmurs
  - Abdominal – splenomegaly versus auto splenectomy; abdominal pain; rebound
  - Genitourinary – priapism
  - Musculoskeletal – joint deformity, abscesses
  - Determination of crisis

- **Causative Organisms**
  - cold
  - stress
  - sepsis
  - dehydration
  - infection
- **Diagnostic Tests**
  - CBC with differential – reticulocytes, immature cells, anisocytosis, poikilocytosis.
  - Reticulocyte count
  - Absolute platelet – large or clumped platelets
  - Urinalysis – sediment, RBCs, hemoglobin, leucocyte esterase, WBCs
  - Cultures – throat, wound, urine
- **Treatment Initiation**
  - Aggressive hydration
  - Analgesic support
  - Folate supplementation
  - Symptomatic treatment – application of localized heat for mild crises
  - Laboratory information – if bone marrow failure is indicated, the patient must be sent to the ER
  - For instances of priapism
    - Assess pain
    - Forced hydration
    - Ensure patient can urinate – consult Urology or send the patient to the ER if blocked
  - CXR – infarcts versus infection
- **Chronic Care Follow-Up**
  - CBC with differential
  - Reticulocytes
  - U/A
  - Echocardiogram – for evidence of high output heart failure
  - Targeted joint x-rays

GOUT AND PSEUDOGOUT

Gout and pseudogout are the two most common crystal-induced arthropathies. The pain and joint inflammation of these debilitating illnesses are caused by monosodium urate monohydrate (MSU) crystal formation within the joint space. If uric acid levels are allowed to remain uncontrolled in patients with gout,

tophi (deposits of MSU crystals) can form on the ears, finger joints and elbows. The goal of long-term gout management is to lower serum uric acid levels to <6 mg/dL to clear tophi and dissolve MSU crystals. Recent data (Perez-Ruiz, F., et al) confirms that the therapeutic target for clearing crystals is five(5) years of serum uric acid levels <6mg/dL and suggests that once the therapeutic target goal has been achieved, the preventive target should be a serum uric acid of 6-6.9mg/dL.

Pseudogout is caused by calcium pyrophosphate (CPP) crystals; it is sometimes referred to as calcium pyrophosphate disease (CPPD). Pseudogout may be clinically indistinguishable from gout.

Some differences between the two disorders are as follows:

Variable	Gout	Pseudogout
Frequency	2.7 of every 1000 adults	1.3 of every 1000 adults
Male-to-female ratio	9:1	1.5:1
Most common joint affected	Big toe	Knee
Other joints affected	Early flares: mid-foot, ankle, heel, knee later flares: wrist, fingers, elbow	Ankle, wrist, elbow
Risk factors	Diet, age, obesity, genetics	Age, joint trauma, genetics, excess iron stored in the body (hemochromatosis)

- Asymptomatic Hyperuricemia
  - Only 1 in 4 people with hyperuricemia will develop symptoms of gout
  - There is no data to support treatment of asymptomatic hyperuricemia with hypouricemic agents

Initial Health Assessment (Physical Examination Findings)

Sudden onset of severe debilitating pain with progressive worsening over first 24 hours; symptoms typically resolve within 3-10 days

Treatment Initiation

TREATMENT INITIATION FOR GOUT AND PSEUDOGOUT

GOUT	PSEUDOGOUT
• Remove offending drugs, if applicable: thiazide diuretics, niacin, levodopa, cyclosporine, Ethambutol, Pyrazinamide, aspirin (low dose aspirin [75-150 mg/daily] is okay) • Limit alcohol intake, particularly beer • Limit high purine foods (e.g., red meat) • Eat protein in moderation • Avoid eating liver, kidney, shellfish and yeast extracts • Manage obesity and hypertension, if present • Non-pharmacologic treatments include resting the affected joint for 1 to 2 days and applying ice to the affected joint • **DO NOT INITIATE CHRONIC TREATMENT DURING AN ACUTE ATTACK; BEGIN 1 TO 2 WEEKS AFTER THE ACUTE ATTACK HAS SUBSIDED**	• Treatment is tailored to presenting symptoms • In patients with 1 or 2 points of acute synovitis, joint aspiration and **steroid injection** (intra-articular) provide rapid relief of pain and inflammation if no infection is present (refer to medications below for dosing, side effects and toxicities) • When more than two joints are involved, systemic therapy with **NSAIDs or systemic corticosteroids** is recommended (refer to medications below for dosing, side effects and toxicities) • Unlike gout, there are no "hypouricemic equivalents" to improve long-term control of pseudogout and to prevent or reverse CPPD (calcium pyrophosphate dehydrate disease) or crystal deposit disease

Medications

- Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)
  - Effective in about 90% of patients
  - Avoid NSAIDs in patients with creatinine clearance <50 mL/min, peptic ulcers, hepatic dysfunction, congestive heart failure (CHF) and those on anticoagulant therapy
  - Monitor creatinine, blood pressure, CBC and chemistry profile periodically
  - Screen patient's medications for potential drug-drug interactions
  - Adverse effects include:

- GI intolerance, bleeding, ulceration or perforation (co-administration of PPIs [proton pump inhibitors] may reduce risk)
- Headache
- Dizziness
- Depression
- Fatigue
- Nephrotoxicity
- Fluid retention
- Edema
- Risk of cardiovascular events
- Severe anaphylactic reactions
- Stevens-Johnson syndrome (treat with sulindac/Clinoril)

- Indomethacin (Indocin)
  - Start at 50mg TID for three(3) days, then 50mg BID for 4 to 7 days
- Naproxen (Naprosyn)
  - Start at 250mg TID for three (3) days, then 250mg BID for 4 to 7 days
- Sulindac (Clinoril)
  - 200mg BID for 7 to 10 days; **give with food**
  - Avoid in elderly due to increased central nervous system side effects in this age group
- Other NSAIDs, including Celebrex (celecoxib), can be used for the treatment of acute gout attacks
- Corticosteroids
  - Very effective in acute gout attacks
  - Useful in patients who cannot tolerate NSAIDs
  - Systemic steroids are the preferred agent in patients with renal failure for whom NSAIDs are contraindicated
  - Corticosteroids may be used locally (intra-articular injection) or systemically (oral, IM, IV)
  - Avoid in patients with systemic infection or septic arthritis
  - Adverse effects include:
    - Hyperglycemia
    - Hypertension
    - Weight gain, fluid retention, electrolyte shifts
    - Infection
    - Mood changes/mental problems
    - Peptic ulcer with possible perforation and hemorrhage
- Intra-articular corticosteroids
  - One of the safest options, particularly if only one joint or larger joints are involved
    - Methylprednisolone acetate (Depo-Medrol) 5mg to 25mg per joint
    - Triamcinolone acetonide (Kenalog 10mg/mL) 2-5mg in smaller joints, 5-15mg in larger joints
    - Betamethasone sodium phosphate/acetate (CelestoneSoluspan) 3mg to 6mg per joint

- Oral corticosteroids
  - Prednisone (Deltasone)20mg to 60mg daily for 5 to 7 days
  - Prednisolone 35mg daily for 5 to 7 days
  - No need to taper as recent data shows that rebound is not an issue when corticosteroids are used short-term (for 5 to 7 days)
- Parenteral corticosteroids
  - Single-dose IM or IV injections are found to be effective
  - Betamethasone sodium phosphate/acetate (CelestoneSoluspan) 7mg IM
  - Triamcinolone acetonide (Kenalog 40mg/mL) 60mg IM
  - Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV
- For chronic gout, prophylactic therapy with NSAIDs decreases the likelihood of acute flares when starting chronic therapy with xanthine oxidase inhibitors, uricosuric agents or pegloticase
  - Indomethacin (Indocin) 25mg BID
  - Naproxen (Naprosyn) 250mg BID
- Xanthine Oxidase Inhibitors
  - Contraindicated in patients receiving azathioprine or mercaptopurine
- Allopurinol (Zyloprim)
  - Allopurinol is effective in both underexcreters and overproducers of uric acid
  - In patients with normal renal function, start with 100mg QD; increase 100mg/day at weekly intervals until goal is met (doses greater than 300mg/day are to be given in divided doses)
  - Average daily dose is 200-300mg/day for mild gout, 400-600mg/day for moderate gout, and 700-800mg/day for severe gout; **maximum daily dose is 800mg/day**
  - In patients with renal insufficiency, start with 50-100mg/day
  - Patients with CrCl 10-20 mL/min should receive no more than 200mg/day; patients with CrCl<10 mL/min should receive no more than 100mg/day; patients with CrCl<3 mL/min should have the interval between doses lengthened
  - Monitor creatinine and LFTs
  - Screen patient's medication for potential drug-drug interactions
  - Adverse effects include:
    - Rash
    - GI disturbance
    - Elevation in liver enzymes
    - Acute gout attacks
    - Drowsiness
    - Nephrolithiasis
    - Rare, potentially fatal hypersensitivity reactions (more common in patients with renal insufficiency and those taking diuretics)
- Febuxostat (Uloric)
  - Start dosing at 40mg QD; **maximum dose is 80mg/day**

- No dosage adjustment is required in patients with mild/moderate renal or hepatic impairment
- Monitor creatinine and LFTs
- Adverse effects include:
  - Increased liver enzymes
  - Nausea
  - Gout flares
  - Arthralgia
  - Rash
- Due to cost, consider febuxostat in patients with Allopurinol hypersensitivity, intolerance or prior treatment failure

- Uricosuric Agents
  - Recommended in younger patients (<60 years old) who:
    - are documented underexcreters of uric acid
    - do not have reduced renal function (CrCl>60 mL/min)
    - do not have a history of kidney stones
    - do not require aspirin (600mg – 2400mg/day)
    - do not require diuretic therapy
  - Adverse effects include:
    - Headache
    - GI disturbance
    - Rash, hypersensitivity reactions
    - Kidney stones
- Probenecid (Benemid)
  - **Contraindicated in patients on methotrexate**
  - Caution in patients with a history of peptic ulcer
  - Screen patient's medication for potential drug-drug interactions
  - Start dosing at 250mg BID for one(1) week, then 500mg BID; increase every four(4) weeks in 500mg increments until goal is met
  - Maintenance dose is 1000mg to 3000mg QD in divided doses
- PEGylated uric acid specific enzyme/pegloticase (Krystexxa)
  - Used in the management of patients with refractory gout who are unresponsive to appropriately-dosed, oral, urate-lowering therapies; treatment lowers serum uric acid level and significantly improves and/or reverses the course of severe, crippling and debilitating refractory gout
  - **Prophylaxis with NSAIDs is recommended for one(1) week prior to starting pegloticase**
  - **Use with caution in patients with heart failure**

- **Contraindicated in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency due to risk of hemolysis and methemoglobinemia; screening for patients at high risk for G-6-PD deficiency is recommended PRIOR TO INITIATING THERAPY**
- Administer under supervision of healthcare professional due to risk of infusion reactions and anaphylaxis
  - **Pre-medicate with antihistamines and corticosteroids prior to each dose and MONITOR CLOSELY**
  - **Risk of infusion reactions and anaphylaxis is higher in patients who have lost therapeutic response; monitor serum uric acid levels PRIOR to infusions and consider discontinuing treatment if uric acid level increases above 6 mg/dL, particularly when two (2) consecutive levels above 6 mg/dL are observed**
- 80% of patients treated with pegloticase experience gout flare(s) in the first few months of therapy; discontinuation of pegloticase is not necessary if gout flare(s) occurs.
- Pegloticase therapy should be continued for up to six(6) months, unless there are contraindications
- Recommended dose of pegloticase is 8mg IV infusion every two(2) weeks
- Adverse effects include:
  - Gout flares
  - Infusion reaction
  - Nausea
  - Contusion or ecchymosis
  - Nasopharyngitis
  - Constipation
  - Chest pain
  - Anaphylaxis
  - Vomiting

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SUMMARY

The mission of this manual is to provide practitioners with clinical guidelines or a template to follow; thereby, ensuring the delivery of care in an ambulatory setting that is both appropriate and consistent across all facilities.

In administering care, clinicians must consider the following provisions:

- Elective and cosmetic interventions requested by inmates shall not be approved.
- The transient nature of jail admissions necessitates early discharge planning by clinical staff.
- All documentation must be legible, thorough and in SOAP (**S**ubjective, **O**bjective, **A**ssessment, **P**lan) format.
- Problem Lists must be complete and must include ICD codes, where appropriate.

FORMS

- Chronic Care Clinic Forms
  - Chronic Care Clinic face page
  - Cardiovascular
  - Endocrine
  - Gastrointestinal
  - General Medicine and Special Needs
  - HIV
  - Infectious Disease
  - Neurology
  - Pulmonary
- Consent for Hormone Therapy
- Consultation Request Form
- Consultation Response Form
- Consult Return Review
- Day 4 Alcohol/Drug Withdrawal Evaluation
- Infirmary Medical Rounds
- Infirmary Medical Rounds – Admission
- Infirmary Medical Rounds – Discharge
- MD/NP Sick-Call/Follow-Up Note
- Medication Reconciliation Form
- Medication Verification Form
- Non-Formulary Requests (Medical and Psychotropic Medications)
- Off-Site Emergency Notification
- Patient Specific Drug Ordering
- Peer Review
- Physician's Orders for Withdrawal
- Problem List
- Sample Monthly Drug Invoicing
- Vivitrol Administration (applicable to Hudson County ONLY)
  Includes:
  - Consent to Vivitrol Treatment
  - Vivitrol Administration Log

  Comment [DD1]: Added 12/19/2016
- Withdrawal Management
  Includes:
  - CAGE Assessment
  - CIWA-Ar
  - T-ACE Assessment

ATTESTATIONS

- All standards & clinical pathways established herein reflect information obtained from the most recent published materials of the appropriate governing oversight and regulatory agencies.
- All standards & clinical pathways included are duly referenced in the Bibliography.
- CFG's Clinical Care Guidelines for Clinical Practitioners Manual has been issued as a resource document.

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SIGNATURE PAGE

CFG Health Systems, LLC

Approved by:

X_____/_____

Corporate Medical Director **Date**

X_____/_____

Site Medical Director **Date**

_____ **(Name of facility)**

X_____/_____

Health Services Administrator **Date**

_____ **(Name of facility)**

Appendix 3

Staff: _____ Date: _____/_____/_____ Time: _____
Document: Nurse Intake (ECCF)

Mental Health Questionnaire

Arresting or transporting officer believes inmate may be a suicide risk?	☐ YES	☐ NO
Has a previous suicide attempt?	☐ YES	☐ NO
If YES, more than 5 years ago?	☐ YES	☐ NO
Between 6 months and 5 years ago?	☐ YES	☐ NO
Less than 6 months ago?	☐ YES	☐ NO
Family member or significant other attempted or committed suicide?	☐ YES	☐ NO
Expresses current thoughts about killing self or has suicide plan?	☐ YES	☐ NO
First time EVER incarcerated?	☐ YES	☐ NO
Is this inmate acting in a significantly strange or bizarre manner?**	☐ YES	☐ NO
Is this inmate a danger to self or others?	☐ YES	☐ NO
Is this inmate disoriented to time, place and person?**	☐ YES	☐ NO
Is the person unresponsive to questioning or withdrawn?**	☐ YES	☐ NO
Holds a position of respect in community and/or alleged crime is shocking in nature? *(Position of respect as in professional or public official. Also select YES if the person expresses feeling of embarrassment and shame.)*	☐ YES	☐ NO
History of psychiatric hospitalization?	☐ YES	☐ NO
Shows signs of depression (crying, emotional flatness, negative thinking)?	☐ YES	☐ NO
Expresses that here is nothing to look forward to in the future (hopelessness, helplessness)?	☐ YES	☐ NO
Shows signs of excessive anxiety (agitated, fearful, panic)?	☐ YES	☐ NO
Currently treated by a psychiatrist/psychologist?	☐ YES	☐ NO
If YES, currently prescribed psychiatric medications?	☐ YES	☐ NO
Previously treated by a psychiatrist/psychologist?	☐ YES	☐ NO
If YES, previously prescribed psychiatric medications?	☐ YES	☐ NO
History of violent behavior/aggression?	☐ YES	☐ NO
Have you been a victim of sexual abuse?	☐ YES	☐ NO
Have you been a victim of criminal violence?	☐ YES	☐ NO
Have you experienced a significant loss in the past 6 months?	☐ YES	☐ NO
Have you ever been placed in a special education setting?	☐ YES	☐ NO
Are you worried about any major problems? (not legal or criminal)	☐ YES	☐ NO

** Not due to withdrawal or intoxication

Staff: _____ Date: _____/_____/_____ Time: _____

Document: Nurse Intake (ECCF)

Mental Health Questionnaire

Arresting or transporting officer believes inmate may be a suicide risk?	☐ YES	☐ NO
Has a previous suicide attempt?	☐ YES	☐ NO
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Family member or significant other attempted or committed suicide?	☐ YES	☐ NO
Expresses current thoughts about killing self or has suicide plan?	☐ YES	☐ NO
First time EVER incarcerated?	☐ YES	☐ NO
Is this inmate acting in a significantly strange or bizarre manner?**	☐ YES	☐ NO
Is this inmate a danger to self or others?	☐ YES	☐ NO
Is this inmate disoriented to time, place and person?**	☐ YES	☐ NO
Is the person unresponsive to questioning or withdrawn?**	☐ YES	☐ NO
Holds a position of respect in community and/or alleged crime is shocking in nature? *(Position of respect as in professional or public official. Also select YES if the person expresses feeling of embarrassment and shame.)*	☐ YES	☐ NO
History of psychiatric hospitalization?	☐ YES	☐ NO
Shows signs of depression (crying, emotional flatness, negative thinking)?	☐ YES	☐ NO
Expresses that here is nothing to look forward to in the future (hopelessness, helplessness)?	☐ YES	☐ NO
Shows signs of excessive anxiety (agitated, fearful, panic)?	☐ YES	☐ NO
Currently treated by a psychiatrist/psychologist?	☐ YES	☐ NO
If YES, currently prescribed psychiatric medications?	☐ YES	☐ NO
Previously treated by a psychiatrist/psychologist?	☐ YES	☐ NO
If YES, previously prescribed psychiatric medications?	☐ YES	☐ NO
History of violent behavior/aggression?	☐ YES	☐ NO
Have you been a victim of sexual abuse?	☐ YES	☐ NO
Have you been a victim of criminal violence?	☐ YES	☐ NO
Have you experienced a significant loss in the past 6 months?	☐ YES	☐ NO
Have you ever been placed in a special education setting?	☐ YES	☐ NO
Are you worried about any major problems? (not legal or criminal)	☐ YES	☐ NO

** Not due to withdrawal or intoxication

Appendix 4

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

 This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

Clinical Opiate Withdrawal Scale (COWS)

Flow-sheet for measuring symptoms for opiate withdrawals over a period of time.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date: _____

Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.

Times: _____ _____ _____ _____

Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness *Observation during assessmen*t 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

GI Upset: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting				
Tremor *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or Irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection				
Total scores **with observer's initials**				

Score:
5-12 = mild;
13-24 = moderate;
25-36 = moderately severe;
more than 36 = severe withdrawal

Appendix 5

Essex County Correctional Facility

Inmate Handbook & Disciplinary Rulebook

ALFARO ORTIZ
Director

Effective Date and First Distribution: January 2005

REVISED

November 2010	January 2017
April 2011	January 2018
May 2011	April 2018
January 2013	July 2018
March 2013	September 2018
May 2013	December 2018
August 2013	May 2019
November 2013	June 2019
April 2014	October2020
August 2014	November 2020
September 2014	April 2021
March 2015	November 2021
April 2015	January 2022
January 2016	February 2022

It is your responsibility to read this handbook carefully and follow the Rules and Regulations outlined within. It is also your responsibility to ask an officer for assistance if you do not understand any rules. Failure to follow the rules outlined herein may result in disciplinary action. The Rules and Regulations contained in this handbook have been adopted by the administration of the Essex County Department of Corrections.

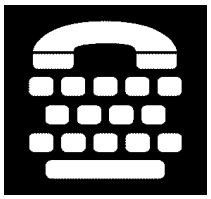
Table of Contents

NOTICE TO DEAF AND HARD OF HEARING INMATES

If you are an individual with a qualifying disability, you may be entitled to a reasonable accommodation. Please indicate your request to a member of our staff for such consideration.

To the extent provided by law, if you are deaf or hearing impaired and sign language is your primary method of communication, you may have the right to a sign language interpreter, if one is required for you to effectively communicate while at this facility.

If you have any qualifying disability and want to request an accommodation, please let us know.



This facility is equipped with a Telecommunications Device for the Deaf (TDD).

PLEASE REFER TO THE SOCIAL SERVICES SECTION TO CONTACT OUR SOCIAL SERVICES DEPARTMENT TO ARRANGE TO USE THIS DEVICE.

1. Initial Admission

Upon your arrival at the ECCF you will undergo intake processing by a facility officer. In general, you can expect the intake processing procedures to occur as follows:

1. The processing officer will retain your clothes, personal property, valuables and money for safe-keeping. The facility will provide you with itemized receipts for all of your clothing, personal property, valuables and money. It is important that you retain these receipts to claim your property, money and valuables when you are released.
2. Facility staff will identify the type of items that you will be permitted to retain when you arrive for intake processing. For example, you will be allowed to retain legal documentation necessary for your legal case or, at a minimum, be allowed access to your case material as needed. You will be allowed to keep some personal items with you.
4. You will be provided a secure bag for storage of your valuable personal items. Your clothes shall be placed in a hanging bag for storage. The ECCF is not responsible for the loss of your personal items that you do not store.
5. You will be provided with (1) Underware, (1) Uniform, (1) pair of inmate footwear, (1) Copy of Inmate Disciplinary Handbook (English or Spanish), (2) sheets, (1) blanket, (1) towel, (1) Care package, (2) Offered Phone calls, (1) Socks, (1) Tee Shirt, and (1) Shower Shoes. Upon admission you shall sign for all issued items. Your signature shall acknowledge that you are responsible for all items issued to you during your time of detention. Upon release you are expected to return all issued items in its original condition (reasonable wear excluded).

6. You will be provided with personal hygiene items (e.g., toothbrush, comb). If you need to replace any of your personal hygiene items at a later time, you must request replacements from an indigent list or purchase them from commissary.
7. You will be able to request writing material, pen/pencils and envelopes for your personal use from commissary or an indigent list.
8. Family members and friends in a concerted effort may use http://inmatelookup/inmatelookup in order to obtain pertinent information regarding your incarceration.
9. An initial health screening and physical examination are given to all inmates upon admission to the facility and before placement in the general population or housing area. Medical staff will also conduct a pre-screening interview to assess your physical and mental health as part of the intake process. If you have any health conditions that require immediate attention from a medical provider, you must inform our staff during your intake processing with out hesitation. If you prefer, you may request to speak directly with medical staff about your health concerns. Any information you provide to our medical staff cannot be shared with non-medical staff and will be treated with strict confidentiality.

2. Introduction

What Is a Jail?

Jails were initially designed as holding facilities for persons arrested and charged with committing a crime. Originally, these facilities were used to house inmates serving short sentences, 364 days or less, as well as those housed awaiting trial.

Our jail currently houses a broad variety of inmates, such as convicted offenders awaiting sentencing, pending grand jury, probation and parole violators, offenders wanted by other states or counties, state remand inmates, federal, I.C.E. detainees, non-support parents, and in some cases, juvenile offenders. Males and females housed within the Essex County Correctional Facility (ECCF) are referred to as "inmates." In Essex County, the jail is referred to as a county correctional facility. Therefore, the words "ECCF" and "jail" mean the same thing.

ECCF has a classification system which determines in what area of the jail an offender will be housed. Overall, inmates do not choose whether or not they will have cell mates or choose who their cellmates might be or where they will be housed. At any time, inmates can be moved.

ECCF

In the United States, there are about 3,150 counties or boroughs. In New Jersey, most of its 21 counties have at least one county jail. Of those 21 counties they contain 566 municipalities; Essex County alone has 22 boroughs, cities or townships with about 770,000+ residents. Our county jail is a "state of the art" Direct Supervision facility which opened for public service in 2004, currently housing thousands of inmates.

Our facility provides a safe and secure environment for the care, custody and control of many different types of inmates. We openly realize that everyone within our facility is an individual, who may be incarcerated for many different reasons. Open communication is encouraged and the **RESPECT** of all is an extreme importance and an integral part of its daily operation.

Commitment or Incarceration

Inmates are committed to the ECCF in accordance with the laws of the state of New Jersey. The officials of this facility are responsible for operating the facility in a manner that assures the control, safety, medical care, sanitary living conditions, and fair treatment to all inmates. Staff will help you if

you ask them but will report you for disciplinary actions if you commit a prohibited act. That is their job. You need not dislike them.

These rules and regulations are designed to provide the inmate population with general information along with a standard for acceptable behavior, which is required for the institution to safeguard the rights of all persons confined to and employed by the jail. Inmates who do not conduct themselves in an acceptable manner could be charged with a specific disciplinary offense. The disciplinary offenses are listed in the Prohibited Acts section. The standards for acceptable behavior by inmates listed in this handbook apply to all inmates. Inmates may have their period of confinement lengthened or shortened according to their conduct while in disciplinary detention.

Your confinement may be as pleasant as possible under these current circumstances, only if you maintain an attitude of cooperation, courtesy and respect during your stay. We encourage all inmates to participate in programs or obtain services that will strengthen social growth and make re-integration to society a success.

Distribution/Revisions of the Inmate Handbook/Disciplinary Rulebook

All inmates will receive this handbook/disciplinary rulebook upon admission to the ECCF. An acknowledgement of receipt has been filed upon your admission and you must keep this handbook available at all times in your cell or assigned bunk area. The Inmate handbook is on the Tablet.

The information in this booklet will be translated into Spanish, or any other language, upon proper request made to the housing unit officer(s) and/or social services. Correctional personnel shall verbally explain the handbook/disciplinary rulebook to inmates who are illiterate or not sufficiently conversant with the English language or otherwise unable to read due to a physical or medical inability. As these rules and regulations are subject to revision, updated procedures will be distributed, as necessary. This handbook is intended to be a beneficial guide with outlines of required behavioral expectations for all individuals within our facility.

3. Rights

It is the policy of ECCF to treat inmates with dignity and respect, while maintaining a safe, secure, sanitary facility. To assist us in this goal, you are expected to cooperate with our staff in the following respects:

- Comply with orders/directions given by staff members.
- Respect facility staff and other inmates.
- Respect government property, county/facility property and the property of other inmates.
- Maintain yourself, your clothing and your living area in a clean condition.
- Address our staff by referring to their title and last name (i.e., Doctor Jones, Officer Smith, Nurse Clark), or by Mr., Mrs., or Ms. followed by their last name and maintain a minimum distance of at least three feet at all times.

While you are in custody, you have the following rights:

- You have the right to be informed of the rules, procedures and schedules concerning the operation of the facility where you are confined. You have the right to be treated respectfully, impartially and fairly by all personnel and to conduct yourself in a responsible manner.

- Care, custody, control and treatment services shall be provided to all inmates in compliance with applicable state and federal penal codes. There shall be no discrimination on the basis of race, sex, sexual orientation, national origin, color, religion, economic status, political belief, reverse discrimination, age, or disability. Reasonable accommodations will be made for physically and mentally handicapped inmates.
- You have the right to freedom of religious affiliation and to voluntary religious worship that does not detrimentally affect others or the order and security of the facility.
- You have the right to reasonable care. You have the right to be held in acceptable conditions of confinement, which include daily personal hygiene, nutritious meals, proper bedding and clothing, a regular laundry schedule, an opportunity to shower regularly, proper ventilation for warmth and fresh air, a regular exercise period, toilet articles and medical treatment.
- You have the right to receive visits from family members and friends, according to the facility's rules and schedules.
- You have the right to legal counsel from an attorney by means of interviews and correspondence, at no cost to the U.S. government or Essex County.
- You have the right to unrestricted and confidential access to your attorney and the courts by correspondence.
- You have the right to use law library reference materials to assist you in resolving legal problems. You also have the right to receive help, when it is available, through a legal assistance program. Documents requiring notary public services may be provided upon appropriate request. A $.50 processing fee shall be charged for each document notarized. Indigent inmates shall be provided the service free of charge.
- You have the right to a wide range of reading materials for educational purposes and for your own enjoyment.
- You may have the right to participate in a work program, depending on your housing location and classification level.
- You have the right to a formal written grievance process.
- Inmates who state that they are foreign nationals shall be provided access to the diplomatic representative of their country of citizenship. Inmates are entitled to contact their consulate, free of charge, using any telephone system in the facility.

4. Responsibilities

While you are in custody, you have the following responsibilities:

- You have the responsibility to have a working knowledge of these rules and regulations and to follow all orders from staff.
- It is your responsibility to follow and adhere to the institutions rules regarding clothing.
- You have the responsibility to respect ECDOC property and the property of others.
- You have the responsibility to conduct yourself in a responsible and respectful manner.
- It is your responsibility not to waste food, to follow the laundry and shower schedules, maintain clean and neat living quarters, and to seek medical care as needed.
- You have the responsibility to recognize and respect the rights of other religious groups and/or beliefs.
- It is your responsibility to obtain your own tray during meal time. The housing unit officer shall be notified if inmates are not able to retrieve their trays.
- It is your responsibility to perform housekeeping duties as directed by a housing unit officer.
- You are responsible for all uniforms, bed sheets, towels, mattress issued and for the return of these items during release.

- It is your responsibility to ensure that cells are not left open or used excessively. Limitations on the number of times you are permitted to access your cell is determined at the officer's discretion.
- You are responsible to take prescribed medication as directed by medical personnel.
- It is your responsibility to maintain high standards concerning sanitation and disposing of refuse. This facility provides regular pest and/or vermin control via a professional exterminator. You are responsible for assisting in these ongoing efforts by limiting the amount of commissary items, personal materials, etc. kept in your living area.
- You are responsible to submit to searches of your person and property at any time.
- It is your responsibility to conduct yourself properly during visits and to not accept or pass contraband.
- It is your responsibility to obtain the services of an attorney.
- Presentation of your case and consultation with your attorney is your responsibility.
- It is your responsibility to use resources according to the prescribed procedures and schedule, and to respect the rights of other inmates using those materials.
- It is your responsibility to use these materials for personal benefit, without depriving others of their equal rights to the use of those materials.
- You have a responsibility to take advantage of work opportunities and activities that may help you live more successfully within the facility and the community. You are expected to abide by the regulations governing the use of such activities.
- It is your responsibility to arrange methods of payment for your bond /bail.
- It is your responsibility to refrain from any type of sexual harassment. Sexual harassment includes but is not limited to: consensual advancement, unwanted sexual advances, gender harassment, seductive behavior, requests for sexual favors, sexual bribery, sexual coercion and other verbal or physical contact of a sexual nature. Indecent exposure, placing or showing sexually explicit pictures, cartoons or drawings where they may be visible to any person is prohibited.
- It is your responsibility to act responsibly and follow the rules of the facility and lawful instructions of the staff. The failure to follow these rules and instructions may result in disciplinary action being taken against you, as necessary, to ensure the order and security of the facility.

5. Prohibited Acts

The following activities are prohibited and constitute major or minor violations as described in "Chapter Sixteen: Disciplinary Process."

- Inmates are prohibited from leaving their cell doors open or having them blocked in any fashion.
- Inmates are prohibited from "popping" (opening) any food-port or manipulating any ECCF locking device.
- Inmates are prohibited from passing the designated (yellow) lines beyond the officer's desk.
- Inmates are prohibited from advancing closer than 3 feet to any staff member.
- Tampering with, or taking any property from a staff member's desk will be considered a major violation of the rules and regulations.
- At no time will any inmate exert or be allowed to exert authority over any other inmate or group of inmates.
- Inmates are not allowed in any unauthorized housing unit, dorm, cell, bed or bunk.
- You must sleep in your own assigned cell/dormitory and bunk.

- Inmates are prohibited from entering, reaching or leaning into another inmates' cell for any reason.
- Inmates are not permitted to be near or to pass anything under access doors or through food-ports.
- Inmates are not permitted to have their food-ports open unless they are opened by the officer.
- Inmates are prohibiting from being loud and boisterous and will not use vulgar or abusive language.
- Inmates shall not approach within 3 feet from any window leading to floor control. Inmates shall not bang on the glass or stand near it or communicate to workers or with inmates on other housing units via "mouthing, hand signs or any other form of communication."
- Inmates shall not participate in unauthorized gatherings or house meetings.
- Sitting, leaning, standing, or loitering on stairs or behind stairs, or on the mezzanine (upper level), visiting area, behind rail, pillars or any other unauthorized area is prohibited. No objects of any type may be hung from rails or placed on stairs. The stairwell will not be blocked at anytime.
- Inmates shall not place their feet, clothing or any other item on the housing balcony railings or furniture.
- Loitering around any shower stall is strictly prohibited; it is not a meeting place or a guard post. It is an area that shall be afforded strict privacy from other inmates. Inmates found to have "bodyguards" may be subject to placement in Involuntary Protective Custody.
- All inmates shall be fully clothed upon entering and exiting the shower. Only one inmate is allowed in a shower stall at a time.
- Use of cell intercoms, where applicable, is only for urgent matters such as medical or safety concerns.
- Inmates are not permitted to cover, hang, or attach blankets, sheets, towels, clothing, or any other item to walls, windows, bunks, air vents, doors or light fixtures anywhere within the ECCF. Adequate lighting and unobstructed vision must be maintained for officers at all times throughout the facility.
- Exterior windows will not be blocked or shaded in any manner.
- Clothes lines are not permitted in the housing units.
- Drawing, writing, or otherwise defacing anything within the facility is strictly prohibited.
- Inmates are prohibited from wearing blankets or sheets outside of their bed/ bunk or cell.
- Wave caps (do-rags) may be worn only in housing unit cells or within your dormitory.
- Inmates shall not remove chairs from the dayrooms to use in cells, in the recreation areas, or on the balconies.
- Inmates shall not sit on stacked dayroom chairs or save chairs for other inmates.
- Inmates shall not take or consume food or snacks in the recreation areas nor misuse the recreation equipment.
- Storage of commissary food that can be consumed within one week is permitted with in your assigned cell or dorm, any other edible is unauthorized. You must keep your original receipts as proof of purchase for retention of all commissary items.
- During lock down time no items will be passed from cell to cell, this includes the housing unit workers.
- Books, magazines, letters in your cell will be strictly controlled and excessive materials will be confiscated.
- Inmates shall not have plastic bags or garbage bags in cells or bunk areas.
- Radios, headphones, magnets, batteries are not permitted inside the facility.

- Only medically cleared inmates assigned as kitchen workers are permitted in the unit pantry and they are the only inmates authorized to handle food. The pantry area is only used to serve precooked food and hot water; **all other forms of cooking are prohibited.**
- Inmates found to be "cooking" may have their commissary privileges suspended or subjected to other appropriate disciplinary action.
- Inmates shall not ask or harass the housing unit officer(s) for inmate worker assignments.
- Trafficking and trading services or items within ECCF is prohibited.
- Inmates shall not transfer ownership of any item.
- Gambling of any fashion will not be tolerated in ECCF.
- Alcohol and narcotics are strictly prohibited within ECCF.
- Only inmates assigned as laundry workers are permitted in the unit laundry room.
- Inmates shall not engage in sparring or martial arts and other horse-playing activities.
- Indoor exercise such as sit-ups and pushups are allowed provided they are done in the day room. The tables in the day room, the stairs, bunks, railings or other items or fixtures in the housing unit or dorm are not to be used to assist in any exercise. Under no circumstance will issued items be altered to produce homemade weights; No homemade exercise equipment will be allowed.
- Inmates will not remove ANY posted information from bulletin boards.
- Inmates are not permitted to have any housing unit tools, chemicals and hazardous substances in their cells or bunk area.
- **AT NO TIME** is anything to be flushed down the toilets except normal body waste. Using toilets as trash cans to flush garbage, food, clothing materials, commissary items and contraband is prohibited.

Destruction or the failure to return county property is prohibited. The cost of destroyed and unreturned property may be charged to personal accounts. Damage to county property may lead to disciplinary and or criminal charges. Further, all work credits and earned good time may be forfeited.

All prices are subject to change without notice to include, but not be limited to:

Uniform Jumper	$10.75	Desk Brush Head	$5.96
Shower Slippers	$1.25	Push Broom Handle	$9.56
Blanket	$8.40	Push Broom Head	$12.91
Towel	$1.42	Straw Broom	$10.41
Sheet	$2.00	Toilet Brush	$1.81
Pillow	$5.50	Plunger	$13.13
Pillow Case	$0.67	Barber Trimmers	$70.91
Mattress	$38.99	Barber Clippers	$142.58
Wristband	$10.00	Curling Iron	$28.40
Water Cambro	$135.00	Flat Iron	$49.78
Plastic Food Trays	$12.00	Law Library Computer	$796.00
Plastic Chair	$67.28	Law Library Printer	$219.88
Plastic Inmate Storage Bin	$23.60	Food Port Lock	$800.00
Tablet	$236.60	Plastic Inmate Garbage Can	$34.12
Dust Pan	$7.51	Sprinkler Head	$600.00
Mop Bucket/Mop Ringer	$119.60	½" Lexan Window	$1800.00
Mop	$14.24	Television	$650.00
Deck Brush Handel	$9.56	Water Cooler	$249.88

6. Privileges

A privilege is a benefit granted by the ECDOC that can be lost due to discipline, failure to obey rules and regulations, being a security risk or in emergent, special situations.

Privileges may include, but not be limited to:

1. Attendance in programs or services;
2 Access to and the use of the inmate telephone system;
3. Visits;
4. Purchase of commissary;
5. Recreational time;
6. Television (t.v.);
7. Cards and board games;
8. Worker assignments;
9. Good time credits.

7. Communication with Staff

You are encouraged to speak informally with staff about everyday concerns and for information about facility policies and procedures.

You may submit written questions, requests or concerns to facility staff using an Inmate Request Form. In addition you may file a written request or complaint regarding your treatment using the Inmate Request Form. You may request this form from your housing officer. These forms are collected and are forwarded to the office of the Ombudsman.

To prepare your request, you may obtain assistance from another inmate, your housing officer, or other facility staff. If you choose, you may seal the request in an envelope that is clearly addressed with the name, title and/or office to which the request is to be forwarded. Your request shall be placed in the designated box and will be promptly routed and delivered to the appropriate officials by staff (not by inmates) without reading, alteration, or delay.

Informal written requests are not intended as a substitute for the more formal process addressed in the Grievance Procedures.

8. Smoking Policy

The ECCF is a smoke-free environment. Smoking is prohibited in the facility and tobacco products or lighting devices will be confiscated during the intake process. Possession of tobacco or other smoking paraphernalia is a chargeable offense.

9. Identification Wristbands

- All inmates shall receive a photo identification wristband during the intake process.
- Wristbands must be worn on the wrist at all times as applied at intake.

- Tampered, altered or removed wristbands will be rendered useless for identification purposes; they shall be confiscated and will result in disciplinary action.
- Swapping the identification with another inmate may also result in disciplinary and/or criminal action.
- You must present your identification wristband during, but not limited to, emergency situations, dispensing of prescribed medications, distribution of commissary, meals, upon arrival at programs, visitation, during counts, upon entering/leaving a housing unit, upon release from the facility, and for all other general identification purposes or as ordered by staff.
- Should you become incapacitated, wristbands are a medical necessity for identification purposes.
- You must present your identification wristband to any officer and/or staff member upon request.
- You will be held responsible for keeping your wristband in good order.
- Wristbands will be inspected each shift during count.
- Officers and staff will randomly check wristbands to insure that bands are present and have not been tampered with.
- Damaged wristbands will be replaced.
- Inmates shall be charged with the cost of the replacement ($10.00) when it is being replaced for any reason other than normal wear and tear. This cost is subject to change without notice.

It will minimally be considered a Major Charge (.101 Escape, .102 Attempting or planning an escape) to remove, turn the outside in, damage, and/or alter any identification wristband or information contained thereon.

10. Classification

Upon your arrival, ECCF personnel will conduct an assessment of your records to ensure that you are placed in an appropriate setting within the facility. This assessment will provide you with a specific "classification level" based on criminal behavior, criminal convictions, disciplinary record, current custody status and any other information considered relevant to determining the most appropriate custody level. Your designated classification level will ensure that you are placed in the appropriate housing unit with other inmates of comparable classification characteristics.

A. Classification Status

1. Utilizing objective classification guidelines, the following major status categories are established:
   a. Males: maximum, medium, and minimum
   b. Females: maximum, medium, and minimum
   c. Inmates with Special Needs; and
   d. Juveniles.

2. Within the major status categories, the following degrees of classification are made:
   a. Sentenced to state prison;
   b. Pre-trial detainees with major charges;
   c. Trial detainees with lesser charges;
   d. County-sentenced prisoners;
   e. Inmates requiring disciplinary detention;
   f. Inmates requiring administrative segregation;
   g. Inmates requiring protective custody; and

h. Federal hold.

3. No inmate shall be segregated because of race, color, creed, or national origin.
4. The classification of inmates in the categories above may be modified based on the direct observation and supervision of individual inmates, and in such instances each classification decision shall be fully documented.
5. Female and male inmates shall have equal access to all programs and activities, according to the schedule of activities.

B. Code on Separation of inmates

The following types of inmates shall be maintained separately insofar as space permits:

1. Male and female inmates;
2. Age;
3. Size;
4. Serious offenders and less serious offenders;
5. Previous incarcerations;
6. Aggressive and passive/dependent inmates;
7. Inmates with special needs such as but not limited to, alcoholism and drug addictions;
8. Physically or mentally ill inmates and healthy inmates;
9. Confinement status, such as pretrial detainee or sentenced inmates and ICE detainees;
7. State remand inmates;
8. Involuntary and voluntary protective custody; and
9. Security needs.

C. Appeal of Classification

A classification status may be appealed by a written request for review to the classification officer. The decision of the classification officer may be appealed to the warden or his designee by presenting in writing the reason a change in classification is desired. A written response shall be given within two working days.

D. Reclassification

Failure to follow rules and regulations may result in changes to your custody classification level. If staff determines that you were engaged in misconduct the facility will initiate an immediate review of your current classification. This could result in your housing assignment being changed.

E. Reduction of Sentence (only applicable to county sentenced inmates)

All county sentenced inmates are required to work if they are not assigned to programs.

1. Inmates may receive up to five days good time credit per month for good behavior.
2. Inmates may receive one day off their sentences for each five days worked.
3. Reduction of sentence through the earning of work credits is cumulative. For example, an inmate may receive six days credit for working thirty days.
4. Violations of rules in the correctional facility or in an alternative to incarceration program may result in the loss of all or part of earned good time or work credits.

11. Property

A. Unauthorized Property

Any item can be considered contraband when possessed by an inmate or visitor within the facility without authorization from the staff. You must obtain permission in advance to possess any item, even if

the type of item is generally allowable in your facility. Staff may limit the quantity of any items, even if the type of item is approved. Any item that is generally permissible for inmates to possess can become unauthorized if it is altered without permission or used in an inappropriate manner. Excess items, altered items or misused items may be discarded in accordance with facility policy and procedure.

B. Authorized Property/Items Permissible for Retention

Property that inmates may maintain during their incarceration is as follows:

1. Prescription eye glasses;
2. Dentures and prosthetic devices approved by medical staff;
3. Hearing aids approved by medical staff
4. Two pairs of approved footwear, or a combination there of;
5. Six pairs of socks;
6. Six sets of underwear;
7. Items purchased from the Commissary, that can be consumed within one week, maximum of 50 items or $95 worth of purchases;
8. Toiletries, purchased from the Commissary, limited to two of each item;
9. Six books or magazines (pornographic Materials are prohibited;
10. One (shall include, but not be limited to) a Bible, Koran, Torah or other approved religious books by the Office of the Warden or Designee;
11. One folder of legal papers;
12. USB flash drive(s), (when approved);
13. Twelve unframed pictures, (no larger than 4" x 6"), which shall not be placed on the wall and NUDE PICTURES AND POLAROID PHOTOGRAPHS ARE NOT PERMITTED; and
14. The following Department of Corrections issued items:
    a. One blanket;
    b. Two sheets;
    c. One pillow;
    d. One pillow case;
    e. One mattress;
    f. Two sets of uniforms; and
    g. One towel

C. Property of Released Inmates

When an inmate is released from ECCF, the inmate shall:

1. Take the personal property when leaving the facility; or
2. Arrange for a family member(s) or friend(s) to pick up the personal property from the facility within thirty (30) calendar days after the inmate's release.

D. Failure to Remove Personal Property

In circumstances where property remains at the facility or the inmate or designee fails to have the property removed within the thirty (30) calendar days of the inmates release, ECCF personnel shall forward written notification to the ex-inmate's last known address stating that:

1. The property will be held for a maximum of thirty (30) additional calendar days;
2. The property will be disposed of if not removed by the specific date; and
3. ECCF is not responsible for property held longer than sixty (60) days.

E. Written Notification

If the written notification sent to the ex-inmate's last known address is not responded to within the thirty (30) calendar days, correctional personnel may dispose of the personal property by:

1. Donating the personal property to any recognized public charitable organization;
2. Retain the personal property for use by the general inmate population, if item(s) has been approved by the facility Administrator or designee; or
3. Destroying the personal property.

The facility Administrator or designee shall approve any property that is to be donated or destroyed.

Perishable items are subject to donation or being destroyed at any time when the property is left at the facility and it creates a health hazard or pest control issue.

Copies of written notices to the ex-inmate about personal property shall become a permanent part of the ex-inmate's record file.

F. Confiscated Medication

All medication brought into the facility shall be confiscated by the Pre-Book Officer in Intake. Confiscated medication shall be stored in Main Medical for the duration of confinement. Unidentifiable Confiscated Medication shall be discarded by medical personnel.

12. Contraband

Items considered to be detrimental to the safe and orderly operation of the facility are prohibited and considered to be "contraband." Contraband items include, but are not limited to:

1. Any item, article or material found in the possession of or under the control of an inmate which is not authorized for retention or receipt that can effect the safe and orderly operation of the facility;
2. Any item, article, or material found within ECCF or on facility grounds which has not been issued by the facility or authorized as permissible for retention or receipt;
3. Any item, article or material found in the possession of, or under the control of visitors within the facility or on facility grounds which is not authorized for receipt, retention or importation;
4. Any item, article or material that is authorized for receipt, retention or importation by inmates but that is found in an excessive amount or that has been altered from its original form. An amount shall be considered excessive if it exceeds stated ECCF limits or exceeds reasonable safety, security, sanitary, or space considerations; and/or
5. Any article that may be harmful or presents a threat to the security and orderly operation of ECCF. Items of contraband shall include, but shall not be limited to:
   a. Guns, firearms, ammunition, explosives or weapons of any type
   b. Knives, tools or other implements which can be construed as an aid to escape that are not provided in accordance with ECCF regulations.
   c. Hazardous or poisonous chemicals and gases
   d. Unauthorized medications or suspected Controlled Dangerous Substance (CDS)
   e. Medicines dispensed or approved by ECCF but not consumed or utilized in the manner prescribed
   f. Intoxicants, including, but not limited to, liquor or alcoholic beverages

g. Currency and stamps
h. Electronic communication devices that can be used to make unauthorized photographs or audio or audio-video recording of inmates, staff or government property; (examples shall include, but not be limited to, cellular telephones, cameras, personal digital assistant, mp3 or audio device, e-mail deceive, text messaging, computers, facsimile, printers, two-way radios and pagers; or the batteries, plugs, cords or wires used to operate them)..
i. Any item which could be used to disguise or alter the appearance of an inmate.
j. Any article of clothing or item for personal use or consumption which has not been cleared first through the Intake process or purchased from commissary.
k. Any information that poses or threatens the security and the orderly running of the institution.

Promoting, introducing and possessing contraband into the ECCF is a violation of the ECDOC disciplinary guidelines, the New Jersey Criminal Code 2C:29-6 Implements for Escape; Other Contraband, and N.J.S.A. 10A:31-8 Security and Control and violators may be subject to penalties pursuant to those guidelines.

You are responsible for ensuring that you are not in possession of any item that can be considered contraband and for knowing the rules regarding contraband items.

13. Search of Persons, Property & Facility

In order to maintain the safety of all persons and the security of the ECCF, the search of inmates and facility shall aim at controlling and deterring the introduction and concealment of contraband.

- All inmates admitted to the ECCF shall be thoroughly searched.
- All searches shall be conducted under sanitary conditions, in a professional and dignified manner, with maximum courtesy and respect for the inmate‘s person.
- No inmate shall be searched as punishment or discipline.
- Routine unannounced searches of the facility, inmates and property will be conducted as necessary.
- All areas to which any inmate has access shall be thoroughly searched on a routine and random continuing basis.
- Strip searches may be conducted as deemed necessary when the facility has reasonable suspicion to believe that an inmate may be concealing a weapon or other contraband.

A Frisk or pat-down search may be done on a routine basis including, but not be limited to, admission to the building, when entering a housing unit, prior to and from court ,transportation, any visit or medical appointment and when being transferred to another housing unit.

You may not refuse to be searched. It is your responsibility to follow the instructions given to you by staff. Failure to follow lawful legal direction may result in disciplinary or criminal action being taken against you. Refusal to be searched may also result in your segregation from the general population.

14. Personal Accounts

1. Inmates are not permitted to have money or jewelry in their possession. During the intake process, such items will be removed, a receipt issued, and a personal account established. The

maximum commissary account balance shall not exceed $1,000, exceptions to the limit amount must be approved by the Warden.

2. Any money received from the outside shall be credited to the personal account. Cash and money orders are accepted at the deposit window in the visitor lobby between the hours of 8:00 A.M. and 4:00 P.M., Monday through Friday (except holidays). Money orders may also be received through the mail. The correctional facility assumes no responsibility for lost money orders. A Kiosk is available for personal account replenishment in the visitors lobby 24/7. . Third party checks are prohibited for deposit. Inmates are advised to insure that depositors have their correct name and jail identification number.
3. Upon release of inmates, the personal accounts are closed and checks issued for the balance due. An administrative fee shall be charged and all accounts with a balance of $4.99 or less shall be closed with zero amounts due.
4. Upon request, third party checks may be drawn from the inmate personal account to pay court-imposed fines, fees and bail. Also once a month, third-party checks may be forwarded to relatives or friends for a $1.00 processing fee.
5. Inmates must claim all property within 30 days of their release from the facility.
6. A $50.00 processing fee shall be charged to all individuals lawfully committed to the ECCF. This fee is intended to partially defray the cost of fingerprinting, photographing and classifying individuals as they are processed into the system. All accounts with less than $50.00 shall have their account placed in the negative for the full or partial amount outstanding. You will be charge a fee each time you are committed to the jail.
7. **Indigent Inmate** - are inmates that have a $5 (or less) account balance with no commissary activity for three weeks or longer. You must indicate that you are indigent on a sign-up sheet. If your account receives funds on a regular monthly basis, such as the 1st of every month, you will not receive indigent items. If your account can minimally cover the cost of one stamped envelope from commissary, you will not receive indigent envelopes.

15. Special Housing Unit (SHU)

ECCF provides the following types of SHU's to inmates who require more intensive supervision:

- Are pending investigation and/or hearings for disciplinary violations;
- Need of medical observation or quarantine;
- Are a security risk; and/or,
- Need protective custody (voluntary and involuntary).

All inmates located in SHU's shall have their cases reviewed to determine the need of continued placement in the Special Housing Unit. You may appeal the SHU order or the review decision, in writing, to the facility administrator.

16. Disciplinary Process

1. Equitable and consistent inmate discipline shall be employed to ensure the maintenance of security and the orderly operation of the ECCF.
2. Rules, upon which inmate discipline is based, must be reasonable and evenly applied, and the action taken to determine an alleged infraction must be based on findings of fact.
3. The sanction(s) for infractions shall not be imposed in any manner that violates the civil rights of an inmate. The sanction(s) must be related to the infraction, and must be fairly applied to all inmates.

4. All persons who supervise the activities of inmates shall receive sufficient training to ensure that these staff members understand the rules of inmate conduct, the sanctions available and the rationale for the rules.
5. N.J.A.C. 10A:4 - Inmate discipline applies to state inmates incarcerated at the ECCF.

A. Disciplinary Rule Book

1. The ECCF has developed this inmate handbook/disciplinary rule book which includes
   a. All chargeable offenses;
   b. The schedule of sanctions;
   c. The disciplinary procedures;
   d. The disciplinary appeal process; and
   e. Notice that the N.J.A.C. 10A:4, Inmate Discipline, also apply to state sentenced inmates incarcerated within the ECCF.

B. Inmate Law Library Violation and Sanctions

Punishment for any inmate law library infraction, such as damage to the law books or disruptive conduct, shall not ordinarily include denial of access to the inmate law library.

C. Minor Violations and Sanctions

Prohibited Acts – Minor

.152 Destroying, altering or damaging government property or the property of another person.
.206 Possession of money or currency ($50.00 or less) unless specifically authorized.
.208 Possession of property belonging to another person.
.209 Loaning of property or anything of value.
.210 Possession of anything not authorized for retention or receipt by an inmate or not issued to him or her through regular correctional facility channels.
.211 Possessing any staff member's clothing and/or equipment.
.212 Possessing unauthorized clothing.
.213 Mutilating or altering clothing and bed linen issued by the county.
.254 Refusing to work or to accept a program or housing pod assignment.
.256 Refusing to obey an order of any staff member.
.257 Violating a condition of any community release program.
.301 Unexcused absence from work or any assignment; being late for work.
.302 Malingering, feigning an illness.
.303 Failing to perform work as instructed by a staff member.
.304 Using abusive or obscene language to a staff member.
.305 Lying, providing a false statement to a staff member.
.351 Counterfeiting, forging or unauthorized reproduction or use of any document not enumerated in prohibited act *.352.
.401 Participating in an unauthorized meeting or gathering.
.402 Being in an unauthorized area.
.451 Failure to follow safety or sanitation regulations.
.452 Using any equipment or machinery which is not specifically authorized.
.453 Using any equipment or machinery contrary to instructions or posted safety standards.
.501 Failing to stand count.
.502 Interfering with the taking of count.
.601 Gambling.
.602 Preparing or conducting a gambling pool.
.603 Possession of gambling paraphernalia.

.651 Being unsanitary or untidy; failing to keep one's quarters in accordance with posted standards.
.652 Tattooing or self-mutilation.
.701 Unauthorized use of mail or telephone.
.702 Unauthorized contacts with the public.
.703 Correspondence or conduct with a visitor in violation of regulations.
.705 Commencing or operating a business or group for profits or commencing or operating a nonprofit enterprise without the approval of the director.
.706 Soliciting funds and/or non-cash contributions from donors within or without the correctional facility except where permitted by the director.
.707 Refusal to keep a scheduled appointment with medical, dental, or other professional staff.
.709 Failure to comply with a written rule or regulation of the correctional facility.
.752 Giving money or anything of value to, or accepting money or anything of value from another inmate.
.753 Purchasing anything on credit.
.754 Giving money or anything of value to, or accepting money or anything of value from a member of another inmate's family or another inmate's friend with an intent to circumvent any correctional facility or institutional rule, regulation or policy or with an intent to further an illegal or improper purpose.
.802 Attempting to commit any of the above acts, aiding another person to commit any of the above acts or making plans to commit any of the above acts shall be considered the same as a commission of the act itself.

D. On-the-Spot Correction

The immediate imposition of a sanction upon an inmate for a minor violation shall be referred to as On-The-Spot Correction. Written guidelines shall specify the minor violations that may be handled informally through their imposition.

The following are authorized sanctions for On-The-Spot Corrections:
1. Verbal reprimand;
2. Loss of recreation privileges for a period of no more than five days;
3. Up to four hours of extra work duty;
4. Up to four hours confinement to tier, room or cell;
5. Loss of radio or television privileges for a period of no more than five days; and/or
6. Confiscation.

Minor violations must be reported in writing and forwarded immediately to the shift supervisor for review. The shift supervisor shall issue the inmate a copy of the report and afford the inmate the right to a conference before the imposition of any sanction.

If the shift supervisor concurs with the written minor violation report, the On-The-Spot Correction sanction shall be imposed within 24 hours of the shift supervisor's review.

The shift supervisor may also dismiss the minor rule violation or upgrade the minor violation to a major violation.

E. Major Violations and Sanctions

<u>Prohibited Acts</u> - <u>Major</u>

*.001 Killing.
*.002 Assaulting any person.

*.003 Assaulting any person with a weapon.
*.004 Fighting with another person.
*.005 Threatening another with bodily harm or with any offenses against his or her property.
*.006 Extortion, blackmail, and protection: demanding or receiving favors, money or anything of value in return for protection against others, to avoid bodily harm, or under threat of informing.
*.007 Hostage taking.
*.008 Abuse/cruelty to animals.
*.009 Misuse of electronic equipment not authorized for use or retention by an inmate such as, but not limited to a cellular telephone(s), two-way radios(s), other communication devices(s) and/or computer(s) and/or related device(s) and peripherals(s).
*.010 Participating in an activity(ies) related to security threat group
*.011 Possession or exhibition of anything related security threat group
*.012 Throwing bodily fluid at any person or otherwise purposely subjecting such person to contact with a bodily fluid.
*.013 Unauthorized physical contact with any person, such as, but not limited to physical contact not initiated by a staff member, volunteer or visitor.
*.014 Unauthorized physical contact with any person with an article, item or material such as anything readily capable of inflicting bodily injury.
*.050 Sexual Assault.
*.051 Engaging in sexual acts with others.
*.052 Making sexual proposals or threats to another.
*.053 Indecent exposure.
*.054 Refusal to register as a sex offender
*.101 Escape.
*.102 Attempting or planning escape.
*.103 Wearing a disguise or mask.
*.150 Tampering with fire, alarms, fire equipment or suppressant equipment.
*.151 Setting a fire.
*.153 Stealing (theft).
*.154 Tampering with or blocking any locking device.
*.155 Adulteration of any food or drink.
*.201 Possession or introduction of an explosive, incendiary device or any ammunition.
*.202 Possession or introduction of a gun, firearm, weapon, sharpened instrument, knife or unauthorized tool.
*.203 Possession or introduction of any narcotic paraphernalia, drugs or intoxicants not prescribed for the individual by the medical or dental staff.
*.204 Use of any prohibited substances such as drugs, intoxicants or related paraphernalia not prescribed for the inmate by the medical or dental staff.
*.205 Misuse of authorized medication.
*.207 Possession of money or currency (in excess of $50.00) unless specifically authorized.
*.214 Possession of unauthorized keys or other security equipment.
*.215 Possession with intent to distribute or sell prohibited substances such as drugs, intoxicants or related paraphernalia.
*.216 Distribution or sale of prohibited substances such as drugs, intoxicants or related paraphernalia;
*.251 Rioting.
*.252 Encouraging others to riot.
*.253 Engaging in, or encouraging, a group demonstration.
*.255 Encouraging others to refuse to work or to participate in work stoppage.
*.258 Refusing to submit to testing for prohibited substances.

*.259 Refusing to submit to comply with an order to submit a specimen for prohibited substance testing (see N.J.A.C. 10A:3-5).
*.260 Refusing to submit to mandatory medical testing.
*.261 Tampering with a test specimen.
*.305 Lying, providing a false statement to a staff member.
*.306 Conduct which disrupts or interferes with the security or orderly running of the correctional facility.
*.352 Counterfeiting, forging or unauthorized reproduction or use of any classification document, court document, psychiatric, psychological or medical report, money or any other official document.
*.360 Unlawfully obtaining or seeking to obtain personal information pertaining to an inmate's victim or the victim's family.
*.551 Making or possessing intoxicants or alcoholic beverages.
*.552 Being intoxicated.
*.553 Possession of any tobacco or lighting material/ devices.
*.701 Unauthorized use of mail or telephone.
*.703 Correspondence or conduct with a visitor in violation of regulations.
*.704 Perpetrating frauds, deceptions, confidence games, riots or escape plots.
*.708 Refusal to submit to a search.
*.751 Giving or offering any official or staff member a bribe or anything of value.
*.803 Attempting to commit any of the above acts, aiding another person to commit any of the above acts, or making plans to commit such acts shall be considered the same as commission of the act itself.

Sanctions for Major Violations

Major violations shall be defined as that conduct which is punishable by sanctions more stringent than those for minor violations. The following are authorized sanctions for major violations:

1. Up to 15 days disciplinary detention;
2. Loss of commutation time subject to confirmation by the administrator of the ECCF;
3. Loss of privileges up to 30 days;
4. Forfeiture/confiscation;
5. Restitution;
6. Any sanction prescribed for On-The-Spot Correction; and/or
7. Suspension of any one or more of the above sanctions at the discretion of the disciplinary board/hearing officer for 60 days.

No inmate may receive more than 15 days in disciplinary detention as a result of a single disciplinary charge.

If an inmate is found guilty of multiple disciplinary charges, he or she may receive up to 15 days disciplinary detention for each charge provided that the total time to be served does not exceed 30 days.

F. Notification of Inmate

1. As notification of the major violation charge(s), a copy of the disciplinary report shall be served upon the inmate within 48 hours of the violation unless there are exceptional circumstances, and at least 24 hours prior to the disciplinary hearing unless such notice is waived by the inmate in writing.

2. The disciplinary report shall be delivered by the reporting staff member or the investigating officer. The report shall be signed by the person delivering it and the time of delivery shall be noted.

G. Use Immunity

1. In all cases, the inmate shall be advised of his or her right to use immunity at any investigative interview and at the disciplinary hearing.
2. The use immunity warning shall consist of a statement which indicates that any statements made in connection with the disciplinary hearing or evidence derived directly or indirectly from those statements shall not be used in any subsequent criminal proceeding.
3. Failure to give the use immunity warning by the investigative officer shall not be grounds for dismissing the disciplinary report.

H. Investigation

1. An investigation of the infraction shall be conducted within 48 hours of the time the disciplinary report is served upon the inmate, unless there are exceptional circumstances for delaying the investigation.
2. The administrator of the ECCF shall appoint an investigating officer/supervisor who was not involved in the incident to conduct the investigation.
3. The inmate shall be advised of his or her right to consult with a counsel substitute prior to the disciplinary hearing.
4. The inmate shall be advised of his or her right to waive the disciplinary hearing and plead guilty to the disciplinary charges.

I. Pre-hearing Detention

1. Until the disciplinary hearing, the inmate shall remain in his or her existing status, unless the inmate constitutes a threat to other inmates, staff members, himself or herself or to the orderly operation of the ECCF.
2. If pre-hearing detention is ordered by the shift supervisor, such order shall be reviewed by the administrator of the ECCF or the designee within 24 hours. Failure to do so shall return the inmate to his or her previous status.

J. Disciplinary Board/Hearing Officer

1. All hearings for major offenses shall take place before a hearing officer or a disciplinary board composed of an impartial three-member panel which shall include one custody supervisor and two non-custody staff members.
2. Any hearing officer or disciplinary board member shall be disqualified in every case in which the hearing officer or board member:
    a. Filed the complaint or witnessed the incident;
    b. Participated as an investigating officer;
    c. Will be charged with subsequent review of the decision; and/or
    d. Has personal interest in the outcome.

K. Disciplinary Hearing

1. The inmate shall be entitled to a hearing within seven days of the alleged violation, including weekends and holidays, unless such hearing is prevented by exceptional circumstances, unavoidable delays or reasonable postponements. Should the seventh day

fall on a Saturday, Sunday or holiday, the hearing shall be held on the weekday immediately following the weekend or holiday.

2. Inmates confined in pre-hearing detention shall receive a hearing within three days of their placement in pre-hearing detention, including weekends and holidays unless there are exceptional circumstances, unavoidable delays or reasonable postponements. Should the third day fall on a Saturday, Sunday or holiday, the hearing shall be held on the weekday immediately following the weekend or holiday.
3 Inmates confined in pre-hearing detention shall be given priority in scheduling their appearance before the disciplinary board or hearing officer.
4. Time spent in pre-hearing detention shall be credited against any subsequent sentence imposed.
5. No delays in hearing a case shall be permitted for the purpose of punishment or discipline.
6. An inmate shall be provided the opportunity to be present during the disciplinary hearing except for the deliberations of the disciplinary board's/hearing officer and for reasons of security. The reasons for excluding an inmate from a disciplinary hearing shall be documented in the record of the inmate.
7. An inmate may be represented by a counsel substitute (staff or inmate) when it is determined by the disciplinary board/hearing officer that the inmate is illiterate, not sufficiently conversant with the English language, or otherwise unable to read, understand or communicate due to a physical/medical inability, or cannot adequately collect and present the evidence in his or her own behalf.
8. An inmate shall be provided an opportunity to call witnesses on his or her behalf, unless doing so would be irrelevant, repetitive or unduly effect the safe, secure or orderly operation of the ECCF. The reasons for denying the opportunity to call witnesses shall be stated in writing and filed in the record of the inmate.
9. An inmate shall be provided the opportunity to make a statement and present documentary evidence.
10. An inmate shall be provided the opportunity to confront and cross-examine his or her accuser and all adverse witnesses unless doing so would be unduly hazardous to facility safety or would endanger the physical safety of a witness. The reasons for denying the opportunity to cross-examine accusers or adverse witnesses shall be stated in writing and filed in the record of the inmate.
11. In-absentia hearings may be held if the inmate refuses to attend the disciplinary hearing. Documentation of this refusal shall be reported in writing.
12. Should further investigation be required, the disciplinary hearing may be postponed by the disciplinary board/hearing officer for up to 48 hours for pre-hearing detention cases and for seven days for all other hearings.

L. Referral to the Prosecutor

All rule violations which may constitute crimes of the first, second, third or fourth degree under the Criminal Code of the State of New Jersey (N.J.S.A. 2C:1-1 et seq.) shall be referred to the Essex County Prosecutor.

M. Decision of the Disciplinary Board/Hearing Officer

At the conclusion of the disciplinary hearing, the disciplinary board/hearing officer shall issue a written decision. This decision shall contain:

1. The finding on the question of guilt;
2. The sanction imposed;

3. A summary of the evidence upon which the finding is based with the exception of confidential information which was withheld for security reasons;
4. A list of all non-confidential witnesses;
5. The reason requested witnesses were not called or cross-examination was not permitted if applicable;
6. The reason for the sanction, which shall include such factors as the offender's past history and circumstances of the offense;
    a. The date and time of the disciplinary hearing; and
    b. The signatures of all board members or the hearing officer.

N. Appeal of Disciplinary Decisions

1. The inmate shall be advised of his or her right to appeal the decision of the disciplinary board/ hearing officer.
2. Appeals of disciplinary decisions shall be submitted to the administrator of the ECCF in writing, within 48 hours of the disciplinary hearing.
3. Appeals of disciplinary decisions shall be reviewed by the administrator of the ECCF who shall affirm, rescind or downgrade the decision. The administrator may reduce but may not increase the sanction imposed by the disciplinary board/hearing officer.
4. Copies of the appeal and the disposition on appeal shall be forwarded to the disciplinary board/hearing officer and Classification Unit for their records.

O. Expungement

1. If the disciplinary board/hearing officer finds the inmate innocent of the charges, all references to the offense shall be removed from the classification file of the inmate.
2. Copies of the disciplinary report, investigation and adjudication sheet shall be maintained by the ECCF, the disciplinary board/hearing officer and the classification unit in the event of judicial review, and for statistical and accounting purposes only. These records shall be maintained separately

P. Disciplinary Detention

Placement in Disciplinary Detention

A decision to place an inmate in disciplinary detention may be made only by the disciplinary board/hearing officer subject to review by the administrator of the ECCF.

Time Spent In Disciplinary Detention

1. Inmates may be placed in disciplinary detention by the disciplinary board/hearing officer for a period not to exceed 15 days as a result of a single disciplinary charge.
2. Inmates found guilty of multiple disciplinary charges may receive up to 15 days disciplinary detention for each charge provided that the total time to be served does not exceed 30 days.
3. The time an inmate spends in disciplinary detention shall be proportionate to the offense committed, taking into consideration:
    a. The severity of the offense;
    b. The prior conduct of the inmate;
    c. The specific program needs of the inmate; and
    d. Other relevant factors.

Disciplinary Problems While in Disciplinary Detention

In the event of further disciplinary infractions by the inmate while in detention, the inmates shall be charged with the appropriate violation and be given a disciplinary hearing.

Q. Correspondence, Visits and Telephone Calls

1. Inmates in disciplinary detention shall have the same correspondence opportunities that are available to inmates in the general population.
2. Inmates/ ICE Detainees in Disciplinary Detention shall not be provided with visit or telephone opportunities while in Disciplinary Detention except for:
    a. Legal visits and legal telephone calls when authorized by the Facility Administrator or designee; and
    b. Special visits or telephone calls when compelling reasons exist and when authorized by the Facility Administrator or designee.
3. Every effort shall be made to notify individuals of the disciplinary detention restriction on visits prior to the next regularly scheduled visiting period. If adequate time for correspondence exists, the burden of this notification shall be placed on the inmates.

R. Criminal Violations

All inmates are subject to all laws of the United States and of the State of New Jersey. Any inmates violating these laws may be charged criminally and tried for that violation in the appropriate local, state, or federal court. You will be formally notified if you are charged with a criminal violation while you are in custody.

The filing or disposition of charges in a judicial court of record for the violation of local, state, or federal law does not, in any way, prevent or affect the administrative handling of the same act as an institutional disciplinary matter, nor of taking disciplinary action against the inmate in question.

17. Daily Routine

Wake Up - Count will be called at 0530 hrs each morning and all cell lights in the housing area will be turned on.

Count Call - may be conducted at various times. When a count call is announced all inmates are to immediately lockdown and stand in their cell, or at their assigned bunks in a dormitory, completely dressed, until dismissed by an Officer. All activities cease during count call such as phones, TV, recreation and etc. Any interference with count call is strictly forbidden.

Inspection - Inmates must be clean and ready for inspection by 07:30 hrs daily, which includes the bed made, desk orderly, shelf and the floor completely cleared and cleaned. Clothes must be on wall hooks or neatly folded on a bunk.

Activities - Housing unit or dormitory activities/privileges will **only** begin if the Unit is in a safe and sanitary condition!

Housing Unit Recreation - Leisure activities may include access to TV, movies or games and game boards. TV's are available for viewing providing this privilege is not removed due to inappropriate behavior.

Outside Recreation - You will have an opportunity participate in a minimum of one hour of physical exercise and recreation each day outside the living unit. Outdoor recreational opportunities can be limited by inclement weather or physical security concerns. Indoor recreation may not be substituted for outdoor recreation.

Use of the recreation yard may be denied at the officer's discretion during or following any emergent situation within the facility.

Inmates violating prohibited acts within the outside recreation area may lead to the suspension of outside recreation for the housing unit.

Typical recreation hours are as follows Sunday – Saturday:

- 07:00 hrs – 12:45 hrs
- 15:00 hrs – 20:45 hrs

Lockdown- you must immediately go inside your cell or to your bunk area. If you are housed in a cell you must secure your door upon entering the cell. You are to lockdown quickly and in an orderly manner at any time you are so ordered. This includes during regular population counts, population switches, medication, commissary, nightly lockdown, any unscheduled/scheduled events, and at the officer's discretion. Refusal or a delay in compliance may result in disciplinary action. **A lockdown order will be called before a designated lockdown time.** You must proceed directly to your assigned cell or bunk. This is so that an accurate count may be taken. All privileges may be ceased at the officer's discretion prior to a lockdown. This includes, but is not limited to, telephones, hot water, barbering services, group prayer, laundry service, recreation, showers, cleaning, law library and TVs.

Lights out - Lights may go out after the count officially clears during 2200 hrs shift and turned on at 0530 hrs. Silence will be observed after lights out.

You are responsible for being alert and standing count at all prescribed times and whenever ordered to do so by an Officer.

18. Official Counts

In order to maintain proper accountability of inmates at this facility, we conduct official counts a minimum of six times each day. Counts are conducted at the beginning and end of each shift. You are required to participate and be counted in accordance with the rules.

- When any officer calls for a count you must report to your respective cell or bed and lock down.
- All activities cease during a count such as phones, TV, recreation and etc.
- Upon reporting to your cell or bed you must remain there until the completion of the count and until released by the housing unit officer.
- When the housing unit officer approach's you must make ready your identification and remove any clothing from your head and/or face.

During all official counts, no movement or talking is permitted. Any disruptions during counts may result in a disciplinary action to the individuals involved.

It is your responsibility to be present and counted during any population count and to follow the instructions of staff conducting the count. Failure to follow procedures established for the count is grounds for disciplinary action against you.

19. Inmate Movement Inter-Facility

When outside the confines of your housing area, whether individually or during a mass movement, you will walk in an orderly, single - file fashion along the wall to your right. There will be no talking whatsoever. When any staff member, or visitor is in the hall inmates shall stop and face the wall to

their right until they pass. You are prohibited from stopping at any area other than your designated destination. You maybe subjected to a search of persons and property. There will be no running, loitering, eating or drinking in any corridor. Normally, you will not be allowed to take anything with you during a movement. You will be allowed to take only necessary legal materials for court, legal visits and educational or designated classroom material. Necessary medication such as nitroglycerin or inhalers maybe kept on person (K.O.P.) as authorized by the medical department.

20. Clothing

All inmates must be fully dressed, in their distinctive county issued uniform or commissary purchased sweat outfit when outside their individual cell or bunk area; this includes a full inmate uniform, socks, underwear, and appropriate footwear. You must wear your full uniform until you enter your cell at the end of the day.

Full Uniform

A full inmate uniform consists of the appropriate area matching shirt and pants; or when permitted a full commissary sweat outfit. Mixing separate uniforms is not permitted.

All issued clothing shall be worn as specified in the following instructions and in no other manner. These requirements are essential to ensure compliance with appropriate security, hygiene and conduct.

- Inmates must be in full uniform at all times before exiting their cell or dormitory, including, travel to and from the shower area.
- Foot wear must be worn entirely covering your foot at all times including to and from the shower.
- Inmates must wear a complete uniform at all times while in medical visits, court appointments, during religious services, visitations, law library and while in the dayroom area.
- Commissary sweats can not be used as a uniform when leaving the confines of a housing unit or dormitory.
- Upon entering the recreation yard you must be in a full uniform. Before concluding exercise and upon exiting the recreation yard inmates must be in full uniform.
- All clothing must be **worn appropriately** and also **sized appropriately** (**pants must be on the waist and not below, underwear can't be showing**, shirts can not be rolled up, clothes can not be excessively oversized, etc).
- Undergarments may be worn without outer garments only while inside the sleeping quarters or the restrooms. **NO EXCEPTIONS!**
- Only authorized headwear shall be approved for use by the general population unless approved as religious items by the facility Chaplain. Workers will be issued the proper head cover when required, which shall be worn only while performing work-related duties.
- Wave caps (do-rag) may be worn only in housing unit cells or within your dormitory.
- No article of clothing may be worn in a manner not normally intended for that item (using a shirt as a head band or head cover, rolling up pants legs, wearing socks over arms, wearing sheets or blankets, etc.).
- No article of clothing may be altered from its original form (ex. cutting pants into shorts, stitching pockets, intentionally discolored, drawn on, torn, cut, etc.).
- Clothing must be clean and in good repair. Torn clothing is not authorized apparel.

Clothing exchanges

All exchanges will be made by request to the housing unit supervisor. All other volunteer workers may exchange outer garments according to facility policy. All issued clothing/linens will be returned upon your release. Failure to return any article will result in that dollar amount permanently deducted from your personal account.

Linen hoarding

In order to ensure an adequate supply of clean clothing and linen for all inmates, the hoarding of clothing and linen is prohibited.

Clothing for Court Appearance

Inmates shall be provided with their personal clothing for court trials only. If inmates do not have appropriate clothing, they shall be permitted to request such from family or friends. Upon delivery, the clothing shall be inspected for contraband. If inmates are not dressed in a reasonable amount of time (15 minutes) when getting ready for court, this fact shall be made known to the judge.

- Court clothes will be accepted twenty-four hours per day, seven days per week at the visit lobby, which shall afford inmates appearing for trial the unlimited opportunity to arrange clothing exchange.
- No inmate may have more than two sets of clothing stored at the ECCF at any given time. Therefore, daily exchanges of trial clothes will be permitted via the ECCF visit lobby.
- Only clip-on ties will be permitted.
- For reasons of security, footwear will be limited to slip-on or Velcro fastening, soft soled shoes. Shoes must be slip-on "loafers" or Velcro® type
  - Flip-flops, sandals and open toed shoes are not acceptable
  - No boots
  - No shoes with laces
  - Any footwear containing metal will not be accepted.
- In the case of **indigent inmates** who are ordered to be dressed for trial the ECDOC will make available grey khaki pants, a white shirt, and a white tennis-type shoe with Velcro fasteners
- Belts and suspenders will not be accepted.
- Jewelry is limited to a wedding band and one religious pendant (no brooches, pins, etc.)
- Clothing containing metal of any kind (sequins, studs, decorative stones, etc.) will not be accepted.

21. Personal Hygiene

You will be living in a secure housing unit or dormitory with other individuals, so personal hygiene is essential for promoting a healthy and harmonious living environment. Inmates are required to keep themselves clean and to wear appropriate clothing and footwear during all activities. Any deviations from maintaining good personal hygiene and from wearing appropriate clothing could cause potential conflicts with your peers and others. Poor personal hygiene or unsanitary habits can also have a negative impact on the health and safety of yourself and others. Failure to comply with the dress code and grooming standards could ultimately become an issue that requires staff intervention, including appropriate disciplinary action.

1. All inmates are afforded the opportunity to take a shower at the time of admittance to the ECCF and are encouraged to bathe regularly. Further, security permitting, inmates may shower at least once daily and must keep themselves and their living quarters clean at all times. All inmates shall always maintain an acceptable odor free appearance, this will entail a full authorized (unaltered) and properly fit/worn uniform, neatly groomed hair, and brushed teeth.

2. Personal hygiene items such as soap, toothpaste, toothbrushes, combs, hairbrushes and other items will be issued to you upon admission. If you run out of any issued item, you must purchase it through commissary or place your name on an indigent list if applicable.
3. Inmates must keep their hair clean. For reasons of individual and public health, the medical staff may order inmates to cut their hair.
4. Fingernails and toenails will be kept clean, neat and short at all times.
5. Female inmates shall be provided sanitary napkins upon request.
6. All inmates must wash their hands frequently and any time something wet is touched. Use soap and water when washing hands and a clean towel or paper towel that can be thrown away.
7. Do not let another inmate borrow your razor, soiled linens, soap or a used towel.
8. Wash towels, linens and clothes often. Hang wet towels and wash cloths out to dry each time they are used.
9. After working out, wipe down benches and equipment with a dry towel.
10. Evidence of vermin or communicable diseases will be brought to the attention of staff immediately.
11. See the nurse for any unusual wounds, boils or pimples that do not heal. If the doctor orders antibiotics, take all the prescribed medication. Keep open wounds covered and change bandages frequently, avoid contact with other person's soiled bandages.

22. Barbering Services

All inmates are permitted to receive haircuts from the approved Barber that is on the housing unit. All barber related activities shall be conducted in the housing unit; this facility does not have centralized barber shop. All barber equipment is secured in a storage locker next to the officer's desk. Haircuts are provided at no charge once a month. You may receive your first hair cut 30 days after your admittance and approximately every 30 days thereafter. The 30 day rule may be waived for medically or security ordered reasons and for inmates ordered to appear in court. Haircuts for inmates **appearing at a trial** will be given within 3 days of their trial date. Extreme styles that include designs, letters, gang related insignia and specialty shapes are not permitted.

Ordinarily, inmates may wear any reasonably safe and hygienic hair and facial hair styles with the following exceptions:

1. For safety and hygiene reasons, kitchen workers shall keep their hair in a neat, clean and commonly accepted style.
2. All kitchen workers shall wear a hairnet and beard net (where necessary) when working in the kitchen.
3. Inmates must keep their hair clean. For reasons of individual and public health, the medical staff may order inmates to cut their hair.

All haircuts shall be done during the approved recreation times.

- 07:00 hrs – 12:00 hrs
- 15:00 hrs – 20:00 hrs

The hours of operation and availability of barber equipment may be revoked by the housing unit officer or supervisor if it conflicts with the security or orderly running of the facility.

23. Sanitary Living Conditions

Clean facilities help to ensure safety and inmate personal health. It is in your best interest to maintain a clean living area and to avoid health and safety problems associated with unsanitary living conditions.

1. When your bed is not in use, it must be made up to facility standards. We require that you keep your bed and immediate area clean, neat and odor free. You are also required to make your bed daily before reporting for your work assignment or when you begin your daily routine. Inmates are not permitted to cover, hang, or attach blankets, sheets, towels, clothing, or any other item to walls, windows, bunks, air vents, doors or light fixtures anywhere within the ECCF. Adequate lighting and unobstructed vision must be maintained at all times throughout the facility.
2. Storage of personal effects, including hygiene items, must be done in accordance with the policies and procedures. Do not place items at any unauthorized location, such as on windowsills, windows, bunks, lockers, under a mattress, etc. Items in violation of storage rules may be confiscated and removed from the unauthorized area. If your items are confiscated for being placed in an unauthorized area, it is your responsibility to identify and reclaim your items from the appropriate supervisor.
3. All inmates will perform housekeeping duties as directed by the housing unit officer. Cleaning supplies will be provided at the officer's discretion.
4. Inmates may use the washers and dryers, where applicable, in the housing laundry room for uniforms, bed sheets, pillowcases, towels and other personal items; see posted housing unit laundry schedule. Blankets shall not be washed in the unit laundry rooms but in the main jail laundry; see posted blanket exchange schedule.
5. You are expected to maintain **High Standards** concerning disposing of refuse.
    - **AT NO TIME** is anything to be flushed down the toilets except normal body waste.
    - Using toilets as trash cans to flush garbage, food, clothing materials and commissary items; will not be tolerated.
    - If a cell toilet is clogged, and it is determined to be due to using the toilet as a trash can, the inmate(s) responsible will face the following penalties:
        - Any inmate who is caught clogging his or her toilet will be charged a fee, to include costs of repair and hourly maintenance wages.
6. Upon release, the cell you are vacating must be properly sanitized for occupancy of new inmates. Mattresses shall be cleaned/ sanitized before reissue.
7. This facility provides regular pest and/or vermin control via a professional exterminator. You are responsible for assisting in these ongoing efforts by limiting the amount of commissary items, personal materials, etc. kept in your living area. Also, you are to report to the staff if any pest and/or vermin are found.

24. Meals

All meals served by our facility are nutritionally balanced, dietician-approved and properly prepared. We only serve our meals in wholesome, clean, safe surroundings. We do not use food as either a disciplinary measure or reward. All inmates will be provided with meals from a standard menu unless a special diet request is approved.

Three meals shall be provided at regular meal times during each 24 hour period. Two of the three meals provided shall be hot meals unless an emergency situation precludes the serving of hot meals. No more than 14 hours shall elapse between the evening and breakfast meals.

When meals are served all inmates shall assemble in an orderly fashion and not cut line as instructed to do so by the housing unit officer(s). Inmates will not try to have more food placed on their trays by inmate workers in the pantry area. Inmate workers have been told how much food is appropriate to dole

out on trays as specified on the food-cart inventory sheet. Inmates shall retrieve their meals and proceed to the designated eating areas. Upon completion of the meal inmates shall clean their areas and return the trays to the approved collection point.

You may request a common fare diet (religious/diet menu) when appropriate. Other special diet requests for religious reasons should be referred to the chaplain for evaluation. If you have a special dietary need due to religious or medical reasons, it is your responsibility to request a special diet that meets your needs. Your request will be evaluated to ensure that you will be provided with an appropriate meal.

Special diet requests for medical reasons are referred to medical personnel for evaluation.

25. Commissary

1. Inmates may purchase authorized food, clothing, and other personal items from an approved list of commissary items. The forms and schedules for ordering and delivery of the commissary purchases are posted on each housing unit.
2. Inmates must have sufficient money in their personal accounts to cover the purchases. If there are insufficient funds, the commissary order form will be filled to the limit of the funds available. Commissary account inquiries should be directed to housing pod officer who may forward them to the commissary clerk.
3. Inmates shall acknowledge receipt of the items on the commissary order form by signing their names and having their photos and jail identification numbers verified.
4. Pursuant to NJSA 30:4-15.1, the ECCF collects a surcharge of 10% of the sale price of every commissary item sold. These funds are forwarded to the New Jersey State Treasurer for deposit into the Victims of Crime Compensation Board account.
5. Funds can be transferred to an inmates commissary account at www.offenderConnect.com (24 hour-a-day access).
6. Commissary is a privilege that can be suspended for disciplinary reasons.
7. Commissary ordering can be done on the Tablet (NOTE: It is here where you can order minutes for paid Tablet services).

26. Outgoing and Incoming Mail

You have the right to correspond with persons or organizations consistent with the safety, security and orderly operation of the facility. All incoming and outgoing letters are subject to inspection, for content and contraband. You are responsible for the contents of your outgoing mail.

If you choose to correspond with others, you must follow the following established procedures:

1. The mail privileges for inmates shall be as protected as those for free citizens. There shall be no restriction on the length, language, or content of letters or on the persons to whom an inmate may write, except where restrictions are necessary to serve the security interests of the ECCF.
2. The following standards shall be applied to outgoing and incoming correspondence:
   Privileged correspondence shall exist between inmates and attorneys, public defenders, inmate advocates, judges, clerks of the federal, state, and local courts; the sheriff, warden, freeholders of the County of Essex; the Governor and Attorney General, and legislators of the state of New Jersey; the President and Vice President of the United States, and members of the parole boards.
3. **Correspondence to or from other inmates**
   All correspondence to or from inmates to other inmates housed in the ECCF or other correctional facilities may be read to ensure that the correspondence does not contain any

content prohibited by N.J.A.C. 10A:18-2.14. Direct In-House Mail (or kites) is not permitted in ECCF. Any inter-facility correspondence must be mailed out of the facility for redirection back into the facility; all mail shall be opened, inspected for contraband and returned unread to the inmate.

4. All outgoing mail shall be sealed and given to the housing pod officers to be placed in the mailbox located in the mailroom during normal hours of operation or to be deposited in the mailbox outside the mailroom at other times. All outgoing mail returned to the correctional facility shall be opened, inspected for contraband and returned unread to the inmates. Inmates should print clearly the following return address on the front of all envelopes containing outgoing mail:

Name of Inmate
Inmate Commitment Number, Housing Unit Cell Number
Essex County Correctional Facility
354 Doremus Avenue
Newark, NJ 07105

Outgoing correspondence shall be sealed by the inmate and shall not be opened, inspected or censored unless there is evidence to suspect it contains contraband or involves a criminal activity.

5. Stamped envelopes are available for purchase through the commissary. Indigent inmates may request up to three complete sets of stationary per week and three stamped post cards. Postage and writing materials will also be provided for the legal mail of indigent inmates through the ombudsman.
6. Incoming correspondence will be delivered to the inmate/ICE Detainee within 24 hours after the correspondence has been received at the facility, excluding weekends and holidays and when precluded by an emergency incident.
7. Inmates may purchase magazines, newspapers, newsletters, and books provided the content is **not** deemed subversive, inflammatory, disruptive or a security threat. The number of items may be restricted providing exclusions are made for a reasonable amount of spiritual, sacred, and educational materials. Inmates are encouraged to donate their discarded books and magazines to the library. A list of authorized publications shall be maintained by the Office of the Warden.
8. The ECCF will only accept packages for inmates that are sent from sources of sale (publishers, distributors) or by mail.
9. Polaroid photographs shall not be accepted through the mail.
10. Inmates shall not collect outgoing mail from other inmates. Only correctional personnel shall handle incoming and outgoing mail.

Incoming mail that does not meet facility standards will be considered contraband and withheld. Correspondence that may be rejected includes, but is not limited to, items with the following content:

- Material that depicts, describes or encourages activities that could lead to physical violence or group disruptions;
- Information regarding the manufacture of explosives or weapons; information regarding escape plots, plans to commit illegal activities or to violate ECCF rules or facility guidelines;
- Information regarding the production of drugs or alcohol;
- Sexually explicit material;
- Threats, extortion, obscenity or profanity;

- Coded messages;
- Hard cover correspondence;
- Anything that affects the safety and security of the facility; or any other contraband.

All incoming mail is normally delivered to you within 24 hours of receipt by facility staff, and your outgoing mail will be routed to the proper postal office no later than the day after receipt by facility staff (excluding weekends and holidays). The sole exception is mail requiring special handling for security purposes. Mail may be delivered to the housing units already opened and inspected.

When you depart the facility, your incoming mail will be marked "Return to Sender" and returned to the post office.

Correspondence to or from other Inmates

All correspondence to or from inmates to other inmates housed in the ECCF or other correctional facilities may be read to ensure that the correspondence does not contain any prohibited content.

Pencils, paper and envelopes may be obtained from the Housing Unit Officer. They may also be purchased from the commissary. Indigent inmates will get at least three stamped envelopes per week for personal mail.

Legal Mail:
Legal correspondence may be held for a reasonable period (not to exceed twenty-four hours) to allow verification of the privileged status of the addressee or sender. Incoming legal correspondence will be opened in the presence of the inmate and inspected for contraband Incoming legal correspondence will be treated as privileged only if the name and official status of the sender appear on the envelope. Outgoing legal correspondence similarly requires that not only the name, but also the official status of the recipient appears on the envelope. It will be your responsibility to advise the senders of legal correspondence of the labeling requirements. **Both incoming and outgoing legal mail shall be labeled "Legal Mail" on the envelope.**

Indigent inmates will be permitted to mail, at government expense, a reasonable amount of correspondence related to a legal matter, including correspondence to a legal representative, potential legal representative, and any court.

You are responsible for knowing the individual rules and regulations regarding correspondence for the ECCF. You are responsible for the contents of ALL of your outgoing mail.

27. Telephone Access

General Telephone Access
You will be provided with access to a telephone during the admission process and within your respective housing area during your commitment. When demand for telephone use is high, the facility may regulate the amount of time you have to make and complete your call. However, it may not be less than 15 minutes per call.

Telephone Calls
1. Upon admittance to the ECCF, provisions shall be made for inmates to make one **free call** to anyone they choose within the state of New Jersey.
2. There are telephones in each housing unit so that inmates may make collect telephone calls.
3. Inmates may make as many calls as necessary to obtain counsel (attorney or lawyer) and to talk with their counsel about the status of the charges, bail, and other legal matters.

4. If inmates are not able to make collect calls to their families or significant others, a written request should be submitted to the social worker or ombudsperson stating the circumstances. Arrangements for a call may be made in emergency situations.
5. All telephone calls are subject to monitoring and recording by correctional personnel.
6. Family members may obtain information on bail and arrest charges by calling the ECCF public information number at 973-274-7500. This information may also be obtained via the internet at www.essexcountynj.org
7. Each inmate may fill out a telephone list, including the inmate's name, signature, commitment number, housing location and date. The telephone list must be filled out legibly and complete in order to be processed. Telephone lists can only be revised every **60** days. These forms shall be provided by your housing unit representative.
8. A telephone pin number will be issued during the Intake process, it is your responsibility to keep this number secure and private.
9. Funds can be transferred to an inmates phone account at www.offenderConnect.com (24 hour-a-day access).
10. At any time that you discover a phone to be inoperable you must immediately report it to the housing unit officer(s) so that a request for repair can be made.

In case of an emergency, such as illness or death in your family, you should request assistance from your housing unit officer to make telephone calls at times that telephones are not normally available. **Routine telephone calls to attorneys are not generally considered to be emergencies.**

Your telephone access may be restricted if you are found to be violating the rules of the facility or are found to be abusing the equipment. Your access may also be severely restricted if you are found using the telephone to further illegal activities.

It is your responsibility to follow the rules of the facility regarding access to telephones and to take proper care of the equipment when you are using it.

Calls made from inmate phone systems are subject to monitoring, with the exception of calls to an attorney and the Internal Affairs Bureau. Facilities may not monitor any call to an attorney.

28. General Visitation

Visitation can be a stressful and frustrating experience not only for the inmate, but for his or her family and friends. To make visiting a pleasant experience, you are required take the time to read and understand the rules and regulations of visitation. Visitation helps everyone involved with the inmate. Visitation can boost the morale of your loved one and make his or her adjustment to incarceration and re-entry more bearable. Visits can also keep your relationship with your loved ones more stable. ECCF staff **WANTS** your visitors to have a pleasant visit. However, all aspects of the visitation program must be abided by in order to ensure the safety of all. It is your responsibility to understand the rules and to ensure that potential visitors understand the rules regarding visitation. Visit list including addition and/or deletion of visitors can be done on the Tablet.

You may notify your visitors that a bus stop is located in the visitors lobby parking lot and they should contact New Jersey Transit for route and schedule information.

Each inmate must fill out a visitation list containing 7 possible adult visitor names, addresses, and relationships, along with his/her name, signature, commitment number, housing location and date. The visitors list must be filled out legibly and complete in order for processing. Children and legal

representatives do not have to be included on the list. Visitation lists can only be revised every 60 days. These forms shall be provided by your housing unit representative.

1. Limitation on the length or frequency of visits shall be imposed only to avoid overcrowded conditions in the visiting area. The visiting schedules are posted on all housing units and available upon request from the housing unit officer or ombudsperson. The schedules are subject to change if necessary for the general safety and order of the ECCF. Appropriate notification of schedule changes shall be made to the inmate population and the general public through custody and social services staff.
2. A total of three visitors are allowed per regular visit. Children under the age of 18 years of age shall not be allowed to visit unless accompanied by a parent or legal guardian. Exceptions are made for emancipated minors possessing proof of emancipation. You are allowed to receive up to three visits from different visitors on the assigned day.
3. All visitors must provide valid credentials limited to: valid driver's license; valid Federal, State, County or Municipal government issued photo identification cards; valid Passports.
4. Inmates are not assigned to units solely for the convenience of visitation privileges. Visitation is a privilege that can be suspended or terminated upon disciplinary infractions. Inmates on disciplinary detention are not permitted visits, except for family emergencies or attorney visits and with the approval of the warden.
5. During visiting hours, inmates shall not leave their assigned areas without specific permission from a correctional officer.
6. Inmates housed outside the ECCF for medical needs shall not have visits unless approved by the warden and may only be seen by the immediate family.
7. Inmates must conduct themselves in an orderly manner during visits.
8. Visitors behaving in an unruly or inappropriate manner shall be escorted immediately from the facility, and if warranted, removed from the approved visitor list.
9. Persons wearing inappropriate attire shall not be permitted to visit.
10. Inmates are not permitted to receive or give items during visits.
11. Inmates must be in full uniform while in a visit.

Searches

The Visitation Lobby Officer (VLO) will not hold property for any visitors. Visitors who enter the facility with hand bags, bags, purses or other packages will be instructed to secure these items off site or in the lockers provided in the lobby. VLO is not responsible for the safe keeping of any property for visitors.

All visitors accessing the ECCF may be subjected to searches including, but not limited to:

a. Metal Detector walk through
b. Wand Scan
c. Search of persons
d. K-9 searches

If a visitor refuses a search or is found with contraband, their visiting privileges will be terminated. Promoting, introducing and possessing contraband in the ECCF is a violation of the New Jersey Criminal Code 2C:29-6 Implements for Escape; Other Contraband, and N.J.S.A. 10A:31-8 Security and Control and violators are subject to penalties pursuant to those guidelines.

Standards of Conduct, Entry Requirements, and Rules for Visitors:

- Visitors and inmates shall conduct themselves in manner that should not bring suspicion or discredit upon themselves nor should they be disruptive or offend the sensibilities of others.
- Visitors and inmates are required to obey all instructions of department personnel as well as all relevant regulations of the ECCF.
- The ECCF is smoke-free. No cigarettes or smoking materials are allowed.
- No food may be brought into the visiting area except baby food.
- Visitors have the responsibility to maintain control over the minor children. If a minor becomes disruptive and is not controlled by verbal instruction from the supervising parent, the visit will be terminated. Physical discipline of minors is not allowed on the premises of the ECCF.
- All visitors, including attorneys and official visitors, must be fully dressed in appropriate, conventional clothing which is not unduly provocative, suggestive or revealing.
- Visitors may not wear clothing that resembles inmate attire, wear adornments that could be used as weapons.
- Visitors may wear a wedding ring, a religious medallion and medical alert badges and bracelets.
- Visitors may not wear clothing that displays obscenities, drug or alcohol designs, controversial messages or profanity.
- Visitors may not wear gang identifiers or displays on clothing.
- Visitors may not be barefoot or wear hats or scarves.
- Visitors may not wear any garment which unduly exposes the shoulders, chest, back, stomach, midriff or underarm such as halter tops, swim wear, muscle shirts or sleep-wear.
- Visitors may not wear clothing made of sheer, transparent, net, mesh or any see-through material.
- Visitors may not wear clothing designed or intended to be tightly worn or excessively accentuate the body.
- Visitors clothing must properly fit.
- Appropriate undergarments must be worn and should not be visible.
- Dresses, skirts, jumpers, culottes and shorts may not be worn if more than four inches above the kneecap when standing.
- Visitors shall not exchange any article or property with an inmate.
- All visitors must arrive at the facility one (1) hour prior to the commencement of the scheduled visitation. All visitors shall refer to the visit schedule that is posted in the facility's public lobby and county website at http://essexcountynj.org/corrections

Denial, Suspension, Termination and Revocation of Visiting Privileges:

If any inmate is found in possession of or using contraband, either during or following a visit, it will be assumed that the contraband was introduced by the inmate's most recent visitor and the contraband shall constitute reasonable suspicion for terminating the visiting privileges of the visitor.

Reasons visiting privileges may be denied, revoked, suspended or terminated may include, but are not limited to:

- The inmate refuses the visit;
- The visitor and or inmate appear to be under the influence of intoxicants or displays unruly behavior;
- The visitor or inmate fails to comply with the clothing requirements;
- The visitor fails to produce valid identification;
- The visitor refuses to be searched;
- The visitor is in possession of contraband;
- The visitor is attempting to introduce contraband;

- The visitor disregards directives issued by department personnel;
- The visitor disregards any relevant rules of the ECCF;
- The visitor creates a disturbance;
- The visitor fails to control minor children;
- The visitor engages in any activity which appears to be aiding an inmate in an escape attempt;
- The inmate or visitor engages in any behavior or action which is deemed by department personnel to place at risk the security and good order of the ECCF;
- Any attempt to exchange unauthorized items;
- The inmate or visitor directs abusive or obscene language to or about department personnel;
- The inmate or visitor damage or attempt to damage government property;
- The visitor attempts to smuggle any item into or out of the ECCF.
- The inmate shall not share their visits with any other inmate;
- The inmate shall not eat or drink in the visiting area;
- The inmate or visitor shall not make any obscene actions or gestures.

Any visitor whose visiting privileges have been denied, revoked, suspended or terminated shall be advised of the reason.

Former inmates are prohibited from visiting anyone committed to ECCF for a period of 60 days beyond their previous incarceration release date.

Visiting Schedule

Non-Contact Visit Schedule:
See attached Appendix A

Contact Visit Schedule:
SPECIAL CRITERIA
See attached Appendix B

As scheduled by Inmate Visits Supervisor

PLEASE ADVISE YOUR FAMILY OF THE SCHEDULE
No visits on Monday, Tuesday and Friday

Attorney/Religious Advisors:
Daily
See Appendix A

Hospital Bedside Visits and Attendance to Funerals:
Bedside visits and attendance at funerals depends upon the legal status of inmates. In cases of serious illness, inmates may be permitted a hospital bedside visit and in cases of death, inmates may be permitted a private viewing of the remains or to attend the funeral. Such visits shall only be approved for members of their immediate families that are defined as father, mother, husband, wife, child, stepchild, sister or brother of the inmate.

The inmate shall at all times be in the actual custody of two or more officer(s) and shall not be permitted to go outside the state of New Jersey (30:4-8.1). The social worker or ombudsperson will assist inmates in obtaining the court orders required for such visits.

29. Attorney Visits

Legal representatives may visit inmates from 07:00 hrs – 19:00 hours seven days a week. You may request to meet with your legal representative during meal hours. If you request this option, you will be provided a meal tray at the conclusion of your meeting.

If you have made an appointment to meet with an attorney or legal representative it is your responsibility to cancel the appointment if you do not intend to keep it. Appointment cancellations may not be accomplished on your behalf.

30. Medical Care

During your period of incarceration, you have the right to timely and adequate medical care if you are sick, injured or otherwise in need of treatment. You have the opportunity to request medical care at any time.

1. An initial health screening and physical examination are given to all inmates upon admission to the facility and before placement in the general population or housing area. The screening includes a tuberculosis test and inquiry into current illness and past health problems.
2. If you are ill or in need of medical attention, or in need of mental health attention, you must fill out a Sick Call on your tablet. A sick call system is in place to access healthcare services. Sick call is available through the tablet system. Sick call is held daily 7 days a week. In the case where the tablet system is not working a paper form will be provided to be filled out and turned into the unit officer or medical staff.
3. Emergency medical treatment is available at all times. Inmates should immediately inform the housing unit officer(s) that medical attention is necessary and they will be referred to a medical practitioner. Inmates having or observing another inmate with a medical emergency should immediately inform the housing unit officer on duty and they will contact the on-call medical staff member.
4. Inmates with special medical problems should bring them to the attention of the nurses or practitioners.
5. Emergency counseling and mental health services and referrals are available on site to all inmates with a history of mental illness and those who are experiencing trauma, anxiety or depression. Inmates should inform the housing officer of the need for such services.
6. Information on preventing and reporting sexual abuse and assault and securing treatment and counseling services is available from the housing officer, nurse, doctor, psychologist, social worker, ombudsperson, and other correctional personnel.
7. Inmates may access dental service through the sick call system. Emergency dental services are available 24 hours, seven days a week.
8. Inmates who are prescribed eyeglasses may purchase them through the medical services provider. Indigent inmates will be provided assistance in obtaining prescribed eyeglasses. For those who have prescription eyeglasses dropped off at the Visitors Lobby for inspection they will be forwarded to the medical department for distribution. Inmates shall sign a consent form stating receipt of prescription glasses.

9. Inmates are not permitted to have or use any medication, unless it is authorized or prescribed by the medical services provider.
10. The ECCF shall provide all medication required and prescribed by the medical services provider. "Keep-on-Person" (KOP) blister packs may be provided for certain medications. Inmates are required to sign for all KOP medications and will be instructed by the nurses in the following blister pack protocol.
    a. The blister pack containing the medication shall be stored in the inmate's cell.
    b. Wrongful possession of medication prescribed for another inmate shall be a chargeable offense. Inmates who abuse the KOP system will be removed from the system immediately.
    c. Inmates transferred to the infirmary or identified as potentially suicidal shall surrender all medication to medical staff.
    d. Inmates released from the facility may be provided with a prescription of a limited supply of medication, based on the determination of the medical services provider.

11. In accordance with N.J.S.A. 2C: 44-6, NJPL 1995 Chapter 254 and Resolution 97-0438 of the County of Essex Board of Chosen Freeholders, inmates shall be held liable for the cost of their health care and will be subject to a co-pay system. The fees for medical care and medication will be deducted from the personal account.

If the inmate is indigent, the medical care and medication will still be provided.

All inmates are subject to the following fees:	
Sick call	$10.00
Doctor visit	$10.00
Dentist visit	$10.00
X-ray/clinical laboratory service	$ 5.00
Prescription fill/refill (each medication)	$ 3.00
Inmate requested non-prescription medication	$ 2.00

- Co-payment fees are waived when appointments or services, including follow-up appointments, are initiated by medical staff.
- The co-payment fee schedule is subject to change without advance notice.

12. Malingering and feigning an illness is a violation and it interferes with the orderly running of the facility. (.302 Malingering, feigning an illness) The medical department will forward all erroneous medical complaints back to the officer.
13. Any inmate in the therapeutic community shall be subject to random drug testing.

31. Mental Health

If you are feeling depressed, think you may harm yourself, or need someone to talk to, you should immediately advise your housing unit officer without delay. You will be referred to the appropriate medical professional. All potentially suicidal or severely depressed individuals are treated with sensitivity and receive the proper referrals for assistance.

Emergency counseling and mental health services and referrals are available on site to all inmates with a history of mental illness and those who are experiencing trauma, anxiety or depression. Inmates should inform the housing officer of the need for such services.

32. Sexual Abuse & Assault Prevention & Intervention Program

The ECCF has a zero-tolerance policy for all forms of sexual abuse or assault.

Prevention and intervention strategies

- All inmates shall be screened upon arrival at the ECCF for potential risk of sexual victimization or sexually abusive behavior, and shall be housed to prevent sexual abuse or assault.
- Inmates identified as having a history of sexually assaultive behavior or at risk for sexual victimization shall be assessed by a mental health or other qualified health care professional, and monitored and counseled as determined by the professional.
- Inmates considered at risk for sexual victimization shall be placed in the least restrictive housing that is available and appropriate.

Definitions and examples of Inmate-on-Inmate sexual abuse, staff-on-Inmate sexual abuse and coercive sexual activity.

- Inmate-on-Inmate Sexual Abuse/Assault

  One or more Inmates, by force, coercion or intimidation, engaging in or attempting to engage in: contact between the penis and the vagina or anus; contact between the mouth and the penis, vagina, or anus; penetration of the anal or genital opening of another person by a hand, finger or an object; touching of the genitalia, anus, groin, breast, inner thighs or buttocks, either directly or through the clothing, with an intent to abuse, humiliate, harass, degrade or arouse or gratify the sexual desire of any person; or the use of threats, intimidation, or other actions or communications by one or more Inmates aimed at coercing or pressuring another Inmate to engage in a sexual act.

- Staff-on-Inmate Sexual Abuse/Assault

  One or more staff member(s), volunteer(s), or contract personnel engaging in or attempting to engage in:

  contact between the penis and the vagina or anus; contact between the mouth and the penis, vagina, or anus; penetration of the anal or genital opening of another person by a hand, finger or any object; touching of the genitalia, anus, groin, breast, inner thighs or buttocks, either directly or through the clothing, except in the context of proper searches and medical examinations; the use of threats, intimidation, harassment, indecent, profane or abusive language, or other actions (including unnecessary visual surveillance) or communications aimed at coercing or pressuring an Inmate to engage in a sexual act; or repeated verbal statements or comments of a sexual nature to an Inmate, including demeaning references to gender, derogatory comments about body or clothing, or profane or obscene language or gestures. Sexual conduct of any type between staff and Inmates amounts to sexual abuse, regardless of whether consent exists.

  Sexual abuse/assault of Inmates by staff or other Inmates is an inappropriate use of power and is prohibited by law.

Methods for reporting sexual abuse or assault, including the investigation processes

Reporting sexual abuse or assault

If you become a victim of a sexual assault, report the incident immediately to any staff person you trust, to include housing unit officers, chaplains, medical staff or supervisors. Staff members keep the reported information confidential and only discuss it with the appropriate officials on a need-to-know basis. If you

are not comfortable reporting the assault to staff, you have other options:

1. Contact the internal SEXUAL ASSAULT Hotline at 973-274-PREA (7732).
2. Contact the ECCF PREA Coordinator, Sergeant Navarro, at 973-274-PREE (7733)
3. File an emergency Inmate grievance. If you decide your complaint is too sensitive to file with the Officer You can get the forms from your housing unit officer, or an ECCF supervisor.

Investigation Processes

- The ECCF investigates all allegations of sexual abuse, including third-party and anonymous reports, and notifies victims and/or other complainants in writing of investigation outcomes and any disciplinary or criminal sanctions, regardless of the source of the allegation. All investigations are conducted by SID carried through to completion, regardless of whether the alleged abuser or victim remains at ECCF.
- ECCF shall ensure that all allegations of sexual abuse or assault involving potentially criminal behavior are referred for investigation by SID.
- At no cost to the Inmate, the facility administrator shall arrange for the victim to undergo a forensic medical examination. All collected forensic evidence must be secured and processed according to the ECCF's established plan for maintaining the chain of custody for criminal evidence. A written summary of all medical evidence and findings shall be completed and maintained in the Inmate's medical record.

Information about self-protection and indicators of sexual abuse

Avoiding Sexual Assault

Sexual assault is never the victim's fault. Knowing the warning signs and red flags can help you stay alert and aware:

1. Carry yourself in a confident manner. Many attackers choose victims who look like they would not fight back or who they think are emotionally weak.
2. Do not accept gifts or favors from others. Most gifts or favors come with special demands or limits that the giver expects you to accept.
3. Do not accept an offer from another Inmate to be your protector.
4. Find a staff member with whom you feel comfortable discussing your fears and concerns. Report concerns.
5. Do not use drugs or alcohol; these can weaken your ability to stay alert and make good judgments.
6. Be clear, direct and firm. Do not be afraid to say "no" or "stop it now."
7. Choose your associates wisely. Look for people who are involved in positive activities like educational programs, work opportunities or counseling groups. Get yourself involved in these activities.
8. If you suspect another Inmate is being sexually abused, report it.
9. Trust your instincts. Be aware of situations that make you feel uncomfortable. If it does not feel right or safe, leave the situation or seek assistance. If you fear for your safety, report you concerns to staff.
10. Reporting an assault shall not negatively impact the Inmates your proceedings.

Indicators of Sexual Abuse

There are many reactions that survivors of rape and sexual assault can experience. For traumatic events in general, it is important to realize that there is not one "standard" pattern of reaction to the extreme stress of traumatic experiences. Some people respond immediately, while others have delayed reactions—sometimes months or even years later. Some have adverse effects for a long period of time, while others recover rather quickly. Reactions can change over time.

Some who have suffered from trauma are energized initially by the event to help them with the challenge of coping, only to later become discouraged or depressed. The impact of sexual abuse varies from person to person and can occur on several levels—physically, emotionally, and mentally.

Survivors may experience some of the following responses:

- Fear responses to reminders of the assault
- Pervading sense of anxiety, wondering whether it is possible to ever feel safe again
- Re-experiencing assault over and over again through flashbacks
- Problems concentrating and staying focused on the task at hand
- Guilty feelings
- Developing a negative self-image, feeling "dirty" inside or out
- Anger
- Depression
- Disruptions in close relationship

- Post Traumatic Stress Disorder - Survivors of sexual assault may experience severe feelings of anxiety, stress or fear, known as Post Traumatic Stress Disorder (PTSD), as a direct result of the assault.
- Substance Abuse - Victims of rape or sexual assault may turn to alcohol or other substances in an attempt to relieve their emotional suffering.
- Self-Harm / Self-Injury - Deliberate self-harm, or self-injury, is when a person inflicts physical harm on himself or herself.
- Stockholm Syndrome - Described as a victim's emotional "bonding" with their abuser, Stockholm Syndrome develops subconsciously and on an involuntary basis.
- Sexually Transmitted Infections - Table of Sexually Transmitted Infections, their symptoms, treatment, and possible complications.
- Dissociative Identity Disorder - Dissociative Identity Disorder (DID), previously referred to as multiple personality disorder (MPD), is a dissociative disorder in which two or more separate and distinct identities (or personalities) control an individual's behavior at different times.
- Borderline Personality Disorder - Borderline Personality Disorder, known as BPD, is one of many possible long-term effects of childhood sexual abuse.
- Adult Survivors of Childhood Sexual Assault - The long term effects on survivors of childhood sexual assault and/or abuse.
- Sleep Disorders - Many survivors of sexual assault suffer from sleep disturbances and disorders.
- Eating Disorders - Victims and survivors with eating disorders often use food and the control of food as an attempt to deal with or compensate for negative feelings and emotions.
- Body Memories - Body memories are when the stress of the memories of the abuse experienced by an individual take the form of physical problems that cannot be explained by the usual means.
- Suicide - If you are currently thinking about suicide, or know someone who is, please reach out for help.

Prohibition Against Retaliation
Reporting an assault shall not negatively impact your proceedings.

Victims of sexual assault or abuse have the right to receive medical and mental health treatment and counseling. Mental health staff shall conduct post-crisis counseling and arrange for psychiatric care if necessary.

For additional information refer to the PREA appendix of this handbook.

33. Bail

Bail Procedures:

1. Inmates who are indigent or financially unable to engage counsel (attorney or lawyer) should make a written request for legal assistance by notifying the social worker or ombudsperson. A 5-A form will then be completed and forwarded to the Criminal Case Management to determine eligibility for legal assistance by a public defender.

2. The bail window of the ECCF is open 24 hours a day, seven days a week. Family members may obtain information on bail conditions by calling 973-274-7500. This information may also be obtained via the internet at www.essexcountynj.org.
3. Bail Source Form – Pursuant to N.J.S.A. 2A:162-13, "a person charged with a crime with bail restrictions must provide, under penalty of perjury, information about the obligor, indemnifier or person posting cash bail, the security offered, and the source of any money or property used to post the cash bail or secure the surety or bail bond, as the case may be. This required information shall include, but not be limited to, the defendant's employment history, the names and addresses of any persons who contributed money or pledged security for the preferred bail or toward a surety bond, the amount, nature and timing of such contributions and the relationship to the defendant of any such persons contributing resources. Bail may not be accepted from a person subject to the requirements of this subsection until the prosecutor is provided the completed form required by this subsection."

If you have not received a copy of these forms at intake or do not now have them, contact your housing officer for assistance.

Types of Bail

Fully secured bond - The defendant will have to post the full amount of bail with the court.
Deposit bail - The defendant or others pay a percentage (generally 10 percent) of the face value of the bond to the court. After trial, the offender will receive most of it back, minus administrative fees.
Cash bail - The offender must pay the full bail amount in cash in order to be released. If the offender makes the court appearance, the money is returned.
Surety bail - The offender is released through services of some private bail bonds person who posts bail and charges a fee. The fee usually ranges between 5-20 percent. The bonds person may also require the offender to post something as collateral.

34. Voluntary Work Program

1. All individuals who are confined to the ECCF are eligible on a voluntary basis for available inmate worker openings. Classification concerns and disciplinary history of inmates will be reviewed and used as one of the determining factors for work eligibility. Each request will be reviewed in the order which it was received.
2. Inmates on work assignments shall not perform tasks not specifically authorized by the supervising officers, including transferring articles from one cell or area to another. When work assignments are completed, all inmates shall report immediately to the supervising officers who may permit them to return to their housing units or assign them additional work.
3. Work is a privilege that may be rescinded for not reporting for work, appearing in an unsanitary condition, or performing unsatisfactorily and for not following orders or being belligerent to an officer. Further, all inmate workers shall be subject to random and probable cause drug testing. A positive drug test shall result in the immediate termination from the job and possible criminal prosecution.
4. Regardless of the size of the tasks to be preformed, all worker requests are to be submitted to the classification captain.
5. In order to participate in this program, you will be required to sign a voluntary work program statement and to complete any work-related training. You will be required to adhere to all dress, grooming and hairstyle restrictions related to your work assignment. If you are accepted into a volunteer work program, you will be expected to work according to an assigned work schedule

and to perform assigned duties at a satisfactory level. Deficiencies such as unexcused absence or unsatisfactory work performance may result in removal from the voluntary work program.

6. You are not entitled to compensation for tasks that involve maintaining your personal area or cleaning up after yourself in general use areas. You are required to perform basic cleaning tasks within your living unit, regardless of where you are held. For example, you could be disciplined if you refuse to make your bed or otherwise refuse to clean up after yourself.
7. Inmate workers shall be assigned specific cells on housing units.
8. Inmate workers do not have any authority over any other inmates.
9. Only medically cleared inmates assigned as kitchen workers are permitted in the unit pantry and they are the only inmates authorized to handle food. The pantry area is only used to serve precooked food and hot water; **all forms of cooking are prohibited.**
10. During lock down time no items will be passed from cell to cell and all workers will lock in on time when ordered to do so.
11. Inmate workers must abide by all of the rules outlined herein.

You are responsible for becoming familiar with the policies and procedures regarding voluntary work at the ECCF where you are confined.

35. Law Library

The law library is located in every housing unit and next to the Sergeant's office for the dormitories. The law library is open seven days per week with a rotating schedule of times. The law library schedule will be posted in all housing units.

You will have access to the Law Library and may receive assistance from a housing unit legal representative knowledgeable about the legal materials as frequently as demand permits, depending on the resources available, space availability and security considerations. The Ombudsman office can provide Notary Services upon request.

The facility uses an intuitive Web-based legal research program from Lexus Nexus. This Web-based research database provides up-to-data access to legal materials in an electronic format. Hence, the system replaces legal books and publications.

Lexus Nexus is free on the Tablet and is up to date to the hour.

Computers are available in the law library for preparation of legal documents **ONLY**. **These computers are not to be used for personal correspondence.** You may request paper and pen from your housing officer for writing personal correspondence.

No inmate shall be allowed to charge a fee or accept anything of value for providing such assistance. The facility will not pay any inmate to provide legal assistance to another inmate.

You are responsible for following the rules regarding access to the law library and use of any equipment. Any deliberate violation or willful failure to follow the rules, disruption of law library operations or destruction of county property may result in disciplinary action being taken against you and a loss of your privilege to use the law library.

At any time you discover that items/equipment in the law library is damaged, out of date, or missing you must immediately report it to your housing unit officer(s).

When approved, USB Flash Drives may be issued, for retention, to inmates for the storage of legal matters only.

36. Television and Library Materials

1. TVs are available for viewing providing this privilege is not removed due to inappropriate behavior. The warden, or his designee, may restrict TV viewing during special programs held in the day room and may approve the viewing of special events during the "lock-down" period.
   a. The officer has total control of the TV.
   b. The TV will be turned on only when the unit officer is satisfied that everything is safe, secure and in sanitary condition.
   c. Channel decision shall be made by the majority of inmates or what may be deemed as appropriate by the officer. Any challenges or disruptions will result in the termination of TV privileges.
   d. TVs shall not interfere with the normal operations of the unit.
   e. TV volume level shall be kept at a non-disruptive level that does not extend beyond the viewing area as determined by the officer.
2. Reading materials are available from the ECCF library. The ombudsman office has a book lending sign-up program.
3. ECCF may provide additional periodicals to the housing units which shall be maintained as determined by the housing unit officer.

37. Religious Services

1. Inmates may identify their religious affiliation during the intake process. The view of agnostics and atheists shall be respected.
2. Pre-registration for attendance at religious services may be enforced if it is determined necessary for the safe and secure operation of the facility.
3. Pastoral care service providers from all major faith traditions are available for religious and spiritual consultation or counseling. Inmates may submit requests for such services to a housing pod officer, ombudsperson, or social worker. Inmates may add their religious or spiritual leader to their lists of visitors.
4. A schedule of religious services is posted in the housing pods and available from a social worker or ombudsperson. Attendance at religious services is voluntary.
5. Inmates are permitted to purchase for delivery by mail spiritual and religious materials. Approved materials may also be distributed by the pastoral care service providers.
6. The granting or denial of privileges, or discrimination or punishment on basis of religious or spiritual beliefs is expressly forbidden.
7. All religious and spiritual groups shall have equal access to facilities and privileges based on security concerns and number of participants.
8. Religious and spiritual services are provided on a rotating schedule. Services shall only be provided for those inmates who are out for recreation activity in his/her respective housing area.

38. Grievance Procedures

The inmates under the custody of the ECCF are offered the following mechanism whereby they may seek resolution from the facility administration and staff for perceived concerns, problems, complaints, and grievances.

A. Grievance Rights

1. The right to grieve any administrative procedure;
2. The right to receive written response, including the reason for the decision within five calendar days excluding weekends and holidays and during emergency situations;
3. The right to seek judicial or administrative redress without fear of reprisals as a consequence.
4. The right to submit grievances without fear of reprisals or punitive segregation;
5. The right to receive immediate response to emergency situations; and
6. The right to appeal decisions to the warden or the designee.

Inmates should exhaust all administrative grievances and appeal procedures before applying to outside agencies.

B. Areas Covered by Grievance Process

The following areas and procedures shall not apply to questions of the guilt or innocence of an inmate for crimes charged. Questions concerning jurisdiction or legal questions regarding justification for sentences imposed shall be directed to the court of jurisdiction. Grievance procedures shall apply to questions concerning:

a. Medical care;
b. Conditions of confinement;
c. General classification procedures;
d. General discipline procedures;
e. Inmate program participation;
f. Telephone, mail and visiting procedures;
g. Food, clothing and bedding issues; and
h. Religious preference.

Disciplinary decisions may not be grieved.

C. Grievance Process

"Inmate Request, Interview, Administrative Remedy and Grievance Process" provides the mechanism whereby inmates may seek resolution from the facility administration and staff for concerns, problems, complaints, and grievances which they may be experiencing. The grievance process is initiated through the submission of a grievance to the proper department through the tablet.

The coordinator supervises the "Inmate Grievance System," a computerized tracking database program that insures concerns are timely and appropriately addressed. This system encourages internal and informal problem solving and establishes specific lines of direct communication, including the availability of interviews, between inmates and staff.

If the inmate cannot achieve an informal solution, the "Inmate Grievance System" provides a means for acquiring written documentation of an incident and includes an appeal process.

Inmates are expected to use the administrative remedy process before applying to courts for relief. The ECCF utilizes the "Inmate Grievance System" as a means for continuous review of its administrative actions, policies and procedures and as an indicator of inmate and staff moral.

1. Definitions of Terms

Grievance: A circumstance or action considered as unjust and grounds for complaint or resentment.

Grievance Folder: A folder for each inmate that contains answered grievance forms and appeals.

Grievance Coordinator: A staff member(s) appointed by the director or warden to process the "Inmate Grievance Forms."

Complaint: A written expression of dissatisfaction or distress.

Reprisal: Any overt or covert action or threat of action against an inmate for the good faith, use of, or participation in, the grievance process or procedure.

Response: A corrective action that eliminates or makes up for conditions perceived to be unjust or the grounds for complaint or resentment.

SBI Number: A fingerprint identification number issued by the New Jersey State Police.

Staff: Any person employed by ECCF or contracted to provide services to the inmate population shall be considered staff. This category includes but is not limited to nurses, doctors, officers, sergeants, lieutenants, captains and those in civilian titles.

2. Purpose of the Grievance Process

If an inmate cannot achieve an informal resolution of a problem he/she is experiencing by an informal interview with his/her custody supervisor or appropriate civilian employee, he/she may file a grievance through the tablet. A grievance submitted through the tablet should be used to address questions, problems, complaints and medical issues that the inmate has not been able to address through other means.

It should be noted that a sick call submitted through the tablet should be used for routine access to the medical care system; a grievance should only be submitted if there is a disagreement with the type or timeliness of a medical treatment. Further, an inmate may not grieve a disciplinary decision.

3. Procedures

SUBMIT GRIEVANCES THROUGH TABLET

Tablets are available on all housing units.

Filing Grievances on Tablets

Only properly completed and submitted grievances will be processed.

The inmate should provide her/his name, SBI number, building location, housing pod and date.

"Part 1" must also include a summary of the requested information, problem or complaint. The inmate may also submit information to support his/her position.

The grievance **may not** be used to address complaints relative to disciplinary charges (court-line sanctions), to re-address a previously established complaint, to address matters currently in litigation, or to circumvent established departmental policies and procedures.

One Request per Grievance
Inmates must submit one grievance per question, complaint or problem. Grievances that list multiple questions/concerns, or do not contain enough information, will be considered incomplete, will not be processed, and shall be returned.

Types of Grievances
The inmate may suggest one of the following types of grievances: routine, interview or remedy.

Submitting Grievance
For the grievance to be processed it **must** be directed to the proper area. The grievances will be checked daily except on weekends, holidays, and during emergency situations. For inmates in detention or those confined to their cells for other reasons, will follow same procedure as all other inmates.

The inmate **shall** direct his/her request to a specific person or area.

An inmate **may not** submit multiple requests regarding the same subject and must adhere to the specified staff response timeframe of ten days excluding weekends, holidays, and during emergency situations.

Under no circumstances shall an inmate complete a grievance for another inmate. If assistance is required, the inmate must contact an ombudsperson or social worker.

Investigating of the Grievance
Upon receipt of a completed grievance, the area supervisor shall handle the investigation. After the determination of an appropriate course of action or response, the area supervisor will instruct their staff how to handle the grievance.

The response will be made as quickly as possible and within the allotted timeframe of ten days, excluding weekend, holidays and during emergency situations. Further, the response shall be based upon facts and issues specifically related to the grievance.

The supervisor will than send the response back to the inmate through the tablet.

Special Extensions of Response Time
Responses to a grievance requiring extensive research and documentation may require a longer period than ten days excluding weekend, holidays and during emergency situations. Consequently, the review may be extended for a specified period if findings

indicate that the initial period is insufficient to make an appropriate response. This extension shall be communicated through the tablet to the inmate.

Follow-up Questions to Response Received

If an inmate has a follow-up question from an answer received or he/she feels that her/his grievance has not been satisfactorily answered, a new grievance may be submitted. The inmate must supply the case number of her/his original request. The new grievance must be attached to the original thread.

If the request was not answered or returned in the established response time frame of ten days excluding weekends, holidays, and during emergency situations, and the inmate has not been advised that a special extension of time is necessary, the inmate may submit another grievance citing the date of the original request and the request number.

Tablet

You may file grievances on the Tablet.

4. Appeal Process

The inmate may appeal a response through the tablet.

Appeal Must be Filed Within Ten Days of Receipt of Response

After the grievance has been processed and returned, if an inmate is dissatisfied with the response, he/she may file an appeal through the tablet. The appeal must occur within ten days of receipt of the response.

The inmate must re-submit her/his original answered grievance to the area supervisor.

The appeal decision shall be rendered by the warden and is considered final. The warden has ten days to answer the appeal, excluding weekends, holidays and during emergency situations. Once the appeal response is decided, the decision will be sent back to the inmate through the tablet.

5. Emergency Situations

Shall follow all of the above procedures (same as non- emergency grievances) however they should be given directly to the Housing Unit Officer so that it can be submitted immediately.

D. Protection of Inmates against Reprisals

Any member of the staff or administration involved in a reprisal against an inmate who makes good faith use of or participates in the "Grievance Process" shall be prosecuted to the fullest extent of the law.

E. Abuse of the Inmate Grievance System

Inmates who abuse or misuse the "Inmate Grievance System may be subject to disciplinary action. Examples of abuse include, but are not limited to, the following actions.

1. Multiple requests submitted regarding the same subject.
2. Follow-up requests submitted prior to the expiration of the established response timeframes.
3. Requests that are, by tone or language, abusive or offensive in nature.

39. Social Services

The social workers and ombudspersons are respond to all personal requests, such as access to religious counseling, probation and parolee consideration, employment training, educational resources, community housing, alternative to incarceration programs, family assistance, hospital visits to critically ill family members, and court orders for private viewings and funerals. Attention is also given to ensuring that inmates have access to the law library, recreation and resources, and spiritual and religious services and materials.

Inmates desiring such services should complete and sign a social services request form available from the housing officers, social workers and ombudspersons. All pertinent information should be completed and incomplete forms will be returned.

A. Rehabilitative Services

The function of the Rehabilitative Services is to provide counseling, support, and recreational services. The following programs are available.

1. Religious Services
2. Law library and library books
3. Daily Recreation

Appointments to discuss concerns and problems may be arranged by completing the social services request form.

B. Alternatives to Incarceration

1. Second Chance is a community-based program designed to earn work credits, life skills and reintegration.
   a. Any inmate that is an active participant in the Second Chance Program may not visit any inmate housed at ECCF. Any inmate found violating this policy will be immediately placed into custody and will finish their remainder of their time at ECCF.
2. Delaney Hall is a community-based program designed to address the issues of substance abuse, criminal behavior, life skills, education, employment and reintegration.

C. Educational Services

The Essex County Jail will make available educational opportunities to the inmate population. You will have access to educational training, when it is available within the Jail. Academic education programs and services to the inmate population will include, but are not limited to:

1. Basic Skills Remediation
2. GED/English as a Second Language (ESL) – preparation and testing, GED certificates are given after testing.

Inmates must apply through the social services department. Before you are accepted into any program you will complete a placement test to determine your educational skills level. Acceptance in several of the programs is contingent on your testing at the appropriate skills level.

I. Parent/Child Visits:

P.A.T.C.H is for both male and female inmates. It is a contact visit between the parent and child. The criterion for this program is that the child must be between the ages of 4-16. Many visits are court ordered through DYFS family court.

II. Life Skills:
Life Skills is for both male and female inmates. The only criterion for this program is that the inmate can not have any write up/disciplinary actions while in the program.

III. Support/Discussion Groups:
Women Empowering Women Discussion Group: The only criterion for this program is that the inmate can not have any write up/disciplinary actions while in the program.

- Men Sharpen Men Discussion Group: The only criterion for this program is that the inmate can not have any write up/disciplinary actions while in the program.
- Book Club (for the females): The only criterion for this program is that the inmate can read and communicate in English.
- NA/AA: The only criterion for this program is that the inmate must have a drug history.

IV. Reentry Post Release Services:
Pre/post Strategies to Address Recidivism ~Inmates can apply once they have 180 days or less left on their sentence.

V. Welfare/Child Support:
Welfare supplies the county with a list of inmates who child has/had received welfare/child support at one point in time.

VII. Office of the Public Defenders:
The supervisor from the Public Defender office comes and speaks to the reps once a month. The only criterion for this program is that the inmate must be a rep.

D. Referral Services

Whenever possible, an ombudsperson or social worker shall try to put the inmate in contact with community agencies that can provide services during incarceration and after release from the facility. Following are a partial list of the participating agencies.

Apostle's House (Females), 513 Avon Ave, Newark, NJ 07106

Center for Great Expectations (Females), 1 Eastern Ave, Somerville, NJ 08876

Center for Urban Education (Females), 2 Odgen St., Newark, NJ 07104

Children's Home Society, 535 S. Clinton Ave, Trenton NJ 08611

C.U.R.A. Inc., 35 Lincoln Park, P.O. Box 180, Newark, NJ 07101

C.U.R.A., Inc. (Spanish), 51 – 75 Lincoln Park, Newark, NJ 07102

Discovery House, P.O. Box 177, Marlboro, NJ 07746

Division of Vocational Rehabilitation Services, 135 E. State St., Trenton, NJ 08625

E. Orange General Hospital In/Out Patients, 300 Central Ave, E.O., NJ 07018

Eva's Village, 393 Main Street, Paterson, NJ 07501

Goodwill Mission, 79 University Ave, Newark, NJ 07102

High Focus Centers, 16 Commerce Dr, Cranford, NJ 07016

Integrity House Inc.,103 Lincoln Park, Newark, NJ 07102

Isaiah House (Females), 238 N. Munn Ave, E. Orange, NJ 07017

Kintock I/II (Males and Females), 50 Fenwick Street, Bldg 6, Newark, NJ 07114

Mount Carmel Guild, 1160 Raymond Blvd, Newark, NJ 07102

Offender Aid and Restoration of Essex County, Inc, 755 S. Orange Ave, Newark, NJ 07106

Office of the Public Defender, 1180 Raymond Blvd, Newark, NJ 07102

One-Stop Center, 990 Broad St., Newark, NJ 07102

One Stop Center, 50 S. Clinton St., East Orange, NJ 07018

Project 1st (Females), 800 Clinton Ave, Newark, NJ 07108

Real House Inc., 95 Grove St, Montclair, NJ 07042

Salvation Army, 65 Pennington St., Newark, NJ 07105

Straight and Narrow, 396 Straight St., Paterson, NJ 07501

SWITCH (Females), 199 E. 23rd St., Paterson, NJ 07501

Summit Oaks Hospital, 19 Prospect Street, Summit, NJ 07901

Sunrise House Foundation, P.O. Box 600, Lafayette, NJ 07848

The Bridge, 54 Mt. Vernon Ave, Irvington, NJ 07111

Tremont House, 344 Summer Ave, Newark, NJ 07104

Tri-City 2nd Chance Home (Females) 55 Washington St., E. Orange, NJ 07017

Turning Point, P.O. Box 111, Verona, NJ 07044

United Community Alcoholism Network, 31 Fulton St, Newark, NJ 07102

Veteran Services, 20 Washington Pl, 4th Fl, Newark, NJ 07102-3127

40. Tablet

1. General Procedures for Tablets:
   a. Tablets will be signed out through your Officer on your housing unit;
   b. Tablets will be off during counts and when Inmates are locked in cells;
   c. Tablets may not be taken into your cells;
   d. Signing on to the tablet is easy. Type in your J# that is on your band, then you create your own password. You must then place your face inside the box and the tablet will take your picture. It will not work unless your face is in the box.
2. Free Services on Tablet:
   a. Lexus Nexus is free on the tablet and is up to date to the hour;
   b. You may file grievances on the tablet. Make sure it is truly a grievance and not a request or general complaint giving details of the policy or right you feel has been violated;

c. The Inmate handbook is on the tablet;
d. Visit list including addition and/or deletion of visitors;
e. Sick call requests;
f. Commissary ordering (NOTE: It is here where you order minutes for paid tablet services);
g. You can contact the Inmate Services Supervisor, Internal Affairs, Social Services and the PREA coordinator;
h. Or, all other requests previously made on paper.

3. Paid Services on Tablet:
The tablets also offer entertainment options that are available at a rate of five (5) cents per minute to include, but not be limited to books, messaging, movies and music. All phone calls made on the tablets are subject to monitoring by Correctional Personnel.

DO NOT GO TO YOUR OFFICER WITH TABLET PROBLEMS OTHER THAN TO ASK HIM TO CONTACT THE INMATE PHONE TECHNICIAN TO HELP WITH BROKEN TABLETS. ANY PROBLEM CAN USUALLY BE FIXED IN LESS THAN AN HOUR BY CONTACTING "TABLET ISSUES" ON THE TABLET.

REFUSAL OF REASONABLE ACCOMMODATIONS OFFERED TO DEAF AND HARD OF HEARING INMATES

I acknowledge that I have been informed and REFUSE to accept the facility's attempt to provide reasonable accommodations for one or more of my major life activities, and hereby release the Essex County Department of Corrections from all responsibility for any ill effects from such refusal.

Inmate's Name: _____ Commitment # _____
Printed

Inmates Signature: _____ Refusal to Sign: _____

Date: _____ Date: _____

Witness: _____ Witness: _____

REQUEST BY DEAF AND HARD OF HEARING INMATES

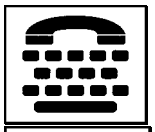
Our Corrections Facility is committed to providing quality care to all inmates. In order to assure that the services which are provided to you are not compromised by ineffective communication, the facility has resources for obtaining sign language interpreters when necessary at no cost to you. Telecommunications devices for the deaf (TTD), amplified telephones and televisions with closed captioning are also available.

1. Will a sign language interpreter help us effectively communicate with you?

YES NO

If you check "YES," we will get a sign language interpreter for you unless you fill out the waiver form on the back of this paper.

2. Do you want any of these services which are also available?

A Telecommunication Device for the Deaf TDD/TTY with Light Signaler	YES	NO	
An Amplified Telephone Receiver	YES	NO	
An Assistive Listening Device (ALD)	YES	NO	
Television Captioning	YES	NO	

Other (please explain):

_____

_____

_____

3. Inmate declined present accommodations offered. See page two of this form for release.

Witness Name: _____ _____

Printed Inmate's Signature / Commitment # / Date

_____

Signature / Date

A copy of the Corrections Facility's written policy for Effective Communications Administrative Policy and Procedure is available without any charge upon request. Please check here if you want a copy of this policy _____.

SEXUAL ASSAULT AWARENESS

The ECCF has a zero tolerance policy for all forms of sexual abuse or assault

SEXUAL ASSAULT

What is Sexual Assault?
Sexual Assault is a broad term that includes any sexual behavior against another person that is forced, coerced, or manipulated, such as rape, child molestation and incest.

- According to Sexual Assault Resource Center only 23% of sexual assaults are ever reported.
- Sexual Assault can affect persons of any gender, age, race, ethnic group, socioeconomic status, sexual orientation, or disability.

Prison Rape Elimination Act (PREA)

The Prison Rape Elimination Act (PREA) of 2003 is a Federal law established to addresses the elimination and prevention of sexual assault and rape in correctional systems. PREA applies to all federal, state and local prisons, jails, police lock-ups, private facilities and community settings such as residential facilities.

Section 10 of the Prison Rape Elimination Act defines the term "rape" as:
- The carnal knowledge, oral sodomy, sexual assault with an object, or sexual fondling of a person , forcibly or against that person's will; not forcibly or against the person's will, where the victim is incapable of giving consent because of his her youth or his or her temporary or permanent mental or physical incapacity; or
- The carnal knowledge, oral sodomy, sexual assault with an object, or sexual fondling of a person achieved through the exploitation of fear or threat of physical violence or bodily injury.
- Predators use sex as a weapon to assault the body, mind, psyche and spirit of their victims.
- Whether it manifest itself as a coerced sex in exchange for protection, repeated gang rapes or a traumatic one night experience in county lock up

According to the National Crime Victimization
Survey (SCVS), seven out of every eight rapes victims were females and one in every eight rape victims was male.
- Rape & Sexual Assault abuse happens to females and males of all ages, from infancy to old age.
- The fact that male victim of a sexual assault ejaculated or became sexually aroused does not mean that he was not raped or that he gave consent. These are normal involuntary physiological reactions.
- A survivor is not at fault for the rape/sexual assault, even if he/she was in a secluded area, or had previous consensual sex with the attacker.
- Reports indicate the rape of an estimated 150,000 males per year.

Common Feelings of Survivors

- Embarrassment
- Anger
- Guilt
- Panic, Depression
- Fear
- Other common reactions include loss of appetite, nausea or stomach aches, headaches, loss of memory and/or trouble concentrating and changes in sleep patterns.

RISK REDUCTION

- Position yourself in "Safe Zone" areas where you can see a staff member and the staff member can see you.
- Be aware of situations that make you feel uncomfortable. Trust your instincts. If it feels wrong, leave, get help, or call for a staff member.
- Do Not accept commissary items, offers of protection, or other gifts from other offenders. Placing yourself in debt to another offender can lead to the expectation of repaying the debt in sexual favors.

What To Do If You Are Sexually Assaulted

IF THE ATTACK HAS JUST HAPPENED…….

- Get to SAFE place
- REPORT THE ATTACK TO A STAFF MEMBER (The longer you wait, the more difficult it is to obtain evidence, necessary for a criminal and/or administrative investigation.)
- Request immediate Medical Attention
- **DO NOT** shower, smoke, drink, brush your teeth, use the restroom, or change your clothes.

SUPPORT SERVICES

- Mental Health Staff
- Social Services
- Chaplain
- Counselor
- Medical Staff

The days ahead can be traumatic and it helps to have people who care about you to support you. Seek professional help. Mental Health Staff is available for crisis care 365 days a year, to listen and offer support.

FACTS FOR THE OFFENDER:

- All cases of sexual assault are investigated by your local law enforcement/ Special Investigations Division (SID) as a criminal investigation. You may be prosecuted for a criminal offense and if found guilty, any additional prison time will be added to your current sentence.

- You will be issued a notice of charges. If you are found guilty, sanctions will be harsh. In addition, your classification level will be reviewed and likely increased, which could mean a transfer to a higher security prison or unit with significantly less freedom of movement and limited privileges. If you have family this may affect them and their ability to visit you.

- Engaging in such conduct in these institutions significantly increases your risk of HIV infection, along with exposing you to other sexually transmitted diseases.

- If you have trouble controlling your actions seek help from mental health staff and/or consider participating in programs designed to control anger or reduce stress. To reduce immediate feelings of anger or aggression try talking to or writing to a friend, meditate or do breathing exercises to relax, work on a hobby or engage in some types of exercise.

ECCF SEXUAL ASSAULT HOTLINE
Report All Cases 24/7
973-274-7732 (PREA)

ECCF Office of the Director PREA Coordinator
Sergeant Navarro
973-274-7733 (PREE)
In order to contact the above number:
1. Enter your Telephone Identification (TID)
2. Select the Special Services Option
3. Then choose Option 2

NJ Coalition Against Sexual Assault
1-609-631-4450
1-800 601-7110
2333 Whitehorse Mercerville Road
Suite B
Trenton, NJ 08618

New Jersey's Crime Victim's Law Center
1-973-729-9342
6 Spring Street, Suite 4D
Newton, NJ 07860

RAINN (National Sexual Assault Hotline)
1-800-656-4673 (HOPE)
1220 L Street NW, Suite 505
Washington, DC 20005

Hotline for Rape Victims
1-866-363-7273
1-866-ENDRAPE

Suicide/Crisis/Caring Hotline
1-800-273-8255 (TALK)

APPENDIX A

VISITATION SCHEDULE

NON-CONTACT VISITS

Wednesdays and Sundays

Building #2 and #5 11:15 am - 1:30 pm

(No visitors will be permitted access after 1:00pm)

2:30 pm – 5:45 pm

(No visitors will be permitted access after 5:00pm)

WEDNESDAYS ONLY

Infirmary 10:15 am – 11:45 am (MALES ONLY)

(No visitors will be permitted access after 11:30 am)

12:00 pm – 1:30 pm (FEMALES ONLY)

(No visitors will be permitted access after 1:00 pm)

THURSDAYS AND SATURDAYS

Building #3 and #4 11:15 am - 1:30 pm

(No visitors will be permitted access after 1:00pm)

2:30 pm – 5:45 pm

(No visitors will be permitted access after 5:00pm)

ATTORNEY VISITS

Daily

7:00 am – 9:45 am

10:30 am -12:45 pm

3:00 pm – 7:00 pm

(No attorneys will be permitted access after 6:30 pm)

All visits are subject to change at the discretion of the Director

APPENDIX C

Essex County Correctional Facility

Phone List Management

Phone List Deployment

Effective May 7, 2018, how you manage your phone list will change. Please read and understand the following information before this change:

- You may have up to **Fifteen (15)** telephone numbers on your phone list.
- Your phone list will be automatically created by the telephone system.
- **The first fifteen (15)** unique numbers you attempt to call (which are not blocked and able to receive calls from the inmate platform) will be automatically added to your phone list.
- You will have the ability to change your Phone list during a change period, occurring every 30 days. The phone list will be cleared on the **First Monday of each month.** You won't need to do anything. The above will apply.
- It is your responsibility to identify all attorneys you may be calling. All new Attorney numbers should be submitted through the attorney contact form you get from the ombudsman counselor. Return the form back to the housing unit officer who will get the approval.

Phone List Rules

1. Change requests.

   When the limit of **15** numbers has been reached, a request to change an existing number will be denied and you will be advised of the next change period.

2. Emergency change requests.

   When the limit of **15** numbers has been reached, any EMERGENCY telephone list change requests need to be submitted to facility administration for approval.

3. Numbers added fraudulently.

   All requests to change a number, due to the number being added against your will, will be referred to Facility Staff.

4. Anyone that accesses an account that is not their own shall have their phone privileges suspended.

All requests or grievances need to be submitted through the inmate grievance form

APPENDIX D
Essex County Correctional Facility
Private Code Registration and Dialing Instructions.

You will be required to register a 4-digit private code to place phone calls on the GTL system. The purpose of this is to add protection to your inmate account so that it cannot be compromised.

Register Your Private Code:

1. From the inmate telephone, remove the handset and Press 1 for English or press 2 for Spanish.
2. This call will be monitored and recorded.
3. Press 1 for English. Marque el número dos para Espanol.
   <default/no selection is English>
4. To make a collect call, dial 0 plus the area code and number.
   To make a debit call, dial 1 plus the area code and number.
   To make an International debit call, dial 011 plus country code and number.
   To hear your debit balance, dial 118.
   <inmate enters destination number>
5. Please enter your pin number at the tone...
   <inmate enters pin number>
6. At the tone, please state your name...
   <inmate records name- first time only>

   You will be asked to establish a 4 digit private code.
7. On future calls, you will need to enter a 4 digit private code. Please select your 4 digit private code at the tone...
   <inmate enters 4 digit private code>
8. You entered...
   <system plays inmate private code number>
9. Press 1 to confirm your private code, otherwise press 2.
   <inmate enters choice>
10. Your 4 digit private code is registered. It is...
    <system plays inmate private code number>
11. Thank you for using Global Tel Link. Your call is being processed.

Private Code Dialing Instructions: -

1. Pick up the telephone. Press 1 for English or press 2 for Spanish.
2. This call will be monitored and recorded.
3. Press 1 for English. Marque el número dos para Espanol.
   <default/no selection is English>
4. To make a collect call, dial 0 plus the area code and number. To make a debit call, dial 1 plus the area code and number.
   To make an International debit call, dial 011 plus country code and number. To hear your debit balance, dial 118.
   <inmate enters destination number>
5. Please enter your pin number at the tone...
   <inmate enters pin number>
6. At the tone, please state your name...
   <inmate recorded name>
7. Enter your 4 digit private code after the tone...
   <inmate enters private code>
8. Thank you for using Global Tel Link. Your call is being processed.

Appendix E

Essex County Jail

Civilian Task Force

The Purpose of the Task Force is to provide public oversight, transparency and accountability with respect to the policies, procedures, practices, supervision, management, and training at the Essex County Correctional Facility ("ECCF").

If you as a detainee or inmate have a concern you would like to share with

the Task Force

You can send them an email at

JailTaskForce@admin.essexcountynj.org

Or you can call (973) 877-8037

It's a free call

(This call is treated as a legal call and is NOT recorded)

Reclusorio Penitencial Correccional del Condado de Essex

Manual del Recluso y Reglamento Disciplinario

ALFARO ORTIZ
Director

Fecha Efectiva y Primera Distribución: 1 de Enero de 2005

REVISADO

Noviembre de 2010
Abril de 2011
Mayo de 2011
Enero de 2013
Julio de 2013
Agosto de 2013
Noviembre de 2013
Abril de 2014
Agosto de 2014
Septiembre de 2014
Marzo de 2015
Abril de 2015
Enero de 2016
Enero de 2017
Enero de 2018
Julio de 2018
Sept de 2018
Mayo de 2019
Junio de 2019
Octubre de 2020
Noviembre 2020
Abril 2021
Noviembre 2021
Febrero 2022

Es su responsabilidad pedir ayuda a un Oficial si usted no entiende las reglas. Infringir las reglas adjuntas puede dar lugar a una sanción disciplinaria. Las reglas y las regulaciones contenidas en este manual han sido adoptadas por la Administración del Departamento de Corrección del Condado de Essex.

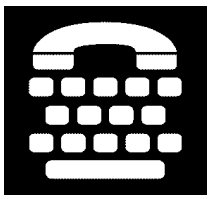
Contenido

AVISO A LOS RECLUSOS SORDOS O CON DIFICULATDES DE OIR

Si usted es un individuo con una incapacidad evidente, tendra derecho a un acomodamiento razonable.Por favor haga su petición a un miembro de nuestro personal para tal consideración.

Dentro de los limites establecidos por la ley, si usted es sordo o tiene dificultades para oir y usa el lenguaje Sordo-Mudo como método primario de comunicación, usted podra tener derecho a un intérprete en su lengua materna, si requiere uno, para comunicarse efectivamente mientras esta en esta reclusorio penitencial.

Si usted tiene cualquier incapacidad y quiere pedir un acomodamiento especial, por favor haga su solicitud.



Esta institucion cuenta con un Dispositivo de Telecomunicaciones para Sordos (TDD).

POR FAVOR REFIERASE A LA SECCIÓN DE SERVICIOS SOCIALES PARA COMUNICARSE CON NUESTRO DEPARTAMENTO DE SERVICIO SOCIAL PARA UTILIZAR ESTE SERVICIO.

1. Admisión Inicial

A su llegada al Establecimiento Correccional del Condado de Essex, el Oficial Encargado procesara su admision al recinto. En general, puede esperar que el trámite de admision se produzca de la siguiente manera:

1. El oficial a cargo del registro, mantendra en custodia su propiedad personal, ropa, objetos de valor y dinero. La institucion le proporcionara todos los recibos correspondientes por cada uno de los articulos que son de su pertenecia. Es importante que usted conserve estos recibos para reclamar su propiedad personal, todos los objetos de valor y su dinero cuando salga libre.
2. El personal del establecimiento determinará los articulos que usted podra retener al momento de registrar su admision. Por ejemplo, se le permitirá conservar los documentos legales necesarios para su caso de inmigración, o por lo menos, se le permitirá tener acceso al material relacionado con su caso, cuando sea necesario. Se le permitirá conservar algunos objetos personales con usted.
4. Se le proporcionará un bolso seguro para guardar sus artículos personales. Su ropa será colocada en un bolso de colgar para almacenamiento. La institucion correccional ECCF no es responsable por la pérdida de sus artículos personales que usted no asegure apropiadamente.
5. Se le proporcionará Se le proporcionará (1) Underware, (1) Uniforme, (1) par de desgaste de los pies de recluso, (1) Copia del Manual Disciplinario del Recluso (Inglés o Español), (2) Hojas, (1) Manta, (1) Toalla, (1) Paquete de cuidado, (2) Llamadas telefónicas ofrecidas, (1) Socks, (1) Camiseta, (1) Zapatos de Ducha. A través de su firma, usted se hara responsable de todos los artículos que se le provean durante su tiempo de encarcelamiento. Al momento de salir libre, se espera que devuelva todos los artículos que se le entrego en su estado original (excluyendo un deterioro natural razonable).

6. Se le proporcionará artículos de higiene personal (por ejemplo: cepillo de dientes, peine). Si necesita reemplazar cualquiera de estos artículos posteriormente, usted debera solicitar su reemplazo(s) usando la lista de necesitados (indigent list) o comprarlos del comisario.
7. Usted podrá solicitar articulos necesarios para escribir como boligrafos, lápices, papeles y sobres de carta, para su uso personal, de la comisaria o a través de la lista para indigentes.
8. Miembros de la familia y amigos pueden usar la pagina del internet: http://inmatelookup/inmatelookup con el proposito de obtener información pertinente a su encarcelamiento.
9. Se sometera a un examen médico completo después de su llegada. El personal médico llevará a cabo un examen para evaluar su salud física y mental como parte del proceso de admisión antes de ser ubicado en su unidad de localizacion.Si usted tiene alguna condición de salud que requiere atención medica inmediata, por favor informe a nuestro personal correccional durante su proceso de admision. Si prefiere, puede pedir hablar directamente con el personal médico acerca de sus preocupaciones personales de salud. Cualquier información que usted proporcione a nuestro personal médico no se puede compartir con el personal que no sea del departamento médico y dicha informacion será tratada con estricta confidencialidad.

2. Introducción

¿Que es una cárcel?

Las cárceles fueron diseñadas inicialmente como instalaciones para las personas bajo arresto y acusadas de cometer un crimen. Originalmente, estas instalaciones se usaron con reclusos que servían sentencias cortas, de 364 días o menos, o reclusos esperando ir a corte.

Nuestra cárcel alberga una gran variedad de reclusos, algunos declarados culpables aguardando sentencia, otros esperando juicio, otros que infringen su libertad condicional, delincuentes buscados en otros estados o condados, presos estatales y federales, y/o detenidos por I.C.E.; incluso padres que no pagan la pensión y manutencion de sus hijos y a veces, delincuentes juveniles. Personas de ambos sexos que esten detenidas dentro del Centro Penitenciario de Condado de Essex (ECCF) se reconocen como "presos". En el Condado de Essex, la cárcel se conoce como un centro penitenciario del condado. Por lo tanto, las palabras "ECCF" y "cárcel" significan lo mismo.

La institucion correccional ECCF tiene un sistema de clasificación que determina en qué área de la cárcel se ubicara al detenido. En general, los reclusos no eligen de si tendrán compañeros de celda o no. Tampoco eligen su companero, o donde seran ubicados. En cualquier momento, los reclusos pueden ser transferidos de lugar.

ECCF

En Estados Unidos, hay cerca de 3,150 condados o ciudades. En New Jersey, la mayoria de sus 21 condados tiene por lo menos una cárcel del condado. Los 21 condados contienen 566 municipios. El Condado de Essex tiene 22 barrios, ciudades, o municipios con más de 770,000 residentes. Nuestra cárcel del condado es un reclusorio penitencial de “Alta Tecnologia con Supervision Directa” que abrió sus puertas para servicio al público en el ano 2,004, y retiene a miles de reclusos actualmente.

Nuestro reclusorio penitencial proporciona un ambiente sano, salvo y seguro para el cuidado, la custodia y el control de diversos tipos de reclusos. Entendemos que cada sujeto dentro de nuestro recinto penitenciario, es un individuo, que puede estar encarcelado por razones diversas. Fomentamos una comunicación abierta y el **RESPETO a** todo, que es de extrema importancia y una parte integral de la operación diaria.

Reclusión o Encarcelamiento

Los reclusos están encarcelados en la institucion correccional ECCF de acuerdo a las leyes del estado de New Jersey. Los funcionarios de este centro son responsables de todas las operaciones que aseguren el control, la seguridad, la asistencia médica, las condiciones higienicas sanitarias, y el tratamiento justo e imparcial a todos los reclusos. El personal correccional le ayudará si usted lo solicita, pero hara un reporte para sancionarlo si usted comete un acto que se considere prohibido. Ése es el trabajo de ellos. Usted no debe tenerles ninguna aversion.

Estas reglas y regulaciones estan diseñadas para proveer a los detenidos de toda información de carácter general junto con el estándard o modelo de comportamiento correcto, que se requiere para asegurar que la institución salvaguarde los derechos de todas las personas confinadas y empleadas por la cárcel. Reclusos que no sigan las reglas o cuya conducta no sea aceptable, podrían ser sancionados de acuerdo a la Seccion de Actos Prohibidos. El estándard de buena conducta de cada recluso se enumera en este manual y se aplica a todos los reclusos. El período de confinamiento para los reclusos se podra alargar o acortar según su propia conducta mientras esten sancionados.

Su castigo podria ser tan agradable como sea posible bajo estas circunstancias, siempre y cuando usted mantenga una actitud de cooperación, de cortesía y de respecto durante su estadia. Apoyamos y animamos a todos los reclusos a participar en los programas disponibles o a obtener servicios que reforzaran un crecimiento social y una reintegración exitosa a la sociedad.

Distribución/Revision del Manual del Recluso/ Reglamento Disciplinario

Todos los reclusos recibirán este Manual o Reglamento Disciplinario durante el proceso de admisión a la institucion correccional ECCF. Un comprobante de recibo automatico se archiva y usted siempre debera mantener disponible este manual en su celda o área de localizacion. El manual del interno está en la Tableta.

La información de este folleto será traducida al Español, o al lenguaje de su preferencia, de acuerdo a la solicitud oficial presentada a los Oficiales de su unidad de vivienda y/o al Servicio Social. Los miembros del personal correccional explicarán verbalmente el manual o reglamento disciplinario a los reclusos analfabetos, a los que no entiendan ingles suficientemente, o a los que sufran una incapacidad física o médica. Como estas reglas y regulaciones están sujetas a cambios y revisiones, los procedimientos actualizados serán distribuidos, cuando sea necesario. Este manual tiene como objetivo ser una guía benefica de las expectativas de comportamiento requeridas por todos los individuos dentro de nuestro reclusorio penitencial.

3. Sus Derechos

Es la regla de la institucion correccional ECCF tratar a los reclusos con dignidad y respeto, mientras se mantiene la tranquilidad, seguridad e higiene. Para lograr esta meta, se espera que usted coopere con nuestro personal en los aspectos siguientes:

- Respetar las órdenes o direcciones impartidas por los miembros del personal correccional.
- Respetar al personal correccional del centro penitenciario y a otros reclusos.
- Respetar la propiedad del Estado de Nueva Jersey, la propiedad del Condado/de la Institucion Correccional, y respetar la propiedad de otros reclusos.
- Mantener su apariencia personal, la ropa que usa y el área donde vive en condiciones limpias e impecables.

- Dirigir la palabra a nuestro personal correccional con respeto, por su rango, título y apellido (es decir, use :Doctor Jones, Oficial Smith, Enfermera Clark), o por Sr., Señora, o Ms., seguido por su apellido y mantenga una distancia mínima de por lo menos tres pies.

Mientras que este bajo custodia, usted tiene derecho a :

- Ser informado de las reglas, procedimientos y horarios referentes a la operación del recinto donde se encuentra. Usted tiene el derecho a ser tratado respetuosa, imparcial y cortesmente por todo el personal y tambien de comportarsese de una manera responsable.
- Recibir los servicios de atencion, custodia, control, y tratamiento que serán proveidos a todos los reclusos de acuerdo con los códigos penales, estatales y federales en vigencia. No habrá discriminación de edad, raza, sexo, orientación sexual, nacionalidad, color, religión, status económico, creencia política, discriminación inversa, o de incapacidad. Se hara acomodos razonables para los reclusos con limitaciones físicas y mentales.
- Usted tiene el derecho a la libertad de afiliación religiosa y a la voluntaria adoración religiosa siempre y cuando no cause detrimento que afecte a otros, o al orden y la seguridad de la institucion.
- Usted tiene el derecho a un cuidado razonable. Usted tiene el derecho de estar en condiciones aceptables de confinamiento que incluyen una higiene personal diaria, comidas nutritivas, cama y ropa apropiada, un horario regular de lavanderia, ducha diaria, ventilación apropiada de calor y aire fresco, un período regular de ejercicio, artículos de bano y tratamiento médico.
- Usted tiene el derecho a recibir visitas de miembros y amigos de familia, de acuerdo al horario y reglas de la institucion correccional.
- Usted tiene derecho a asesoria legal de un abogado atraves de entrevistas y correspondencia, sin costo para el gobierno de los Estados Unidos o para el Condado de Essex.
- Usted tiene derecho al acceso confidencial y sin restricción, de su abogado y de las cortes judiciales, usando el servicio de correspondencia.
- Usted tiene el derecho a utilizar los materiales de referencia de la Biblioteca Juridica para asistirle en la resolución de sus problemas legales. Usted también tiene el derecho de recibir ayuda, cuando este disponible, o del programa de ayuda legal. Documentos que requieran servicios de un Notario Público se proporcionaran de acuerdo a su solicitud. El costo de procesamiento es de $.50 por cada documento notarizado. Se proporcionará a los reclusos indigentes este servicio en forma gratuita.
- Usted tiene el derecho al acceso de una amplia gama de materiales didacticos de lectura con fines educativos y para su propio entretenimiento o deleite.
- Usted puede tener el derecho de participar en un programa de trabajo, dependiendo de su nivel de clasificación y localización de su vivienda.
- Usted tiene el derecho a un proceso escrito formal de quejas y reclamos.
- Usted tiene derecho a un representante diplomatico. Reclusos que manifiesten tener nacionalidad foranea o ser extranjeros, tendran acceso a un representante diplomatico de su pais de origen. Los reclusos tienen el derecho de ponerse en contacto con su Consulado,sin costo alguno, usando el sistema de telefonos de la institucion correccional.

4. Responsabilidades

Mientras que está en custodia, usted tiene las responsabilidades siguientes:

- Usted tiene la responsabilidad de tener un conocimiento basico de estas reglas y regulaciones y de seguir todas las órdenes del personal.

- Es su responsabilidad de adherirse y seguir las reglas de la institucion con respecto a la ropa o vestuario.
- Usted tiene la responsabilidad de respetar la propiedad de la institucion correccional ECDOC y la propiedad de otros.
- Usted tiene la responsabilidad de comportarse de una manera responsable y respetuosa.
- Es su responsabilidad no desperdiciar la comida, seguir el horario de lavar ropa y mantener limpias y en orden sus celdas, y de buscar asistencia médica según lo requiera.
- Usted tiene la responsabilidad de reconocer y de respetar los derechos y creencias de los otros grupos religiosos.
- Es su responsabilidad de obtener su propia bandeja durante la comida. Notifique al oficial de la unidad de alojamiento si los reclusos no pueden recoger o devolver sus bandejas.
- Es su responsabilidad , realizar los quehaceres domésticos según lo indique el oficial de su unidad de alojamiento.
- Usted es responsable de todos los articulos que usa como la ropa, uniforme, sabanas, toallas, colchón y de su pronta devolucion al salir libre.
- Es su responsabilidad, asegurarse de que las céldas no queden abiertas ni se usen excesivamente. El numero de veces que se le permite tener acceso a su célda queda a discreción del oficial.
- Usted es responsable de tomar su medicamento recetado según lo indique el personal médico.
- Ud. es responsable de mantener el mas alto nivel o estándar de saneamiento y eliminacion de basura. Esta institucion cuenta con los servicios de un exterminador profesional que se encarga del control de insectos, bichos y parásitos. Usted es responsable de ayudar en estos esfuerzos sanitarios limitando la cantidad de artículos del comisario y de materiales personales, etc. que guarde en su dormitorio.
- Usted es responsable de someterse a inspeccion , registro y pesquisas de su persona y de sus pertenencias en cualquier momento.
- Ud. es su responsable de tener un comportamiento correcto durante las visitas y de no aceptar o pasar articulos de contrabando.
- Es su responsabilidad de obtener los servicios de un abogado.
- Es su responsabilidad la presentación de su caso y la consulta personal con su abogado
- Es su responsabilidad de utilizar los recursos disponibles según los procedimientos y horarios establecidos, y respetar los derechos de otros reclusos que usan esos materiales.
- Es su responsabilidad, utilizar estos materiales para su provecho personal, sin deprivar los derechos de otros reclusos, de usar los mismos materiales.
- Usted tiene la responsabilidad de sacar provecho de las oportunidades de trabajo y de las actividades que puedan ayudarle a convivir con más éxito dentro de la institucion y en la comunidad. Se espera que respete las regulaciones que gobiernan el uso de tales actividades.
- Es su responsabilidad de facilitar los métodos de pago usados para su fianza.
- Es su responsabilidad refrenarse de cualquier tipo de hostigamiento sexual. El acoso sexual incluye pero no se limita: al avanze consensual, al avanze sexual no deseado, al hostigamiento sexual masculino o femenino, a la conducta seductiva, a pedidos de cualquier favor sexual, al soborno sexual, a la coaccion sexual y al contacto verbal o físico de naturaleza sexual. Una exposición indecente; asi como tambien, colocar o ensenar cuadros, historietas o dibujos explícitos de naturaleza o contenido sexual donde pueden ser visibles a cualquier persona esta estrictamente prohibido.
- Es su responsabilidad de actuar responsablemente y seguir las reglas de la institucion y de las instrucciones legales provenientes del personal. Infringir estas reglas e

instrucciones puede resultar en una sanción o castigo contra usted, cuando sea necesario, para asegurar el orden y la seguridad del centro correccional.

5. Actos Prohibidos

Las siguientes actividades estan prohibidas y constituyen una violacion mayor o menor según lo descrito en el "Capítulo Dieciséis: Proceso Disciplinario."

- Se prohíbe a los reclusos de dejar las puertas de su célda abiertas o de tenerlas bloqueadas de una u otra forma.
- Se prohíbe a los reclusos de abrir cualquier estacion de alimentos, o de manipular y alterar cualquier cerradura o dispositivo de bloqueo de la institucion correccional ECCF.
- Se prohíbe a los reclusos de pasar o cruzar las líneas (amarillas) señaladas más allá del escritorio del oficial.
- Se prohíbe a los reclusos acercarse a 3 pies de distancia de cualquier miembro del personal.
- Se prohibe alterar la propiedad, o tomar cualquier artículo de escritorio del oficial o de cualquier otro miembro del personal correccional. Dicha accion será considerada una violación grave de las reglas y regulaciones.
- Bajo ninguna circunstancia, ningun recluso ejercerá o sera permitido ejercer autoridad sobre cualquier otro recluso o grupo de reclusos.
- Se prohibe a los reclusos estar u ocupar una unidad de vivienda, dormitorio, celda, cama o litera no autorizada.
- Usted debe dormir en la celda, dormitorio o litera que se le asigne.
- Se prohíbe a los reclusos entrar, intentar alcanzar o inclinarse en la celda de otros reclusos por cualquier razón.
- No se permite a los reclusos estar cerca o pasar cualquier objeto debajo de las puertas de acceso o a través de las estaciones de alimentos.
- No se permite a los reclusos tener su estacion de alimentos abierta a menos que el oficial mismo la abra.
- Se prohibe a los reclusos de hacer ruido y bullicio y de utilizar un lenguaje vulgar y ofensivo.
- Se prohibe a los reclusos acercarce a 3 pies de distancia de cualquier ventana que conduzca al piso de control. Los reclusos no golpearán sobre el vidrio ni se colocarán cerca de él o no se comunicarán con los trabajadores o con los reclusos de otras unidades de vivenda vía " senales de, o con la mano o con ninguna otra forma de comunicación."
- Los reclusos no participarán en ningun tipo de reunion no autorizada.
- El sentarse, inclinarse, pararse, merodear en las escaleras o detrás de las escaleras, o en el pasillo (nivel superior), área de visita, detrás del carril, de los pilares o cualquier otra área desautorizada esta terminantemente prohíbido. Ningun objeto de cualquier clase se puede colgar de la baranda o pasamanos o poner en las escaleras. La escalera no será bloqueada en ningun momento.
- Se prohibe a los reclusos poner los pies, ropa o cualquier otro artículo en los pasamanos, o muebles del balcón de su unidad de vivienda.
- Se prohibibe merodear o pararse alrededor de cualquier ducha; no es un lugar de reunión o un poste protector, es un área privada prohibida para el aislamiento de los reclusos. Si se descubre que un recluso tiene "Guardaespaldas" podra estar bajo el programa Proteccion de Custodia Involuntaria.
- Todos los reclusos se arroparán completamente al entrar y salir de la ducha. Se permite solamente un recluso a la vez en la ducha.
- El uso de los intercomunicadores de su célda, está permitido en caso de emergencia tales como por razones médicas o de seguridad.

- No se permite a los reclusos cubrir, colgar, atar mantas, sabanas, toallas, ropa, o ningun otro artículo en las paredes, ventanas, literas, conductos de aire, puertas o accesorios de luz en ningun sitio dentro de la institucion correccional ECCF. Una iluminación adecuada y una visión sin restricciones debe mantenerse para los oficiales en todo momento dentro del reclusorio penitencial.
- Las ventanas exteriores no serán bloqueadas o sombreadas de ninguna forma.
- Líneas de ropa no se permiten en las unidades de vivienda. Dibujar, escribir, o deteriorar cualquier cosa dentro de la institucion esta terminantemente prohíbido.
- Se prohíbe a los reclusos usar mantas o sabanas fuera de su celda, cama o litera.
- Panuelos de nylon se pueden usar solamente en celdas de la unidad de vivienda o dentro de su dormitorio.
- Los reclusos no moveran sillas del cuarto diario o dayroom para usarlas en celdas, o en áreas de recreo, o en el balcon.
- Los reclusos no se sentarán en sillas apiladas del dayroom ni reservaran sillas para otros reclusos.
- Los reclusos no llevaran ni consumirán comida o bocados en las áreas de recreacion ni haran mal uso del equipo de entretenimiento.
- El almacenaje de comida proveniente del comisario que se pueda consumir en el plazo de una semana se permite en su celda o dormitorio asignado, cualquier otro comestible no sera autorizado. Usted debe guardar sus recibos originales como prueba - de - compra para mantener sus artículos del comisario.
- Durante “lock down” o periodo de inmobilizacion , ningun articulo pasará de celda a la celda, y ésta medida incluye y aplica a los trabajadores de la unidad de vivienda.
- El número de libros, revistas y cartas guardadas en su celda será limitado y cantidades excesivas serán confiscadas.
- Los reclusos no tendrán bolsas de plástico o de basura en celdas o áreas de la litera.
- Radios, auriculares, imanes, baterías no se permiten dentro del recinto.
- Solamente se permite a reclusos clinicamente aprobados como trabajadores asignados a la cocina y la despensa de la unidad y son los únicos reclusos autorizados para manejar alimentos. El área de la despensa se utiliza solamente para servir alimentos pre-cocidos y agua caliente, **cualquier otra forma de cocinar esta terminantemente prohíbida.**
- Los privilegios de comisario de aquellos reclusos que se encuentren “cocinando” podran ser suspendidos o sujetos a una sanción disciplinaria aplicable.
- Los reclusos no solicitarán ni acosarán a oficiales de la unidad de vivienda para conseguir trabajo.
- Se prohíbe el tráfico y el intercambio de servicios o artículos dentro de la institucion correccional ECCF.
- Los reclusos no pueden transferir titulo de propiedad de ningun artículo a nadie.
- Juegos de azar de cualquier indole no será tolerados en ECCF.
- Alcohol y narcóticos estan terminantemente prohibidos dentro de ECCF.
- Solamente reclusos asignados como trabajadores de lavanderia se permiten en los cuartos de lavanderia de la unidad de localizacion.
- Los reclusos no podran boxear, practicar artes marciales u otras peleas bruscas o payasadas.
- Ejercicios que se practiquen dentro del recinto tales como abdominales o sit-ups y pectorales son permitidos siempre y cuando se hagan en el cuarto diario o dayroom. Ninguna mesa, escalera, litera, pasamano u otro artículo o accesorio del cuarto diario de la unidad de alojamiento o dormitorio sera utilizada como ayuda o herramienta de ejercicio. Bajo ninguna circunstancia se entregara artículos para ser alterados,o para hacer pesas.No se permitirá ningun equipo casero para hacer ejercicio.

- Los reclusos no quitarán NINGUNA información puesta en el tablero de anuncios.
- No se permite a los reclusos tener ningun tipo de herramienta, productos químicos o sustancias peligrosas en sus celdas o en la unidad de albergue.
- **EN NINGUN MOMENTO** se podra activar la cadena del toilet del bano excepto despues de defecar. El uso del toilet para eliminar basura, comida, ropa, artículos del comisario y contrabando esta terminantemente prohibido.

Destruir o no devolver cualquier articulo propiedad del condado esta prohibido. El costo de la propiedad destruida y/ o no devuelta se podra deducir de sus cuentas personales. El daño a la propiedad del condado puede conllevar a sanciones disciplinarias y /o a cargos criminales. Además, puede perder todo crédito y merito ganado por su esfuerzo y trabajo.

Todos los precios estan sujetos a cambio sin aviso previo, y no se limita a:

Saltador Uniforme	$10.75	Cabezal de cepillo de cubierta	$5.96
Zapatillas de ducha	$1.25	Empuje el mango de la escoba	$9.56
Manta	$8.40	Empuje el cabezal de escoba	$12.91
Toalla	$1.42	Esco de paja	$10.41
Sabana	$2.00	Escobilla	$1.81
Almohada	$5.50	Decatascador	$13.13
Caso Almohada	$0.67	Recortadoras de barbero	$70.91
Colchon	$38.99	Cortadoras de barbero	$142.58
Munequera	$10.00	Tenaza	$28.40
Cambro de Agua	$135.00	Plancha	$49.78
Bandejas de plastic par alimentos	$12.00	Computador de la biblioteca de derecho	$796.00
Silla de plastico	$67.28	Impresor de la biblioteca de derecho	$219.88
Contenedor de almacenamiento de plastico	$23.60	Esclusa depuerto de alimentos	$800.00
Tableta	$236.60	Cubo de basura de plastico	$34.12
Bandeja para al polvo	$7.51	Cabezal del rociador	$600.00
Cubo de fregona / Timbre de Fregona	$119.60	1/2” Ventana de Lexan	$1800.00
Fregona	$14.24	Television	$650.00
Mango de cepillo de cubierta	$9.56	Enfriador de agua	$249.88

6. Privilegios

Un privilegio es un beneficio concedido por el centro correccional ECDOC que se puede perder debido a la falta de disciplina,o de obedecer reglas y regulaciones que representen un riesgo para la seguridad, o en casos de emergencia, o situaciones especiales.

Estos privilegios pueden incluir, pero no limitarse a:

1. Asistencia a programas o servicios
2. Acceso a, o el uso del sistema teléfonico del recluso
3. Visitas
4. Compra del comisario

5. Tiempo recreacional
6. Televisión (T.V.)
7. Barajas y juegos de mesa
8. Responsabilidades de trabajo
9. Crédito de tiempo por buena conducta

7. Comunicación con el Personal

Se le pide y solicita a hablar informalmente con miembros del personal acerca de sus preocupaciones diarias y de la información de las polizas y procedimientos de la institucion.

Usted puede enviar preguntas escritas, peticiones o sus preocupaciones al personal del reclusorio penitencial usando un formulario de solicitud del recluso. Además, usted puede archivar su petición escrita, o una queja o reclamo con respecto al trato que recibe, usando el formulario de petición del recluso. Usted puede conseguir este formulario de su oficial de vivienda. Estos formularios se recogen y se remiten a la oficina del mediador (Ombudsman).

Para preparar su petición, usted puede obtener ayuda de otro recluso, de su oficial de vivienda, o de otro personal del reclusorio penitencial. Si lo prefiere, usted puede sellar el sobre de petición que indique claramente el nombre, título y/o la oficina a los cuales la petición debe ser remitida. Su petición será puesta en la caja designada y enviada inmediatamente a los funcionarios a quienes va dirigida por el personal (no por los reclusos) sin leer, alterar, o el retrazar su entrega.

Las peticiones informales escritas no se consideran un sustituto del proceso formal establecido para Quejas y Reclamos.

8. Regulaciones para Fumar

La institucion correccional ECCF es una infraestructura libre de humo y tabaco. Esta terminantemente prohibido fumar en la institucion correccional y productos relacionados al tabaco como encendedores, por ejemplo, serán confiscados durante el proceso de su admision y registro. La posesión de tabaco o de piezas o utensilios (parafernalia) de fumar es una ofensa punitiva.

9. Bandas de Muñeca de Identificación

- Todos los reclusos recibirán una banda de identificación con su foto durante el proceso de admision.
- La banda en la muñeca se debe usar a toda hora de acuerdo al reglamento.
- Bandas alteradas, estropeadas, o removidas serán consideradas inútiles para propósitos de identificación; serán confiscados y darán lugar a la acción disciplinaria.
- El intercambio de identificación con otro recluso puede también dar lugar a una sanción disciplinaria y/o criminal.
- Usted debe presentar su banda de identificación durante, o en situaciones de emergencia, durante la dispensación de su medicamento, distribución del comisario, de alimentos, al llegar a programas, o cuando tenga visitas; durante el recuento, al entrar o salir de su unidad de vivienda, al salir libre del recinto, y para cualquier propósito de identificación en general, o según lo ordene miembros del personal.
- Si usted resultara incapacitado, la banda de identificacion es un requisito médico para propósitos de identificación.

- Usted debe presentar su banda de identificación a cualquier miembro oficial y/o de personal que lo solicite.
- Usted es responsable de mantener su banda en buena condicion.
- Las bandas serán inspeccionadas en cada cambio de turno durante el recuento.
- Oficiales y miembros del personal inspeccionaran al azar las bandas para asegurarse que se usan y que no han sido alteradas.
- Las bandas con deterioro serán reemplazadas.
- Los reclusos pagaran el costo del reemplazo ($10.00) cuando se haga por cualquier razón que no sea un propio desgaste natural. Este precio está sujeto a cambio sin aviso.

Como minimo, y por lo menos, será considerado un Cargo Mayor (.101 Escape, .102 Intentando o Planeando un escape) el remover, voltear de afuera para adentro, danar y/o alterar cualquier banda de muneca (wristband) o la información contenida en ella.

10. Clasificación

A su llegada, el personal del Condado de Essex llevará a cabo una evaluación de su registro para asegurarse de que usted está colocado en un lugar adecuado dentro de la instalación penitenciaria. Esta evaluación le proporcionará un nivel de clasificación específica "basada en el comportamiento criminal, condenas penales, historial de inmigración, antecedentes disciplinarios, el estado de custodia actual y cualquier otra información que se considere pertinente para determinar el nivel de custodia más adecuado. El nivel de clasificación designada asegurará de que usted se ubique en la unidad de vivienda adecuada, con otros reclusos de características de clasificación semejantes.

A. Estado de clasificación

1. Utilizando pautas objetivas de clasificación, las siguientes categorías de condicion primordial se establecen:
   a. Masculino: máximo, medio y mínimo
   b. Femenino: máximo, medio y mínimo
   c. Los reclusos con Necesidades Especiales
   d. Poblacion juvenil
2. Dentro de las categorías de condicion primordial, se hace los siguientes grados de clasificación:
   a. Condenados a prisión estatal
   b. Reclusos Antesala de Juicio, con cargos mayores
   c. Juicio a reclusos con cargos menores
   d. Sentenciados por el Condado-Prisioneros
   e. Reclusos que requieren sancion disciplinaria
   f. Reclusos que requieren segregación administrativa
   g. Reclusos que requieren Protección de Custodia
   h. Reclusos Federales
3. Ningún recluso será segregado por motivo de raza, color, credo u origen nacional.
4. La clasificación de los reclusos de acuerdo a las categorías mencionadas anteriormente, puede ser modificada en base a la observación directa y a la supervisión individual de los reclusos, en cuyos casos, cada decisión de clasificación, deberá estar documentada apropiadamente.
5. Los reclusos de ambos sexos tendrán igualdad de acceso a todos los programas y actividades, de acuerdo a la programacion de actividades.

B. Código de Separación de Reclusos

Los reclusos permaneceran separados siempre y cuando el espacio lo permita, de acuerdo a la siguiente clasificacion:

1. Recluso masculino y femenino
2. Edad
3. Estatura
4. Delitos serios versus delitos menos serios
5. Encarcelamiento previo
6. Recluso agresivo-Recluso pasivo/dependiente
7. Recluso con necesidades especiales como por ejemplo pero no limitado a, alcoholismo y drogadiccion
8 Reclusos enfermos física y/o mentalmente y Reclusos sanos
9. Estado de confinamiento, como por ejemplo: detenido en antesala de juicio o reclusos y versus detenidos condenados en ICE
7. Reclusos en Prision Preventiva Estata
8. Bajo Custodia Involuntaria versus Bajo Custodia Voluntaria
9. Necesidad de Seguridad

C. Apelacion de la Clasificación

Usted puede apelar su estado de clasificación presentando una solicitud escrita, pidiendo una revisión al oficial encargado de la clasificación. Dicha decisión del oficial que hizo la clasificación puede ser apelada ante el Director o personal correccional designado, presentando por escrito la razón por el cambio de clasificación que desea. Una respuesta por escrito se emitirá en un plazo de dos días laborales.

E. Reclasificación

Todo incumplimiento de las reglas y regulaciones puede resultar en cambios del nivel de clasificación de custodia. Si el personal determina que usted tiene mala conducta, la institucion iniciará una revisión inmediata de su clasificación. Esta medida podría cambiar su localizacion asignada inicialmente.

F. Reducción de la Sentencia (Se aplica solamente a reclusos sentenciados por el Condado)

Todo recluso sentenciado por el Condado debe de trabajar si no tiene asignado a algun programa.

1. Los reclusos pueden recibir crédito de tiempo de hasta cinco días en el mes por buen comportamiento, por buena conducta.
2. Los reclusos pueden reducir un día de sentencia por cada cinco días trabajados.
3. La reducción de la sentencia a través del reconocimiento de los créditos ganados por su trabajo es acumulativa. Por ejemplo, un recluso puede recibir crédito de seis días por cada treinta días trabajados.
4. Las violaciones de las reglas de la institucion correccional o de algun programa alternativo de encarcelamiento pueden dar lugar a la pérdida total o parcial del crédito ganado por tiempo de trabajo invertido.

11. Propiedad

A. Propiedad Sin Autorizacion

Cualquier articulo puede ser considerado articulo de contrabando cuando esta en posesion de un detenido o visitante dentro de la instalación, sin autorización del personal. Usted debe obtener permiso previo para poseer cualquier articulo u objeto, incluso aun, si el tipo de articulo se admite por lo general en el recinto penitenciario. El personal correccional podra limitar la cantidad de cualquier artículo, incluso si el tipo de artículo esta aprobado. Cualquier artículo que esté permitido inicialmente para los presos, puede llegar a convertirse en posesión no autorizada, si se altera sin permiso o usa de manera inadecuada. El exceso de articulos, articulos alterados o de uso incorrecto, pueden ser desechados de acuerdo con la regulacion y reglamento de la institucion correccional.

B. Propiedad/Artículos Autorizados Permitidos para su Retención

La propiedad que los reclusos pueden tener durante su encarcelamiento se describe como:

1. Gafas con receta medica
2. Dentaduras y dispositivos prostéticos aprobados por el personal medico
3. Audífonos aprobados por el personal médico
4. Gafas con receta medica
5. Dentaduras y dispositivos prostéticos aprobados por el personal medico
6. Audífonos aprobados por el personal médico
7. Dos pares de calzado aprobados, o una combinación de ellos
8. Seis pares de calcetines
9. Seis conjuntos de ropa interior
10. Artículos para el bano comprados del comisario, que pueden ser consumidos dentro de una semana, con un máximo de 50 artículos por un valor de $95 en compras
11. Artículos de bano, comprados del comisario, limitado a dos por cada artículo
12. Seis libros o revistas (se prohíbe materiales pornográficos)
13. Un (debe incluir, pero no limitarse a) una Biblia, el Corán, Torá u otros libros religiosos aprobados por la Oficina del Director o Persona Designada;
14. Una carpeta o folder con papeles o documentos legales
15. Unidad flash USB (cuando sea aprobado)
16. Doce fotos sin marco (con dimensiones que no excedan 4” x 6”) que no serán expuestas en la pared, y NO SE PERMITE exhibir fotos de personas desnudas ni el uso de FOTOGRAFÍAS POLAROID

16. El siguientes son artículos del Departamento Correccional:
    a. Una manta
    b. Dos sabanas
    c. Una almohada
    d. Una funda de la almohada
    e. Un colchón
    f. Dos pares de uniformes
    g. Una toalla

C. Propiedad de los presos liberados

Cuando un preso es liberado de ECCF, el preso deberá:

1. Tome la propiedad personal al salir de la instalación; o
2. Hacer arreglos para que un miembro (s) de la familia o un amigo (s) recoja la propiedad personal de la instalación dentro de los treinta (30) días calendario posteriores a la liberación del recluso.

D. Falta de remover propiedad personal

En circunstancias donde la propiedad permanece en la instalación o el preso o la persona designada no logra que la propiedad se retire dentro de los treinta (30) días calendario posteriores a la liberación de los reclusos, el personal de ECCF enviará una notificación por escrito a la última dirección conocida del ex recluso que indique que:

1. La propiedad se mantendrá por un máximo de treinta (30) días calendario adicionales;
2. La propiedad se desechará si no se elimina en la fecha específica; y
3. ECCF no se responsabiliza por los bienes retenidos por más de sesenta (60) días.

E. Notificación por escrito

Si la notificación por escrito enviada a la última dirección conocida del ex recluso no se responde dentro de los treinta (30) días calendario, el personal correccional puede disponer de la propiedad personal mediante:

1. Donar la propiedad personal a cualquier organización benéfica pública reconocida;
2. Retener la propiedad personal para uso de la población general de reclusos, si el Administrador de la instalación o la persona designada ha aprobado el (los) artículo (s); o
3. Destruir los bienes personales.

El Administrador de la instalación o la persona designada aprobará cualquier propiedad que deba ser donada o destruida.

Los artículos perecederos están sujetos a donación o son destruidos en cualquier momento cuando la propiedad se deja en la instalación y crea un problema de salud o de control de plagas.

Las copias de las notificaciones escritas al ex recluso sobre propiedad personal se convertirán en una parte permanente del archivo de registro del ex recluso.

F. Medicación confiscada

Todos los medicamentos que se traigan a la instalación serán confiscados por el Oficial de Pre-Reserva en Ingreso. La medicación confiscada se almacenará en el Médico Principal durante el período de confinamiento. La medicación confiscada no identificable debe ser descartada por el personal médico.

12. Contrabando

Los artículos considerados como perjudiciales a la seguridad y el orden de la institucion estan prohíbidos y se consideran como "contrabando." Los artículos de contrabando incluyen, pero no se limitan a:

1. Cualquier artículo, o material encontrado en posesión de, o bajo control de un recluso sin autorizacion de posesion o recibo que puede afectar la función de seguridad y el orden de la institucion.
2. Cualquier artículo, o material encontrado dentro de la instalacion correccional ECCF o dentro de su suelo, que no haya sido expedido por la institucion o que se haya autorizado como admisible para su retención o recibo.
3. Cualquier artículo o material encontrado en posesión de, o bajo el control de cualquier visita dentro del reclusorio penitencial o dentro de la propiedad que no tenga autorizacion para su recibo, su retención o para su importación.
4. Cualquier, artículo o material autorizado para su recibo, retención o importación por los reclusos cuya cantidad se considere excesiva o cuya forma original se haya alterada. Una cantidad será considerada excesiva si excede los límites indicados por ECCF o si excede las consideraciones razonables de seguridad, sanitarias, o de espacio.
5. Cualquier artículo que pueda representar detrimento o amenaza a la seguridad y al orden operacional de ECCF. Los artículos del contrabando incluirán, pero no serán limitados a:
    a. Armas, armas de fuego, munición, explosivos o armas de cualquier tipo
    b. Cuchillos, herramientas u otros instrumentos que se pueden interpretar como medios de ayuda para escapar y que no hayan sido proporcionados de acuerdo a las regulaciones de ECCF.
    c. Productos químicos y gases peligrosos o venenosos
    d. Medicamentos no autorizados o sustancias peligrosas controladas (CDS)
    e. Medicamento dispensado o aprobado por ECCF pero no consumido o usado de la manera prescrita.
    f. Productos tóxicos, incluyendo, pero sin limite al, uso de licor o bebidas alcohólicas
    g. Monedas y estampillas
    h. Dispositivos de comunicación electrónica que se pueden utilizar para tomar fotografías sin autorizacion , o grabación de audio o de audio-video de los reclusos, del personal o grabacion de la propiedad inmueble del Estado; (los ejemplos incluirán, pero no seran limitados a, teléfonos celulares, cámaras, asistente digital personal, mp3 o dispositivo de audio, correo electronico, envíos de mensajes de texto, computadoras, facsímil, impresoras, radios de dos vías y los paginadores/localizadores, o baterías, enchufes, cordones o cables, alambres usados para hacerlos funcionar).
    i. Cualquier artículo de ropa o vestuario que se podría utilizar para disfrazar o para alterar la apariencia o aspecto de un recluso.
    j. Cualquier artículo de ropa o artículo para uso o consumo personal que no se haya presentado y esclarecido primero durante el proceso de admision o se haya comprado del comisario.
    k. Cualquier información que plantee o amenaze la seguridad y el funcionamiento ordenado de la institución.

Promover, poseer e introducir contrabando en ECCF es una violación de las pautas disciplinarias de ECDOC, del código penal 2C de New Jersey: 29-6 Implementos para escapar; El otro contrabando, y N.J.S.A. 10A: 31-8 la Seguridad y el Control y los violadores pueden ser sujetos a penalidades y castigo conforme a estas pautas y guias establecidas.

Usted es responsable de asegurarse de que no está en posesión de ningun artículo que se puede considerar contrabando y de saber las reglas con respecto a artículos de contrabando.

13. Registro de Personas, Detenidos, de la Propiedad por ECCF

Para mantener la seguridad de todas las personas y de la institucion ECCF, el registro e inspeccion de reclusos y del reclusorio penitencial tendrán como objetivo el control y disuacion de la introducción y ocultamiento de contrabando.

- Se hara un registro integral a todos los reclusos admitidos a la institucion correccional ECCF.
- Toda búsqueda y registro se conducira bajo condiciones sanitarias, de manera profesional y digna, con la máxima cortesía y respecto por los reclusos.
- No se rebuscará a ningun recluso como castigo o disciplina.
- Requisas imprevistas rutinarias del reclusorio penitencial, de los reclusos y de sus pertenencias se llevaran a cabo según sea necesario.
- Se hara un registro e inspeccion minuciosa de todas las áreas a las cuales los reclusos tienen acceso rutinariamente y al azar.
- Registros de viviendas se efectuaran y llevaran a cabo cuando el reclusorio penitencial tenga suficiente sospecha para creer que un recluso puede ocultar un arma u otro articulo de contrabando.

Un registro corporal a mano se puede hacer rutinariamente incluyendo, sin limitarse a, la admisión al edificio, la inscripcion en una unidad de alojamiento, antes y despues de ir a la corte, al efectuarse cualquier transporte, cualquier visita o cita médica y al ser transferido a otra unidad de alojamiento.

Usted no puede rehusarse a un registro personal. Es su responsabilidad seguir las instrucciones que el personal correccional le hizo entrega inicialmente. Infringir su curso legal puede dar lugar a una sancion disciplinaria o criminal en contra suya. La negación a un registro personal también puede dar lugar a su segregación o separacion de la población reclusa en general.

14. Cuentas Personales

1. No se permite a ningun recluso tener en posesión dinero o joyas. Durante el proceso de ingreso, tales artículos serán incautados, se le dara un recibo por dichos articulos , y se abrira una cuenta personal a su nombre. El balance máximo de su cuenta de comisario no excederá $1,000.00 y cualquier excepcion a la cantidad límite debera ser aprobada por el Director.
2. Cualquier dinero proveniente del exterior será acreditado a la cuenta personal. Ordenes hechas en efectivo o a traves de giros postales o money orders se aceptan en la ventana de depósito en la sala de visita, entre las horas de 8:00 A.M. a 4:00 P.M., de Lunes a Viernes (excepto días feriados). Los giros postales también se reciben a través del correo. El reclusorio penitencial correccional no asume ninguna responsabilidad por la perdida de sus giros postales. Un quiosco está disponible para reabastecer su cuenta personal en la sala de visitas 24 horas al dia, 7 dias a la semana (24/7). Asegurese de que los depositantes usen correctamente su nombre y su número de identificación asignado por ECCF.
3. Cuando un recluso recobre su libertad, se le cerrara su cuenta personal y cualquier balance sera remitido para su debido pago. Un honorario administrativo será recargado y todas las cuentas con un balance de $4.99 o menos seran cerradas sin ningun pago de recargo.
4. A petición suya, los cheques provenientes de terceras personas se pueden retirar de la cuenta personal del recluso para pagar multas impuestas por la corte, honorarios y fianza. Asi mismo,

una vez al mes, cheques de terceras personas se podran remitir a parientes o amigos por un cargo honorario de procesamiento de $1.00.

5. Los reclusos deben solicitar la devolucion de todas sus pertenencias dentro de un plazo de 30 días de su liberacion del recinto.
6. Un cargo honorario de procesamiento de $50.00 será recargado a todos los individuos encarcelados legalmente en ECCF. Este pago sirve para costear los gastos de huella digital, fotos y clasificacion de los individuos mientras que se procesan en el sistema. Todas las cuentas con menos de $50.00 tendrán un balance negativo para su credito parcial o completo en su cuenta a pagar. Se le recargara un honorario cada vez que usted este encarcelado.
7. **Recluso Indigente** - son los reclusos que tienen un balance de cuenta de $5.00 (o menos), y sin actividad del comisario por tres semanas o más. Usted debe indicar que tiene recursos economicos limitados en una hoja de registro inicial (sign-up sheet). Si su cuenta recibe fondos mensuales regulares, como por ejemplo el 1er dia de cada mes, usted no recibirá artículos para indigentes. Si su cuenta puede cubrir como mínimo el costo de un sobre con una estampa del comisario, usted no recibirá sobres para indigentes.

15. Unidad de Alojamiento Especial (SHU)

ECCF proporciona los siguientes tipos de SHU a los reclusos que requieran una supervisión rigurosa:

- Reclusos bajo investigacion pendiente y/o bajo audencias por infracciones disciplinarias
- Reclusos con necesidad de observación o de cuarentena médica
- Reclusos que estan/son un riesgo para la seguridad
- Los que necesiten Custodia Protectora (Voluntaria e Involuntaria)

Se hara una revision de todos los casos penitenciarios de los reclusos ubicados en SHU para determinar la necesidad de su localización continua en la Unidad de Alojamiento Especial. Usted puede apelar la orden de SHU o la decisión proveniente de su revisión, enviando un documento escrito, al administrador del reclusorio penitencial.

16. Proceso Disciplinario

1. Una disciplina penitenciaria equitativa y coherente será empleada para garantizar el mantenimiento de la seguridad y el funcionamiento ordenado del Establecimiento Correccional del Condado de Essex.
2. Un reglamento, en el que se basa la disciplina penitenciaria, debe ser razonable e imparcialmente aplicable de manera uniforme, y cualquier medida o accion adoptada para determinar una supuesta infracción debe basarse en los hechos.
3. La sanción (o sanciones) por las infracciones no se impondrá(n) de manera que viole los derechos civiles de un detenido. La sanción (es) debe(n) estar relacionada(s) con la infracción, y debe(n) ser aplicada(s) de manera equitativa a todos los detenidos.
4. Todas las personas que supervisan las actividades de los reclusos deberán recibir suficiente entrenamiento para asegurar que estos miembros del personal comprendan las normas de conducta de los reclusos, las sanciones disponibles y la justificación de las reglas.
5. N.J.A.C. 10A: 4 - La disciplina del recluso se aplica a los reclusos estatales encarcelados en ECCF.

A. Reglamento de Disciplina

1. El Establecimiento Correccional del Condado de Essex ha desarrollado este Manual / Libro de Normas Disciplinarias, que incluye
   a. Todos los delitos imputables
   b. El programa de sanciones
   c. Los procedimientos disciplinarios
   d. El proceso de apelación disciplinaria
   e. Advertencia de que N.J.A.C. 10A: 4, Disciplina del Recluso, también se aplica a los presos estatales encarcelados dentro de ECCF

B. Violaciónes y Sanciones para Reclusos contra la Biblioteca Jurídica

El castigo por cualquier infracción a la biblioteca de leyes por parte de los reclusos, tales como el detrimento a libros o materiales, o la exhibicion una conducta disruptiva, normalmente no incluiran la negación al acceso de la biblioteca.

C. Violaciónes Menores y Sanciones

Actos Prohibidos - Menores

.152 Destruccion, alteracion o daño a la propiedad gubernamental o de otra persona
.206 Posesión de dinero o divisas ($ 50.00 o menos) a menos que este específicamente autorizado
.208 Posesión de propiedad ajena
.209 Préstamo de la propiedad o de cualquier cosa de valor
.210 Posesión de cualquier articulo no autorizado para su retencion o recibo por un recluso, o posesion del mismo sin que se le haya concedido permiso por vía regular ordinaria a través de la institución correccional
.211 Posesión de prendas de vestir y / o equipos de cualquier miembro del personal.
.212 Posesión de ropa no autorizada
.213 Mutilación o alteración de ropa y ropa de cama expedidos por el condado
.254 Denegarse a trabajar o no aceptar un programa o una asignación o tarea de vivienda
.256 Denegarse a obedecer una orden de un miembro del personal
.257 Violar una condición del programa de relevo a la comunidad
.301 Faltar injustificadamente al trabajo o asignación si lo hubiere; llegar tarde al trabajo
.302 Pretender, fingir una enfermedad
.303 Fallar, no realizar el trabajo según las instrucciones impartidas por un miembro del personal.
.304 Usar lenguaje ofensivo u obsceno hacia un miembro del personal
.305 Mentir, proporcionando una declaración falsa a un miembro del personal
.351 Falsificar, participar en la reproducción no autorizada o el uso de cualquier documento no enumerado en acto prohibido *. 352
.401 Participar en una reunión o meeting no autorizado
.402 Estar o merodear en una zona no autorizada
.451 Denegar a seguir los reglamentos de seguridad o de saneamiento
.452 Usar cualquier equipo o maquinaria que no esté expresamente autorizado
.453 Usar cualquier equipo o maquinaria contraria a las instrucciones o reglas de seguridad colocadas
.501 Fallar a presentarse durante la toma de recuento
.502 Interferir con la toma de recuento
.601 Participar en juegos de azar
.602 Preparar o llevar a cabo un grupo de juegos de azar
.603 Poseer parafernalia de juegos de azar
.651 Ser o mantenerse sucio; no mantener su area en conformidad con las normas establecidas

.652 Tatuarse o auto-mutilarse
.701 Usar sin autorizacion el correo o teléfono
.702 Hacer contacto no autorizado con el público
.703 Mantener correspondencia o un comportamiento con un visitante que este en violación con los reglamentos
.705 Empezar u operar un negocio o grupo de negocios para generar beneficios u operar una empresa sin fines de lucro, sin la aprobación del director
.706 Solicitar dinero y / o aportaciones no monetarias de donantes dentro o fuera del establecimiento penitenciario, salvo cuando lo permita el director
.707 Denegar a mantener una cita con el personal médico, dental, o profesional de cualquier tipo
.709 Incumplir una norma escrita o el reglamento de la institución correccional
.752 Aceptar dinero o cualquier cosa de valor, o dar dinero o algo de valor a otro detenido.
.753 Comprar cualquier cosa a crédito
.754 Dar dinero o algo de valor, o aceptar dinero u objetos de valor de un miembro de la familia del detenido o de un amigo del detenido con la intención de embaucar o eludir cualquier instalación correccional o regla institucional, o su regulación o poliza, o con la intención de seguir un propósito ilegal o impropio
.802 El intento de cometer cualquiera de los actos antes mencionados, ayudar a otra persona a cometer cualquiera de estos actos o hacer planes para cometer cualquiera de los actos antes mencionados, se considerará lo mismo que cometer el acto mismo

D. Correccion en el Acto

La imposición inmediata de una sanción a un detenido por una violación menor se conoce como "Correccion en el Acto." Directrices escritas deberán especificar las violaciones menores que se pueden efectuar informalmente a través de su imposición.

A continuación, se presenta las sanciones autorizadas para aplicar las Correcciones Inmediatas:

1. Amonestación verbal
2. Pérdida de privilegios de recreación por un período de no más de cinco días
3. Hasta cuatro horas de trabajo extra adicional
4. Hasta cuatro horas de aislamiento en su habitación o celda
5. La pérdida de privilegios de radio o televisión durante un período de no más de cinco días
6. Confiscación

Toda violación menor debe ser notificada por escrito y remitida inmediatamente al supervisor de turno para su revisión. El supervisor de turno le expedirá una copia del formulario y le ofrecera al detenido el derecho a una conferencia antes de la imposición de cualquier sanción.

Si el supervisor de turno esta de acuerdo con el formulario escrito de Violaciónes Menores y Sanciones, la sancion correspondiente a la Correccion Inmediata se impondrá dentro de las 24 horas de la revisión del reporte.

El supervisor de turno también puede absolver la violación menor de la regla o cambiar el grado de la violación de menor a mayor.

E. Violaciones Mayores y Sanciones

<u>Actos Prohibidos</u> – <u>Mayores</u>

*. 001 Asesinar-Matar

*. 002 Asaltar-Atracar a cualquier persona
*. 003 Asaltar a cualquier persona con un arma
*. 004 Pelear con otra persona
*. 005 Amenazar a otra persona con causarle daños corporales o contra su propiedad
*. 006 Extorsionar, chantajear, ofrecer protección, pedir, exigir o recibir favores, dinero o cualquier cosa de valor a cambio de protección contra otros, para evitar lesiones corporales, o bajo la amenaza de informar
*. 007 Tener como rehen a alguien
*. 008 Abusar o maltratar animales
*. 009 Usar inapropiadamente los equipos electrónicos no autorizados para su uso o posesión por un detenido tales como, pero sin limitarse a: teléfono(s) celular (es), radio(s) de dos vías, cualquier dispositivo de comunicación (es) y / o computadora (s), y / o dispositivo(s) relacionado(s) y periférico(s)
*. 010 Participar en una o varias actividades que amenazen la seguridad del grupo
*. 011 Tener en posesión o exposición cualquier cosa o artículo relacionado con la amenaza de la seguridad del grupo
*. 012 Arrojar fluidos corporales a una persona, o someter a dicha persona a propósito para que tenga contacto con fluidos corporales
*. 013 Efectuar contacto físico no autorizado con cualquier persona, sin límite a, un contacto físico no iniciado por un miembro del personal, voluntario o visitante
*. 014 Efectuar un contacto físico no autorizado con cualquier persona, artículo, o material que pueda fácilmente ser capaz de infligir lesiones corporales
*. 050 Cometer asalto sexual
*. 051 Participar en actos sexuales con otras personas
*. 052 Formular propuestas sexuales o amenazas a otro
*. 053 Realizar una exposición indecente
*. 054 Denegar a registrarse como delincuente sexual
*. 101 Huir-Escapar
*. 102 Intentar o planear escapar
*. 103 Usar un disfraz o máscara
*. 150 Forzar, estropear o manosear las alarmas de incendios, equipo contra incendios o equipos supresores
*. 151 Hacer-Causar un incendio
*. 153 Robar (Hurto)
*. 154 Forzar, estropear o manosear cualquier dispositivo de bloqueo
*. 155 Adulterar cualquier alimento o bebida
*. 201 Poseer o introducir un artefacto explosivo, incendiario o cualquier tipo de munición
*. 202 Poseer o introducir una pistola o revolver, una arma de fuego, un instrumento afilado, un cuchillo o una herramienta no autorizada
*. 203 Tener en posesión de, o la introducción de cualquier parafernalia de narcoticos, drogas no recetadas para el individuo por el personal médico o dental
*. 204 Usar sustancias prohibidas como drogas, narcoticos, sustancias toxicas o parafernalia relacionada no prescritas o recetadas para el detenido por el personal médico o dental
*. 205 Usar indebidamente medicamentos autorizados
*. 207 Poseer dinero o divisas (en exceso de $ 50.00) sin la autorización expresa
*. 214 Poseer sin autorizacion llaves u otro equipo de seguridad
*. 215 Tener posesión con la intención de distribuir o vender sustancias prohibidas como drogas, narcoticos o parafernalia relacionada
*. 216 Distribuir o vender sustancias prohibidas como drogas, narcoticos o parafernalia relacionada

*. 251 Crear disturbios
*. 252 Alentar a otros para la creacion de disturbios
*. 253 Participar en, o alentar, una demostración de grupo
*. 255 Apoyar a otros a negarse a trabajar, o a participar en un paro de labores
*. 258 Denegar a someterse a una prueba de sustancias prohibidas
*. 259 Denegar a someterse a cumplir con una orden de presentar una muestra para la prueba de sustancias prohibidas (véase NJAC 10A :3-5)
*. 260 Denegar a someterse a exámenes médicos obligatorios
*. 261 Estropear o alterar un espécimen de prueba
*. 305 Mentir, proporcionando una declaración falsa a un miembro del personal
*. 306 Exhibir una conducta que interfiere con la seguridad o el orden del funcionamiento de la institución correccional
*. 352 Falsificar, adulterar o hacer una reproducción no autorizada o uso de cualquier documento clasificado, documento de la corte, reporte psiquiátrico, o psicológico, o formulario médico, dinero o cualquier otro documento oficial
*. 360 Obtener ilegalmente o intentar obtener información personal relacionada con la víctima del recluso o con la familia de la víctima
*. 551 Fabricar o tener posesión de narcoticos o bebidas alcohólicas
*. 552 Estar intoxicado
*. 553 Estar en posesión de cualquier material de tabaco o dispositivos de encendedor
*. 701 Usar sin autorizacion el correo o teléfono
*. 703 Tener correspondencia o contacto con un visitante en violación de los reglamentos
*. 704 Perpetrar fraude, engaño, juegos confidenciales, motines o planes de escape
*. 708 Denegar a someterse a un registro
*. 751 Dar a u ofrecer a cualquier funcionario o miembro del personal un soborno o cualquier cosa de valor
*. 803 Intentar o tratar de cometer cualquiera de los actos antes mencionados, ayudando a otra persona a obtener cualquiera de los actos antes mencionados, o hacer planes para cometer estos actos se considerará lo mismo que la ejecucion del acto mismo

Sanciones a las Violaciones Mayores

Una violación mayor se define como la conducta que se castiga con sanciones más severas que las violaciones menores. A continuación, se presenta las sanciones autorizadas de violaciones mayores:

1. Hasta 15 días de detención disciplinaria
2. Pérdida de tiempo para conmutar, sujeta a confirmación por parte del administrador del Establecimiento Correccional del Condado de Essex
3. La pérdida de privilegios de hasta 30 días
4. Confiscación / Decomiso
5. La restitución
6. Cualquier sanción prevista de Correcciónes Inmediatas
7. Suspensión de uno o más de las sanciones anteriores a discreción de la Junta de Disciplina u Oficial de Audiencia por 60 días

Ningún detenido puede recibir más de 15 días de detención disciplinaria como resultado de un cargo disciplinario único.

Si un detenido es imputado con múltiples cargos disciplinarios, él o ella podra recibir hasta 15 días de detención disciplinaria por cada cargo, siempre y cuando el tiempo total de sentencia, no exceda los 30 días.

F. Notificación de Detenidos

1. Como aviso de la grave acusación de violación (es), una copia del reporte disciplinario se notificará a la persona detenida dentro de las 48 horas de ocurrida la violación a menos que existan circunstancias excepcionales, y por lo menos 24 horas antes de la audiencia disciplinaria, a menos que el detenido renuncie a tal notificación por escrito.
2. El formulario disciplinario será entregado por el agente informante u oficial investigador. El formulario será firmado por la persona que entrega éste documento y del momento de la entrega.

G. Uso de Inmunidad

1. En todos los casos, el detenido será informado de su derecho a usar la inmunidad en cualquier entrevista de investigación y en la audiencia disciplinaria.
2. La advertencia del uso de inmunidad consistirá en una declaración que indica que las declaraciones hechas en relación con la audiencia disciplinaria o evidencia derivada directa o indirectamente de estas declaraciones no se utilizarán en ningún procedimiento penal posterior.
3. El incumplimiento de no dar aviso del uso de su inmunidad por el oficial de investigación no será motivo para desestimar el reporte disciplinario.

H. La Investigación

1. Una investigación de la infracción se llevará a cabo dentro de las 48 horas en que el reporte disciplinario se entrega al detenido, a menos que existan circunstancias excepcionales para retrasar la investigación.
2. El administrador del Establecimiento Correccional del Condado de Essex nombrará a un agente investigador que no estuvo envuelto en el incidente.
3. Se informara al detenido de su derecho a consultar con un consejero sustituto antes de la audiencia disciplinaria.
4. El detenido será informado de su derecho a renunciar a la audiencia disciplinaria y declararse culpable de los cargos disciplinarios.

I. Pre-audiencia de Detención

1. Previo a la audiencia disciplinaria, el detenido mantendrrá su status o estado vigente, a menos que el detenido constituya una amenaza para otros detenidos, para los funcionarios, para sí mismo o para el funcionamiento ordenado del Establecimiento Correccional del Condado de Essex.
2. Si se ordena una pre-audiencia por el supervisor de turno, dicha orden serán revisada por el administrador del Establecimiento Correccional del Condado de Essex o la persona designada en un plazo de 24 horas. De lo contrario, se deberá devolver al detenido su status previo.

J. Junta de Disciplina / Auditor

1. Todas las audiencias por delitos mayores se llevará a cabo ante un oficial de audiencia o una junta de disciplina integrada por un panel imparcial de tres miembros, que incluirá un supervisor de custodia y dos miembros del personal no custodia.
2. Cualquier oficial de audiencia o miembro de la junta disciplinaria debe ser descalificado en todos los casos en que el oficial de audiencia o miembro del consejo:
    a. Presentó la queja o presencio el incidente;
    b. Participó en calidad de agente investigador;

c. Será responsabilizado con una revisión posterior de la decisión; y / o
d. Tiene interés personal en el resultado.

K. Audiencia Disciplinaria

1. Todo detenido tendrá derecho a una audiencia dentro de siete días de la supuesta violación, incluyendo fines de semana y días feriados, a menos que dicha audiencia se vea impedida por circunstancias excepcionales, inevitables retrasos o aplazamientos razonables. Si el séptimo día fuese un Sábado, Domingo o día feriado, la audiencia se llevará a cabo el día de la semana inmediatamente posterior al fin de semana o dia festivo.
2. Todo preso recluido en detención previa a la audiencia recibirá una audiencia dentro de tres días de su ubicación en la detención de pre-audiencia, incluyendo fines de semana y dias festivos a menos que existan circunstancias excepcionales, retrasos inevitables o aplazamientos razonables. Si el tercer día fuese un Sábado, Domingo o día festivo, la audiencia se llevará a cabo el día de la semana inmediatamente posterior al fin de semana o dia festivo.
3. Todo preso recluido en detención previa a la audiencia recibira prioridad en el calendario programado para su comparecencia ante la junta disciplinaria o funcionario de audiencia.
4. El tiempo transcurrido en detención previa a la audiencia será acreditado y deducido de cualquier sentencia impuesta posteriormente.
5. No se permitira retraso alguno en caso de audiencia con el proposito de castigar o disciplinar.
6. Al detenido se le ofrecera la oportunidad de estar presente durante la audiencia disciplinaria con excepción de las deliberaciones del oficial del Consejo de Disciplina de la Audiencia y por razones de seguridad. Las razones para excluir a un detenido en una audiencia disciplinaria serán documentadas en el expediente del detenido.
7. Un detenido puede estar representado por un consejero suplente (miembro de personal u otro detenido) cuando se determine por el Consejo de Disciplina Oficial de la Audiencia que el detenido es analfabeto, que no está suficientemente familiarizado con el idioma Inglés, o que no puede leer, comprender o comunicarse por una incapacidad física o médica, o que no puede recoger y presentar de forma adecuada las pruebas o evidencia por si mismo.
8. Se dara la oportunidad a un detenido de presentar testigos a su nombre, a menos que sea irrelevante, repetitivo o afecte indebidamente la seguridad y el orden del Establecimiento Correccional del Condado de Essex. Las razones para negar la oportunidad de llamar a los testigos se hará constar por escrito y sera presentada en el expediente del detenido.
9. Se ofrecerá la oportunidad a un detenido de formular declaraciones y presentar pruebas, documentos u otra evidencia.
10. Se ofrecerá la oportunidad a un detenido de confrontar e interrogar a su acusador y a todos los testigos adversos, a menos que con ello pudiera resultar un peligro excesivo para la seguridad o para la institución correccional y podría poner en peligro la seguridad física de un testigo. Las razones para negar la oportunidad de interrogar a los acusadores o testigos de cargo se hará constar por escrito y presentada en el expediente del detenido.
11. Audiencia-Ausente podrá celebrarse si el detenido se niega a asistir a la audiencia disciplinaria. La documentación de esta negación se informará por escrito.
12. En caso de que sea necesario hacer una investigación más profunda, la audiencia disciplinaria podrá ser pospuesta por el Consejo de Disciplina / Oficial de la Audiencia hasta por 48 horas para casos de detención previa a la audiencia y durante siete días para todas las otras audiencias.

L. Remisión a la Fiscalia

Todas las violaciónes a las reglas que pueden constituir crímenes de primer, segundo, tercer o cuarto grado en el Código Penal del Estado de Nueva Jersey (N.J.S.A. 2C:1-1 et seq.), se remitiran al Fiscal del Condado de Essex.

M. Decisión del Consejo de Disciplina / Oficial de Audiencias

Al término de la audiencia disciplinaria, el Consejo de Disciplina / Oficial de Audiencia emitirá una decisión por escrito. Esta decisión deberá contener:

1. El hallazgo sobre la cuestión de la culpa
2. La sanción impuesta
3. Un resumen de las pruebas en que se basan las conclusiones con la excepción de la información confidencial que fue retenida por razones de seguridad
4. Una lista de todos los testigos no confidenciales
5. La razón solicitada del porque los testigos no fueron llamados a comparecer o no se les interrogo, si es aplicable.
6. La razón de la sanción, que deberá incluir factores tales como antecedentes del delincuente y las circunstancias del delito;
   a. La fecha y hora de la audiencia disciplinaria, y
   b. Las firmas de todos los miembros de la junta o el oficial de audiencia.

N. Apelación de Decisiones Disciplinarias

1. El detenido será informado de su derecho a apelar la decisión del Consejo de Disciplina / Oficial de Audiencia.
2. Apelaciones a las decisiones disciplinarias serán presentadas al administrador del Establecimiento Correccional del Condado de Essex por escrito, dentro de las 48 horas de la audiencia disciplinaria.
3. Apelaciones a las decisiones disciplinarias serán revisadas por el administrador del Establecimiento Correccional del Condado de Essex, que acreditará, derogara o rebajara la decisión. El administrador puede reducir, pero no puede aumentar la sanción impuesta por el Consejo de Disciplina / Oficial de Audiencia.
4. Copias de la apelacion y la disposición en la apelación se remitirá a la Junta Disciplinaria / Oficial de la Audiencia y la Unidad de Clasificación para sus archivos.

O. Expurgamiento

1. Si el Consejo de Disciplina / Oficial de Audiencia encuentra que el detenido es inocente de los cargos, todas las referencias a la infracción, se retirarán del expediente de clasificación del detenido.
2. Copias del formulario disciplinario, la hoja de investigación y de adjudicación deberán ser mantenidas por el Establecimiento Correccional del Condado de Essex, el Consejo de Disciplina / Oficial de la Audiencia y la Unidad de Clasificación en caso de una revisión judicial, y para efectos estadísticos y de contabilidad. Estos registros se mantienen por separado.

P. Detención Disciplinaria

<u>Colocación en Detención Disciplinaria</u>

La decisión de colocar a un detenido en detención disciplinaria sólo podrá efectuarse por el Consejo de Disciplina / Oficial de Audiencia sujeta a revisión por el administrador del Establecimiento Correccional del Condado de Essex.

Tiempo Mandatorio en Detencion Disciplinaria

1. Los reclusos pueden estar bajo detención disciplinaria por el Consejo de Disciplina / Oficial de la Audiencia por un período no mayor de 15 días como resultado de un cargo disciplinario único.
2. Los reclusos declarados culpables de varios cargos disciplinarios puede recibir hasta 15 días de detención disciplinaria por cada cargo, siempre y cuando el tiempo total a servir no exceda 30 días.
3. El tiempo asignado a un recluso en detencion disciplinaria sera proporcional al delito cometido, teniendo en cuenta:
    a. La gravedad de la infracción
    b. La conducta previa del detenido
    c. El programa de necesidades específicas del detenido
    d. Otros factores relevantes.

Problemas de Disciplina Durante la Detención Disciplinaria

En el caso de nuevas infracciones disciplinarias cometidas por el recluso durante su detención, se le imputara la violación pertinente y se le concederá una audiencia disciplinaria.

Q. Correspondencia, Visitas y LLamadas Telefonicas

1. Reclusos puestos en detencion diciplinaria tendran las mismas oportunidades de correspondencia que estan disponibles para los reclusos de la poblacion general.
2. Reclusos puestos en detencion diciplinaria perderan la oportunidad a tener visita o llamadas telefonicas, con excepcion de las llamadas de su abogado.
3. El administrador de ECCF podra autorizar una visita especial o una llamada telefonica de un recluso cuando existan razones apremiantes.
4. Debera hacerse todo lo possible para notificar a los individuos en detencion diciplinaria acerca de la restriccion de las visitas antes del proximo dia de visitas. Si existe tiempo suficiente para la correspondencia, la responsabilidad de esta notificacion sera del recluso.

R. Violaciones Criminales

Todo detenido está sujeto a todas las leyes de los Estados Unidos y del Estado de Nueva Jersey. Cualquier detenido que viole estas leyes puede ser acusado de cargos criminales y juzgado por dicha violación en la corte local, estatal, o federal. Se le notificara formalmente si usted es acusado de una violación penal mientras este en custodia.

La presentación o disposición de los cargos en una corte judicial de registro por la violación de leyes locales, estatales o federales, no impide en modo alguno, no previene ni afecta la tramitación administrativa del mismo hecho como un asunto disciplinario institucional, ni de tomar una acción disciplinaria contra el detenido en cuestión.

17. Rutina Diaria

Despertar – Se convocara al conteo a las 05:30 horas cada mañana y todas las luces de las céldas en el área de las viviendas serán encendidas.

Llamada de Recuento – se puede efectuar a diferentes horas. Cuando se anuncia una llamada de recuento, todos los reclusos inmediatamente se encerraran y mantendran erguidos en su céldas, o literas asignadas en un dormitorio, vestidos completamente, hasta el termino del recuento por un

oficial. Toda actividad cesara durante la llamada de recuento tal como uso de teléfono, television, recreacion , etc. Se prohíbe cualquier interferencia durante el recuento.

Inspección - Los reclusos deben estar limpios y listos para la inspección de las 07:30 horas, esto incluye la cama tendida, el escritorio en orden, el estante y el piso despejado y limpio totalmente. La ropa debe estar en los ganchos de la pared o doblada cuidadosamente en una litera.

Actividades - Las actividades de la unidad de alojamiento o del dormitorio o el ejercicio de los privilegios comenzarán **solamente** si la unidad está en condiciones seguras e impecables!

Recreacion en la Unidad de Alojamiento – Entre los pasatiempos se pueden incluir el acceso a la television, a películas o juegos y los juegos de mesa. Los televisores están disponibles para su uso siempre y cuando este privilegio no se suspenda debido a un comportamiento inadecuado.

Recreacion Exterior - Usted tendra una oportunidad de participar por un mínimo de una hora de ejercicio físico y de recreacion cada día fuera de su unidad de vivienda. Las oportunidades recreacionales al aire libre se pueden limitar debido al tiempo inclemente o por problemas de seguridad física. La recreacion interior no es un sustituto de la recreacion al aire libre.

El uso de la yarda de recreacion se puede denegar y esta a discreción del oficial durante o después de cualquier situación inesperada dentro del reclusorio penitencial.

Los reclusos que violen cualquier acto prohibido dentro del área de recreacion exterior pueden ocasionar la suspensión de recreacion exterior para la unidad de alojamiento en su totalidad.

Las horas típicas de recreacion son de Domingo - Sábado:

- 07:00 horas – 12:45 horas
- 15:00 horas – 20:45 horas

Encerramiento- Usted debe ir inmediatamente a su célda o a su área de dormir. Si esta en una célda, usted debe asegurar su puerta. Usted se encerrara rápidamente y de una manera ordenada. Este ejercicio se ejecutara durante los recuentos de la población regular, intercambio de la población reclusa, distribucion de medicamentos o articulos de comisario, encerramiento nocturno, cualquier acontecimiento imprevisto/programado, y cuando este a discreción del oficial. La denegación o un retardo en conformidad puede dar lugar a una acción disciplinaria. **Una orden de lockdown será llamada antes del momento señalado para encerramiento.** Usted debe proceder directamente a su celda asignada. Esto se hace para poder hacer un conteo exacto. Todos los privilegios pueden cesar a discreción del oficial antes de un encerramiento. Esto incluye, pero no se limita a, uso de teléfonos, agua caliente, servicios de barberia, oracion de grupo, servicio de lavanderia, recreacion, duchas, limpieza, biblioteca juridica y el uso de la television.

Apagon de Luces - Las luces se apagaran después que el recuento oficial este claro y conforme, durante el cambio de puesto a las 2200 horas y seran encendidas a las 0530 horas. Se guardara silencio después de que se apagen las luces.

Usted es responsable de mantenerse alerto y participe durante el recuento en horas prescritas o cuando sea ordenado por un oficial.

18. Conteo Oficial

Con el fin de mantener la cuenta correcta de los reclusos en esta instalacion, realizamos cuentas oficiales un mínimo de seis veces al día. El conteo es realizado al principio y al final de cada turno. Usted está obligado a participar de dicho conteo en conformidad con las reglas.

- Cuando cualquier oficial requiera un recuento, usted se debe de reportar a su cama o a su celda respectiva y encerrarse.
- Toda actividad se paraliza durante el recuento tal como uso de teléfono, television, actividad recreacional, etc.
- Tras reportarse a su celda o cama, debe permanecer allí hasta el final de la cuenta, hasta que el oficial de vivienda lo solicite.
- Cuando el oficial de su unidad se acerque, ustead debe tener lista su identificacion y remover cualquier pedazo de tela o ropa que cubra su cabeza o cara.

Durante todo recuento oficial, no está permitido ningun tipo de conversacion o movimiento. Cualquier interrupción del recuento puede resultar en una sanción disciplinaria contra los que contribuyan a dicha interrupción.

Es su responsabilidad estar presente y ser contado durante cualquier clase de recuento que se haga y de seguir las instrucciones que efectúe el personal correccional durante el recuento. No seguir los procedimientos establecidos para dicho conteo sera motivo suficiente para una sanción disciplinaria en su contra.

19. Movimiento de Reclusos Dentro del Reclusorio Penitencial

Cuando se encuentre fuera de los límites del área de su unidad, individualmente o durante un movimiento masivo, usted caminará en forma ordenada, en fila india, solo, a lo largo de la pared a su derecha. No se permite ningun tipo de conversacion. Cuando cualquier miembro de personal, o visita este en los pasillos, los reclusos pararán y harán frente a la pared, a su derecha, hasta que pasen. Se le prohibe detenerse en cualquier area que no sea su destino. Usted estara sujeto a un registro personal y de propiedad. No se puede correr, merodear, comer o beber en los corredores. Normalmente, no se permitirá llevar o tomar cualquier cosa con usted durante una maniobra. Se permitirá tomar solamente los materiales legales necesarios para la corte, las visitas legales y material educativo o señalado en la sala de clase. Todo medicamento necesario tal como inhaladores o nitroglicerina puede mantenerse con la persona (K.O.P.) según lo autorize el departamento médico.

20. Ropa

Todos los reclusos deben estar vestidos completamente, con su uniforme distintivo del condado o con ropa comprada del comisario cuando este fuera del área individual, de su célda o de su litera; esto incluye su uniforme completo, sus calcetines, ropa interior, y calzado apropiado. Usted debe usar su uniforme completo hasta que usted se reincorpore a su célda al final del día.

Uniforme Completo

Un uniforme de preso completo consiste de la camisa y los pantalones que combinan con el área apropiada; o cuando se permite un atuendo completo de sudor de la comisaría. No se permite mezclar uniformes separados.

Toda ropa emitida será usada según las especificaciones estipuladas en las instrucciones y de ninguna otra forma. Estos requerimientos son imprescindibles y estan en conformidad con la seguridad, higiene y conducta correctas.

- Los reclusos siempre deben usar su uniforme completo antes de salir de su celda o dormitorio, incluyendo el trayecto hacia la, y desde el área de ducha.
- Siempre debe usar zapatos que deben cubrir completamente sus pies al salir y/o entrar a la ducha.
- Los reclusos deben usar su uniforme completo mientras esten de visita médica, con cita en corte, durante los servicios religiosos, durante el periodo de visita, en la biblioteca de leyes y mientras que esten en el área del dayroom.
- Las sudaderas del comisario no se pueden usar como uniforme al salir de los límites de una unidad de alojamiento o de un dormitorio.
- Al entrar en la yarda recreacional usted debe estar en uniforme completo. Antes de concluir su ejercicio fisico y al salir de la yarda de recreacion, los reclusos deben estar en uniforme completo.
- Toda ropa debe **ser usada apropiadamente** y también **de la talla correcta** (los **pantalones deben estar en la cintura y no por debajo de la cintura, no se puede mostrar la ropa interior**, no se puede remangar las camisas, la ropa no puede ser de talla grande excesiva, etc…).
- La ropa interior se puede usar sin uniformes solamente mientras que este dentro de los dormitorios o banos. ¡**NINGUNA EXCEPCION!**
- Solamente se podra usar gorras aprobadas para uso de la población en general a menos que sean aprobadas como artículos religiosos por el capellán del reclusorio penitencial. Se dara a los trabajadores la cubierta de cabeza apropiada cuando sea requerido, que será usada solamente mientras que realiza deberes relacionados con el trabajo.
- Los trapos de nylon en la cabeza se pueden usar solamente en las celdas de la unidad de alojamiento o dentro del dormitorio.
- Ningun artículo de ropa se puede usar de una forma inusual, no prevista normalmente para ese artículo (el uso de una camisa como cinta en la cabeza , remangando los pantalones arriba de las rodillas, usando calcetines en los brazos,o las sabanas o mantas que se usan, etc.).
- Ningun artículo de ropa se puede alterar de su forma original (ejemplo: corte de pantalones para hacer “shorts”, coser los bolsillos, descolorizarlos intencionalmente, disenar dibujos, rasgarlos, recortarlos, etc.).
- La ropa debe estar limpia y en buena condición. Toda ropa rasgada no es ropa autorizada.

Intercambios de Ropa

Todo intercambio será hecho a petición del supervisor de la unidad de alojamiento. El resto de trabajadores voluntarios podran intercambiar ropa exterior según la norma y el reglamento del reclusorio penitencial. Toda clase de ropa será devuelta al momento de su liberacion. El no devolver cualquier artículo que no sea de su pertenencia, dará lugar a una deduccion de dinero permanente de su cuenta personal.

Acumulamiento de Ropa

Para asegurar una provision adecuada de ropa y trapos limpios para todos los reclusos, la acumulacion y las lineas de tender ropa estan terminantemente prohibidas.

Vestimenta Para Aparecer En Corte

Se proveera a los reclusos de su ropa personal para aparecer en corte solamente. Si los reclusos no tienen ropa apropiada, se les permitirá pedir ropa apropiada a la familia o amistades. Al momento de entrega, la ropa será examinada para evitar contrabando. Si los reclusos no se visten en un tiempo razonable (15 minutos) para ir a la corte, se le hara saber al juez.

- La ropa a usarse en la corte será aceptada veinticuatro horas al día, siete días a la semana en la sala de visita, permitiendo a los reclusos que aparezcan ante la corte de juicio la ilimitada oportunidad para el intercambio de ropa.
- Ningun recluso puede tener más de dos juegos de ropa guardados en ECCF en un momento dado. Por lo tanto, el intercambio diario de ropa será hecho a través de la sala de visita de ECCF.
- Solamente las corbatas con broche o sujetador serán permitidos.
- Por razones de seguridad, los zapatos deben ser sin cordones o tipo Velcro, zapatos suaves de caucho, tipo Velcro ®
  - Sandalias o zapatos abiertos en la punta del pie no son aceptables.
  - Botas no son aceptables
  - Zapatos con lazos o cordones no seran aceptados
  - Ningun calzado que contiene metal será aceptado.
- En el caso de los **reclusos indigentes** que se ordenen vestir para ir a la corte, el ECDOC hará disponible pantalones de color caqui grises, una camisa blanca, y tipo de zapato tenis- blanco con sujetadores de Velcro
- Correas y sujetadores no serán aceptados.
- La joyería se limita al uso de un anillo de boda y a un pendiente religioso (no se permitirá ningun broche, alfiler, etc.)
- Toda ropa que contenga metal de alguna forma o clase (lentejuelas, adornos, piedras decorativas, etc.) no será aceptada.

21. Higiene Personal

Usted vivirá en una unidad de alojamiento o en un dormitorio seguro con otros individuos, así es que la higiene personal es esencial para promover un ambiente limpio, armonioso y saludable. Se requiere a los reclusos a mantenerse limpios y a usar la ropa y el calzado apropiado durante todas las actividades. Cualquier desviación de mantener buena higiene personal y de usar la ropa apropiada potencialmente podría causar conflictos con sus semejantes y con otros. La falta de higiene personal o los hábitos antihigiénicos puede también tener un impacto negativo en su propia salud, su seguridad y la de otros. No seguir los estándares del código de vestimenta y de arreglo personal podría convertirse, en última instancia, en un problema que va a requerir la intervención del personal, incluyendo la sanción disciplinaria respectiva.

1. Todos los reclusos tienen la oportunidad de banarse a la hora de entrada al ECCF y se les pide a todos bañarse regularmente. Además, si la seguridad lo permite, los reclusos pueden banarse por lo menos una vez al dia y siempre deben mantener sus celdas limpias. Todo recluso mantendrá siempre un aspecto aceptable, libre de hedor u olores repulsivos, ésto implica el uso de un uniforme autorizado completo (inalterado) y de acuerdo a su talla, con el cabello cuidadosamente cortado, y con los dientes bien cepillados.
2. Los artículos de higiene personal tales como jabón, crema dental, cepillos de dientes, peines, cepillos para el pelo y otros artículos le serán entregados durante su admisión. Si se le acaba cualquier artículo después de su uso, usted debera comprarlo a través del comisario o poner su nombre en la lista para indigentes si fuera aplicable.
3. Todo recluso deben mantener su cabello limpio. Por razones de salud individual y pública, el personal médico puede ordenar a cortarse el cabello.
4. Las uñas de las manos y de los pies estarán limpias, aseadas y siempre bien recortadas.
5. Las reclusas obtendrán toallas sanitarias a solicitud o petición.

6. Todo preso debe lavarse las manos con frecuencia y cada vez que toque algo humedo o mojado, sea cual sea el momento. Utilize jabón y agua para lavarse las manos y una toalla limpia o papel toalla que se pueda tirar a la basura.
7. No debe prestar o permitir a otro recluso usar su maquina de afeitar, su ropa si esta manchada o sucia, su jabón o su toalla de uso personal.
8. Lave las toallas, los trapos y la ropa a menudo. Cuelgue las toallas y los paños mojados afuera para secarse cada vez que se usen.
9. Después del ejercicio fisico, limpie las bancas y equipo que uso con una toalla seca.
10. La evidencia de bichos, insectos o enfermedades contagiosas será puesta en conocimiento y atención del personal correccional de la penitencieria inmediatamente.
11. Vea a la enfermera por cualquier herida inusual, barros o espinillas que no curen. Si el doctor le receta antibióticos, tome todo el medicamento recetado. Mantenega cubiertas las heridas abiertas y cambie los vendajes con frecuencia; evite el contacto con vendajes manchados de otra persona.

22. Servicios de Barberia

Se permite a todo lo recluso cortarse el cabello por el peluquero aprobado por ECCF que está en la unidad de alojamiento. Todas las actividades relacionadas con el peluquero serán conducidas en su unidad de localizacion; esta institución penitenciaria no tiene centralizado el servicio de peluqueria. Todo el equipo del peluquero se asegura en un armario de almacenaje al lado del escritorio del oficial. Los cortes de cabello se hacen sin costo alguno una vez al mes. Usted puede recibir su primer corte de pelo 30 días después de su entrada y aproximadamente cada 30 días después de esa fecha. La regla de 30 días se puede aplazar por una orden médica o por razones de seguridad y para los detenidos que tienen que comparecer en la corte. Se cortara el cabello a los **que comparezcan en corte** dentro del plazo de 3 días antes de la fecha de juicio. Los recortes con estilos exagerados que incluyan diseños, letras, insignias relacionadas con sus pandillas y formas especiales no se permitiran.

Ordinariamente, los reclusos pueden usar cualquier estilo de cabello dentro de ciertos límites razonables, seguros e higiénicos y con pelo facial con estilo, con las excepciones siguientes:
1. Por razones de seguridad y de higiene, los trabajadores de la cocina mantendrán su cabello con un estilo aseado, limpio y generalmente aceptado.
2. Todos los trabajadores de la cocina usarán una proteccion o redecilla de cabello y de la barba (en caso necesario) al momento de trabajar en la cocina.
3. Los reclusos deben mantener su pelo limpio. Por razones higienicas, tanto individual como pública, el personal médico puede ordenar a cualquiera, a cortar su cabello.

Todos los recortes de pelo serán hechos durante el horario aprobado para recreacion.
- 07:00 horas – 12:00 horas
- 15:00 horas – 20:00 horas

Las horas de operación y de disponibilidad del equipo del peluquero pueden ser suspendidas por el oficial o el supervisor de la unidad de alojamiento si está en conflicto con la seguridad o el funcionamiento ordenado de la institución carcelaria.

23. Condiciones Sanitarias

Una institución correccional limpia ayuda a la seguridad y salud personal del recluso. Es de interés personal, mantener un área limpia y evitar problemas de salud y de seguridad asociados con condiciones antihigiénicas.

1. Cuando su cama no este en uso, mantengala de acuerdo a las reglas de la carcel. Se requiere que usted mantenga su cama y área limpias, aseadas y libres de mal olor. También se requiere tender su cama diariamente antes de reportarse para su asignación de trabajo o rutina diaria. No se permite a los reclusos cubrir, colgar, o atar mantas, sabanas, toallas, ropa, o ningun otro artículo a las paredes, ventanas, literas, conductos de aire, puertas o accesorios de luz en ninguna parte dentro de ECCF. Una iluminación adecuada y una visión sin obstáculos se deben mantener siempre a través del centro correccional.
2. El deposito y almacenamiento de efectos personales, incluyendo artículos de higiene, se debe hacer de acuerdo con las reglas y procedimientos establecidos. No se debe colocar artículos en ninguna localización no autorizada, por ejemplo en las ventanas, literas, armarios, debajo del colchón, etc. Articulos que esten en violación flagrante de las reglas de almacenaje pueden ser confiscados y retirados del área no autorizada. Si sus artículos se confiscan por estar colocados en un área no autorizada, es su responsabilidad identificarlos y reclamarlos al supervisor respectivo.
3. Todos los reclusos realizarán deberes de limpieza doméstica según lo dirigido por el oficial de la unidad de alojamiento. Los utensilios de limpieza serán proporcionados a discreción del oficial.
4. Los reclusos podran usar las lavadoras y secadoras cuando sea posible en el cuarto de lavanderia de su unidad, para lavar sus uniformes, sabanas, almohadas, toallas, y otros articulos personales. Observe el horario de lavanderia en su unidad de alojamiento. Las mantas se lavaran en la lavanderia principal del recinto penitencial.
5. Se espera que usted mantenga **el más alto nivel de pulcritud** en lo que se referiere a la eliminacion de la basura.
   - **NUNCA** use el toilet o retrete para eliminar cualquier cosa excepto materia fecal.
   - Usar el retrete como tacho de basura para eliminar basura, comida, materiales de vestir y artículos del comisario esta terminantemente prohibido.
   - Si se atora el retrete o toilet de su célda, y se determina que fue debido a su uso indebido, como por ejemplo, darle uso como tacho de basura, entonces usted sera responsable y sufrira las siguientes consecuencias:
     - Si se determina que es responsable de atascar adrede el retrete, entonces usted tendra que costear los gastos de reparación y el salario por cada hora de mantenimiento.
6. Al ser puesto en libertad, la célda que usted desocupe se debe esterilizar correctamente para el alojamiento de nuevos reclusos. Los colchones se limpiarán y esterilizaran antes de ser puestos en circulacion nuevamente.
7. Esta institución correccional proporciona un control regular de parásitos y bichos atraves de un exterminator profesional. Usted es responsable de asistir en estos esfuerzos limitando la cantidad de artículos del comisario, de materiales personales, etc. que guarde o mantenga en su área. También, usted debe de comunicarselo al personal si encuentra algun parásito y/o bichos.

24. Comidas

Todas las comidas servidas por nuestra institucion correccional estan balanceadas nutricionalmente y preparadas adecuadamente por un dietista. Sólo se sirve comidas saludables y nutritivas en un ambiente pulcro y seguro. No se usa la comida como instrumento de castigo o recompensa. Todos los

detenidos serán incluidos en las comidas con un menú estándar a menos que una solicitud de dieta especial para algún recluso sea aprobada.

Se servira tres comidas en los tiempos regulares de alimentacion durante las 24 horas al dia. Dos de las tres comidas proporcionadas serán comidas calientes a menos que una situación de emergencia imposibilite su suministro. No transcurrirán más de 14 horas entre la cena y el desayuno.

Cuando se sirvan las comidas, todos los reclusos se tienen que alinear en forma ordenada sin cortar o adelantar la linea, siguiendo las instrucciones del oficial. Los reclusos no intentarán obtener más comida en sus bandejas solicitandola a los trabajadores del área de la despensa. Se ha impartido instrucciones a los trabajadores de la porcion de comida apropiada que debe ir en las bandejas según lo especificado en la hoja de inventario de suministro de alimento. Los reclusos recibiran sus alimentos y procederán a las áreas señaladas para comer. Al término de la misma, limpiarán sus áreas y devolveran las bandejas al punto designado para su colección.

Usted puede pedir un regimen alimenticio (menú de dieta religiosa) cuando sea apropiado. Otros pedidos especiales de dieta por razones religiosas se deben referir el capellán para la evaluación pertinente. Si usted tiene una necesidad dietética especial debido a razones religiosas o de salud, es su responsabilidad pedir una dieta especial que satisfaga sus necesidades. Su petición será evaluada para asegurar de que se le proporcionará los alimentos requeridos apropiados.

Toda solicitud de dieta especial por razon medica se referira al personal medico para su evaluacion.

25. Comisario

1. Los reclusos pueden comprar alimentos, ropa y otros artículos personales seleccionándolos de una lista aprobada de artículos disponibles de la comisaría. Los formularios y horarios de solicitud y entrega de las compras de comisaría se publican en cada unidad de vivienda.
2. Los reclusos deben tener suficiente dinero en sus cuentas personales para abonar sus compras. Si no hay suficientes fondos, el formulario de pedido de la comisaria se llenará hasta el límite de los fondos disponibles. Cualquier peticion de informacion de cuenta del comisario debe ser dirigida al oficial de vivienda, quien podria remitirla al secretario del comisario.
3. Los reclusos deben acusar recibo de los articulos recibidos en el formulario de pedido del comisario atraves de su firma personal y con sus fotografias y números de identificación de cárcel verificada.
4. Conforme a 30:4 de NJSA - 15.1, el centro correccional ECCF recibe un impuesto del 10% del precio de venta por cada artículo vendido del comisario. Estos fondos se remiten al Tesorero del Estado de New Jersey, a la cuenta de depósito, para la Compensacion a las Víctimas de Crimen.
5. Los fondos monetarios se pueden transferir a una cuenta del comisario establecida para los reclusos usando la pagina en el internet www.offenderConnect.com (de acceso 24 horas al día).
6. La comisaria es un privilegio que se puede suspender por razones disciplinarias.
7. El orden del comisario se puede hacer en la Tableta (NOTA: es aquí donde solicita los minutos para los servicios pagados de la tableta).

26. Entrada y Salida del Correo Postal

Usted tiene el derecho de mantener correspondencia con las personas u organizaciones relacionadas con la seguridad y operación ordenada de la institución correccional. Todas las cartas que se reciban o remitan están sujetas a inspección, tanto en su contenido,o como contrabando. Usted es responsable del contenido de lo que remite o envía.

Si elige mantener correspondencia con otros, usted debe seguir los siguientes lineamientos establecidos:

1. Los privilegios del servicio de correo para los reclusos tendran la misma proteccion, semejante o igual a la proveida a los ciudadanos libres. No habrá restricción en cuanto a la extension, idioma, o contenido que tienen las cartas, o en el número de personas a quienes un recluso desea escribir, excepto donde exista conflicto para garantizar los intereses de seguridad de la institución correccional ECCF.
2. Los siguientes estándares serán aplicados a la correspondencia que se recibe o remite:
   Una correspondencia privilegiada existirá entre reclusos y abogados, defensores públicos, reclusos que abogen por otros, jueces, secretarios de las cortes federales, estatales, y locales; el Sheriff, Director, Freeholders del Condado de Essex; el Gobernador y el Procurador General de la República, y Legisladores del Estado de New Jersey; el Presidente y el Vice Presidente de los Estados Unidos, y los miembros encargados de su libertad condicional.
3. **Correspondencia hacia o proveniente de otros reclusos**
   Toda correspondencia hacia o proveniente de unos a otros reclusos detenidos en el centro correccional ECCF o en otras instalaciones correccionales se podra leer para garantizar de que la correspondencia no contenga ningun mensaje prohibido por N.J.A.C. 10A: 18-2.14. El correo directo interno (de recluso a recluso o cometas) no se permite en esta institución correccional. Cualquier correspondencia dentro de la institucion se debera enviar primero, fuera del recinto carcelario para luego cambiar su curso y dirección nuevamente hacia dentro de esta institucion; todo correo será abierto y examinado para asegurar de que no hay contrabando y devuelto al recluso integramente.
4. Todo correo que sale será sellado y entregado a los oficiales de la unidad de localización para ser colocados en la caja de correo postal situada en la sala de correo durante horas normales de operación, o se depositarán en la caja fuera de la sala del correo postal en cualquier otro horario. Todo correo devuelto a la institucion correccional será abierto, examinado por si hay contrabando y devuelto intacto a los reclusos.
   Al remitir, los reclusos deben imprimir claramente la siguiente informacion al frente de todos los sobres que contienen el correo postal que sale:

   Nombre del Recluso
   Número de Encarcelamiento, Número de Celda de la Unidad de Alojamiento
   Essex County Correctional Facility
   354 Doremus Avenue
   Newark, NJ 07105

   La correspondencia remitida será cerrada y sellada por el recluso, sin examinar o censurar a menos que haya evidencia o sospecha de contener contrabando, o sospecha de que implique una actividad criminal delictiva.
5. Sobres con estampa están disponibles para la compra a través del comisario. Los reclusos indigentes pueden pedir hasta tres sets o juegos completos de papel para escribir cartas y tres postales estampadas cada semana. Los materiales del franqueo y de escritura tambien serán proveidos para el correo legal de reclusos indigentes a través del intermediario. (ombudsman)
6. Todo envio de correo se recibe en la sala de correo postal de la institución correccional ECCF al final del día y se entrega a las unidades de vivienda para su distribución al día siguiente.
7. Los reclusos pueden comprar revistas, periódicos, boletines de noticias, y libros siempre y cuando el contenido no se juzgue subversivo, inflamatorio, perjudicial o como una amenaza a la seguridad. El número de artículos puede ser limitado con ciertas exclusiones como materiales

espirituales, sagrados, y educativos. Se apoya a los reclusos a donar los libros y revistas que no usen a la biblioteca.

8. ECCF solamente aceptará paquetes para los reclusos que se envíen directamente a traves de companias de venta (editoriales, distribuidores) o por correo.
9. Las fotografías Polaroid no serán aceptadas a través del correo postal.
10. Ningun recluso coleccionara o recogerá el correo perteneciente a otro. Solamente el personal correccional podrá estar a cargo del correo postal remitido o del remitente.

Todo correo postal recibido que no cumpla el stándard y reglamento establecido por la institución correccional será considerado como contrabando y retenido. La correspondencia que puede ser rechazada incluye, pero no se limita a, los artículos con el siguiente contenido:

- Todo material que representa, describe o enerva a actividades que podrían conllevar a irrupciones de violencia física o de grupo.
- Toda información con respecto a la fabricación de explosivos o de armas; información con respecto a diagramas de escape, planes para cometer actividades ilegales o para violar pautas de las reglas o del centro penitenciario ECCF.
- Toda nformación referente a la producción de drogas o de alcohol
- Todo material explícito sexual
- Toda amenaza, extorsión, obscenidad o blasfemia
- Todo mensaje codificado
- Toda correspondencia con un forro grueso de proteccion o de cubierta dura.
- Cualquier cosa que afecte a la seguridad del centro correccional; o cualquier otro contrabando.

Todo correo recibido se entrega normalmente en un plazo de 24 horas de recibo por el personal del reclusorio penitencial, y el correo remitido será entregado a la oficina postal correspondiente a no más tardar , un día después de acusar su recibo por el personal de la institucion correccional (excepto fines de semana y días de fiesta). La única excepción es el correo que requiere un procedimiento especial para los propósitos de seguridad. El correo postal se puede entregar a las unidades de alojamiento una vez abiertas y examinadas.

Cuando usted sale de la institucion correccional, sus cartas y correo postal en general serán marcadas “Return to Sender” y devuelto a la oficina de correos.

Correspondencia entre reclusos

Toda la correspondencia hacia o proveniente de unos reclusos a otros, detenidos en el centro correccional ECCF o en otra instalacion correccional se puede leer para asegurarse de que la correspondencia no conlleve ningun contenido prohibido.

Lápices, papel y sobres se pueden obtener del oficial de la unidad de alojamiento. También se pueden comprar del comisario. Los reclusos indigentes recibirán por lo menos tres sobres estampados por semana para su correo personal.

Correo Legal:

La correspondencia legal se puede retener por un período razonable (sin exceder las veinticuatro horas) para permitir la verificación del status o estado privilegiado del destinatario o del remitente. Toda correspondencia legal que se reciba, será abierta en presencia del recluso y examinada por contrabando

Toda correspondencia legal recibida será tratada como privilegiada solamente si el estado oficial del remitente y su nombre aparecen en el sobre. La correspondencia legal remitida requiere igualmente que, no sólo el nombre, pero también el estado oficial del recipiente aparezca en el sobre. Será su responsabilidad aconsejar a los remitentes de la correspondencia legal, de la informacion necesaria en

la etiqueta. **En todo correo postal legal remitido o del remitente se marcará "Legal Mail" en el sobre.**

Se permitirá a los reclusos indigentes enviar, a expensas del gobierno, una cantidad razonable de correspondencia relacionada con todo asunto legal, incluyendo la correspondencia a un representante legal, a un representante legal potencial, y a cualquier corte de justicia.

Usted es responsable de saber las reglas y las regulaciones individuales vigentes con respecto a la correspondencia del centro correccional ECCF. Usted es responsable del contenido de TODO su correo postal remitido.

27. Acceso al Teléfono

Acceso general al Teléfono

Se le proporcionará acceso a un teléfono durante el proceso de admisión y dentro de su respectiva área de vivienda durante su encarcelamiento. Cuando exista una gran demanda para el uso del teléfono, la institución correccional puede regular el tiempo que usted dispone para empezar y concluir su llamada. Sin embargo, la llamada no podra ser de menos de 15 minutos.

Llamadas Telefónicas

1. Al ser admitido al centro correcional (ECCF), las provisiones correspondientes serán adoptadas para que los reclusos hagan una **llamada gratis a** cualquier persona que eligan dentro del estado de New Jersey.
2. Hay teléfonos en cada unidad de vivienda de modo que los reclusos pueden hacer llamadas con cargo telefónico. (Collect phone calls)
3. Los reclusos pueden hacer tantas llamadas como sean necesarias para obtener consejeria legal con un abogado, y para hablar con su consejero acerca del estado o "status" de los cargos, de la fianza, y de otros asuntos legales.
4. Si los reclusos no pueden hacer llamadas telefonicas a sus familias u otros parientes o amistades, se debe hacer una petición por escrito al asistente social o al mediador (ombudsperson) indicando las circunstancias. Se pueden hacer ciertos arreglos para permitirle una llamada en situaciones de emergencia.
5. Todas las llamadas telefónicas están sujetas a supervisión y grabación del personal correccional.
6. Los miembros de familia pueden obtener información acerca de la fianza y de los cargos de arresto llamando al centro correccional ECCF con número de información pública 973-274-7500. Esta información también se puede obtener vía internet en la página www.essexcountynj.org
7. Cada recluso puede completar una lista teléfonica, incluyendo el nombre del recluso, firma personal, número de encarcelamiento, localización y la fecha. La lista de teléfonos debe ser completa y legible para ser procesada. Las listas del teléfono se pueden revisar solamente cada **60** días. Estos formularios serán proveidos por su representante de la unidad de vivienda.
8. Un número telefonico con su identificacion personal será publicado durante el proceso de ingreso; es su responsabilidad mantener este número en lugar seguro y privado.
9. Fondos o dinero disponible se puede transferir a la cuenta telefonica de los reclusos usando la pagina del internet www.offenderConnect.com (de acceso las 24 horas al día).
10. En cualquier momento que usted descubra que un teléfono no funciona, debe comunicarlo inmediatamente a los oficiales de la unidad de vivienda para poder hacer un pedido de reparación.

En caso de una emergencia, tal como enfermedad o muerte en la familia, usted debe pedir ayuda a su oficial de la unidad de vivienda para hacer llamadas telefónicas en horas en que los teléfonos no están normalmente disponibles. **Las llamadas telefónicas rutinarias a los abogados no se consideran generalmente como emergencias.**

Su acceso al teléfono puede ser limitado si se encuentra que usted esta violando las reglas de la institución correccional o se encuentra abusando del equipo. Su acceso puede también ser seriamente restringido si se determina que usted esta usando el teléfono para cualquier actividad ilegal.

Es de su entera responsabilidad, seguir las reglas de la institución correccional con respecto al acceso a los teléfonos y al uso apropiado del equipo, cuando lo este usando.

Las llamadas hechas desde los sistemas de teléfono para uso del recluso están sujetas a supervisión, con excepción de llamadas a un abogado, o a la Oficina de Asuntos Internos (Internal Affair Bureau). La institución correccional no puede supervisar las llamadas a su abogado.

28. Visitas Generales

Toda visita puede ser una experiencia que conlleve alto niveles de estrés y frustración no sólo para el recluso; pero, para su familia y amigos. Para hacer de las visitas una experiencia agradable, se requiere tomar un tiempo para leer y entender las reglas y las regulaciones de la visitas. La visita ayuda a cada uno de los implicados o involucrados con el recluso. Las visitas pueden alzar o levantar la moral de sus seres queridos y pueden ayudar a tener un ajuste más llevadero durante el tiempo de encarcelamiento y/o el reingreso. Asi mismo, las visitas pueden ayudar a mantener una relación con sus seres queridos más estable. El personal de la institución correccional ECCF **DESEA que** sus visitantes tengan una experiencia agradable. Sin embargo, todos los aspectos del programa de visita se deben respetar para asegurar la seguridad de todos. Es su responsabilidad entender las reglas y asegurarse de que los visitantes potenciales entiendan las reglas con respecto a la visita. La lista de visitas que incluye la adición y / o eliminación de visitantes se puede hacer en la Tableta.

Usted puede notificar a sus visitantes que una parada de autobús está situada en el estacionamiento nexo a la sala de visita y de ponerse en contacto con el Departamento de Tránsito de New Jersey para informarse de la ruta y horario de servicio y funcionamiento del autobus correspondiente.

Cada recluso debe completar una lista de visitas que incluye 7 nombres de adultos como posibles visitas, la dirección de sus domicilios, y su relacion, adjunto a su nombre, firma personal, número de celda, su localizacion y la fecha. La lista de los visitantes debe ser completa y legible, lista para su procesamiento. Los menores de edad y los representantes legales no tienen que ser incluidos en la lista. La lista de visitas se puede revisar solamente cada 60 días. Estos formularios serán proveidos por el representante de su unidad de alojamiento.

1. La limitación en el tiempo o frecuencia de visita(s) será impuesta solamente para evitar una congestion en el área de visita. Los horarios de visita se publican en todas las unidades de alojamiento y estan disponibles a petición del oficial o del ombudsperson o mediador, de la unidad de localizacion. Los horarios están sujetos a cambio si fuera necesario, para la seguridad y el orden general del centro correccional ECCF. Se hara una notificación apropiada de los cambios de horario a todos los reclusos y al público en general a través del personal encargado de la custodia y del servicio social.
2. Se permite a un total de tres visitantes por cada visita regular. No se permitirá a los niños menores de 18 años de edad visitar, a menos que esten acompañados por un padre o un guardian legal. Se hacen excepciones para los menores de edad emancipados, que poseen una

prueba de emancipación. Se permite recibir hasta tres visitas de diversos visitantes en el día asignado.

3. Todos los visitantes deben proporcionar sus credenciales vigentes limitados a: la Licencia de Conducir válida, a una Tarjeta de Identificacion Federal, del Estado, del Condado o del Gobierno Municipal vigente, sin caducar, con foto, o Pasaportes vigentes.
4. Los reclusos no estan asignados a las unidades solamente por la conveniencia de los privilegios de visita. Este privilegio se puede suspender o terminar basado en infracciones disciplinarias. A todo recluso que este en detención disciplinaria, no se le permitira tener visitas, con la excepción de emergencias de familia o de visitas del abogado, y con previa aprobación del director.
5. Durante las horas de visitas, los reclusos no dejarán sus áreas asignadas sin el permiso específico de un oficial correccional.
6. Los reclusos detenidos fuera de la institución correccional ECCF, por razones médicas no tendrán visitas a menos de que sea aprobado por el director y puedan ver solamente a familia inmediata.
7. Los reclusos deben comportarse de una manera correcta y ordenada durante la visita.
8. Se escoltará a la visita que se comporte de una manera indisciplinada, revoltosa o inadecuada inmediatamente fuera de la institución correccional, y si está justificada la accion, se les eliminara de la lista de visita aprobada previamente.
9. No se permitirá a las personas el uso de traje o vestimenta inadecuada para visitar.
10. No se permite a los reclusos recibir o dar artículos durante las visitas.
11. Los reclusos deben estar en uniforme completo mientras que tengan visita.

Pesquisas y Registros

El Oficial de la Sala de Visitas (VLO) no es responsable ni se hace cargo de la propiedad de ningun visitante. La visita recibira instrucciones de asegurar los bolsos de mano, los monederos u otros paquetes, para que estos artículos sean puestos fuera del lugar, en sus vehiculos, etc, o en los armarios o “lockers” que se proveen en la sala de recepcion o lobby. VLO no es responsable de guardar o asegurar ninguna propiedad de los visitantes.

Todos los visitantes que tienen acceso a la institución correccional ECCF pueden ser sujetos a un registro individual que incluye, y sin limitarse a:

a. Caminar através del detector de metales
b. Permitir la detección con la vara de escrutinio.
c. Permitir un registro de personas
d. Permitir el registro K-9

Si una visita se rehusa al registro o se encuentra en posesion de artículos de contrabando, sus privilegios como visitante serán terminados. El promover, introducir y poseer artículos de contrabando en la institución correccional ECCF es una violación del Código Penal 2C de New Jersey: 29-6 Instrumentos de Escape; Otro Contrabando, y N.J.S.A. 10A: 31-8 Seguridad y Control y los violadores estaran sujetos a penalidad y castigo conforme a esas pautas.

Estándares de Conducta, Requisitos de Entrada, y Reglas para la Visita:

- Tanto la visita como los reclusos se comportarán de manera que no atraigan sospecha o mala reputacion hacia sí mismos, ni deberan ser revoltosos u ofensivos a las sensibilidades de otras personas.

- Se requiere tanto a la visita como a los reclusos que obedezcan todas las instrucciones del personal del departamento así como todas las regulaciones relevantes de la institución correccional ECCF.
- No se debe fumar en el recinto penitenciario ECCF. No se permite ningun cigarrillo o material para fumar.
- No se puede traer al área de visita ningun alimento, excepto alimentos para niños.
- La visita tiene la responsabilidad de mantener control sobre los niños menores de edad. Si un menor de edad interrumpe, hace bulla y no es reprimido o controlado verbalmente por uno de los padres o encargados, la visita será terminada. La disciplina física de menores de edad no se permite en las premisas de la institución correccional ECCF.
- Todo visitante, incluyendo abogados y/o cualquier visita oficial, debe vestir ropa apropiada, convencional, que no sea indebida, provocativa, sugestiva o reveladora.
- La visita no puede usar ropa que se asemeje al traje del recluso, o usar adornos que se podrían utilizar como armas.
- Los visitantes pueden usar un anillo de bodas, medallas religiosas, pulseras y brazaletes de alerta médica.
- La visita no puede usar ropa que exhiba obscenidades, diseños de droga o alcohol, mensajes polémicos controversiales o blasfemia.
- La visita no puede usar ningun tipo de identificacion o exhibicion de pandillas en la ropa.
- La visita no puede usar sombrero o bufanda o caminar descalza.
- La visita no puede usar ninguna ropa que exponga indebidamente los hombros, pecho, espalda, parte posterior, estómago,o ropa de dos piezas, blusas sin espalda, traje de natacion, camisas para exhibir los músculos o pijamas.
- La visita no puede usar ropa fina, visible, de malla, o hecha de cualquier material transparente.
- La visita puede usar ropa diseñada o prevista para ser usada de manera firme, sin acentuar excesivamente el cuerpo.
- La ropa de la visita debe ser ropa hecha a la medida.
- Se debe usar ropa interior apropiada, no visible.
- Si viste faldas, pantalones, y pantalones cortos o shorts, no se pueden usar si estan a más arriba de cuatro pulgadas sobre la rodilla al estar en posicion erguida.
- La visita no intercambiará ningun artículo o propiedad con ningun recluso.
- Todos los visitantes deben llegar a la instalación una (1) hora antes del comienzo de la visita programada. Todos los visitantes deben consultar el cronograma de visitas que se publica en el vestíbulo público y el sitio web del condado en la instalación http://essexcountynj.org/corrections

Negación, Suspensión, Terminación y Revocación de Privilegios de Visita:

Si se encuentra a cualquier recluso en posesión de, o en uso de artículos de contrabando, durante o después de una visita, se asumira que el contrabando fue introducido por la visita más reciente que tuvo el recluso y el contrabando constituirá razon y sospecha suficiente para terminar todos los privilegios de visita.

Las razones por las que el privilegio de visita puede ser negado, revocado, suspendido o terminado puede incluir, sin limitarse a que :

- El recluso rechaze la visita
- La visita y/ o el recluso parecen estar bajo la influencia de productos tóxicos o exhiben un comportamiento revoltoso.
- La visita o el recluso infringen los requisitos de vestir
- La visita es incapaz de ensenar una identificación válida, vigente.

- La visita rehusa, o rechaza el registro
- La visita esta en posesión de articulos de contrabando
- La visita intenta introducir artículos de contrabando
- La visita hace caso omiso a las instrucciones impartidas por el personal de la institución correccional.
- La visita desatiende cualquier regla relevante al centro correccional ECC
- La visita crea un disturbio
- La visita no puede controlar a sus niños menores
- La visita se involucra en cualquier actividad que parezca ayudar al recluso en una tentativa de escapar
- El recluso o el visitante se involucra en cualquier comportamiento o acción que sea juzgada por el personal del recinto penitenciario como un atentado o como poner en riesgo la seguridad y el buen orden del centro correccional ECCF
- Cualquier tentativa de intercambiar artículos no autorizados
- El recluso o la visita usa un lenguaje ofensivo y obsceno con personal del departamento correccional.
- El recluso o la visita dañan o tratan de dañar la propiedad gubernamental o del estado.
- La visita intenta pasar contrabando de cualquier artículo dentro o fuera del centro correccional ECCF.
- El recluso no compartirá sus visitas con ningun otro recluso.
- El recluso no comerá ni beberá en el área de visita.
- El recluso o visita no hará ninguna accion o gesto obsceno.

Al visitante que le hayan negado, revocado, suspendido o terminado cualquier derecho a visita se le dara la razon por cual se le ha negado, revocado, suspendido o terminado sus derechos.

Se prohíbe a los que fueron reclusos anteriormente de visitar a cualquier otro recluso encarcelado en la institución correccional ECCF por un período de 60 días más allá de la fecha previa de liberacion.

Horario de Visita

Horario de Visita Sin Contacto:
Ver el Apéndice A

Horario de la Visita de Contacto:
** CRITERIOS ESPECIALES **
Ver el Apéndice B

Según lo programado por el Supervisor de Inmate Visits

No visitas los lunes, martes y viernes

Abogado/Consejeros Religiosos:
Diariamente
Ver el Apéndice A

Visitas al Hospital o Asistencia al Funeral:

La visita a los hospitals o la asistencia a entierros depende del estado jurídico del recluso. En casos de enfermedad seria, se le puede permitir una visita al hospital y en casos de muerte de un familiar, se le puede dejar ver en forma privada los restos o atender al entierro. Tal visita será solamente aprobada para los miembros de las familias inmediatas que se definan como padre, madre, marido, esposa, niño, hijastro, hermana o hermano del recluso.

El recluso estará siempre bajo custodia de dos o más oficiales y no se le permitirá ir fuera del Estado de New Jersey (30: 4-8.1). El asistente social o el ombudsperson asistirá a los reclusos que necesiten la obtención de la órden judicial requerida para tales visitas.

29. Visitas Del Abogado

Los representantes legales o paralegales pueden visitar a los detenidos durante las horas establecidas por el administrador de la institución, siete días a la semana. Usted puede solicitar reúnirse con su representante legal durante las horas de comida. Si usted solicita esta opción, se le proporcionará una bandeja de comida al final de su reunión.

Si usted ha hecho una cita con un abogado o un representante legal, es su responsabilidad cancelar la cita si usted no se propone guardarla. Las cancelaciones de cita no pueden ser hechas a su nombre.

30. Asistencia Médica

Durante su período de encarcelamiento, usted tiene el derecho a asistencia médica oportuna y adecuada si usted esta enfermo, herido o lastimado o si necesita tratamiento de cualquier naturaleza. Usted tiene la oportunidad de pedir asistencia médica en cualquier momento.

1. Un examen de salud y examen físico inicial se hara a todos los reclusos al momento de admisión al centro y antes de colocarlos en el área de localizacion y formar parte de la población general. La investigación incluye una prueba de tuberculosis y una encuesta de los problemas actuales que lo aquejan, cualquier enfermedad y previo record de salud.
2. Si está enfermo o necesita atención médica, o necesita atención de salud mental, debe completar una Llamada por enfermedad en su tableta. Existe un sistema de llamadas por enfermedad para acceder a los servicios de atención médica. La llamada por enfermedad está disponible a través del sistema de tableta. La llamada por enfermedad se lleva a cabo todos los días, los 7 días de semana. En el caso de que el sistema de tableta no funcione, se proporcionará un formulario en papel para que lo llene y lo entregue al oficial de la unidad o al personal médico.
3. El tratamiento médico de emergencia está disponible siempre. Los reclusos deben informar inmediatamente a los oficiales de su unidad de vivienda de que requiere atención médica y ellos lo referirán a un médico facultativo. Los reclusos que tienen o que observan a otro recluso con una emergencia médica deben informar inmediatamente al oficial de la unidad de alojamiento de servicio y se pondrán en contacto con un miembro de personal médico de turno.
4. Los reclusos con problemas médicos especiales deben comunicarlo expresamente a la atención de las enfermeras o del personal médico.
5. El asesoramiento de emergencia y los servicios médicos de salud mental, y los referidos estan disponibles en la institución correccional ECCF para todos los reclusos con un historial de enfermedad mental y para los que esten experimentando trauma, ansiedad o depresión. Los presos deben informar al oficial de vivienda de la necesidad de tales servicios cuando la situación asi lo apremie.
6. La información sobre la prevención, reporte de abuso sexual o asalto sexual, y la seguridad del tratamiento y asesoramiento de servicios está disponible por el oficial de la unidad de

vivienda, de la enfermeria, del doctor, del psicólogo, del asistente social, del ombudsperson, y del personal correccional disponible.

7. Los reclusos pueden tener acceso al servicio dental a través del sistema de la llamada para enfermos. Los servicios dentales de emergencia estan disponibles 24 horas al dia, 7 días a la semana.
8. Los reclusos que usen gafas, (lentes, espejuelos, o anteojos) pueden comprarlas a través del proveedor de servicios médicos. Se proveera asistencia a los reclusos indigentes para la obtención de gafas recetadas. Para aquellos que usen gafas con receta medica, estas seran inspeccionadas en la sala de visita y remitidas luego al departamento médico para su distribución correspondiente. El recluso firmará un formulario de consentimiento que indica el recibo de las gafas con prescripción médica.
9. No se permite a los reclusos estar en posesion de, o utilizar ningun medicamento, a menos que sea autorizado o recetado por el proveedor de servicios médicos.
10. El centro correccional ECCF proporcionará todo medicamento requerido y recetado por el representante del servicio médico. El paquete de ampolletas ("Keep- on- Person") (KOP) o "Guarden-en-Persona" se puede proporcionar para ciertos medicamentos. Se requiere firmar todos los medicamentos considerados KOP y las enfermeras darán instrucciones a los reclusos acerca del protocolo a seguir con el paquete de ampolletas.
    a. El paquete de ampolleta que contiene el medicamento será guardado en la célda del recluso.
    b. La posesión ilícita de medicamento recetada para otro recluso es una ofensa delictiva. Los que abusen del sistema KOP seran eliminados de la lista inmediatamente.
    c. Los reclusos transferidos a la enfermería o identificados como suicidas potenciales entregarán todo medicamento en posesion al personal médico.
    d. Se proveera al recluso, una vez en libertad, de una receta con una cantidad limitada de medicamento, basada en la determinación del representante del servicio médico.
11. De acuerdo con N.J.S.A. 2C: 44-6, Capítulo 1995 de NJPL 254 y la Resolución 97-0438 de La Junta Directiva Electa del Condado de Essex (County of Essex Board of Chosen Freeholders), todo recluso será responsable del costo de cuidado médico y de los pagos requeridos por el sistema.(Co-payments) Las tarifas para la asistencia médica y medicamento serán deducidos de la cuenta personal.

Si el recluso es indigente, se le proveera asistencia médica y medicamento

Todos los reclusos estaran sujetos a los honorarios siguientes:	
Llamada de enfermo	$10.00
Visita del doctor	$10.00
Visita del dentista	$10.00
Radiografía/Servicio de Laboratorio Clínico	$ 5.00
Receta medica/reemplazar-rellenar (cada medicamento)	$ 3.00
Medicamento solicitado por el recluso (sin receta)	$ 2.00
Cualquier co-pago sera omitido cuando el servicio o cita medica sea recomendada por el personal medico. El honorario del co-pago sera sujeto a cambio sin previo aviso. .	

12. Fingirse enfermo y fingir una enfermedad es una violación e interfiere con el orden y funcionamiento de la institución correccional. (.302 Fingimiento, fingir una enfermedad). El departamento médico remitirá de regreso al oficial, todas las quejas y reclamos erróneos enviadas al personal médico.
13. Cualquier preso en la comunidad terapéutica se someterán a pruebas de drogas al azar.

31. Salud Mental

Si se siente deprimido, cree que puede hacerse daño, o que necesita hablar con alguien, usted debe notificar inmediatamente a su oficial de vivienda. Usted será referido al profesional médico adecuado. Todo individuo que sea un suicida potencial o que este severamente deprimido, sera tratado con sensibilidad y recibira el referido apropiado para una asistencia correspondiente.

Consejería de emergencia y servicios de salud mental y referidos están disponibles en la institucion correccional para todos los reclusos con antecedentes de enfermedad mental y para los que están atravesando momentos traumáticos, ansiedad o depresión. Los reclusos deberían informar al oficial de la unidad de vivienda de la necesidad de tales servicios.

32. Abuso Sexual y la Prevencion de Asalto y Programa de Intervencion

El ECCF tiene una política de tolerancia cero para todas las formas de abuso sexual o asalto.

Las estrategias de prevención e intervención

- Todos los reclusos serán controlados a su llegada al ECCF por el riesgo potencial de la victimización sexual o conducta de abuso sexual, y se conservarán para prevenir el abuso sexual o asalto.
- Los reclusos identificados con un historial de comportamiento sexual agresivo o en riesgo de victimización sexual serán evaluadas por un problema de salud mental o de otro profesional médico calificado, y monitoreados y asesorados según lo determinado por el profesional.
- Los presos considerados de riesgo para la victimización sexual se deben colocar en la carcasa menos restrictivo que está disponible y apropiada.

Definiciones y ejemplos de abuso sexual-Preso de Preso,-personal en el Recluso abuso sexual y actividad sexual coercitiva.

- Preso de Preso Abuso / Asalto Sexual
  Uno o más reclusos, por la fuerza, la coacción o la intimidación, realizar o intentar realizar: el contacto entre el pene y la vagina o el ano, el contacto entre la boca y el pene, la vagina o el ano, la penetración del orificio anal o genital de otra persona por un lado, el dedo o un objeto; conmovedor de los genitales, el ano, la ingle, pecho, muslos o las nalgas, ya sea directamente oa través de la ropa, con una intención de abusar, humillar, acosar, degradar o excitar o satisfacer el deseo sexual de cualquier persona, o el uso de amenazas, intimidación u otras acciones o comunicaciones de una o más reclusos dirigidas a coaccionar o presionar a otro recluso para participar en un acto sexual.

- Personal-sobre Preso Abuso / Asalto Sexual
  Personal de uno o más miembros (s) del personal, voluntarios (s), o de contratos que realizan o intentan participar en:

el contacto entre el pene y la vagina o el ano, el contacto entre la boca y el pene, la vagina o el ano, la penetración del orificio anal o vaginal de otra persona por un lado, los dedos o cualquier objeto; conmovedora de los genitales, el ano, la ingle , los senos, los muslos o las nalgas interiores, ya sea directamente oa través de la ropa, excepto en el contexto de las búsquedas adecuadas y los exámenes médicos, el uso de amenazas, intimidación, acoso, indecente, profano o lenguaje abusivo u otras acciones (incluida la vigilancia visual innecesaria) o comunicaciones dirigidas a coaccionar o presionar a un preso de participar en un acto sexual; o repetido declaraciones verbales o comentarios de naturaleza sexual a un preso, incluyendo referencias humillantes al género, comentarios despectivos sobre el cuerpo o la ropa, o el lenguaje profano u obsceno o gestos. La conducta sexual de cualquier tipo entre el personal y los internos asciende a los abusos sexuales, independientemente de si existe o no consentimiento.

El abuso sexual / asalto de reclusos por parte del personal o de otros reclusos es un uso inadecuado de la energía y está prohibido por la ley.

Los métodos para reportar el abuso o asalto sexual, incluyendo los procesos de investigación

Presentación de informes de abuso sexual o asalto

Si usted es víctima de un asalto sexual, reportar el incidente inmediatamente a cualquier miembro del personal de su confianza, para incluir a oficiales de la unidad de vivienda, capellanes, personal médico o supervisores. Los funcionarios mantienen la información reportada confidencial y sólo se discuten con las autoridades correspondientes en la necesidad de conocer base. Si usted no se siente cómodo informar del asalto al personal, usted tiene otras opciones:

1. Póngase en contacto con la línea directa de ASALTO SEXUAL interna a 973-274-PREA (7732).
2. Póngase en contacto con el Coordinador ECCF PREA, Sregeant Navarro, a 973-274-PREE (7733).
3. Presentar una queja del interno de emergencia. Si decide que su queja es demasiado sensible a presentar ante el Oficial Usted puede obtener las formas de su oficial de unidad de vivienda, o un supervisor de ECCF.

Procesos de Investigación

- El ECCF investiga todas las denuncias de abuso sexual, incluyendo terceros y anónima re ¬ puertos, y notifica a las víctimas y / o en otros denunciantes por escrito de los resultados de investigación y las sanciones disciplinarias o penales, independientemente de la fuente de la denuncia. Todas las investigaciones se llevan a cabo por SID lleva hasta el final, independientemente de si el presunto agresor o de la víctima se mantiene en ECCF.
- ECCF velará por que todas las denuncias de abuso sexual o asalto implica comportamientos potencialmente criminal son referidos para investigación por SID.
- Sin costo alguno para el Recluso, el administrador de la institución se encargará de que la víctima a someterse a un examen médico forense. Toda la evidencia forense recogida debe ser asegurada y se procesa de acuerdo al plan establecido de la ECCF de mantener la cadena de custodia de la evidencia criminal. Un resumen escrito de todas las pruebas médicas y los resultados se completará y se mantiene en el expediente médico del interno.

Información sobre autoprotección y los indicadores de abuso sexual

Evitar el Asalto Sexual

Asalto sexual nunca es culpa de la víctima. Conocer las señales de advertencia y las señales de alerta puede ayudarle a mantenerse alerta y consciente:

1 . Llevar a ti mismo de una manera segura . Muchos agresores escogen víctimas que parecen que no defenderse o que ellos piensan que son emocionalmente débil.

2 . No acepte regalos o favores de otros . La mayoría de los regalos o favores vienen con exigencias especiales o límites que el donante espera que usted acepte .

3 . No acepte una oferta de otro preso a ser su protector.
4 . Encuentra un miembro del personal con quien se sienta cómodo discutiendo sus temores y preocupaciones. Informe preocupaciones.
5 . No use drogas o alcohol , ya que pueden debilitar su capacidad para mantenerse alerta y tomar buenas decisiones .
6 . Sea claro, directo y firme . No tenga miedo de decir "no" o " parar ahora".
7 . Elija sus socios sabiamente. Busque personas que están involucradas en actividades positivas como programas educativos, oportunidades de trabajo o grupos de asesoramiento. Consígase involucrados en estas actividades.
8 . Si usted sospecha que otro recluso está siendo abusado sexualmente , informe de ello.
9 . Confíe en sus instintos. Esté al tanto de las situaciones que te hacen sentir incómodo. Si no se siente bien o seguro, dejar la situación o solicitar asistencia . Si teme por su seguridad, informar a usted las preocupaciones del personal .
10 . Comunicación de un asalto no será un impacto negativo en los reclusos de sus actuaciones.

Indicadores de Abuso Sexual

Hay muchas reacciones que los sobrevivientes de violación y asalto sexual pueden experimentar. Para los eventos traumáticos en general, es importante darse cuenta de que no hay un patrón "normal" de la reacción a la tensión extrema de experiencias traumáticas. Algunas personas responden de inmediato, mientras que otros han retrasado reacciones, a veces meses o incluso años más tarde. Algunos tienen efectos adversos durante un largo período de tiempo, mientras que otros se recuperan con bastante rapidez. Las reacciones pueden cambiar con el tiempo.

Algunos de los que han sufrido de trauma se activan inicialmente por el evento para ayudar con el reto de hacer frente, sólo para más tarde desanimado o deprimido. El impacto del abuso sexual varía de persona a persona y puede ocurrir en varios niveles-física, emocional y mentalmente.

Los sobrevivientes pueden experimentar algunas de las siguientes respuestas:
• Las respuestas de miedo a los recordatorios del asalto
• Impregnación sensación de ansiedad, preguntándose si es posible sentir siempre seguro de nuevo
• asalto Vuelva a experimentar una y otra vez a través de flashbacks
• Problemas para concentrarse y mantener la concentración en la tarea a mano
• Sentimientos de culpa
• El desarrollo de una auto-imagen negativa, sentirse "sucia" dentro o fuera
• Enojo
• Depresión
• Las interrupciones en estrecha relación

• Trastorno de Estrés Postraumático - Los sobrevivientes de asalto sexual puede experimentar sentimientos severos de ansiedad, el estrés o el miedo, conocida como trastorno de estrés postraumático (TEPT), como resultado directo del asalto.
• Abuso de Sustancias - Las víctimas de violación o asalto sexual pueden recurrir al alcohol u otras sustancias en un intento de aliviar su sufrimiento emocional.
• autolesiones / Auto-lesión - autolesión deliberada, o auto-lesión, es cuando una persona se inflige daño físico a sí mismo.
• Síndrome de Estocolmo - Descrito como emocional "unión" de la víctima con el agresor, síndrome de Estocolmo se desarrolla inconscientemente y de forma involuntaria.
• Infecciones de Transmisión Sexual - Lista de las infecciones de transmisión sexual, sus síntomas, tratamiento y complicaciones posibles.
• Trastorno de identidad disociativo - Trastorno de identidad disociativo (DID), anteriormente conocido como trastorno de personalidad múltiple (MPD), es un trastorno disociativo en el que dos o más identidades separadas y distintas (o personalidades) controlan el comportamiento de un individuo en diferentes momentos.

- Trastorno Límite de la Personalidad - Trastorno límite de la personalidad, conocido como displasia broncopulmonar, es uno de los muchos posibles efectos a largo plazo del abuso sexual infantil.
- Los sobrevivientes adultos de LLA infantil Asalto Sexual - Los efectos a largo plazo sobre los sobrevivientes de asalto sexual en la infancia y / o el abuso.
- Trastornos del sueño - Muchos sobrevivientes de asalto sexual sufren de trastornos y trastornos del sueño.
- Trastornos de la alimentación - Las víctimas y sobrevivientes con trastornos de la alimentación suelen utilizar los alimentos y el control de los alimentos como un intento de hacer frente o compensar los sentimientos y las emociones negativas.
- Memorias del cuerpo - memorias del cuerpo son cuando el estrés de los recuerdos del abuso sufrido por una persona toma la forma de problemas físicos que no se pueden explicar por los medios habituales.
- Suicidio - Si usted está pensando en el suicidio, o conoce a alguien que es, por favor, busque ayuda.

Prohibición de represalias
Comunicación de un asalto no será un impacto negativo en sus actuaciones.

Las víctimas de asalto sexual o abuso tienen el derecho a recibir tratamiento médico y de salud mental y consejería. Personal de salud mental llevará a cabo el asesoramiento posterior a la crisis y se encargará de la atención psiquiátrica en caso necesario.

Para obtener información adicional, consulte el apéndice PREA de este manual.

33. Fianza

Procedimientos Para La Fianza:

1. Todo recluso indigente, financieramente incapaz de contratar un abogado debe hacer un pedido escrito de ayuda legal notificando al Asistente Social o al Ombudsperson. El formulario 5-A será llenado y remitido a la Gerencia de Caso Criminal (Criminal Case Management) para determinar la elegibilidad de asistencia legal por un defensor público.
2. La ventana para pagar la fianza del centro correccional ECCF está abierta 24 horas al día, 7 días a la semana. Los miembros de la familia pueden obtener la información sobre las condiciones de la fianza llamando al 973-274-7500. Esta información se puede también obtener vía Internet en la pagina www.essexcountynj.org.
3. Formulario del Origen de la Fianza - Conforme a N.J.S.A. 2A: 162-13, "una persona acusada con un crimen, con restricciones en la fianza, debe proporcionar bajo pena de perjurio, la información sobre el deudor, indemnizador o persona que fija la fianza o deposita el efectivo; la garantia ofrecida, y la fuente de donde proviene el dinero o propiedad usada para fijar y garantizar la fianza, de acuerdo con las circunstancias. Esta información requerida incluirá, pero no será limitada a, el historial o record de empleo del demandado, los nombres y las direcciones de cualquier persona que contribuya con dinero, o la seguridad ofrecida para la fianza; la cantidad, la naturaleza y la sincronización de tal contribución, y la relación con el demandado de cualequier persona que contribuya con sus recursos. La fianza no se puede aceptar de una persona sujeta a los requisitos de esta subdivisión hasta que el fiscal reciba el formulario completo requerido por ley."

Si usted no recibio una copia de este formulario al ingresar ni tampoco las tiene ahora, busque asistencia con su oficial de vivienda.

Tipos de Fianza

Deposito completamente asegurado – El demandado tendrá que depositar totalmente la cantidad de dinero requerida para su fianza con la corte.

Depósito para la fianza- El demandado u otros pagaran un porcentaje (generalmente el 10 por ciento) del valor nominal de la fianza a la corte. Después del juicio, el demandado recibirá la mayor parte del dinero, descontando los honorarios administrativos.

Fianza en Efectivo – El infractor debe pagar completamente el valor de la fianza en efectivo para ser puesto en libertad. Si el delincuente hace la comparecencia judicial, el dinero le sera devuelto.

Fianza con garantia – El infractor sale libre atraves de los servicios de alguna entidad privada que fije la fianza con un cargo honorario adicional. El honorario generalmente varía del 5 al 20 por ciento. La persona o entidad financiera puede requerir al infractor un depósito colateral.

34. Programa de Trabajo Voluntario

1. Todo individuo recluso en el Establecimiento Correccional del Condado de Essex ECCF, es elegible en forma voluntaria a trabajos disponibles para reclusos. La clasificacion y el historial disciplinario del recluso se revisarán y utilizaran como factor(es) determinante(s) para su elegibilidad de trabajo. Cada solicitud de trabajo sera procesada de acuerdo al orden de llegada.
2. Reclusos con labores asignadas no realizarán trabajos para los que no estén específicamente autorizados por los oficiales encargados de la supervision, incluyendo el transporte de artículos de una celda o área a otra. Cuando se complete la asignacion de trabajo, todos los detenidos se reportaran inmediatamente a sus oficiales de control, quienes podran permitirles el regreso a sus unidades de vivienda o asignarles un trabajo adicional.
3. El trabajo es un privilegio que podrá ser revocado por no reportarse a su posicion, por aparecer en condiciones anti-higienicas, o por realizar su tarea por debajo de un nivel satisfactorio; y, por no seguir las ordenes o ser beligerante contra un oficial. Más aun, todos los trabajadores reclusos serán sujetos al azar, a pruebas de drogas con causa probable. Un resultado positivo proveniente de la prueba de drogas dará lugar a la terminación inmediata del empleo y a un posible juicio criminal.
4. Prescindiendo del volumen del trabajo, todas las peticiones de los trabajadores deberán presentarse al capitán de clasificación.
5. Para participar en este programa, se le pedirá que firme una declaración del programa de trabajo voluntario y que complete el entrenamiento de trabajo respectivo. Se le pedirá que se adhiera a las restricciones relacionadas con su asignación de trabajo en lo referente al vestuario, peinado y estilo. Si usted es aceptado en un programa de trabajo voluntario, se espera que trabaje de acuerdo a un horario de labor asignado y que realice las tareas asignadas a un nivel satisfactorio. Deficiencias evidentes tales como ausencia sin excusa, o rendimiento insatisfactorio, pueden provocar su eliminación del programa de trabajo voluntario.
6. Usted no tiene derecho a compensación por tareas que impliquen el mantenimiento de su espacio personal o de limpieza después de su uso, en áreas de uso general. Usted está obligado a realizar tareas básicas de limpieza dentro de su unidad de vivienda, independientemente del lugar donde usted este detenido. Por ejemplo, usted podría ser sancionado si se niega a tender su cama o de lo contrario si se niega a limpiar algo después de su uso.
7. Se les asignará celdas específicas en las unidades de alojamiento a los trabajadores reclusos.
8. Los trabajadores reclusos no tienen autoridad sobre ningun otro recluso.
9. Solamente se permiten a los reclusos médicamente aprobados, asignados como trabajadores de la cocina, en la despensa de la unidad, y son los únicos reclusos autorizados a manejar el alimento. El área de la despensa se utiliza solamente para servir alimento y agua caliente; **todas las formas de cocinar son prohíbidas.**

10. Durante el tiempo que permanezca encerrado, no se pasará ningun artículo de una célda a otra célda y todos los trabajadores se encerraran a tiempo, cuando reciban la orden de hacerlo.
11 Los trabajadores reclusos deben seguir todas las reglas contorneadas adjunto.

Usted es responsable de familiarizarse con las políticas y procedimientos en relación con el trabajo voluntario en las instalaciones donde están detenidos.

35. Biblioteca de Leyes Juridica

La biblioteca de la ley se encuentra en todas las unidades de vivienda y al lado de la oficina del sargento de los dormitorios. La biblioteca de la ley está abierto los siete días a la semana con un horario rotativo de veces. El horario de la biblioteca ley se publicará en todas las unidades de vivienda.

Usted tendrá acceso a la biblioteca de leyes y puede recibir ayuda de un representante legal de la unidad de vivienda, quien esta bien informado sobre los materiales legales, tantas veces como la demanda lo permita, dependiendo de los recursos disponibles, de la disponibilidad del espacio y de los criterios de seguridad. La oficina del ombudsman puede proporcionar servicios de Notario Publico a solicitud o petición.

La reclusorio penitencial utiliza un programa de investigación legal intuitivo del internet usando Lexus Nexus. Esta fuente de datos de investigacion basada en el Web, proporciona acceso a materiales actualizados en formato electronico. Por lo tanto el sistema reemplaza libros juridicos y publicaciones.

Lexis Nexus es gratuito en la Tableta y está actualizado a la hora
Las computadoras están disponibles en la biblioteca de leyes para la preparación de documentos jurídicos **SOLAMENTE**. **Estas computadoras no deben ser utilizadas para la correspondencia personal.** Usted puede pedir papel y boligrafo de su oficial de vivienda para la correspondencia personal.

No se permitirá a ningun recluso cobrar una tarifa o aceptar cualquier cosa de valor por proporcionar tal ayuda. El reclusorio penitencial no pagará a ningun recluso por proveer ayuda legal a otro recluso.

Usted es responsable de seguir las reglas con respecto el acceso a la biblioteca de leyes y al uso de cualquier equipo. Cualequier violación de seguir las reglas, adrede o voluntaria, la interrupción de las operaciones de la biblioteca de leyes o la destrucción de la propiedad del condado puede dar lugar a una sanción disciplinaria contra usted y una pérdida de su privilegio de utilizar la biblioteca de leyes.

En cualquier momento se descubre que los artículos / equipos en la biblioteca de derecho están dañados, obsoletos, o que falta debe informar inmediatamente a su oficial de unidad de vivienda (s).

Una vez aprobada, unidades flash USB se pueden emitir, para la retención, a los internos para el almacenamiento de sólo asuntos legales.

36. Materiales de la Televisión y de la Biblioteca

1. Cada televisor está disponible para su uso siempre y cuando este privilegio no se suspenda debido a un comportamiento inadecuado. El director, o su designado, puede restringir el uso de la television durante programas especiales que se presenten en el cuarto de día(dayroom) y

puede aprobar su uso y permiso mientras dure la presentación de acontecimientos especiales durante el período del "confinamiento".

a. El oficial tiene control total de la television.
b. La television será encendida solamente cuando el oficial de la unidad este satisfecho de que las medidas de seguridad, y las condiciones sanitarias estén bajo control.
c. La decisión del canal sintonizado se decidirá por la mayoría de reclusos o lo qué se puede juzgar como apropiado por el oficial. Cualequier desafío o interrupción dará lugar a la terminación de los privilegios del uso de la television.
d. La television no interferirá con las operaciones normales de la unidad.
e. El volumen de la television se mantendrá en un nivel adecuado para que no se extienda más allá del área de entretenimiento según lo determine el oficial.

2. Los materiales de lectura están disponibles de la biblioteca de la institución correccional ECCF. La oficina del ombudsman tiene un programa de préstamos de libros atraves de su firma (sign-up).
3. ECCF puede proveer periodicos adicionales a las unidades de vivienda que seran preservadas de acuerdo al criterio del oficial de la unidad de vivienda.

37. Servicios Religiosos

1. Los reclusos pueden identificar su afiliación religiosa durante el proceso de ingreso. La opinión y creencia de los agnosticos y ateos será respetada.
2. La pre-registracion para atender los servicios religiosos puede ser impuesta por el oficial de resguardo, si es necesario, para la seguridad de la operación del reclusorio penitencial.
3. Los proveedores de servicio pastorales de todas las tradiciones religiosas están disponibles para la consulta o el asesoramiento religioso y espiritual. Los reclusos pueden hacer las peticiones para tales servicios a un oficial, al ombudsperson, o a un asistente social de su vivienda. Los reclusos pueden agregar a su líder religioso o espiritual a sus listas de visitantes.
4. Un horario de servicios religiosos esta publicado en cada unidad de vivienda y disponible atraves de un asistente social o de un ombudsperson. La asistencia a los servicios religiosos es voluntaria.
5. Los reclusos pueden comprar materiales espirituales y religiosos para su entrega por correo. Todo material aprobado se puede también distribuir atraves de los proveedores de servicios del cuidado pastoral.
6. El otorgamiento o la negación de privilegios, o la discriminación o el castigo en base a su creencia religiosa o espiritual esta terminantemente prohíbida.
7. Todos los grupos religiosos y espirituales tendrán igualdad de acceso a las instalaciones y a los privilegios correspondientes basados en un marco de seguridad y de acuerdo al número de participantes.
8. Los servicios religiosos y espirituales se proveen en un horario rotativo. Los servicios serán proporcionados solamente para aquellos reclusos que estén fuera de la actividad recreativa en su área respectiva de vivienda.

38. Procedimientos de Reclamo

A los reclusos bajo la custodia del ECCF se les ofrece el siguiente mecanismo mediante el cual pueden solicitar la resolución de la administración de la instalación y del personal para las preocupaciones, problemas, quejas y quejas percibidas.

A. Derechos de queja

1. El derecho a lamentar cualquier procedimiento administrativo;

2. El derecho a recibir respuesta por escrito, incluido el motivo de la decisión en un plazo de cinco días naturales, excluyendo los fines de semana y días festivos y durante situaciones de emergencia;
3. El derecho a solicitar recurso judicial o administrativo sin temor a represalias como consecuencia.
4. El derecho a presentar quejas sin temor a represalias o a una segregación punitiva;
5. El derecho a recibir una respuesta inmediata a situaciones de emergencia; Y
6. El derecho a apelar las decisiones ante el alcaide o al designado.

Los reclusos deben agotar todas las quejas administrativas y los procedimientos de apelación antes de aplicar a agencias externas.

B. Áreas Amparadas por el Proceso de Quejas y Reclamos (Grievance Process)

Las siguientes áreas y procedimientos no se aplicarán a las cuestiones de culpabilidad o inocencia de un recluso por delitos imputados. Las cuestiones relativas a la competencia judicial o a las cuestiones jurídicas relativas a la justificación de las penas impuestas se dirigirán al tribunal de jurisdicción. Los procedimientos de reclamación se aplicarán a las cuestiones relativas a:

a. Atención médica;
b. Condiciones de confinamiento;
c. Procedimientos generales de clasificación;
d. Procedimientos disciplinarios generales;
e. Participación en el programa de reclusos;
f. Procedimientos telefónicos, de correo y de visitas;
g. Problemas con la comida, la ropa y la ropa de cama; Y
h. Preferencia religiosa.

Las decisiones disciplinarias no pueden ser afligidas.

C. Proceso Del Agravio

"Solicitud de recluso, entrevista, reparación administrativa y proceso de quejas" proporciona el mecanismo por el cual los reclusos pueden solicitar la resolución de la administración de la instalación y el personal para las preocupaciones, problemas, quejas y quejas que pueden estar experimentando. El proceso de queja se inicia a través de la presentación de una queja al departamento adecuado a través de la tableta.

El coordinador supervisa el "Sistema de Quejas de Los Presos", un programa de base de datos de seguimiento computarizado que asegura que las preocupaciones sean atendidas oportuna y apropiadamente. Este sistema fomenta la resolución interna e informal de problemas y establece líneas específicas de comunicación directa, incluida la disponibilidad de entrevistas, entre reclusos y personal.

Si el recluso no puede lograr una solución informal, el "Sistema de Quejas de Presos" proporciona un medio para adquirir documentación escrita de un incidente e incluye un proceso de apelación.

Se espera que los reclusos utilicen el proceso de recurso administrativo antes de solicitar alivio a los tribunales. El ECCF utiliza el "Sistema de Quejas de Los Presos" como medio para la revisión continua de sus acciones, políticas y procedimientos administrativos y como indicador de la moral del recluso y del personal.

1. Definiciones de Términos

Agravio: Una circunstancia o una acción considerada como injusta y los fundamentos para la queja o reclamo.

Carpeta de Quejas y Reclamo: Una carpeta por cada recluso que contenga el formulario de quejas y reclamos y las apelaciones.

Coordinador de las Quejas y Reclamos: Un miembro del personal designado por el Director para procesar "las formularios de quejas y reclamos del recluso."

Queja: Una expresión escrita del descontento o de la señal de angustia, aflicción y congoja.

Represalia: Cualquier acción evidente o secreta, o la amenaza de dicha acción en contra un recluso que actue de buena fe, el uso, o la participación en el proceso de quejas y reclamos.

Respuesta: Una acción correctiva que elimina o compensa las condiciones percibidas como injustas o la razon para la queja o resentimiento.

Número de SBI: Un número de identificación de la huella digital publicado por la policía del Estado de New Jersey.

Personal: Cualquier persona empleada por la institución correccional ECCF o contratada para proveer servicios a la población reclusa, será considerado como miembro del personal. Esta categoría incluye pero no se limita a las enfermeras, doctores,oficiales, sargentos, tenientes, capitanes y a aquellos con títulos civiles.

2. Propósito del Proceso de Quejas y Reclamos

Si un recluso no puede lograr una resolución informal de un problema que está experimentando por una entrevista informal con su supervisor de custodia o empleado civil apropiado, puede presentar una queja a través de la tableta. Una queja presentada a través de la tableta debe utilizarse para abordar preguntas, problemas, quejas y problemas médicos que el recluso no ha podido abordar por otros medios.

Cabe señalar que una llamada de enfermedad presentada a través de la tableta debe utilizarse para el acceso rutinario al sistema de atención médica; una queja sólo debe presentarse si hay un desacuerdo con el tipo o puntualidad de un tratamiento médico. Además, un recluso no puede lamentar una decisión disciplinaria.

3. Procedimientos

ENVIAR QUEJAS A TRAVÉS DE LA TABLETA

Las tabletas están disponibles en todas las unidades de alojamiento.

Presentar quejas en tabletas

Solo se procesarán las quejas debidamente completadas y presentadas.

El recluso debe proporcionar su nombre, número de SBI, ubicación del edificio, vaina de vivienda y fecha.

La "Parte 1" también debe incluir un resumen de la información, problema o queja solicitada. El recluso también puede presentar información para apoyar su posición.

La queja no puede utilizarse para atender quejas relativas a cargos disciplinarios (sanciones de línea judicial), para volver a abordar una queja previamente establecida, para abordar asuntos actualmente en litigios, o para eludir las políticas y procedimientos departamentales establecidos.

Una Petición Por Cada Formulario
Los reclusos deben presentar una queja por pregunta, queja o problema. Las quejas que enumere múltiples preguntas/preocupaciones, o que no contengan suficiente información, se considerarán incompletas, no serán procesadas y serán devueltas. .

Tipos de Agravios
El recluso puede sugerir uno de los siguientes tipos de quejas: rutina, entrevista o remedio.

Presentacion de Formularios de Agravio
Para que la queja sea procesada debe dirigirse a la zona adecuada. Las quejas se revisarán todos los días excepto los fines de semana, días festivos y durante situaciones de emergencia. Para los reclusos detenidos o aquellos confinados en sus celdas por otras razones, seguirán el mismo procedimiento que todos los demás reclusos.

El recluso dirigirá su solicitud a una persona o área específica.

Un recluso no puede presentar varias solicitudes con respecto al mismo tema y debe adherirse al plazo de respuesta del personal especificado de diez días, excluyendo fines de semana, días festivos y durante situaciones de emergencia.

En ningún caso un recluso completará una queja por otro recluso. Si se requiere asistencia, el recluso debe ponerse en contacto con un ombudsperson o trabajador social.

Investigación del Agravio
Una vez recibida una queja completa, el supervisor de área se encargará de la investigación. Después de la determinación de un curso de acción o respuesta apropiado, el supervisor de área instruirá a su personal cómo manejar la queja.

La respuesta se realizará lo antes posible y dentro del plazo asignado de diez días, excluyendo fines de semana, días festivos y durante situaciones de emergencia. Además, la respuesta se basará en hechos y cuestiones específicamente relacionadas con la queja.

El supervisor enviará la respuesta de vuelta al recluso a través de la tableta.

Extensiones Especiales del Tiempo Para Responder
Las respuestas a una queja que requiere una amplia investigación y documentación pueden requerir un período más largo que diez días, excluyendo fines de semana, días festivos y durante situaciones de emergencia. Por consiguiente, el examen puede prorrogarse por un período

determinado si las constataciones indican que el período inicial es insuficiente para dar una respuesta adecuada. Esta extensión se comunicará a través de la tableta al recluso.

Preguntas Complementarias a la Respuesta Recibida
Si un recluso tiene una pregunta de seguimiento de una respuesta recibida o siente que su queja no ha sido respondida satisfactoriamente, se puede presentar una nueva queja. El recluso debe proporcionar el número de caso de su solicitud original. La nueva queja debe adjuntarse al hilo original.

Si la solicitud no fue respondida o devuelta en el plazo de respuesta establecido de diez días excluyendo fines de semana, días festivos y durante situaciones de emergencia, y no se ha informado al recluso de que es necesaria una prórroga especial de tiempo, el recluso puede presentar otra queja citando la fecha de la solicitud original y el número de solicitud.

Tableta
Puede presentar quejas en la Tableta.

4. <u>Proceso de Apelacion.</u>
El recluso puede apelar una respuesta a través de la tableta.

La apelación debe presentarse dentro de los diez días siguientes a la recepción de la respuesta
Después de que la queja ha sido procesada y devuelta, si un recluso está insatisfecho con la respuesta, él / ella puede presentar una apelación a través de la tableta. La apelación debe ocurrir dentro de los diez días siguientes a la recepción de la respuesta.

El recluso debe volver a presentar su queja contestada original al supervisor de área.

La decisión de apelación será dictada por el alcaide y se considerará definitiva. El alcaide tiene diez días para responder a la apelación, excluyendo fines de semana, días festivos y durante situaciones de emergencia. Una vez que se decida la respuesta de apelación, la decisión será enviada de vuelta al recluso a través de la tableta.

5. <u>Situaciones de Emergencia</u>
Seguirá todos los procedimientos anteriores (igual que las quejas que no sean de emergencia) sin embargo deben ser entregados directamente al Oficial de la Unidad de Vivienda para que pueda ser presentado inmediatamente.

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D. Protección de Reclusos contra Represalias
Cualquier miembro del personal o administración involucrado en una represalia contra un recluso que haga uso de buena fe o participe en el "Proceso de Quejas" será procesado en la máxima medida de la ley.

E. Abuso del Sistema de Reclamos y de los Formularios
Los reclusos que abusan o hacen mal uso del "Sistema de Quejas de Presos pueden estar sujetos a medidas disciplinarias. Los ejemplos de abuso incluyen, pero no se limitan a, las siguientes acciones.

1. Múltiples peticiones registradas con respecto al mismo tema.
2. Solicitudes de seguimiento enviadas antes de la expiración de los plazos de respuesta establecidos.
3. Pedidos que, por su tono o lenguaje, son ofensivos o injuriosos en su naturaleza.

39. Servicios Sociales

Los asistentes sociales y los mediadores (ombudsmen) responden a todas las peticiones personales, tales como acceso a consejeria religiosa, consideración de libertad condicional, entrenamiento de empleo, recursos educativos, vivienda en la comunidad, programas alternativos al encarcelamiento, asistencia familiar, visitas al hospital para los miembros de familia críticamente enfermos, órdenes judiciales para velatorio y entierros privados. También se presta atención para asegurarse de que los reclusos tengan acceso a la biblioteca, recreacion y a todos los recursos de ley material, y a los servicios espirituales y religiosos. .

Los reclusos que desean tales servicios deben completar y firmar el formulario de servicios sociales, disponibles de los asistentes sociales y de los "ombudsman" de la vivienda. Toda la información pertinente debe ser completa y los formularios impresos incompletos serán devueltos.

A. Servicios Rehabilitativos

La función de los servicios rehabilitativos es de proveer el asesoramiento, la ayuda, y servicios recreacionales. Los programas siguientes están disponibles.

1. Servicios religiosos
2. Biblioteca de Leyes Juridicas y libros de la biblioteca en general.
3. Recreacion diaria

Las citas para discutir cualquier preocupacion y problema pueden ser hechas llenando el formulario de petición de servicios sociales.

B. Alternativas al Encarcelamiento

1. La Segunda Oportunidad (Second Chance) es un programa basado en la Comunidad diseñado para ganar créditos de trabajo, y adquirir destrezas de supervivencia y la reintegración a la sociedad.
   a. Cualquier preso que es un participante activo en el Programa de Segunda Oportunidad no puede visitar a cualquier preso alojado en ECCF. Cualquier recluso que viole esta política será puesta inmediatamente en custodia y terminará su resto de su tiempo en ECCF.
2. Delaney Hall es un programa basado en la comunidad, diseñado para abordar los casos de abuso y consumo de sustancias, de comportamiento criminal, de las habilidades y destrezas necesarias en esta vida, temas de la educación, empleo y la reintegración a la sociedad.

C. Servicios Educativos

La cárcel del Condado de Essex pondrá a disposición las oportunidades educativas a la población reclusa. Usted tendrá acceso al entrenamiento educativo, cuando este disponible dentro de la cárcel. Los programas educativos y los servicios académicos a la población reclusa incluirán, y no serán limitados:

1. Destrezas Basicas (Basic Skills Remediation)
2. GED/Inglés como Segundo Idioma (ESL) - Preparación y examen, los Certificados de GED o Educación Secundaria equivalente, se daran después de la prueba.

Los reclusos deben aplicar al departamento de servicios sociales. Antes de que lo acepten en cualquier programa usted completará una prueba de ingreso para determinar su nivel de formación academico. La aceptación a varios de los programas disponibles esta supeditado a la prueba en el nivel de formación que le corresponde.

I. Visitas del Padre/del Niño:
P.A.T.C.H es para ambos reclusos, masculinos y femeninos. Es una visita de contacto entre el padre y el niño. El criterio de este programa es que el niño debe estar entre las edades de 4-16. Las mayoría de las visitas son ordenadas a través de la corte de familia de DYFS.

II. Destrezas Basicas (Life Skills):
Life Skills es para los reclusos de ambos sexos, masculinos y femeninos. El único criterio para participar en este programa es que el recluso no puede haber recibido sanciones disciplinarias mientras que esta en el programa.

III. Grupos de la Apoyo/de Discusión:
(Women Empowering Women Discussion Group) Grupos de Apoyo Femenino: El único criterio para participar en este programa es que el recluso no puede haber recibido sanciones disciplinarias mientras que esta en el programa.

- Men Sharpen Men Discussion Group: El único criterio para participar en este programa es que el recluso no puede haber recivido sanciones disciplinarias mientras que esta en el programa.
- Book Club (Femenino): El único criterio para participar en este programa es que el recluso sepa leer y comunicarse en inglés.
- NA/AA: El único criterio para participar en este programa es que el recluso debe tener un historial de uso de drogas.

IV. Servicios del Reingreso del poste del reingreso:
(Pre/post) Antes /Despues -Estrategias para tratar a reclusos con reincidencia: Pueden aplicar una vez que cumplan 180 días o menos en su sentencia.

V. Welfare/ Manutención del Menor de Edad:
El Welfare suministra al condado, de una lista de reclusos cuyos niño(s) tenga(n) o haya(n) recibido manutención de menor(es) en algun punto de su vida.

VII. Oficina de los Defensores Públicos:
El supervisor de la oficina del defensor público viene y habla con los representantes una vez al mes. El único criterio para participar en este programa es que el recluso debe ser un representante.

D. Servicios para los Referidos

Siempre que sea posible, un ombudsperson o un asistente social intentara poner al recluso en contacto con las agencias de la comunidad que pueden proporcionar servicios durante el encarcelamiento y después de la liberacion del reclusorio penitencial. La siguiente es una lista parcial de las agencias participantes.

Apostle's House (Females), 513 Avon Ave, Newark, NJ 07106

Center for Great Expectations (Females), 1 Eastern Ave, Somerville, NJ 08876

Center for Urban Education (Females), 2 Odgen St., Newark, NJ 07104

Children's Home Society, 535 S. Clinton Ave, Trenton NJ 08611

C.U.R.A. Inc., 35 Lincoln Park, P.O. Box 180, Newark, NJ 07101

C.U.R.A., Inc. (Spanish), 51 – 75 Lincoln Park, Newark, NJ 07102

Discovery House, P.O. Box 177, Marlboro, NJ 07746

Division of Vocational Rehabilitation Services, 135 E. State St., Trenton, NJ 08625

E. Orange General Hospital In/Out Patients, 300 Central Ave, E.O., NJ 07018

Eva's Village, 393 Main Street, Paterson, NJ 07501

Goodwill Mission, 79 University Ave, Newark, NJ 07102

High Focus Centers, 16 Commerce Dr, Cranford, NJ 07016

Integrity House Inc.,103 Lincoln Park, Newark, NJ 07102

Isaiah House (Females), 238 N. Munn Ave, E. Orange, NJ 07017

Kintock I/II (Males and Females), 50 Fenwick Street, Bldg 6, Newark, NJ 07114

Mount Carmel Guild, 1160 Raymond Blvd, Newark, NJ 07102

Offender Aid and Restoration of Essex County, Inc, 755 S. Orange Ave, Newark, NJ 07106

Office of the Public Defender, 1180 Raymond Blvd, Newark, NJ 07102

One-Stop Center, 990 Broad St., Newark, NJ 07102

One Stop Center, 50 S. Clinton St., East Orange, NJ 07018

Project 1st (Females), 800 Clinton Ave, Newark, NJ 07108

Real House Inc., 95 Grove St, Montclair, NJ 07042

Salvation Army, 65 Pennington St., Newark, NJ 07105

Straight and Narrow, 396 Straight St., Paterson, NJ 07501

SWITCH (Females), 199 E. 23rd St., Paterson, NJ 07501

Summit Oaks Hospital, 19 Prospect Street, Summit, NJ 07901

Sunrise House Foundation, P.O. Box 600, Lafayette, NJ 07848

The Bridge, 54 Mt. Vernon Ave, Irvington, NJ 07111

Tremont House, 344 Summer Ave, Newark, NJ 07104

Tri-City 2nd Chance Home (Females) 55 Washington St., E. Orange, NJ 07017

Turning Point, P.O. Box 111, Verona, NJ 07044

United Community Alcoholism Network, 31 Fulton St, Newark, NJ 07102

Veteran Services, 20 Washington Pl, 4th Fl, Newark, NJ 07102-3127

40. Tableta

1. Procedimientos generales para tabletas:
   a. Las tabletas se cerrarán a través de su Oficial en su unidad de vivienda;
   b. Las tabletas estarán desactivadas durante los conteos y cuando los internos estén encerrados en celdas;
   c. Las tabletas no se pueden tomar en sus celdas;
   d. Iniciar sesión en la tableta es fácil. Escriba su J # que está en su banda, luego cree su propia contraseña. Luego debe colocar su cara dentro de la caja y la tableta tomará su fotografía. No funcionará a menos que su cara esté en la caja.
2. Servicios gratuitos en tableta:
   a. Lexis Nexis es gratuito en la tableta y está actualizado a la hora;
   b. Puede presentar quejas en la tableta. Asegúrese de que se trate de una queja formal y no de una solicitud o queja general que brinde detalles de la política o el derecho que considera ha sido violado;
   c. El manual del interno está en la tableta;
   d. Lista de visitas que incluye la adición y / o eliminación de visitantes;
   e. Solicitudes de llamadas enfermas;
   f. Orden del economato (NOTA: es aquí donde usted solicita los minutos para los servicios de tableta paga);
   g. Puede comunicarse con el Supervisor de Servicios del Recluso, Asuntos Internos, Servicios Sociales y el coordinador de PREA;
   h. O bien, todas las demás solicitudes hechas previamente en papel.
3. Servicios pagos en la tableta:
   Las tabletas también ofrecen opciones de entretenimiento que están disponibles a una tasa de cinco (5) centavos por minuto para incluir, entre otros, libros, mensajes, películas y música.

   NO VAYA A SU OFICIAL CON PROBLEMAS DE LA TABLETA QUE LE PEDAN QUE SE COMUNIQUE CON EL TÉCNICO DE TELÉFONO INTERNO PARA AYUDAR CON LAS TABLETAS ROTAS. CUALQUIER PROBLEMA PUEDE SER FIJADO GENERALMENTE EN MENOS DE UNA HORA MEDIANTE EL CONTACTO CON "PROBLEMAS CON LA TABLETA" EN LA TABLETA.

RECHAZO DE LAS COMODIDADES RAZONABLES OFRECIDAS A LOS RECLUSOS SORDOS

Reconozco haber sido informado y RECHAZO aceptar la tentativa del reclusorio penitencial de proveer las comodidades razonables para una o más de las actividades importantes de mi vida, y libero por la presente, al Departamento de Correcciónes del Condado de Essex, de toda la responsabilidad por cualquier mal efecto de tal denegación.

Nombre del Recluso: _____ Commitment # _____
Imprenta

Firma del Recluso: _____ Denegación a Firmar: _____

Fecha: _____ Fecha: _____

Testigo: _____ Testigo: _____

SOLICITUD DE RECLUSOS SORDOS O CON PROBLEMAS AUDITIVOS

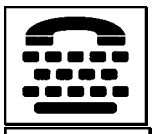
Nuestro reclusorio penitencial está encomendado a proveer un cuidado de alta calidad a todos los reclusos. Para asegurar que los servicios que se le proporcionan no esten comprometidos por una comunicación ineficaz, el reclusorio penitencial tiene recursos para obtener intérpretes expertos en hablar por senas cuando sea necesario, sin costo alguno. Los dispositivos de telecomunicaciones para sordos (TTD), telefonos y televisores amplificados con subtitulos también están disponibles.

1. ¿Un intérprete del lenguaje por senas nos ayudará con eficacia a comunicarnos con usted?

SÍ NO

Si usted marca "SÍ," entonces le conseguiremos un intérprete del lenguaje por senas, a menos que usted renuncie a este derecho en la parte posterior de este papel.

2. ¿Usted quiere alguno de estos servicios que estan también disponibles?

Un dispositivo de Telecomunicación para Sordos TDD/TTY con Luz de Senales.	SÍ	NO	
Un Receptor de Teléfono Amplificado	SÍ	NO	
Un Dispositivo para Ayudar a Escuchar (ALD)	SÍ	NO	
El Subtitular de la Televisión	SÍ	NO	

Otro (explicar por favor):

_____

_____

_____

3. El recluso rechazó las comodidades ofrecidas actuales. Ver la página dos de esta forma para su exencion.

Nombre del Testigo : _____ _____

Escrito en Imprenta Firma del Recluso / Commitment # / Fecha

_____

Firma / Fecha

Una copia escrita del reglamento de ECCF de las Reglas y Procedimientos Administrativos de Comunicacion Efectiva está disponible sin ningun cargo a petición. Marque por favor aquí si usted quiere una copia de este reglamento _____.

CONCIENCIA ASALTO SEXUAL

El ECCF tiene una politica de tolerancia cero para todas las formas de abuso sexual o asalto

ASALTO SEXUAL

¿Qué es el Asalto Sexual?
Asalto sexual es un término amplio que incluye cualquier conducta sexual contra otra persona que se ve obligada, forzada o manipulada, como la violación, el abuso sexual infantil e incesto.

- De acuerdo con el Centro de Recursos Asalto Sexual son reportadas sólo el 23% de las agresiones sexuales.
- Asalto sexual puede afectar a personas de cualquier género, edad, raza, grupo étnico, nivel socioeconómico, orientación sexual o discapacidad.

ASALTO Ley de Eliminación de Violaciones en Prison (PREA)

La Ley de Eliminación de Violaciones en Prisión (PREA) de 2003 es una ley federal establece que aborda la eliminación y prevención de asalto sexual y violación en los sistemas penitenciarios. PREA se aplica a todas las prisiones federales, estatales y locales, las cárceles, los calabozos policiales, centros privados y comunitarios, tales como las instalaciones residenciales.

Sección 10 de la Ley de Eliminación de Violaciones en Prisión define el término "violación" como:

- El conocimiento carnal, sodomía oral, asalto sexual con un objeto o caricias sexuales de una persona, la fuerza o contra la voluntad de esa persona, no por la fuerza o contra la voluntad de la persona, cuando la víctima es incapaz de dar su consentimiento debido a su su juventud o su incapacidad mental o física temporal o permanente, o
- El conocimiento carnal, sodomía oral, asalto sexual con un objeto o caricias sexuales de una persona logra a través de la explotación del miedo o la amenaza de violencia física o lesiones corporales.
- Los depredadores utilizan el sexo como un arma de asalto del cuerpo, la mente, la psique y el espíritu de sus víctimas.
- Si se manifiesta como sexo forzado a cambio de protección, que se repite violaciones en grupo o una experiencia traumática noche en el condado de encerrar

De acuerdo con la victimización National Crime
Encuesta (SCVS), siete de cada ocho violaciones víctimas fueron mujeres y uno de cada ocho víctimas de violación era un hombre.

- Violación y abuso de Asalto Sexual ocurre a mujeres y hombres de todas las edades, desde la infancia hasta la vejez.
- El hecho de que el hombre víctima de un asalto sexual eyaculó o se convirtió en excitación sexual no significa que no fue violada o que ha dado su consentimiento. Estas son reacciones fisiológicas normales involuntarios.
- Un sobreviviente no es culpable de la violación / asalto sexual, incluso si él / ella estaba en una zona aislada, o tenía anterior sexuales consentidas con el atacante.
- Los informes indican que la violación de unos 150,000 hombres por año.

Sentimientos Comunes deSobrevivientes

- Vergüenza
- Enojo
- Culpa
- Pánico, Depresión
- Miedo
- Otras reacciones comunes incluyen pérdida de apetito, náuseas o dolores de estómago, dolores de cabeza, pérdida de memoria y / o dificultad para concentrarse y cambios en los patrones de sueño.

REDUCCION DEL RIESGO

- Colóquese en zonas "zona segura" donde se puede ver a un funcionario y el funcionario puede verte.
- Esté al tanto de las situaciones que te hacen sentir incómodo. Confíe en sus instintos. Si se siente mal, salir, obtener ayuda, o llame a un miembro del personal.
- No aceptamos los artículos del economato, ofertas de protección, u otros regalos de otros delincuentes. Poner en la deuda a otro delincuente puede dar lugar a la esperanza de devolver la deuda en favores sexuales.

¿Qué Hacer Si Ustedes Asaltado Sexualmente

- **Si el ataque ACABA DE PASADO .....**
- Llegar a lugar seguro
- INFORME DEL ATAQUE A UN MIEMBRO DEL PERSONAL (Cuanto más tiempo espere, más difícil es obtener pruebas necesarias para la investigación penal y / o administrativa.)
- Solicite Atención Médica de urgencia.
- **No se** bañe, fumar, beber, cepillarse los dientes, usar el baño o cambiar su ropa.

SERVICIOS DE APOYO

- El personal de Salud Mental
- Servicios Sociales
- Capellán
- Consejero
- Personal médico

Los próximos días pueden ser traumáticos y que ayuda a tener las personas que se preocupan por ti para apoyarte. Busque ayuda profesional. Personal de Salud Mental está disponible para atención de crisis 365 días del año, para escuchar y ofrecer apoyo.

DATOS PARA EL AGRESOR:

- Todos los casos de asalto sexual son investigadas por la policía local / División de Investigaciones Especiales (SID) como una investigación criminal. Usted puede ser procesado por un delito penal y si es declarado culpable, se le añadirá tiempo adicional prisión a su oración actual.

- Se le entregará una notificación de cargos. Si se le encuentra culpable, las sanciones serán duras. Además, se revisará su nivel de clasificación y probablemente aumentó, lo que podría significar un traslado a una cárcel de mayor seguridad o la unidad con mucho menos libertad de movimiento y los privilegios limitados. Si tiene familiares que esto puede afectar a ellos ya su capacidad para visitarte.

- Participar en tal conducta en estas instituciones aumenta significativamente el riesgo de infección por el VIH, además de que la exposición a otras enfermedades de transmisión sexual.

- Si usted tiene problemas para controlar sus acciones buscan la ayuda de personal de salud mental y / o considerar la participación en los programas diseñados para controlar la ira o reducir el estrés. Para reducir los sentimientos inmediatos de la ira o la agresión intentar hablar o escribir a un amigo, meditar o hacer ejercicios de respiración para relajarse, trabajar en un hobby o realizar algún tipo de ejercicio.

ECCF LÍNEA DIRECTA ASALTO SEXUAL
Informar todos los casos 24/7
973-274-7732 (PREA)

ECCF Oficina del
Coordinador de PREA Director
Sergeant Navarro
973-274-7733 (PREE)
Con el fin de ponerse en contacto con el número más arriba:

1. **Introduzca su identificación Teléfono (TID)**
2. **Seleccione la opción Servicios Especiales**
3. **a continuación, elija la opción 2**

NJ Coalicion Contra el Asalto Sexual
1-609-631-4450
1-800 601-7110
2333 Whitehorse Mercerville Road
Suite B
Trenton, NJ 08618

Centro de Derecho de la Victima del Delito de Nueva Jersey
1-973-729-9342
6 Spring Street, Suite 4D
Newton, NJ 07860

De RAINN (Linea Nacional de Asalto Sexual)
1-800-656-4673 (HOPE)
1220 L Street NW, Suite 505
Washington, DC 20005

Linea Directa Para Las Victimas de Violacion
1-866-363-7273
1-866-ENDRAPE

Suicidio/Crisis/Linea Directa de Cuidados
1-800-273-8255 (TALK)

APENDICE A

HORARIO DE VISITAS

VISITAS-SIN CONTACTO

Miércoles y Domingos

Edificio #2 and #5 11:15 am - 1:30 pm

(A ningún visitante se le permitirá el acceso después de la 1:00pm)

2:30 pm – 5:45 pm

(A ningún visitante se le permitirá el acceso después de la 5:00pm)

Solo Los Miércoles

Enfermeria 10:15 am – 11:45 am (Solo Hombres)

(A ningún visitante se le permitirá el acceso después de la 11:30 am)

12:00 pm – 1:30 pm (Solo Mujeres)

(A ningún visitante se le permitirá el acceso después de la 1:00 pm)

Jueves y Sábados

Edificio #3 and #4 11:15 am - 1:30 pm

(A ningún visitante se le permitirá el acceso después de la 1:00pm)

2:30 pm – 5:45 pm

(A ningún visitante se le permitirá el acceso después de la 5:00pm)

Visitas De Abogados

Diario

7:00 am – 9:45 am

10:30 am -12:45 pm

3:00 pm – 7:00 pm

(A ningún abogado se le permitirá el acceso después 6:30 pm)

Todas las visitas están sujetas a cambios a discreción del Director

Apéndice C

Centro Correccional del Condado de Essex

Gestión de la lista de teléfonos

Implementación de la lista de teléfonos

A partir del 7 de mayo de 2018 cambiará la manera en que gestiona su lista de teléfonos. Debe leer y comprender las siguientes instrucciones antes de este cambio:

- Puede tener un máximo de **quince (15)** números de teléfono en su lista de teléfonos.
- Su lista de teléfonos será creada automáticamente por el sistema de teléfonos.
- Los primeros quince **(15)** números de teléfono únicos a los que intenta llamar (que no están bloqueados y pueden recibir llamadas desde la plataforma de presidiarios) serán agregados automáticamente a su lista de teléfonos.
- Tendrá la oportunidad de cambiar su lista de teléfonos durante un período de cambio que tendrá lugar cada 30 días. Todos los números de la lista de teléfonos serán eliminados **El primer lunes de cada mes.** No tendrá que hacer nada. Corresponderá lo anterior.
- Es su responsabilidad identificar todos los abogados a los que llamará. Debe enviar todos los números de los nuevos abogados mediante el formulario de contacto con abogado que puede solicitar al consejero defensor. Entregue el formulario al oficia de la unidad de vivienda, quien obtendrá la aprobación.

Normas de la lista de teléfonos

1. Solicitudes de cambio.

   Cuando llegue al límite de **15** números, se rechazarán las solicitudes de cambio de un número existente y se le informará del próximo período de cambio.

2. Solicitudes de cambio de emergencia.

   Cuando llegue al límite de **15** números, toda solicitud de cambio de EMERGENCIA de la lista de teléfonos se debe enviar a la administración del centro para su aprobación.

3. Números agregados de forma fraudulenta.

   Todas las solicitudes para cambiar un número debido a que fue agregado en contra de su voluntad serán derivadas al personal del centro.

4. Se suspenderán los privilegios de teléfono de las personas que accedan a una cuenta que no es la suya propia.

Todas las solicitudes o quejas se deben enviar mediante el formulario de quejas de presidiarios

Apéndice D

Centro Correccional del Condado de Essex

Instrucciones para el registro de código privado y de marcado.

Tendrá que registrar un código privado de 4 cifras para hacer llamadas de teléfono en el sistema de GTL. El objeto de este proceso es una mayor protección de su cuenta de presidiario para evitar el acceso no autorizado.

Registre su código privado:

1. Desde el teléfono para presidiarios, levante el auricular y pulse 1 para inglés o pulse 2 para español.
2. Esta llamada será monitoreada y grabada.
3. Pulse 1 para inglés. Marque el número dos para español.
   <el valor preseleccionado/sin selección es inglés>
4. Para hacer una llamada por cobrar, marque 0 seguido del código de área y el número.
   Para hacer una llamada por débito, marque 1 seguido del código de área y el número.
   Para hacer una llamada por débito internacional, marque 011 seguido del código de país y el número.
   Para escuchar su saldo de débito, marque 118.
   <el presidiario Ingresa el número de destino>
5. Ingrese su NIP después del tono…
   <el presidiario ingresa el NIP>
6. Después del tono, diga su nombre…
   <el presidiario graba el nombre - la primera vez únicamente>

El sistema le pedirá que establezca un código privado de 4 cifras:

7. En llamadas futuras, tendrá que ingresar un código privado de 4 cifras. Seleccione su código privado de 4 cifras después del tono…
   <el presidiario ingresa el código privado de 4 cifras>
8. Usted ingresó…
   <el sistema reproduce el número de código privado del presidiario>
9. Pulse 1 para confirmar su código privado; de otra manera, pulse 2.
   <el presidiario ingresa la selección>
10. Su código privado de 4 cifras quedó registrado. El código es…
    <el sistema reproduce el número de código privado del presidiario>
11. Muchas gracias por utilizar Global Tel Link. Estamos procesando su llamada.

Instrucciones para el marcado de código privado:

1. Levante el teléfono. Pulse 1 para inglés o pulse 2 para español.
2. Esta llamada será monitoreada y grabada.
3. Pulse 1 para inglés. Marque el número dos para español.
   <el valor preseleccionado/sin selección es inglés>
4. Para hacer una llamada por cobrar, marque 0 seguido del código de área y el número. Para hacer una llamada por débito, marque 1 seguido del código de área y el número.
   Para hacer una llamada por débito internacional, marque 011 seguido del código de país y el número. Para escuchar su saldo de débito, marque 118.
   <el presidiario Ingresa el número de destino>
5. Ingrese su NIP después del tono…
   <el presidiario ingresa el NIP>
6. Después del tono, diga su nombre…
   <el nombre grabado del presidiario>
7. Ingrese su código privado de 4 cifras después del tono…
   <el presidiario ingresa el código privado>
8. Muchas gracias por utilizar Global Tel Link. Estamos procesando su llamada.

Apendice E

Cárcel del condado de Essex

Grupo de Trabajo Civil

El Propósito del Grupo de Trabajo es proporcionar supervisión pública, transparencia y rendición de cuentas con respecto a las políticas, procedimientos, prácticas, supervisión, gestión y capacitación en el Centro Correccional del Condado de Essex ("ECCF").

Si usted como detenido o recluso tiene una preocupación que le gustaría compartir con

el Grupo de Trabajo

Puede enviarles un correo electrónico en

JailTaskForce@admin.essexcountynj.org

O puede llamar al (973) 877-8037

Es una llamada gratuita

(Esta llamada se trata como una llamada legal y NO se registra)

Appendix 6

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CFG Health Systems, LLC and Affiliates as of December 31, 2017 and 2016, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying supplementary information is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audits of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Kreischer Miller

Horsham, Pennsylvania
May 31, 2018

CFG HEALTH SYSTEMS, LLC AND AFFILIATES

Consolidated Balance Sheets
December 31, 2017 and 2016

	2017	2016
ASSETS		
Current assets:		
Cash (restricted 2017: $29,948; 2016: $3,929)	$ 14,628	$ 105,110
Accounts receivable, net (restricted 2017: $1,973,862)	12,112,929	9,278,495
Due from related parties	4,299,710	3,098,827
Prepaid expenses	66,676	100,021
Total current assets	16,493,943	12,582,453
Property and equipment:		
Leasehold improvements	35,000	35,000
Computer equipment	504,527	485,568
Office equipment	194,074	194,074
Vehicles	101,050	79,938
	834,651	794,580
Accumulated depreciation and amortization	(769,762)	(730,795)
	64,889	63,785
Security deposits	87,297	87,297
Other asset	4,250	4,250
	$ 16,650,379	$ 12,737,785
LIABILITIES AND MEMBER'S EQUITY		
Current liabilities:		
Accounts payable (nonrecourse 2017: $236,611; 2016: $25,204)	$ 1,240,695	$ 1,410,489
Accrued expenses (nonrecourse 2017: $878,545; 2016: $675,261)	3,499,665	3,669,221
Due to related parties	1,711,279	9,805
Total current liabilities	6,451,639	5,089,515
Deferred compensation	172,316	162,563
	6,623,955	5,252,078
Member's equity:		
Member's equity, CFG Health Systems, LLC	9,829,377	7,127,171
Noncontrolling interest in VIEs	197,047	358,536
	10,026,424	7,485,707
	$ 16,650,379	$ 12,737,785

See accompanying notes to consolidated financial statements.

CFG HEALTH SYSTEMS, LLC AND AFFILIATES

Consolidated Statements of Operations
Years Ended December 31, 2017 and 2016

	2017		2016	
	Amount	%	Amount	%
Revenue	$ 50,771,506	100.0 %	$ 49,357,082	100.0 %
Cost of revenue	36,461,198	71.8	36,329,737	73.6
Gross profit	14,310,308	28.2	13,027,345	26.4
Operating expenses	11,769,534	23.2	11,891,156	24.1
Income before other expense	2,540,774	5.0	1,136,189	2.3
Other expense: Interest expense	57	-	5,461	-
Net income	2,540,717	5.0	1,130,728	2.3
Net loss attributable to noncontrolling interest in VIEs	161,489	0.3	52,653	0.1
Net income attributable to CFG Health Systems, LLC	$ 2,702,206	5.3 %	$ 1,183,381	2.4 %

See accompanying notes to consolidated financial statements.

CFG HEALTH SYSTEMS, LLC AND AFFILIATES

Consolidated Statements of Changes in Member's Equity
Years Ended December 31, 2017 and 2016

	Member's Equity, CFG Health Systems, LLC	Noncontrolling Interest in VIEs	Total Member's Equity
Balance, December 31, 2015	$ 5,943,790	$ 411,189	$ 6,354,979
Net income (loss)	1,183,381	(52,653)	1,130,728
Balance, December 31, 2016	7,127,171	358,536	7,485,707
Net income (loss)	2,702,206	(161,489)	2,540,717
Balance, December 31, 2017	$ 9,829,377	$ 197,047	$10,026,424

See accompanying notes to consolidated financial statements.

CFG HEALTH SYSTEMS, LLC AND AFFILIATES

Consolidated Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	2017	2016
Cash flows from operating activities:		
Net income	$ 2,540,717	$ 1,130,728
Adjustments to reconcile net income to net cash used in operating activities:		
Depreciation and amortization	38,967	29,147
Bad debt expense	51,610	-
(Increase) decrease in:		
Accounts receivable	(2,886,044)	(1,013,861)
Prepaid expenses	33,345	19,445
Security deposits	-	4,400
Increase (decrease) in:		
Accounts payable	(169,794)	(61,220)
Accrued expenses	(169,556)	(154,384)
Deferred compensation	9,753	9,202
Net cash used in operating activities	(551,002)	(36,543)
Cash flows from investing activities:		
Purchase of property and equipment	(40,071)	(39,556)
Net repayments from related parties	500,591	16,416
Net cash provided by (used in) investing activities	460,520	(23,140)
Net decrease in cash	(90,482)	(59,683)
Cash, beginning of year	105,110	164,793
Cash, end of year	$ 14,628	$ 105,110
Supplemental disclosure of cash flow information:		
Cash paid during the year for interest	$ 57	$ 5,461

See accompanying notes to consolidated financial statements.

(1) Nature of Business

CFG Health Systems, LLC (HS) is a limited liability company that was formed in New Jersey on June 4, 1999. The Company contracts to provide and/or administer medical and behavioral health care services to correctional facilities throughout New Jersey and Pennsylvania.

Effective January 1, 2013, HS became a wholly-owned subsidiary of Onobo, LLC.

Elmwood Administrators, Inc. (Elmwood) is an S corporation that was formed in New Jersey and began operating in 2011. Elmwood performs health care claims management functions on behalf of HS.

CFG Dental Services, LLC (Dental) is a limited liability company that was formed in New Jersey and began operating in 2012. Dental performs professional dentistry services on behalf of HS.

JLM Correctional Medicine Group, LLC (JLM) is a limited liability company that was formed in New Jersey and began operating in 2013. JLM performs professional medical and behavioral health care services on behalf of HS.

CFG Medical Service, PLLC (MS) is a limited liability company that was formed in New York and began operating in 2017. MS performs medical and behavioral health care services to a correctional facility in New York.

Dental Correctional Care, PLLC (DC) is a limited liability company that was formed in New York and began operating in 2017. DC performs professional dentistry services to a correctional facility in New York.

(2) Summary of Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements of CFG Health Systems, LLC and Affiliates include the accounts of HS, Elmwood, Dental, JLM, MS and DC (collectively, the Company). All significant intercompany transactions and account balances have been eliminated in the accompanying consolidated financial statements.

Continued...

(2) Summary of Significant Accounting Policies, Continued

Revenue and Cost Recognition

The Company's contracts with correctional institutions are principally fixed price contracts with revenue adjustments for census fluctuations and risk sharing arrangements, such as stop-loss provisions and aggregate limits for off-site or pharmaceutical costs. Such contracts typically have terms of one to three years with subsequent renewal options and generally may be terminated by either party without cause upon proper notice. Revenues earned under contracts with correctional institutions are recognized in the period that services are rendered. Cash received in advance for future services is recorded as deferred revenue and recognized as income when the service is performed.

Revenues are calculated based on the specific contract terms and fall into one of two general categories: fixed fee or population-based. For fixed fee contracts, revenues are recorded based on fixed monthly amounts established in the service contract irrespective of inmate population. Revenues for population-based contracts are calculated either on a fixed fee that is subsequently adjusted using a per diem rate for variances in the inmate population from predetermined population levels or by a per diem rate multiplied by the average inmate population for the period of service.

Normally, contracts will also include additional provisions which mitigate a portion of the Company's risk related to cost increases. Off-site utilization and pharmacy expense risks are mitigated in some of the Company's contracts through caps for off-site expenses or stop-loss provisions. Typically under the terms of such provisions, the Company's revenue under the contract increases to offset increases in specified cost categories such as off-site expenses or pharmaceutical costs. For contracts which include such provisions, the Company recognizes the additional revenues due from clients when the specified expenses exceed the caps or the stop-loss provision. Because such provisions typically specify how often such additional revenue may be invoiced and require all such additional revenue to be ultimately settled based on actual expenses, the additional revenues are initially recorded as unbilled receivables until the time period for billing has been met and actual costs are known. Any differences between the Company's estimates of incurred costs and the actual costs are recorded in the period in which such differences become known along with the corresponding adjustment to the amount of recorded additional revenues.

Continued...

(2) Summary of Significant Accounting Policies, Continued

Revenue and Cost Recognition, Continued

Cost of revenues includes the compensation of physicians, psychiatrists, nurses and other health care professionals including any related benefits and all other direct costs of providing and/or administering the managed care including the costs associated with services provided and/or administered by off-site behavioral and/or medical providers and the costs of professional and general liability insurance. The cost of healthcare services provided, administered or contracted for are recognized in the period in which the services are provided and/or administered based in part on estimates, including an accrual for estimated unbilled medical services rendered through the balance sheet date. The Company estimates the accrual for unbilled medical services using actual utilization data including hospitalization, one-day surgeries, physician visits and emergency room and ambulance visits and their corresponding costs, which are estimated using the average historical cost of such services.

Accounts Receivable

Accounts receivable represent billed and unbilled amounts due from state and local governments and certain private entities for medical and/or behavioral health care services provided and/or administered by the Company. Included in unbilled accounts receivable is the Company's estimate of revenue earned under risk sharing provisions.

Accounts receivable are stated at estimated net realizable value. The Company routinely evaluates receivables based on a variety of factors, including the length of time receivables are past due, significant one-time events, contractual rights, client funding, discussions with clients and historical experience. If circumstances change, estimates of the recoverability of receivables would be further adjusted and such adjustments could have a material adverse effect on the Company's results of operations in the period in which they are recorded.

Property and Equipment

Property and equipment are recorded at cost. Expenditures for maintenance, repairs and betterments, which do not materially extend the useful life of an asset, are charged to operations as incurred. Renewals and betterments, which substantially extend an asset's useful life, are capitalized. Upon sale or other disposition of assets, the cost and related accumulated depreciation and/or amortization is removed from the accounts and the resulting gain or loss, if any, is reflected in income.

Continued...

(2) Summary of Significant Accounting Policies, Continued

Property and Equipment, Continued

Depreciation and amortization is computed using accelerated methods for financial accounting and income tax purposes. The Company uses estimated lives of 5-7 years for office equipment, 3-5 years for computer equipment, and 4-5 years for vehicles. Leasehold improvements are amortized over the shorter of the estimated useful lives of the assets or the remaining term of the lease.

Depreciation and amortization expense was $38,967 and $29,147 for the years ended December 31, 2017 and 2016, respectively.

Advertising

The Company's policy is to expense advertising costs as incurred. Advertising expense was $53,310 and $56,878 for the years ended December 31, 2017 and 2016, respectively.

Income Taxes

HS, Dental, JLM, MS and DC are limited liability companies whereby federal and state income are taxed directly to the members. Accordingly, no provision for income taxes has been made in the accompanying consolidated financial statements for HS, Dental, JLM, MS or DC.

Elmwood has elected to be taxed under subchapter S of the Internal Revenue Code and under similar provisions for state tax purposes. The operating results of Elmwood will be reflected on the individual income tax returns of the stockholders. Therefore, no provision for income taxes has been made in the accompanying consolidated financial statements for Elmwood.

Financial Accounting Standards Board (FASB) *Accounting Standards Codification* (ASC) 740, *Income Taxes*, is the authoritative pronouncement on accounting for and reporting income tax liability and expense. FASB ASC 740 clarifies the accounting for uncertainty in income taxes recognized in an enterprise's financial statement. FASB ASC 740 prescribes a more-likely-than-not recognition and measurement of a tax position taken or expected to be taken. In addition, FASB ASC 740 provides guidance on derecognition, classification and disclosure. Management has evaluated the Company's tax positions and concluded that the Company has taken no uncertain tax positions that require adjustment to the financial statements to comply with the provisions of this guidance.

The Company is no longer subject to federal, or state and local income tax examinations by tax authorities for years before 2014. Based on the Company's assessment of many factors, the Company does not currently anticipate significant changes in its tax positions over the next 12 months.

Continued...

(2) Summary of Significant Accounting Policies, Continued

Use of Estimates

The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Variable Interest Entities

HS follows FASB ASC 810, *Consolidation*, which provides guidance in determining when variable interest entities (VIEs) should be consolidated in the financial statements of the primary beneficiary. In accordance with FASB ASC 810, HS must consolidate an entity in which it is deemed to have controlling financial interests as a result of having the power to direct the activities that most significantly impact the VIE's economic performance, and the obligation to absorb losses that could potentially be significant to the VIE.

The Company along with its affiliates guarantee the debt of JLMR, LLC (JLMR) which qualifies as a VIE for which the Company is not the primary beneficiary. The entity was formed for the purpose of holding and leasing real estate, and its activities primarily relate to such activities. As of December 31, 2017, the amount of debt the Company has guaranteed (see Note 7) was approximately $804,000. As of December 31, 2017, JLMR has total assets and liabilities of approximately $1,288,000 and $1,080,000, respectively. As of December 31, 2016, JLMR had total assets and liabilities of approximately $1,285,000 and $1,034,000, respectively.

HS is charged for certain health care services from Elmwood, Dental, and JLM, which qualify as VIEs. Elmwood, Dental, and JLM perform certain health care services on behalf of HS and, as such, all revenue of Elmwood, Dental, and JLM is derived from HS. During 2017, HS provided financial support to newly created entities, MS and DC. Additionally, HS charges MS and DC for certain general and administrative expenses for managing its correctional contract. HS has determined that it is the primary beneficiary of Elmwood, Dental, JLM, MS, and DC. Consequently, these entities have been consolidated with HS for financial statement reporting purposes. Accordingly, these entities have been reported as a noncontrolling interest of HS in the accompanying consolidated financial statements. Management does not believe that it is exposed to significant risk as a result of HS's involvement with these entities.

Continued...

(2) Summary of Significant Accounting Policies, Continued

Variable Interest Entities, Continued

The following table summarizes the assets and liabilities of the consolidated VIEs at December 31, 2017 and 2016:

	2017	2016
Current assets	$ 3,009,545	$ 1,028,483
Current liabilities	$ 2,826,435	$ 674,197

FASB ASC 810 also requires certain balance sheet disclosures of restricted assets and nonrecourse liabilities of the VIEs. Assets of the VIEs that can only be used to settle the obligations of the VIEs are identified as restricted. Liabilities of the VIEs for which creditors do not have recourse to the general credit of PC are identified as nonrecourse.

Recent Accounting Pronouncements

Revenue from Contracts with Customers

In May 2014, the FASB issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers* (Topic 606). The standard provides entities with a single model for use in accounting for revenue arising from contracts with customers and supersedes current revenue recognition guidance, including industry-specific revenue guidance. The core principle of the model is to recognize revenue when control of the goods or services transfers to the customer, as opposed to recognizing revenue when the risks and rewards transfer to the customer under the existing revenue guidance.

In April 2016, the FASB issued ASU 2016-10, Topic 606, which updates the accounting guidance for identifying performance obligations and licensing. This standard intends to achieve the core principle that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

The ASUs are effective for annual reporting periods beginning after December 15, 2018. A nonpublic entity may elect to apply this guidance earlier, under certain conditions. The Company does not believe the adoption of these ASUs will have a significant impact on its consolidated financial statements.

Continued...

(2) Summary of Significant Accounting Policies, Continued

Recent Accounting Pronouncements, Continued

Leases

In February 2016, the FASB issued ASU 2016-02, *Leases* (Topic 842), which requires lessees to recognize a right-of-use asset and lease liability on the balance sheet for both finance (capital) and operating leases and disclose key information about leasing arrangements. ASU 2016-02 is effective for annual reporting periods beginning after December 15, 2019. Early application of the pronouncement is permitted. The Company is currently evaluating this guidance to determine the potential impact on its consolidated financial statements.

Reclassifications

Certain items in the accompanying 2016 consolidated financial statements have been reclassified to conform to the current year presentation.

Subsequent Event

The Company has performed an evaluation of subsequent events through May 31, 2018, which is the date the consolidated financial statements were available to be issued.

(3) Accounts Receivable

Accounts receivable consist of the following:

	2017	2016
Billed accounts receivable	$ 11,430,508	$ 8,427,428
Unbilled accounts receivable	682,421	851,067
	$ 12,112,929	$ 9,278,495

Unbilled accounts receivable generally represent additional revenue earned under shared-risk contracting models that remain unbilled, due to provisions within the contracts governing the timing for billing such amounts.

(4) Concentrations of Risk

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash and accounts receivable. The Company places its cash with financial institutions and, at times, such balances may exceed federally insured amounts. The Company provided services under four contracts which comprised approximately 67% of the Company's total revenues for the year ended December 31, 2017. The accounts receivable balances from these four contracts represent approximately 79% of total accounts receivable as of December 31, 2017.

(5) Commitment

Self-Insurance

The Company maintains a self-insurance program for substantially all of its employees' medical, mental health/substance abuse, and pharmacy costs.

Specific excess: The Company is liable for paid claims up to $150,000 per participant, per policy period, which is on a calendar year basis. The reimbursement allowance on specific claims over $150,000 is unlimited.

Aggregate excess coverage: The Company is liable for paid claims for the total participant base, up to an aggregate limit. The contract is on a calendar basis. If annual claims paid exceed the annual aggregate limit, the maximum reimbursement allowance is unlimited.

Self-insurance costs are accrued based on claims reported as of the balance sheet date as well as an estimated liability for claims incurred but not reported. In 2017 and 2016, the Company recorded self-insurance expense in the amount of $1,908,846 and $2,506,027, respectively. Of these amounts, the Company has accrued $121,578 and $174,050, at December 31, 2017 and 2016, respectively, which is included in accrued expenses in the accompanying consolidated balance sheets.

(6) Related Party Transactions

The Company is charged a management fee for general and administrative services from one affiliate, CFG Health Network, LLC (HN). HN provides various administrative services to the Company. A portion of the fee includes related party rent. The Company shares the administrative costs with its affiliates based on its percentage of total revenue.

The Company incurred $5,212,627 and $5,679,650 in management fees to HN for the years ended December 31, 2017 and 2016, respectively.

The Company may make advances to and borrow from related parties on an as needed basis. The amounts are included in the due to and from related parties on the accompanying consolidated balance sheets. These balances are noninterest bearing, unsecured and due on demand.

(7) Contingencies

The Company has a nonqualified deferred compensation plan for one executive. Benefits under the plan are payable to the participant as an unsecured promise upon agreed upon triggering events. The participant was fully vested on the effective date of the agreement. The present value of the liability, with an imputed interest rate of 6%, has been reflected in the Company's balance sheets as of December 31, 2017 and 2016, respectively.

The Company and its affiliates have guaranteed a $9,000,000 revolving line of credit with a bank on behalf of one affiliate, Center for Family Guidance, PC. Interest is payable annually at LIBOR plus 1.20 percent (2.75% at December 31, 2017). The line is scheduled to expire on August 31, 2018. At December 31, 2017, outstanding borrowings under the line of credit are $6,050,000.

The Company has guaranteed the payment of a commercial mortgage on behalf of one affiliate, JLMR. JLMR was formed for the purpose of holding and leasing real estate, and its activities primarily relate to such activities. The loan is collateralized by the real estate which is leased to the Company, HN, and other related parties. The related party rent is included in the management fee from HN (see Note 6). The monthly payment on the loan is $11,132 including interest at 4.10%. This loan matures November 25, 2024, at which time the remaining principal balance is due and payable. The principal balance outstanding on December 31, 2017 approximates $804,000.

Some of the Company's contracts require the Company's customers to reimburse the Company for all treatment costs or, in some cases, only treatment costs related to certain catastrophic events, and/or for specific diagnosed diseases. Certain contracts of the Company do not contain such limits. The Company attempts to compensate for the increased financial risk when pricing contracts that do not contain individual, catastrophic or specific diagnosed disease limits. However, the occurrence of severe individual cases, specific disease diagnoses, illnesses or a catastrophic event in a facility governed by a contract without such limitations could render the contract unprofitable and could have a material adverse effect on the Company's operations.

The Company is involved in legal proceedings from time to time in the ordinary course of business. Management believes that none of these legal proceedings will have a material adverse effect on the financial condition or results of operations of the Company.

(8) Retirement Plan

The Company maintains a 401(k) defined contribution plan covering substantially all of its full time employees who have attained 21 years of age and completed three months of service. The plan provides the option for the Company to make discretionary contributions to the plan. For the years ended December 31, 2017 and 2016, the Company made contributions to the plan of $200,566 and $243,335, respectively.

(9) Collective Bargaining Agreements

HS is subject to two collective bargaining agreements which expire July 2018 and September 2019. These union agreements mandate wage rates, working hours, working conditions, and other related policies and procedures for covered employees.

SUPPLEMENTARY INFORMATION

CFG HEALTH SYSTEMS, LLC AND AFFILIATES

Supplementary Information
Consolidated Cost of Revenue
Years Ended December 31, 2017 and 2016

	2017		2016	
	Amount	%	Amount	%
Salary, professional	$ 23,491,777	46.2 %	$ 22,839,144	46.3 %
Subcontracted professional services	1,034,681	2.0	951,561	1.9
Insurance for disability, health, life and workmen's compensation	2,893,135	5.7	3,149,556	6.4
Outpatient services	1,548,650	3.1	948,379	1.9
Outside medical services	1,104,694	2.2	1,152,745	2.3
Payroll taxes	1,916,891	3.8	1,930,566	3.9
Pharmacy	3,346,755	6.6	4,286,121	8.7
Rent	-	-	1,506	-
Supplies, medical and dental	676,272	1.3	648,681	1.3
Temporary staffing	448,343	0.9	421,478	0.9
	$ 36,461,198	71.8 %	$ 36,329,737	73.6 %

CFG HEALTH SYSTEMS, LLC AND AFFILIATES

Supplementary Information
Consolidated Operating Expenses
Years Ended December 31, 2017 and 2016

	2017		2016	
	Amount	%	Amount	%
Advertising	$ 53,310	0.1 %	$ 56,878	0.1 %
Bad debt expense	51,610	0.1	-	-
Computer	69,627	0.1	164,550	0.3
Continuing education	22,905	-	16,500	-
Contributions	-	-	1,033	-
Data processing and payroll services	11,106	-	23,544	-
Depreciation and amortization	38,967	0.1	29,147	0.1
Dues and subscriptions	33,324	0.1	57,204	0.1
Entertainment and meals	46,762	0.1	40,022	0.1
Insurance for disability, health, and life	666,711	1.3	671,087	1.4
Legal	279,584	0.6	285,935	0.6
Licenses and permits	63,404	0.1	85,780	0.2
Maintenance and repairs	25,406	0.1	10,517	-
Management and administrative fees	5,212,627	10.3	5,679,650	11.6
Office supplies and expenses	182,020	0.4	181,196	0.4
Outside professional services	670,515	1.3	458,024	0.9
Outside services	7,530	-	4,956	-
Payroll taxes	315,065	0.6	310,904	0.6
Postage	6,927	-	5,599	-
Equipment rental	20,906	-	21,656	-
Retirement plan contributions	200,566	0.4	243,335	0.5
Salaries	3,634,606	7.2	3,436,683	7.0
Taxes, other	2,725	-	3,007	-
Telephone	1,445	-	1,371	-
Travel and transportation	151,886	0.3	102,578	0.2
	$ 11,769,534	23.2 %	$ 11,891,156	24.1 %

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COUNTY OF ESSEX

DEPARTMENT OF CORRECTIONS
ESSEX COUNTY CORRECTIONAL FACILITY
354 Doremus Avenue – Newark, New Jersey 07105
973-274-7500 --- 973-274-6193 (Fax)

Joseph N. DiVincenzo, Jr.
Essex County Executive

Alfaro Ortiz
Director

MEMORANDUM

TO: **Administrator Julius Coltre**

FROM: **Lt. Orlando Camacho, Business Manager**

DATE: **November 18, 2020**

SUBJECT: **Bid to Provide Health Care Services to Inmates at the Essex County Correctional Facility**

Please be advised that the Department of Corrections wishes to award the medical services contract to CFG Health Systems, LLC, who was the sole and responsible bidder. The amount should not exceed $53,225,129 for the term from January 1, 2021 to December 31, 2023.

Funding Source: 01-201-25-280-100-028

If you have any questions or need additional information, please contact me at 973.274.7632.

Respectfully submitted,

Orlando Camacho, Business Manager

17,741,709.67

Alfaro Ortiz, Director

TOTAL PRICE BID
CFG

YEAR	STAFFING	ANCILLARY SERVICES	OTHER	PHARMACY	MEDICAL BILLS	TOTAL
1/1/21-12/31/21	$10,218,524	$624,000	$3,789,545	$2,244,750	$380,000	$17,256,819
Monthly	*$851,544*	*$52,000*	*$315,795*	*$187,063*	*$31,667*	
1/1/22-12/31/22	$10,525,080	$624,000	$3,963,574	$2,244,750	$380,000	$17,737,404
1/1/23-12/31/23	$10,840,832	$624,000	$4,141,324	$2,244,750	$380,000	$18,230,906
TOTAL BID PRICE						**$53,225,129**

Percentage Increase based on last bid submission for calendar year 2017/2018:

YEAR	STAFFING	ANCILLARY SERVICES	OTHER	PHARMACY	MEDICAL BILLS	TOTAL
3/1/17-2/29/18	$6,579,058	$624,000	$3,187,873	$1,780,638 $3.25/inmate/day	$380,000	$12,551,569
1/1/21-12/31/21	$10,218,524	$624,000	$3,789,545	$2,244,750	$380,000	$17,256,819
% increase	***36%***	***0%***	***16%***	***21%***	***0%***	***27%***

Evaluations of Medical Bidders
November 2020
CFG

Qualifications	**Yes/No**	**Comments**
Licensed and registered with federal and state authorities for all aspects of the program	Yes	Section V
Demonstrate at least five years experience of providing a full range of medical/health care services, including medical, mental health and pharmaceutical, to correctional facilities with an inmate/detainee capacity of not less than 1250 inmates/detainees.	Yes	Section V and VI E
Met and maintained all relevant standards for health care at their correctional facilities, as stipulated by the State Department of Correction and accreditation agencies, i.e., NCCHC and the ACA. Bidders must also be Health Insurance Portability and Accountability Act (HIPAA) compliant.	Yes	Section V C

Have at least five years of experience in the use and training of an EHR system, including interfacing software, medical application and error correction software.	Yes	Section V D
Bidders must evidence financial status and capability sufficient to ensure their ability to undertake and perform the services.	2018 Assets - $20,154,247 Net income - 2,975,599 Liabilities - $20,154,247 Operating expenses - $13,038,636	Section V E and Section VI
Supplemental Documents To Be Submitted By Bidder		
Location(s) of all business offices.	Marlton, NJ	
Business name(s) previously used.	None	
Number of years in business as a provider of medical/health care services to correctional facilities.	18 years	Section V B
Form of business (i.e. corporation, partnership, limited liability company, etc.).	Limited liability company	Section V A

List of all correctional facilities (federal, state and county) with an inmate/detainee capacity of not less than 1250 inmates/detainees to which the bidder has provided health care services during the past five years, setting forth the name of the facility, location, average daily population, types of services rendered, dates of service, contact person, address and phone number.	Camden 2004-present (capacity 1889) Essex 2008-present (capacity 2434) Atlantic 2004-present (capacity 1255) Middlesex 2002-present (capacity of 1554)	Section VI E
List of all correctional facilities for which the bidder provided medical/health care services during the past five years where the contract was either not completed or was terminated by the facility and the reasons thereof.	None; Hudson was mutual	Section VI F
List of all litigation in the past five years filed against the bidder or any of its shareholders, officers or key personnel by any correctional facility or by any party with respect to the rendering of health care services, the nature of the litigation and the outcome thereof.	Listed	Section IV and Section V
List of all federal, state and county administrative proceedings or investigations commenced within the past	None	See attachment

five years, involving bidder or any of its shareholders, officers or key personnel related to the rendering of health care services, the nature and outcome thereof.		
Names, business addresses and telephone numbers of at least three individuals and/or organizations who can attest to the bidder's financial capability to carry out the requirements set forth in this bid. References should include hospitals, pharmacies, laboratories or medical suppliers that the bidder is utilizing or has utilized within the past five years.	Provided	Section VI I and VI supplemental documents page 6
List of all material judgments, decrees, stipulations, arbitrations, investigations, labor disputes, other administrative proceedings or claims pending or threatened against or affecting the bidder's business, financial condition or assets and property which, if adversely determined, would materially affect its business, financial condition or ability to fully perform the services required by this bid.	None	Section VI J
A statement as to whether, in the past five years, the bidder has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or	None	Section VI K

involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, submit an explanation providing relevant details.		
Financial statements for the bidder's three most recent fiscal years, prepared by independent certified public accountants, including profit and loss statements and year-end balance sheets, in such form as will enable the ECCF to determine the financial status and stability of the bidder and its ability to fully perform its contractual obligations hereunder.	Provided	Section VI L See attachments

Contents

VII. OBLIGATIONS OF VENDOR

CFG's corporate office shall continue to be open for conducting business daily (Monday – Friday) with staff available between the hours of 8:00 AM and 5:00 PM. As necessary, corporate staff shall be available on-site within several hours.

A. Staffing Requirements

1. CFG shall comply with the minimum staffing requirements established by ECCF, as outlined in Exhibit D of the RFB.

   a. As the incumbent provider of health services, CFG has appointed a New Jersey licensed physician as the Medical Director for this Contract. Any individual holding this position shall be board-certified in primary care and shall have completed a primary care residency unless otherwise approved by the Director. This individual shall also have considerable experience in correctional health, especially in acquiring and maintaining NCCHC and ACA accreditation. The Medical Director shall oversee the proper delivery of healthcare services, per ECCF medical standards. As necessary, the Medical Director shall be involved in the hiring of the Health Services Administrator (HSA) and the Mental Health Director.

   b. As the incumbent provider of health services, CFG will appoint a Health Services Administrator (HSA) who functions as the overall administrative manager for the healthcare program. The HSA will be a licensed RN with at least five (5) years of administrative experience preferably with a Masters in Administration. Any individual holding this position shall have significant experience in correctional healthcare and in acquiring and maintaining NCCHC and ACA accreditation. The HSA shall be responsible for implementing and overseeing the administrative requirements of the healthcare program, including recruitment, staffing, the gathering of data, financial monitoring, development of policy and procedure, medical recordkeeping, and working in conjunction with ECCF staff to maximize the integration of healthcare services with all aspects of ECCF operations. The HSA shall also prepare timely reports and oversee service contracts, as deemed appropriate.

   c. As the incumbent provider of health services, CFG has appointed a Director of Nursing (DON), who is a New Jersey licensed RN and has at least three (3) years of experience in an administrative role. This individual has experience in correctional health and in obtaining and/or maintaining NCCHC and ACA accreditation. The DON will oversee the nurses at the ECCF and be responsible for the training, in-servicing, and competencies of the nursing staff. The DON will control the supplies/inventory of the medical department. The hiring of this position requires the involvement and recommendation of the Medical Director.

d. As the incumbent provider of health services, CFG has already appointed a Psychiatrist for this Contract. Any individual holding this position shall be licensed in the State of New Jersey shall be board-certified and shall have ample experience in correctional healthcare, as well as in acquiring and maintaining NCCHC and ACA accreditation. CFG is aware that the hiring of this position shall require the involvement and recommendation of the Medical Director.

e. As the incumbent provider of health services, CFG has already appointed a Mental Health Director who is a New Jersey licensed Psychologist with at least three years of correctional experience in a management position. The hiring of this position requires the involvement and recommendation of the Medical Director.

f. As the incumbent provider of health services, CFG has appointed New Jersey licensed dentists with experience in correctional healthcare to service this Contract. Any individuals holding these positions shall have experience in acquiring and maintaining NCCHC and ACA accreditation.

g. All physicians, nurse practitioners, physician assistants, nurses, dentists, dental technicians, and all other clinicians assigned to this Contract shall be certified in CPR. Also, all physicians, nurse practitioners, physician assistants, and at least one (1) RN per shift shall be trained and certified in Advanced Cardiac Life Support (ACLS) with (2) clinicians on each shift are ACLS certified.

h. All staff shall is knowledgeable and experienced in working with the Fusion EHR and EMAR.

i. As the incumbent healthcare provider, CFG's payroll system is already well-established and shall continue to meet ECCF specifications as outlined within the RFB.

Please see CFG's Staffing Matrix on the following pages.

STAFFING MATRIX

Staffing Matrix for the Essex County Correctional Facility (ECCF)									
Positions	M	T	W	Th	F	Sa	Sun	Total Hrs.	Total FTEs
Day Shift 7:00 AM - 3:30 PM									
Health Services Administrator (HSA)	8	8	8	8	8			40	1
Assistant HSA (ICE Nurse)	8	8	8	8	8			40	1
Medical Director	8	8	8	8	8			40	1
*Physicians	16	16	16	16	16	8	8	96	2.4
Director of Nursing (DON)	8	8	8	8	8			40	1
QI RN	8	8	8	8	8			40	1
Infection Control	8	8	8	8	8			40	1
*Nurse Practitioners (NPs)/Physician Assistants (PAs)	32	32	32	32	32	8	8	176	4.4
*NP/PA – ICE	8	8	8	8	8	8	8	56	1.4
*Registered Nurses (RNs)	24	24	24	24	24	24	24	168	4.2
*Licensed Practical Nurses (LPNs)	64	64	64	64	64	64	64	448	11.2
*Certified Nursing Assistants (CNAs)	16	16	16	16	16	16	16	112	2.8
*Certified Medical Assistants (CMAs)	8	8	8	8	8			40	1
*Psychiatrist (possibly Director of MH)	8	8	8	8	8			40	1
*Psychiatric APN	8	8	8	8	8	8	8	56	1.4
*Psychologist (Mental Health Supervisor or Director of MH)	8	8	8	8	8			40	1
*Mental Health Counselors	24	16	16	16	24	16	16	128	3.2
Discharge Planner	8	8	8	8	8			40	1
Mental Health Administrative Assistant	4	4	4	4	4			20	0.5
Scheduler	4	4	4	4	4			20	0.5
Drug/Alcohol Counselor	8	8	8	8	8			40	1
Administrative Assistant	8	8	8	8	8			40	1
*Unit Clerks	8	8	8	8	8	8	8	56	1.4
Medical Record Coordinator (Director)	8	8	8	8	8			40	1
Medical Record Clerks	8	8	8	8	8	16	16	72	1.8
Affordable Care Act Coordinator	8	8	8	8	8			40	1
Billing Analyst	8	8	8	8	8			40	1

Staffing Matrix for the Essex County Correctional Facility (ECCF)									
Positions	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Sun**	**Total Hrs.**	**Total FTEs**
Day Shift 7:00 AM- 3:30 PM									
Dentist	8	8	8	8	8	8	8	56	1.4
*Dental Assistant	8	8	8	8	8	8	8	56	1.4
*Dental Hygienist	4	4	4	4	4			20	0.5
*Pharmacy Techs	8	8	8	8	8	8	8	56	1.4
Phlebotomist	8	8	8	8	8	8	8	56	1.4
Support Analyst (Level 1) EHR	8	8	8	8	8			40	1
Development Analyst (Level 2) EHR	4	4	4	4	4			20	0.5
Total Day								2,312	57.8
Evening Shift 3:00 PM - 11:30 PM									
*Physicians	8	8	8	8	8	8	8	56	1.4
*NPs/PAs	8	8	8	8	8	8	8	56	1.4
*RNs	24	24	24	24	24	24	24	168	4.2
*LPNs	64	64	64	64	64	64	64	448	11.2
*LPNs (ICE)	12	8	12	8	12	8	8	68	1.7
*CNAs	8	8	8	8	8	8	8	56	1.4
*CMAs	8	8	8	8	8	8	8	56	1.4
*Mental Health Counselors	8	8	8	8	8	8	8	56	1.4
Pharmacy Techs	8	8	8	8	8	8	8	56	1.4
Medical Record Clerks	8	8	8	8	8	8	8	56	1.4
*Unit Clerk	8	8	8	8	8			40	1
Total Evening		-		-		-		1,116	27.9
Night Shift 11:00 PM - 7:30 AM									
*NPs/PAs	8	8	8	8	8	8	8	56	1.4
*RNs	16	16	16	16	16	16	16	112	2.8
*LPNs	32	32	32	32	32	32	32	224	5.6
*CNAs	8	8	8	8	8	8	8	56	1.4
Pharmacy Techs	8	8	8	8	8			40	1
*Unit Clerk	8	8	8	8	8			40	1
Total Night		-		-		-		528	13.2

Staffing Matrix for the Essex County Correctional Facility (ECCF)									
Positions	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Sun**	**Total Hrs.**	**Total FTEs**
MAT (Grant Reimbursed)									
Program Coordinator	8	8	8	8	8			40	1
Discharge Planner	8	8	8	8	8			40	1
*LPN	5	5	5	5	5	5	5	35	0.875
Substance Abuse Counselor	8	8	8	8	8			40	1
Total MAT		-		-		-		155	3.875
On Site Specialists									
OB/GYN			6		6			12	0.3
Orthopedist		6		6				12	0.3
Oral Surgeon						4		4	0.1
(Billed through Ancillary Services)*Dialysis RN	12	12	12	12	12	12		72	1.8
Optometry				3				3	0.075
Physical Therapy							PRN		
Total Specialists		-		-		-		103	2.575
Grand Totals		-		-		-		4,214	105.35

*** Denotes Backfilled positions**

****Time may vary based on facility needs.**

B. Security Clearance and Requirements

1. CFG is aware that the ECCF will conduct criminal background checks and drug screening on all CFG employees assigned to the ECCF. CFG shall continue to be responsible for said costs (approximately $150.00 per person). All CFG staff shall be fingerprinted and issued identification cards.

2. CFG and its personnel shall be subject to and shall comply with all security regulations and procedures of the ECCF, including, but not limited to, searches of persons and property. CFG understands that violation of security regulations or policies may result in CFG's employees, independent contractors, and/or sub-contractors being denied access to the facilities.

3. CFG acknowledges the ECCF's right to require immediate removal of any staff member or person without prior notification.

4. CFG personnel shall be required to display their ECCF-issued ID cards at all times when on ECCF premises.

5. CFG shall ensure all personnel ending their relationship with CFG – for any reason – shall relinquish their ECCF ID card to the HSA and shall further ensure that all relinquished ID cards are returned to the Director or his/her designee.

6. CFG acknowledges that all on-site staff may be required to submit to random and/or unannounced drug screening as part of the ECCF's overall drug testing policy. CFG is aware that the failure of a staff member to comply with this stipulation shall result in that person's permanent ban from all ECCF facilities.

7. Before entering the facility, staff may be subject to temperature checks and other safety measures as part of the ECCF's COVID-19 protocols.

C. Credentials

As required by New Jersey law, CFG conducts credentialing, maintaining, and complying with written policy and procedures specific to the physician, physician assistant, and nurse practitioner credentialing processes.

D. Training and Orientation

1. **New Employee Training and Orientation Requirements for Healthcare Personnel**
   CFG shall ensure new healthcare personnel is provided with an orientation that includes CPR training, as well as appropriate training on healthcare practices in place at the ECCF. Each CFG staff member shall be provided with twenty-four (24) hours of orientation appropriate to the employee's assignment. Formal training received by staff shall be fully documented in permanent training records, with copies of such records submitted to the ECCF Training Bureau.

2. **ECCF Custody and Security Orientation Requirements**
   CFG is aware that a mandatory sixteen (16) hours of orientation regarding custody and security operations shall be provided by the ECCF for all healthcare staff. CFG understands that custody orientation hours required by the Contract shall be considered time worked (with regard to the Staffing Matrix).

3. **New Employee EHR Training Requirements**
   CFG shall continue to provide EHR training throughout the term of this contract. All employee training shall be completed before the commencement of on-site duties, with additional training provided thereafter, as needed. CFG shall also train select employees as "advanced users." These individuals shall conduct in-services on-site, as required to maintain proficient EHR staff.

4. **Quarterly Custody Training/Inservice Education Requirement**
   All CFG staff shall complete sixteen (16) hours of custody training each quarter, facilitated by the ECCF. Additionally, all CFG staff shall complete professional inservice education, which adheres to NCCHC/ACA standards and PBNDS 2011 standards. Training shall include health care practices for all disciplines, including CPR and EHR training. The formal training received by each trainee shall be fully documented in permanent training records and copies provided to the ECCF training bureau.

E. Access to Personnel Records

CFG shall maintain personnel files for all current and former employees, contract employees (both active and inactive), independent contractors, and sub-contractors assigned to the ECCF at any time. These files shall include copies of current New Jersey licensure, proof of professional certification, DEA and CDS certificates, résumés, evaluations, position responsibilities, training records, attendance records, and payroll records. CFG acknowledges that the Director, the Director's designee, and the Special Investigations Division reserve the right to review these files.

F. Responsibility for Hiring and Termination

CFG is aware that the ECCF Director (or the Director's designee) reserves the right to interview all CFG staff and shall maintain final approval of all personnel who provide services according to this contract. CFG agrees to immediately notify the Director (or the Director's designee) of any staff separations/terminations.

G. Staffing Matrix and Staffing Levels

CFG understands the Staffing Matrix provided as Exhibit D of the RFB addresses only the minimum mandatory staffing requirements. It is understood that CFG is responsible for providing the staff necessary to meet all service elements and requirements of the contract. Any requests for adjustments in staffing levels (e.g. – reallocation of staff, reduction in staff) after contract award shall be submitted in writing to the Director (or the Director's designee) for approval.

CFG acknowledges that the ECCF inmate/detainee population may fluctuate widely, based upon arrest volume and the anti-crime initiatives of the local police department. In consideration of such, CFG shall

be prepared with staffing options and plans that accommodate a variance in the inmate/detainee population and admissions of +/- twenty percent (20%).

CFG is aware that the ICE population is housed separately from other facility populations, affecting the delivery of care since these detainees must be seen at intake, sick-call, and for other visits separate from the general inmate population.

CFG acknowledges that certain positions (including physicians, psychiatrists, NPs, PAs, RNs, LPNs, dentists, dental assistants, dental hygienists, and mental health counselors) require one hundred percent (100%) or total back-fill. CFG shall ensure that staff replacements used to fill in for regular staff using benefit hours or to fill vacancies for positions identified as requiring one hundred percent (100%) or total back-fill are managed in the following manner: Only personnel of the same or higher discipline or profession shall replace nurse practitioners, physician assistants and licensed practical nurses.

The aforementioned individuals shall be oriented and trained in the corrections environment, shall meet the minimum licensure and CPR requirements established, shall be experienced with the use of an EHR system, and shall be subject to appropriate background clearances and drug screens. Replacement hours shall be provided on the same shift, on the same day as the hours originally scheduled, with all essential functions performed during the shift that would otherwise have been routinely provided by regularly-scheduled staff.

H. Operational Continuity

CFG operates based on permanently assigned staff. All scheduled staff positions shall continue to be filled by either permanently assigned staff members or by authorized relief workers. CFG shall retain key staff (i.e. – the Medical Director, the HSA, physicians, nurse practitioners, physician assistants, nurses, psychiatrists, mental health counselors, and dentists) for a term of least one (1) year.

I. Translation and Bilingual Personnel Requirement

As part of this contract, CFG shall utilize the interpretive services of AT&T Language Line to meet the language needs of the diverse inmate/detainee population. Certified and bonded foreign language and sign language translators/interpreters may also be used, as necessary. In no instance shall inmates/detainees serve as interpreters. County employees shall only be used as interpreters in emergencies – not regularly – and shall not include security/custody staff without the written consent of the inmate(s)/detainee(s) involved.

J. Work Hours Required On-Site

1. CFG shall ensure all hours of compensable service are spent on-site at ECCF, except as otherwise agreed to in writing by the Director or the Director's designee. Work schedules shall only be

modified upon prior written agreement between the Director (or the Director's designee) and CFG.

2. Credit for filling a post shall only be given when an individual reports for duty at the ECCF. Travel time shall not be considered time worked.

K. Timekeeping System

All personnel shall clock in and out using the time clock system mandated in section XIF1. Official Pricing and Statements, F. Invoice Processing Requirement, #1. Time Clock of the RFB. CFG is aware that compensation shall not be granted for hours not logged using the time clock system.

L. Compensation and Benefits to Personnel

CFG shall maintain sole and exclusive responsibility for determining the compensation, terms, and conditions, and benefits of employment offered its employees, as well as for paying for said compensation and other benefits to its personnel. CFG is aware that hourly rates of compensation for each category of personnel, including independent contractors, submitted as part of the bid are viewed as not-to-exceed amounts.

CFG is cognizant that the vendor shall only be compensated for persons who perform services and for hours worked, not to exceed the hours and hourly rates specified in the bid. Rates CFG has proposed are loaded and inclusive of benefits and sick time.

M. Not-to-Compete or Non-Competition Clauses

CFG is aware that the vendor is prohibited from entering into "not-to-compete" or "non-competition" clauses/covenants with its employees, independent contractors, and any other parties that would in any way restrict the ECCF's ability to provide services in its facilities.

N. On-Call Requirements and Emergency Contacting

1. **On-Call Requirements**

   CFG shall designate an administrator, physician, RN, psychiatrist, and a dentist on-call twenty-four (24) hours per day, seven (7) days per week. The Director (or the Director's designee) shall be provided with monthly on-call schedules in advance of the first day of each month. The Director/Director's designee shall also be given the contact information of key clinicians and administrative personnel, including individuals' home and cellular telephone numbers.

   CFG is aware that the Essex County Correctional Facility will not pay for the vendor's on-call staff hours.

2. **On-Call Response**
   CFG shall respond to administrative and medical problems within thirty (30) minutes of being called, with appropriate personnel returning to the facility, as necessary.

3. **Emergency Contacting**
   Urgent administrative and medical problems shall be immediately addressed by the appropriate personnel. Complete contact information shall continue to be kept on file and made available to the ECCF Director or the Director's designee.

O. Healthcare Personnel Call-Back to Duty

CFG shall continue to make provisions for the call-back of a sufficient number of physicians, nurses, and other support staff to meet any lockdown, emergency, or mass casualty situations (employees should be able to get to the facility within one [1] hour). CFG is aware that if the Director/Director's designee determines a situation could have been safely handled on-site but was addressed off-site because CFG staff did not return to the facility as specified, the ECCF reserves the right to assess the costs of security escort, transportation and/or outside medical services against the monthly payment made to CFG.

P. Professional Medical Liability Insurance

CFG shall provide and maintain medical professional liability insurance for the duration of this contract, as specified within the RFB and subsequent addenda. CFG shall pay for and maintain, in full force and effect, with an insurance company/companies admitted by the New Jersey Department of Banking & Insurance to do business in the State of New Jersey and rated not less than "A: VII" in the Best Insurance Key Rating Guide, medical professional liability insurance, with combined single limits of not less than $1,000,000 per occurrence/medical incident, and, if written on an aggregate basis, a $3,000,000 aggregate limit. The limits of liability shall apply jointly to a submitted list of medical providers responsible for providing the services of this contract. The policy/policies shall also provide coverage for the following:

- Sexual molestation, at full policy limits
- Specified physicians and employees – staffing additions or deletions during the term of this agreement shall be provided to the County as a policy endorsement
- Claim expenses are to be in addition to the applicable policy limit and deductibles
- Deductibles and self-insured retentions must be declared as such are subject to approval by the County.
- Should CFG sub-contract all or any portion of specialist services in this contract, CFG shall cover the sub-contractor, and/or require each sub-contractor to adhere to all conditions of this section. A listing of all sub-contracted medical specialists shall be provided to the County and updated, as necessary, during the term of this contract.

Upon CFG's notification of policy cancellation, a major change, modification, or reduction in coverage, CFG shall notify the County, file a copy of the said notice with the County, and also provide the County with a copy of the new, modified, or renewal policy (as required).

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VIII. SCOPE OF SERVICES

CFG Health Systems, LLC (CFG) shall provide a continuum of healthcare services for inmates/detainees of the Essex County Correctional Facility, inclusive of screening, chronic care, sick-call, specialty care, medication services, emergency care, and treatment in an infirmary. All inmates/detainees received by the ECCF shall be screened and interviewed by a nurse within four (4) hours of admission and shall be evaluated by a medical provider within seventy-two (72) hours using an assessment that meets NCCHC's definition of the "initial health assessment." New admissions shall be placed in quarantine until all medical evaluations and medical tests (PPD, COVID-19 screening, etc.) have been completed, with results read by qualified medical staff. Once the quarantine is completed within three (3) to twenty-one (21) days, inmates shall be released from quarantine to general population housing assignments. All healthcare services, except initial screening performed during the intake process and medical emergencies, shall be offered by appointment only, to control inmate/detainee movement.

A. Healthcare Services to Be Provided

1. Admission Services – Medical Services Intake and Transfers

Inmates/detainees initially enter a pre-book area where medical screening is completed, including vital signs, COVID-19 screening, and pre-book questions. Following pre-book, inmates/detainees are processed at the ECCF's intake reception area. In exceptional cases where an inmate/detainee bypasses or is incompletely processed at a reception area, full medical intake services are to be performed at the assigned clinic or in the main medical area.

a. Nurse Intake Screening

A complete nurse intake screening shall be performed on an inmate's/detainee's date of arrival, within four (4) hours of admission, by an RN or LPN. The primary intent of the nurse intake screening shall be ensuring the prompt recognition of an inmate's/detainee's immediate medical, dental and mental health needs; the timely provision of care; and furthering continuity of care. The screening shall consist of, but not be limited to, the following:

1) Review of all available medical records and applicable admitting information
2) A confidential interview, inclusive of the taking of the inmate's/detainee's medical history and assessment for mental illness and suicidal ideation
3) Recording of vital signs
4) Review of systems
5) Allergies
6) Pain assessment
7) Observation of an inmate's/detainee's appearance, behavior, etc.
8) CIWA/Drug/Alcohol screening

9) PREA screening
10) Communicable and sexually transmitted diseases
11) Administration of the Mantoux/PPD skin test for tuberculosis (TB); screening for symptoms, if past-positive; and/or chest x-ray
12) Pregnancy testing for female inmates/detainees
13) Immediate referral, as clinically indicated, for appropriate healthcare services

b. Intake Physical Examination (Initial Health Assessment)

A CFG physician, nurse practitioner, or physician assistant shall take a complete inmate/detainee history and perform a physical examination that includes, but is not limited to, the following:

1) Review of all available medical records
2) Patient history and review of symptoms
3) Physical exam
4) Assessment, including completion of an initial problem list
5) Initiation of a treatment plan that includes medications and ancillary tests
6) Initial chronic care visit, for patients diagnosed with chronic disease
7) Appropriate referral for chronic care disease clinic, specialty medical, dental, and mental health treatment/follow-up (must be documented and forwarded to respective parties)

c. Transfers-In

CFG is aware that an abbreviated intake screening may be performed for inmates who have been transferred to ECCF from another jail or prison, so long as proper medical documentation has been provided by the transferring facility.

2. Sick-Call

CFG acknowledges that currently, on average, approximately 1,400 inmates/detainees must be accommodated at sick-call each month. Sick-call shall continue to be conducted at each ECCF housing clinic and shall be made available to all inmates/detainees, seven (7) days per week - including weekdays, weekends, and holidays. Sick-call shall be conducted by an MD, NP/PA, or RN.

CFG has procedures in place that enable all inmates/detainees (including those in segregation and/or closed custody units) to submit requests for healthcare services daily, including weekends and holidays. At the ECCF, most sick call requests are sent by inmates/detainees through an electronic tablet. CFG understands that RN's must review the requests by the next shift. Patients are seen by an RN or practitioner within 24 hours for a face to face encounter/triage.

If tablets are unavailable to patients, paper requests may be deposited in locked boxes on each housing unit. CFG shall collect and triage them on each shift. The sick call slip shall be scanned in

the EHR. All documentation of the triage, examination, and subsequent treatment will be entered into the EHR at the point of service.

2. Infirmary Services

CFG shall continue to provide oversight of the infirmary that includes a review of the unit's overall cleanliness, maintenance, and equipment. CFG is aware there are a total of forty-two (42) infirmary beds, including twelve (12) male and nine (9) female single rooms, and that these beds are provided for inmates/detainees requiring close medical monitoring by a healthcare professional, but whose conditions do not warrant hospital transfer. As the incumbent provider of healthcare services, CFG knows the male and female areas have separate dayrooms, with one (1) exam room located in the infirmary area. CFG acknowledges that approximately fifty (50) inmates/detainees are admitted to the infirmary on an average monthly basis.

CFG is cognizant that the nursing station has been positioned to permit staff to view patient rooms and dayrooms, with the nursing station itself housing computers, printers, medical supplies, a built-in chart file, and a small refrigerator.

CFG is aware the infirmary accommodates a total of four (4) negative pressure isolation rooms, with baths and vestibules, each constructed for respiratory isolation, with the vestibules used to complete re-entry and post-exit isolation techniques. Each vestibule is also equipped with a washbasin, storage for disposable treatment items, and clean linen.

CFG shall continue to utilize infirmary beds to the fullest extent - consistent with acceptable medical standards and the following minimum standards:

a. A sufficient number of appropriate healthcare personnel shall be on duty, as dictated by Staffing Matrix requirements, as well as by clinical need.
b. A CFG physician shall be on-call twenty-four (24) hours per day, seven (7) days per week.
c. The infirmary shall be supervised by a CFG physician during daytime hours and by a CFG MD, NP, PA, or RN at all other times – twenty-four (24) hours per day, seven (7) days per week
d. Admission to the infirmary shall require the order of a CFG physician, within eight (8) hours of arrival. The practitioner shall sign admission notes, which shall include physical examination and designation of acuity level, and shall dictate the frequency of practitioner and nurse encounters. Patient assessments shall be consistent with acuity scale requirements by both physicians and nurses.
e. Completion of a nursing care plan shall occur within twenty-four (24) hours of admission to the infirmary.
f. All encounters occurring in the infirmary shall be documented on an EHR infirmary encounter screen and entered into the EHR system at the point of service.
g. A discharge plan, including a summary of care and specific treatment interventions and discharge medications, shall be written by a CFG MD, NP, or PA.

4. Mental Health Services

CFG knows well that the purpose of a competent and conscientious mental health program is to maintain inmates'/detainees' best level of functioning, alleviate symptoms of serious mental disorders, and prevent relapse. Mental health services shall continue to be made available to all ECCF inmates/detainees, with CFG collaborating with Essex County Corrections to deliver proper treatment for any inmate/detainee in crisis and inmates/detainees with special needs stemming from mental illness and/or intellectual deficits. The goals of mental health treatment shall be improving patient functioning, assisting patients in managing life in a jail setting, and successfully reintegrating inmates/detainees within their respective communities. CFG shall continue to work with ECCF custody personnel to help staff members better understand the difference in symptomatology among various mental illnesses and to identify and appropriately respond to oppositional and manipulative behaviors. CFG is aware of the forensic unit which has about 22 beds and that a step-down unit is being established to deliver a more therapeutic approach to mental health care.

All mental health services shall be provided by New Jersey board-eligible or board-certified psychiatrists, New Jersey-licensed APNs, and New Jersey-licensed mental healthcare workers. CFG's Mental Health Director position shall only be filled by a licensed psychiatrist or psychologist.

Patients referred for mental health services shall be seen by a qualified mental health professional as medically indicated within seventy-two (72) hours or sooner, if necessary.

a. Psychiatric Care

The scope of psychiatric services provided to the inmate/detainee population of the ECCF shall include, but shall not be limited to:

1) Timely identification, screening, and assessment of inmates/detainees with mental health issues, both upon admission and as needed throughout an inmate's/detainee's period of incarceration
2) Crisis intervention and timely referral of inmates/detainees requiring more care than can be provided within ECCF
3) Suicide prevention and intervention
4) Twenty-four (24) hour emergency care and coverage for psychiatric emergencies
5) Individual treatment plans for inmates/detainees requiring on-going monitoring and care
6) Administration and monitoring of all psychotropic medication
7) Evaluation of each inmate/detainee housed in administrative or disciplinary confinement or segregation, according to ECCF policy and/or direction of the ECCF Director (or the Director's designee)
8) Referrals/communication with Ann Klein Forensic Center and Trenton Psychiatric Center

9) Referral for continued community services

b. Psychological Care

The scope of psychological services CFG shall provide ECCF shall include, but shall not be limited to: psychological treatment of inmates/detainees with mental illness and emergency/crisis intervention services, as needed, with appropriate follow-up for medical/psychiatric services. Services provided shall also include individual and group counseling.

c. Suicide Watch

All inmates on suicide watch shall be appropriately housed in the sixteen(16) camera monitored cells and seen by mental health professionals according to the schedule established by ECCF policy, and according to NCCHC and ACA standards, State statutes and regulations, and PBNDS (2011). All mental health counselors' encounters with inmates/detainees placed on suicide watch shall be documented appropriately.

5. Dental Services

All dental services shall be delivered by appropriately licensed professionals, with dental care provided according to N.J.A.C. 10A requirements and according to guidelines promulgated by the American Dental Association (ADA), NCCHC, ACA and PBNDS 2011. CFG shall ensure the following dental services are provided to all ECCF inmates/detainees, with all dental encounters entered in the EHR at the point of service:

a. Intake Screen

CFG nursing staff shall conduct a brief dental screening as part of nurse intake screening, with immediate referral made to the Dental Department, as appropriate.

b. Dental Coverage

CFG shall provide the ECCF with dental coverage all weekdays, with a dentist available for telephone consultation twenty-four (24) hours per day, seven (7) days per week.

c. Daily Sick-Call Requirement

The licensed dentist provided by CFG shall conduct daily sick-call, Monday – Friday, excluding holidays, to address inmates'/detainees' dental complaints. Dental sick-call slips shall be triaged by dental staff during regularly scheduled work hours. On days when no dental coverage is scheduled at the facility, nursing staff shall triage requests.

d. Emergency Care

Emergency dental care shall be made available to all inmates/detainees daily through both on-site and on-call dental services. In the event a dental emergency occurs when the dentist is not on-site, the dentist shall be available by telephone for case consultation and to provide instructions.

e. Specialty Dental Care

Oral surgery services shall be provided at least four (4) hours per week by a New-Jersey licensed oral surgeon.

f. Prosthetic Services

Dental prosthetics shall be provided for inmates/detainees when the health of the inmate/detainee would be adversely affected by not having the dental prosthetic, as determined by the CFG dentist.

g. Dental Cleaning

CFG will provide dental cleaning services to patients, according to the American Dental Association (ADA) guidelines. CFG will supply and utilize an extraoral suction unit during the provision of these services.

6. Chronic Disease Management

CFG shall ensure that chronic medical conditions are identified during the initial admission physical examination and are noted on the Problem List at the time of encounter. The initial chronic care clinic visit shall occur in conjunction with the initial health assessment, with a subsequent follow-up scheduled based on disease control. CFG shall offer chronic care clinics in hypertension, asthma/COPD, diabetes, hyperlipidemia, seizure disorders, and HIV, though chronic care clinics shall not be limited to just these medical conditions. To properly address and treat common chronic diseases, CFG utilizes nationally recognized chronic care treatment guidelines that include recommendations for the frequency of encounters, lab, and other diagnostic baseline and routine testing, monitoring for patient compliance, patient education, and assessment of patient disease control. All chronic care encounters, orders, and services shall be entered into the EHR system at the point of service.

7. COVID-19 Management

The COVID-19 plan for the ECCF includes a prescreening at all entrances to the facility for staff inmates and visitors. The plan is comprehensive and includes recommendations for the CDC on PPE use, surveillance, tracking and reporting as well as quarantine and social distancing guidelines. CFG has written protocols to include initial diagnosis and treatment and screening tools to identify and manage COVID patients. Please refer to IV. Required Documents.

8. Specialty Services

a. CFG shall continue to ensure that specialty services are made available to the ECCF's inmate/detainee population, preferably on-site, inclusive of obstetrics/gynecology, orthopedics, optometry, ophthalmology, oral surgery, endocrinology, pulmonology/respiratory, cardiology, kidney/renal disease(including dialysis), neurology, cancer/oncology, pain management, infectious disease, tuberculosis, and gastroenterology, regardless of housing assignment.

b. Obstetrics/gynecological services (including women's health, prenatal and postpartum care), orthopedic services and oral surgery shall be provided on-site by specialty physicians employed by CFG.

c. On-Site Clinics – Whenever possible, specialty physicians (e.g. – infectious disease physicians, optometrists, podiatrists) shall see patients on-site at the ECCF. Other physicians shall be obtained by CFG in consultation with the County, based on facility needs.

d. All specialty care requests shall be recorded and tracked in a logbook kept at the ECCF and shall also be entered into the EHR. CFG shall ensure all necessary medical information related to a requested procedure and/or evaluation is released to the treating specialist(s). Utilization review, as practiced by CFG, includes a process of approval for outside consultation and accounts for direct verbal communication between the requesting and reviewing physicians. As per RFB specifications, this process is completed within five (5) working days.

e. CFG medical staff shall be responsible for reviewing daily movement sheets to determine if any inmates/detainees awaiting care have changed location.

f. For security reasons, inmates/detainees shall not be informed in advance of any scheduled movement off-site. CFG shall continue to ensure its personnel both understand and abide by this practice.

The priority of specialty consults and referrals shall be ranked as follows:

- Patients with emergent referrals shall be seen within twenty-four (24) hours
- Patients with urgent referrals shall be seen within two (2) weeks
- Patients with routine referrals shall be seen within thirty (30) days

9. Special Needs

CFG acknowledges that special needs conditions may include, but shall not be limited to: chronic and convalescent care, physical handicaps, frail/elderly, terminal illnesses, developmental disabilities, and mental illnesses. Special needs treatment plans shall specify instructions about patient housing, diet, exercise, medication, type and frequency of diagnostic testing, patient education, and frequency of follow-up for medical evaluation and adjustments to treatment modalities. CFG shall continue to maintain up-to-date rosters of inmates/detainees in each category of special needs treatment. CFG in conjunction with custody administration attends a weekly Special Needs conference call to discuss the management and care of special needs cases.

10. Telemedicine

CFG will have the capability of providing telemedicine services, which must be approved by the Director before implementation. Telemedicine will not used be as a substitute for onsite medical care and will not compromise patient care. CFG understands that it is the goal of the ECCF to use telemedicine to decrease wait times for specialty appointments, such as infectious disease or dermatology clinics. The treating practitioner MUST have appropriate training and have access to the patient's complete medical record.

11. Informed Consent/Right to Refuse Treatment

a. CFG shall obtain written informed consent from each patient, per ECCF policy. Informed consent will be obtained electronically per ECCF policy to assure that the inmate/detainee receives the facts about any proposed treatment, examination, or procedure and the alternatives to the same.

b. If an inmate/detainee refuses recommended treatment, CFG shall ensure the inmate/detainee is counseled about the benefits and risks of the diagnostic and/or therapeutic recommendations being made. The refusal will be documented electronically in every case in which an inmate/detainee refuses treatment after being informed about his/her condition and the treatment prescribed.

12. Medical Diet Program

CFG shall evaluate and make appropriate orders for inmate/detainee medical diets that correspond with special needs treatment plans established by chronic care clinics. CFG is aware that medical diets shall only be supplied by ECCF when ordered by an MD, NP, PA, or dentist for documented clinical reasons. Diets recommended shall be chosen from among ECCF's approved list of medical diets, noted on the appropriate EHR encounter form, and entered into the EHR system as part of a treatment plan at the point of service.

13. Optical Services

CFG will make every effort to get inmates'/detainees' eyeglasses. In those cases where this is not possible, CFG agrees to purchase institutionally safe eyeglasses that will be dispensed to inmates/detainees as clinically indicated and as ordered by an optometrist or ophthalmologist. Replacement glasses shall be subject to inmate/detainee payment if the need for replacement glasses is the result of inmate/detainee neglect or intentional destruction/loss. Contact lenses shall only be provided to inmates/detainees when clinically indicated and ordered by an optometrist or ophthalmologist.

14. Medical Prosthetics

CFG shall provide inmates/detainees with medical prosthetics only when the health of the inmate/detainee would be adversely affected by not having the prosthetic, based upon the Medical Director's decision. CFG shall coordinate with the Warden or the Warden's designee

regarding the use of apparatuses and prostheses that might compromise security. CFG shall also seek the Warden's approval before ordering inmates/detainees special shoes.

B. Ancillary Services

CFG shall utilize on-site ECCF ancillary services, including, but not limited to: phlebotomy, x-ray, dialysis, EKG, and ultrasound services. Additional ancillary services shall be delivered on-site at the ECCF whenever possible (e.g. – mobile MRI/CT scan/mammography).

CFG shall be responsible for the payment of all off-site laboratory and diagnostic services, as required and indicated. Only persons with appropriate credentials shall provide ancillary services. CFG shall ensure that tests sent to another state for analysis, consultation, and/or interpretation shall only be analyzed and/or interpreted by individuals and facilities with current and valid New Jersey licenses. All test results shall be documented/scanned into the EHR.

1. Radiology Services

CFG shall ensure all routine x-rays are provided on-site at the ECCF. Special studies, such as ultrasounds, shall be provided by CFG, who shall ensure all testing is performed by a registered technician and read by a New Jersey-licensed, board-certified radiologist. All results shall be reported to the ECCF and reviewed by a CFG practitioner within twenty-four (24) hours of receipt during weekdays, and within forty-eight (48) hours of receipt over weekends. CFG shall make provisions for emergency x-rays needed outside of normal working hours. CFG has instituted a mechanism for the rapid reporting of STAT and/or abnormal results, with the CFG on-call physician notified immediately of such. CFG shall assume responsibility for the cost of x-ray registration.

2. Electrocardiogram (EKG) Services

CFG shall provide on-site EKG services for both scheduled and emergencies, with CFG assuming responsibility for supplies, repair, replacement, and maintenance of the EKG unit.

3. Dialysis

As the incumbent provider, CFG is aware that ECCF's medical area includes a dialysis room with three (3) chairs. CFG shall continue to assume responsibility for coordinating all dialysis services for ECCF's inmate/detainee population. CFG has assessed the physical plant and equipment inventory and has developed a plan, at CFG's cost, for the provision of complete dialysis services in-house. All dialysis services provided shall continue to be entered into the EHR system at the point of service.

The following services shall be maintained and paid for by CFG (CFG is aware a sub-contractor may be used, subject to the Director's approval, to deliver these services):

a. All associated professional and technical labor, including an RN trained in dialysis, is on duty and present in the hemodialysis unit at all times when hemodialysis procedures are being conducted;

b. Regular assessments (at least monthly, but more frequently, if indicated) by board-certified nephrologists;

c. Dialysis supplies;

d. Pharmaceuticals related to the dialysis process or clinical patient need.

4. Laboratory Services

CFG shall be responsible for all medical laboratory services, supplies, tests, forms, and dedicated printers. Lab services shall be ordered through the EHR system at the point of service. Per the RFB, BioReference shall be the laboratory service provider and shall use an automated lab result system that interfaces with the EHR.

CFG shall ensure all lab services and specimen testing are conducted by a lab accredited by the College of American Pathologists and shall arrange for daily pick-up and delivery of specimens. A CFG practitioner shall review all lab results electronically using the EHR system - within twenty-four (24) hours of receipt during weekdays and within forty-eight (48) hours of receipt over weekends. To assess indicated follow-up care and to screen for discrepancies between clinical observations and laboratory results, CFG's physician shall also document all lab results and address all abnormal lab results in the EHR within twenty-four (24) hours of receipt on weekdays and within forty-eight (48) hours of receipt over weekends.

CFG has developed a mechanism for ensuring the availability of instant (STAT) services. When STAT results are received and a CFG physician is unavailable on-site, the CFG physician on-call shall be notified immediately.

CFG shall be responsible for the collection of specimens needed for forensic testing required by State law and/or court order. CFG understands this may include DNA testing requiring the drawing of blood.

C. Hospitalization and Off-Site Specialists

CFG shall utilize existing County contracts for emergency, inpatient, and outpatient services provided by local hospitals as part of required care for inmates/detainees. CFG will also establish any additional contracts with hospitals and providers as needed. On-going communication shall be maintained with representatives from designated hospitals and medical providers, to properly coordinate medical services. Policies and procedures, scheduling, transportation, the reporting of test results, discharge summaries, utilization review, and patient follow-up shall be fully managed.

CFG shall continue to work with the County to negotiate rates with hospitals and physicians' offices, in obtaining pre-approvals, in controlling admissions, on case management, on the payment and processing of all hospital and practitioner bills, and on resolving any billing problems. CFG utilizes cost savings initiatives and strategies to pass savings on to the county.

All inmates/detainees sent to the hospital shall have a Transfer form and a Medical Referral form completed. The latter form shall accompany all inmates/detainees to the hospital.

1. Billing

CFG shall be responsible for securing claims from hospitals and physicians who have provided services, for reviewing said claims, and for forwarding them to the ECCF for final approval. All medical claims shall be reviewed by CFG, forwarded to the County for approval, and then paid directly by CFG. The County shall reimburse CFG for all payments.

Prompt Payment

CFG understands that in all circumstances, all medical bills must be paid by CFG within 180 days of service. Each month, CFG shall provide the Director (or the Director's designee) with a report of all outstanding bills.

2. Inmates with Private Insurance

CFG shall first seek payment from third-party insurance carriers for all inmates, based on information provided by the inmate during nursing intake. CFG shall be responsible for preparing claim forms and other paperwork related to the reimbursement process.

3. Automated Billing System

CFG uses an automated billing system to track bills. Accessible by both CFG and County staff, this system is used to record and view billing information (including patient name, provider, claim amount, date, and purchase order/check information).

4. Affordable Care Act

CFG shall comply with all requirements of the Affordable Care Act. CFG is aware this may include enrolling inmates for healthcare benefits and communicating with hospitals. The Affordable Care Act Coordinator will manage all aspects of program compliance.

5. Transportation

CFG shall coordinate with custody for security arrangements necessary for outside referrals. Transportation shall be scheduled and coordinated through Master Control and ECCF Transportation Services. CFG shall arrange for ambulance and wheelchair transportation.

CFG shall ensure all ambulances utilized are equipped with life support systems and are operated by personnel who are both trained in life support and certified by the State of New Jersey.

CFG medical staff shall be responsible for reviewing daily movement sheets and/or the OMS (Offender Management System) to determine if any inmates/detainees awaiting medical services have experienced a location change.

All costs for routine inmate/detainee transport within the approved network of care providers using the ECCF van shall be the responsibility of ECCF. The approved network consists of:

a. Local hospital emergency rooms, including University Hospital
b. Other agencies that provide services that have been pre-approved by the Director or the Director's designee

CFG acknowledges that all costs related to medical transportation, including correction officer salaries and benefits, shall be CFG's responsibility when preventable inmate/detainee transport/service occurs outside the approved network, as determined by ECCF.

D. Inmate/Detainee Workers

CFG shall conduct pre-service physical examinations and annual rechecks for all potential and actual inmate/detainee workers. Additionally, inmate/detainee workers shall be trained by CFG's Infection Control Nurse on such topics as blood-borne pathogens, exposure control, and other topics relevant to the jobs/positions held. All initial evaluations, annual evaluations, and training shall be documented in the EHR.

E. Community-Based Programs

CFG acknowledges that contracted offsite housing facilities may provide eligible inmates/detainees with an alternative to incarceration programs. Up to 950 inmates/detainees/month may be transferred to these alternate facilities. CFG understands that before being transferred, each inmate/detainee must be medically and psychologically cleared. Dedicated staff will be assigned to oversee the time-sensitive clearances. CFG will communicate with ECCF staff regarding the appropriateness of transfers.

It is understood that the transferred inmates/detainees continue to be Essex inmates/detainees, although medical services are provided at the offsite facilities. As the incumbent, CFG is aware of its responsibility to maintain communication with the medical providers at the offsite housing facilities. Inmates/detainees may be sent back to the ECCF for medical reasons, custodial reasons, or sent to the hospital. CFG understands that responsibility for the utilization review of inmates/detainees sent to the hospital from these facilities rests with us. CFG acknowledges that while the community-based program medical staff has access to the EHR and have their licenses, ECCF owns the electronic record.

F. Discharge Planning

As the incumbent provider of healthcare services, CFG has developed and maintains relationships with various community groups to facilitate continuity of care upon inmate/detainee release, as described below:

CFG's discharge planner working in conjunction with the ECCF MAT discharge planner will continue to work with the **Collaborative Justice Services (CJS) of Essex County**, in identifying alternatives to incarceration for individuals with serious and persistent mental illness. To ensure continuity of care, CFG and CJS also work together to identify community referral sources for offenders about to re-enter the community as part of discharge planning. Discharge planning is a crucial area of mental health outreach services and is often a challenge for corporations headquartered outside of New Jersey; however, this has been an area of critical success for locally-owned and operated CFG. Conscientious discharge planning is integral in lowering rates of recidivism by assisting inmates in connecting with vital resources for continued medical and mental healthcare, housing, skills acquisition, and more. Case management is now available through ICMS by referral, as warranted. Joint overall goals are to support the physical and mental well-being of inmates, open doors to available care, and increase access to necessary services through patient advocacy, education, early intervention, and appropriate, multifaceted treatment. Other local affiliations CFG has formed alliances with include the Hyacinth program – for HIV positive patients; the Newark Community Health Center – for patients with chronic conditions; the New Jersey Community Research Initiative – for HIV positive patients who also grapple with substance abuse issues; and the Newark Beth Israel Medical Center – for treatment of forensic patients. CFG will continue to work on developing additional community relationships to facilitate a seamless transition for the inmate /detainees at ECCF back into the community. To facilitate this CFG has hired a well-experienced ACA discharge planner and MAT discharge planner who are well-versed in facilitating reactivation of Medicaid benefits as well as multiple options in areas such as housing, nutrition and other areas necessary for successful reentry into the community.

G. Health Education for Inmates/Detainees

CFG shall continue to provide a health education program for inmates/detainees that includes formal and informal sessions, pamphlets, videos, etc. Additionally, each discipline is involved in the orientation of inmates/detainees to the services offered, including the availability and means of accessing said services.

H. Inmate Co-Pay

CFG shall cooperate with the ECCF policy (P.L. 1995, c. 254) regarding inmate co-pay for healthcare services. No inmate shall be denied healthcare due to an inability to pay a fee for service. CFG shall not have access to inmate funds or accounts.

I. Infection Control

CFG shall implement an infection control program that includes concurrent surveillance of inmates/detainees and staff, as well as prevention, treatment, and reporting of incidents of infection/disease following local and state laws. The program shall be managed by a certified Infection Control RN and shall encompass complete implementation of the ECCF's tuberculosis and blood-borne pathogens policy, as well as tracking and reporting of skin infections, ensuring the reporting of all applicable diseases, as required. The program shall also include overseeing sanitation and infection control procedures, as well as the provision of training for healthcare staff. Reports to the NJ DHSS and/or

any other agency regarding an individual or a specific condition shall be sent to the Director or the Director's designee, as well.

J. Pharmaceutical Services

CFG is aware the ECCF maintains a medication area expressly for the storage and maintenance of medications. This secure area shall be staffed by CFG pharmacy technicians. CFG shall be responsible for the ordering, distribution, and security of all formulary and non-formulary pharmaceutical drugs, per State and federal laws, regulations, and accreditation standards.

CFG is aware that we may identify a pharmaceutical sub-contractor responsible for providing all prescribed medication or supplements ordered by healthcare providers. CFG acknowledges that between at least 50%-70% of ECCF offenders require prescriptions at the time of admission, on average requiring 2-3 medications; with approximately 30 inmates/detainees receiving HIV/AIDS medications, and between 370 inmates/detainees receiving psychotropic medications per month.

CFG pharmacy technicians shall be responsible for safely storing and securing personal medication for inmates/detainees until an inmate/detainee is released.

1. Operating Procedures

CFG shall order, receive, and administer prescriptions and medications for inmates/detainees and shall resolve any administrative, billing, accounting, and technical/software problems.

2. Formulary and Non-Formulary Medications

CFG shall be responsible for supplying all formulary and non-formulary medications to the ECCF. CFG is aware of and has reviewed the currently proposed formulary, included within the RFB as Exhibit F. CFG acknowledges that CFG's Medical Director may approve non-formulary and/or alternative medications, according to the Medical Director's professional judgment.

3. Generic Medications

CFG understands that generic medications may be substituted for prescribed brand names unless prohibited by law or as ordered by the Medical Director.

4. Over-the-Counter (OTC) Medications

CFG shall provide OTC medications within the context of pricing models.

5. Medications Stocked at ECCF

CFG shall maintain an on-site locked area where medications are both received and stored. CFG also shall maintain a "convenience dose" stock system that is based on the formulary and other pharmaceutical product needs demonstrated by the ECCF.

6. Controlled substances

CFG will continue to follow the state of NJ's requirements for the handling and storing of controlled substances.

7. Medication Delivery

To ensure prompt distribution of necessary medications, CFG shall maintain a mechanism for filling and delivering prescriptions twenty-four (24) hours per day, six (6) days per week (excluding Sundays). Medication deliveries shall be organized to promote efficiency, accountability, ease of use, and cost-effectiveness for the County.

All ECCF security procedures shall be strictly followed. Medication shall be delivered in containers sealed in security packaging able to show any signs of the shipping container having been tampered with, any violations of institutional security, and/or any evidence of contraband. Each shipping container shall include a packing slip listing all medications sent and any that are missing. The packing slip must also list any back-ordered medications, along with the anticipated date of arrival.

If a medication is expected to be on back-order for longer than two (2) days, CFG may consider alternative medications. CFG has a contingency plan in place for providing pharmaceutical products if the primary means of drug supply to ECCF is otherwise unavailable due to any circumstances.

8. STAT or Emergency Pharmacy

a) CFG shall maintain STAT starter/emergency dosing capability as part of the stock medication supply, with a suitable stock of emergency medications kept on hand.

b) CFG shall maintain a "STAT" system for ordering medications, as well, with CFG ensuring all STAT orders are delivered within four (4) hours of an order being generated. CFG understands that a local pharmacy may be contracted for this service, subject to ECCF approval.

9. Medication Carts

To ensure secure storage, ease of medication transport/delivery, and the timely administration of all medications and related supplies, CFG shall maintain and replace, as necessary, the nine (9) medication carts used by the ECCF. CFG shall also replace the carts' wheel bearings regularly, as needed. CFG is aware the replacement of any carts must be approved by the ECCF and that any carts provided by CFG shall be considered ECCF property at the end of the contract.

10. Prescription Order Automation

CFG shall ensure all medication orders continue to be electronically ordered, are signed in the EHR system at the point of service, and are sent electronically to the pharmacy using a Biscom facsimile server and software which is compatible with the EHR.

11. Renewals/Refills

To further continuity in medication administration, CFG shall ensure against disruptions in the renewal/refill process.

12. Electronic Medication Administration Record (EMAR)

CFG shall continue to utilize an Electronic Medication Administration Record (EMAR) that includes all information on the prescription label and the name of the practitioner prescribing the medication. CFG's contracted pharmacy is electronically compatible with the Fusion EMR.

13. Return/Disposal of Unused Medications

CFG has instituted a procedure for the proper return, disposal, and replacement (as appropriate) of all unused and expired medications, including controlled substances. Inventory control procedures include rotation of stock and timely return of stock overages and drugs with a short shelf life. CFG shall check and promptly restock all "convenience dose" stock pharmaceutical products at least quarterly and sooner, as needed.

14. Discharge Medications

CFG is aware of and will comply with ECCF policy requiring inmates/detainees be released from jail with a seven to fourteen (7-14) day supply of all current prescription medications, including psychotropic medications, controlled substances, and other DOT (Directly Observed Therapy) medications to ensure continuity of care beyond inmate/detainee release. All inmates/detainees on TB (tuberculosis) medications shall receive a fifteen (15) day supply of such, while all inmates/detainees on HIV/AIDS medications shall receive a thirty (30) day supply. Medications shall be provided in packaging consistent with State pharmacy law. Whether a medication is provided outright or inmates/detainees are given a prescription for the same to a local pharmacy, the cost of all discharge medications shall be borne by CFG.

15. Emergency Medical Boxes

CFG shall provide, at no cost to the County, emergency medical boxes, to be kept in designated areas of the facility. Medications contained within the emergency boxes shall be determined by CFG and the ECCF Director/Director's designee, in consultation with the licensed pharmacy consultant. CFG shall also stock and maintain all emergency kits in the ECCF with required medical supplies.

16. Supplies

CFG shall utilize hypodermic supplies, including needles, syringes, and tamper-proof puncture-resistant disposal containers. CFG shall also appropriately account for, store, and dispose of needles and syringes, documenting such in the Regulated Medical Waste Report.

17. Licensed Pharmacist

CFG shall ensure a licensed pharmacist conducts quarterly inspections of all facility areas where medications are maintained. These inspections shall include, but not be limited to, review of expiration dates, security measures, proper storage, and medication records. Attendant reports shall be submitted to the Director (or the Director's designee) and shall include CFG's action plans in response to any deficiencies or other findings identified.

18. Pharmacy and Therapeutics Committee

CFG shall ensure that the Pharmacy and Therapeutics Committee includes the participation of the Director (or the Director's designee) and meets at least quarterly. The Pharmacy and Therapeutics Committee shall be responsible for additions and deletions to the formulary, monitoring pharmaceuticals usage (including psychotropic and infectious disease medications, with particular emphasis placed upon HIV and hepatitis C [HCV] management), identifying the prescribing patterns of practitioners, and medication distribution quality assurance. The written minutes of all Pharmacy and Therapeutics Committee meetings shall be submitted to the Director (or the Director's designee). Quarterly reports provided at these meetings shall include listings of the top ten (10) most commonly ordered drugs and the top ten most expensive drugs.

19. Utilization Review and Quality Assurance

CFG shall ensure that utilization review reports include drug utilization review and statistical information by drug and prescribing authority, along with the number of prescriptions and doses dispensed. The Quality Assurance Program shall identify and report on all potential medication errors. The Director of Nursing shall compile information and report quarterly on medication errors using a standard format that describes the relation of the error to harm caused to the patient.

20. Medication Assisted Therapy (MAT Program)

CFG will manage a Medication Assisted Therapy (MAT) program for patients with opioid use disorder and will provide staffing, medication, supplies, substance abuse treatment, mental health treatment (individual counseling and group therapy), case management, and referrals to community organizations and programs. This program is contingent on a grant issued by the State of NJ Department of Health and Human Services Division of Mental Health and Addiction Services in the amount of $658,754. All program expenses must be documented and submitted to the county with the monthly invoices. Currently, the MAT program serves 52 inmates/detainees and anticipates serving approximately 250 patients per month. Four clinicians will be hired and managed by the vendor, including a full-time Program Coordinator, full-time Discharge Planner, full-time Drug Consultant, and a part-time Licensed Practical Nurse, who will provide medication administration. Amongst other duties, the Program Coordinator will work with community partners, retrieve data, and provide reporting, while the Discharge Planner will provide discharge planning services. The Drug Consultant will provide cognitive and behavioral therapy for participants (this position will be funded under a separate grant).

CFG will purchase, maintain and administer the required medications and purchase, maintain, and manage related supplies.

K. ECCF Employee Health Education Program

CFG shall continue to provide new hire and annual training for ECCF employees on various aspects of health education. Training may cover, but shall not be limited to, the following:

- Bloodborne Pathogen Exposure Control Plan
- Tuberculosis Surveillance Program
- COVID-19 Safety
- HIV and AIDS
- Hepatitis Infection and Protection
- Other Infectious Diseases and STD Transmission
- PREA Health Issues
- Response to Medical Emergency/Disaster
- Confidentiality of Medical Information
- Relevant mental health topics, inclusive of suicide prevention

L. AED's (Automated External Defibrillators)

CFG shall provide at least one (1) AED (automated external defibrillator) in each health service area of the facility and shall ensure all clinical staff receives appropriate AED training.

M. Healthcare Services for CFG Employees, ECCF Employees, and Visitors

1. Emergency Services for Visitors and Staff

CFG shall provide emergency treatment for all visitors, staff, employees, sub-contractors, and independent vendors of the ECCF who become ill or injured while on ECCF premises. Medical and dental health emergencies involving ECCF visitors and staff shall be addressed as follows:

- Ill/injured parties shall be stabilized and referred to a personal physician or a local hospital, as indicated.
- Arrangements shall be made for emergency transportation, as necessary, but shall not be considered CFG's financial responsibility.
- The Director (or the Director's designee) shall receive a copy of the documentation of the event.

2. Tuberculosis (TB) Surveillance for ECCF and CFG Employees

For both CFG and ECCF personnel, CFG shall provide a comprehensive tuberculosis surveillance program that conforms to the guidelines of the New Jersey Department of Health and Senior Services' Public Occupational Safety and Health (PEOSH) TB requirements, as well as ECCF policy.

As part of TB surveillance programming, CFG shall provide and administer TB tests for all County staff employed at the ECCF and shall also be responsible for supplying all necessary test supplies, as well as vaccines. The TB surveillance program shall also include, but shall not be limited to, the following provisions:

a. ECCF Tuberculosis Risk Assessment

To assess the risk of TB transmission at ECCF, CFG shall evaluate the incidence and prevalence of positive purified protein derivative reaction, as well as of active disease, on both initial and annual bases.

The risk assessment shall be documented annually by the Infection Control Nurse in a statistical report that summarizes the rate of infection and the rate of disease. The report shall also include a narrative that contains all findings and recommendations.

b. ECCF Employee Tuberculosis Screening

TB screening and Mantoux testing shall be considered mandatory for both ECCF and CFG employees. CFG shall assume responsibility for communicating to the ECCF the names of employees non-compliant with screening procedures.

1) Initial Screening Requirement

CFG shall administer initial Mantoux (PPD) testing on all newly hired CFG staff and ECCF employees.

2) Annual Screening Requirement

Annual TB testing of ECCF and CFG employees shall be conducted at an agreed-upon time. Those employees with past positive results shall be subject to annual screening of symptoms for active TB disease. CFG shall make appropriate referrals for employees who develop positive PPDs and/or other positive results. At the time annual testing is conducted, CFG shall not be required to retest those employees who were hired and previously tested in the prior quarter. At no time shall an ECCF employee go more than fifteen (15) months without being retested.

3) Recording and Reporting Requirement

CFG shall document all TB screening performed and shall comply with all standards for reporting TB testing results.

3. Blood-borne Pathogen Prevention and HBV Vaccination

a. Provide Vaccine

CFG shall both offer and supply the hepatitis B vaccine to all CFG staff considered at risk for exposure to blood-borne pathogens (ECCF Exposure Control Policy shall identify employees who meet this criterion). CFG shall counsel employees on the risks and benefits of the vaccine. Employee consent/refusal and administration of the vaccine series shall be documented on the Employee Hepatitis Vaccine Record.

b. Protective Equipment

As needed, CFG shall ensure Personal Protective Equipment (PPE) and other medical protective equipment required for respiratory isolation and compliance with universal

precautions is readily available. PPE shall include gloves, masks, goggles, fluid impervious gowns, etc.

This equipment shall be made available to staff whenever exposure to blood and/or other bodily fluids is reasonably expected to occur. Emergency response bags shall contain a PPE bag and a CPR mask with a one-way valve. All used equipment shall be disposed of in appropriate containers. This equipment shall be made available to both sworn and non-sworn staff.

c. Post-Exposure Services Requirement

CFG shall ensure the infection control program addresses employee exposure to bodily fluids, as well as the provision of counseling after the same. CFG agrees to provide first aid, counseling, and referral for follow-up care to any CFG or ECCF staff member who has been exposed to bodily fluids. CFG shall document any such care and referral in the staff person's health record.

4. COVID-19 Testing

CFG will continue to provide COVID-19 testing that is FDA-approved. If a new test becomes approved and available, CFG will implement it as needed.

5. Record keeping for ECCF Employee Healthcare

CFG shall ensure the individual medical records of ECCF employees are securely and confidentially maintained. CFG shall access these records, as needed, and shall make all necessary entries about education, testing, vaccination, and treatment.

N. Handicaps/Disabilities/American Disabilities Act (ADA)

1. Identification and Communication of Need

CFG is aware that, in addition to the medical treatment of inmates/detainees with handicaps and/or disabling conditions, the provisions of the ADA may require certain accommodations to be made. Since needs are driven by the actual presence of medically recognized conditions and limitations, CFG shall be responsible for identifying such conditions, documenting them in the EHR, and informing appropriate ECCF staff. Handicaps and disabilities shall include, but not be limited to, those affecting hearing, vision, and mobility. CFG shall be responsible for medically-related care and for supplying communication aids in compliance with the ADA.

2. Hearing-Impaired

CFG is aware that services for the hearing impaired are mandated by the County of Essex. CFG shall be responsible for determining the most appropriate method of communication for a deaf inmate/detainee within the medical area. CFG shall provide certified, qualified interpreters capable of using required specialized vocabulary and skills. In emergency situations, when the seriousness of an inmate's/detainee's need precludes waiting for an interpreter to arrive before

assessment and treatment are initiated, written notes, charts and diagrams shall be used to communicate with the patient until an interpreter arrives.

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IX. PROGRAM SUPPORT SERVICES

A. Utilization Review

CFG shall review all outside consults, emergency and inpatient services performed for ECCF inmates/detainees treated at hospitals and/or doctors' offices. Utilization review shall also be conducted for inmates in ECCF community-based programs, who are admitted to the hospital.

CFG has delineated a Utilization Management (UM) Plan that covers pre-certification, inpatient admissions, concurrent review of inpatient hospitalizations on each shift, diagnostic procedures, medical interventions, ambulatory/mobile surgery, specialty referrals and consults, medical transfers and inmate/detainee movement, and retrospective reviews of claims. The program also includes benchmarks for clinical outcomes, UM process documentation within the EHR, chart review, evaluation of the timeliness of care, readmissions within a given period, sentinel events, unnecessary admissions, unauthorized admissions, unauthorized lengths of stay, and denied days.

B. Continuous Quality Improvement

CFG shall continue to provide professional management services that support the medical program, inclusive of Continuous Quality Improvement (CQI) and professional peer review. An RN will lead the program as a Quality Improvement (QI) Coordinator. He/she will implement process improvement, work with utilization management data, manage the development and analysis of statistical data, and assist with forming objectives to maximize quality outcomes. The CQI program shall include monthly meetings and reviews, showing measurement and improvement of the quality of services delivered. The CQI program shall include both process and outcome studies.

1. Quality Improvement Committee

CFG shall institute a multidisciplinary CQI committee that monitors the health services provided, chaired by the Medical Director. Committee membership shall also include the HSA, the ICE Assistant HSA, the Nursing Director, the Infection Control and QI RN, the Mental Health Director, the Dental Director, the Warden (or the Warden's designee)ECCF Director/designee, the Coordinator for Monitoring and Evaluation, and representatives from other departments, as appropriate. The committee shall be responsible for performing the following functions:

a. Reviewing total healthcare operations and conducting studies of health services
b. Analyzing issues referred by or identified within the quality improvement process
c. Taking corrective actions and evaluating their effectiveness
d. Ensuring that meetings are held at least once per month between appropriate staff and the ECCF to review significant issues and changes and to provide feedback relative to the

Quality Improvement Plan so that any deficiencies identified or recommendations made can be addressed

e. Submitting a monthly incident review report to the Coordinator for Monitoring and Evaluation that details all adverse events

2. Medical Audit Committee

This program shall continue to include a regular chart review, with all reviews, deliberations, and actions taken appropriately documented.

3. Peer Review

The Medical Director shall continue to review the work of all practicing providers (including physicians and mid-level providers) on an annual basis, with results communicated to the provider being reviewed.

4. Clinical Performance Enhancement

The work of all providers, nurses, and mental health professionals shall be reviewed as part of an educational program on at least an annual basis. The results will be shared with the clinicians.

5. Risk Management/Patient Safety/Morbidity and Mortality Review

CFG has a process in place for reviewing sentinel events and deaths through administrative review, clinical mortality review, and psychological autopsy, as appropriate. The Director (or the Director's designee) and Coordinator of Monitoring and Evaluation shall be included in all reviews. The purpose of the review is to effectively determine opportunities for improvement and demonstrate strategies for accomplishing goals set. Reports on any incident shall be submitted to the Director within thirty (30) days.

6. Administrative Meetings, Reports, and Reviews

CFG shall prepare and participate in external reviews, inspections, and audits – as requested – as well as in the preparation of responses to critiques. CFG shall also develop and implement plans to address and/or correct any identified deficiencies.

7. Performance Improvement Plan

CFG has developed and maintains an annual performance improvement plan designed to improve the quality of services provided at the ECCF. When implemented, the plan identifies a framework by which all processes, systems, and outcomes of care are designed, measured, and improved. The plan is comprehensive in scope, applicable organization-wide, and multidisciplinary.

C. Client Services Meetings

Monthly meetings shall be scheduled to address any contractual issues. Participants of these meetings shall include key ECCF and CFG staff.

As part of these meetings, statistical reports shall be submitted that pertain to intake screening; inmate/detainee sick-call requests; sick-call encounters; on-site and off-site specialty consults; infirmary admissions and length of stay; mental health evaluations and treatment-related data; emergency room visits; hospital admissions and length of stay; the percentage of inmates/detainees on medication (including usage and treatment); radiology exams; chronic care clinics; and any other areas CFG and the County agree would be useful for evaluating the healthcare program.

D. Inmate/Detainee Grievances and Complaints

CFG shall continue to follow ECCF policies and procedures concerning inmate/detainee grievances and complaints. CFG acknowledges and shall comply with the ECCF's right to review any inmate/detainee complaint, as well as CFG's actions.

E. Supplies and Equipment

1. CFG understands the ECCF is under no obligation to provide additional equipment after the contract commencement date. CFG has reviewed Exhibit G of the RFB (the inventory of County-owned equipment that must be serviced and maintained by CFG). CFG understands all warranties shall be assigned to the ECCF. All equipment shall be returned to the County at the end of the contract in the condition in which it was received, less ordinary wear and tear. Equipment that is no longer usable that CFG feels does not need replacement shall be brought to the attention of the Director (or the Director's designee) for determination. Any damaged or lost equipment shall be replaced by CFG.

2. CFG is aware that if CFG purchases additional equipment as part of this contract, the equipment shall become ECCF property upon contract termination or expiration.

3. While equipment shall belong to the County and shall be registered in the County's name, CFG shall assume responsibility (both administrative and financial) for equipment registration renewal, repair, inspection, maintenance, calibration, and replacement.

4. As a common business practice, CFG shall not lease equipment or replace existing ECCF equipment without prior approval from the ECCF.

5. Office equipment, such as computers, printers, copiers, and fax machines – shall be provided by CFG, but shall become the property of the ECCF upon contract termination or shall be subject to continued ECCF lease (in the instance of leased equipment).

6. CFG has in use at ECCF: - 41 workstations and 46 monitors, which are used for the EHR; 8 printers, 17 scanners/printers/faxes (3-1), and 2 scanners.

7. CFG shall bear responsibility for the cost of any information technology equipment, including, but not limited to, new and/or replacement computers (PCs). The cost for all computer and printer consumable supplies (e.g. – ink cartridges, paper, toner, replacement parts, etc.) shall be CFG's responsibility. CFG is aware that any IT and/or office equipment supplied by CFG must first be approved by the IT Manager and ECCF Administration.

8. CFG shall be responsible for procuring and stocking all medical, dental, and pharmaceutical, and office supplies. A minimum of two (2) weeks of all such supplies shall be maintained. Supplies shall be safely stored and secured and shall be inventoried.

9. Upon termination or expiration of the contract, CFG shall ensure the on-site availability of at least one (1) month of medical, dental, and routine office supplies.

10. All existing telephone lines and equipment are available for the vendor's use. Telephone service is coordinated with the ECCF Information Technology department.

11. CFG shall submit a list of all damaged equipment to the County thirty (30) days before the contract date. If CFG should not be the successful vendor, CFG shall work with the incoming vendor to reconcile equipment.

F. Hazardous Waste

CFG shall be responsible for the appropriate registration, licensure, collection, storage, and removal of regulated medical waste and sharps containers, per State and federal regulations.

G. Disaster Plan

CFG has developed a disaster plan, to be used in the event of an internal or external man-made or natural disaster, disturbance, or riot. The plan includes the location of triage areas, supplies, local support and medical services, emergency transportation, hospital notice, and other key elements. Training includes an annual disaster drill that is documented and subsequently evaluated. The plan incorporates designated triage areas with the capacity to perform necessary emergency medical procedures. The plan also accounts for extraordinary demands that may be placed upon staff, such as the possible recall of staff to the facility, the safety of patient and staff areas, the use of emergency equipment and supplies, evacuation procedures, and the stocking of emergency supplies and equipment.

H. Professional Medical Database

CFG provides "Up to Date", a clinical database that medical staff can access.

I. Medical Records/Electronic Health Records (EHR)

CFG is aware the County uses the Fusion EHR system which includes the Athena Practice solution EHR and Fusion EHR applications for the management of electronic records and document scanning. CFG shall continue to utilize this system to document and record all medical encounters, relevant follow-up activities, medical orders, and prescriptions. CFG shall ensure all equipment and software is compatible with this EHR. As the incumbent vendor, CFG is aware that GE Centricity requires at least Windows10 64-bit or newer, with a minimum of 8GB RAM, and an i-series Intel or equivalent processor.

CFG shall fully utilize and cooperate with any upgrades to the EHR and related applications, as determined by ECCF, including (but not limited to) upgrading forms, reports, and automated triggers. Work shall be completed by GE Centricity certified staff. CFG shall be financially responsible for upgrades and for purchasing and maintaining as many licenses as are required. CFG shall also be responsible for licensing fees; however, the licenses shall be owned by the County.

1. Electronic Interface Requirements

CFG shall train a staff person on each shift (24/7) to respond to and reset the Data Transfer Station (DTS) of the EHR system, should it fail. The DTS is responsible for transferring key inmate/detainee identification data between the OMS and the EHR. CFG is well aware that OMS and DTS capability is critical to creating medical charts in the EHR system.

2. Training

The EHR training program shall consist of three (3) major components: 1) new employee training; 2) in-services, and 3) advanced user training. CFG shall provide EHR training for all new hires, including agency staff and on-site contractors, before the commencement of employment with ECCF. In the event of any new releases, significant program modifications, and/or major system enhancements impacting medical workflow, CFG staff shall attend in-service training. CFG shall assign staff to an advanced training program conducted by CFG's EHR Analyst. This program shall cover computer security, computer access/log-on IDs, setting/resetting passwords, GE-EHR access, and medical record confidentiality. Advanced users shall be the first line of support for all other medical staff and shall be accessible 24/7, 365 days per year.

3. EHR Security Requirements

CFG shall comply with the ECCF IT policy on computer security. Signed computer security access forms shall be submitted to the Director (or the Director's designee) for all employees. All new employees, including agency staff and on-site contractors, shall be required to sign a Computer Access Form before beginning employment with the ECCF.

5. Medical Records File

a. In addition to providing documentation in the EHR, as required, CFG shall ensure that timely, accurate, comprehensive, legible records are kept for each inmate/detainee. All documents requiring signatures, plus copies of hospital reports shall be placed in an inmate's/detainee's medical record file. These paper documents shall also be scanned into the EHR.

b. All medical records prepared by CFG, both electronic and paper, shall be considered the sole property of the ECCF, though CFG shall be considered the custodian of said medical records throughout the term of the contract. Upon expiration/termination of the agreement, the custody of such medical records shall be transferred to ECCF. Throughout the term of the agreement, ECCF designated representatives shall have access to all medical records per established ECCF protocols.

c. CFG shall comply with ECCF policies on the transfer, release, and retention of health records, with CFG responsible for costs incurred to produce duplicate copies of medical records, as necessary. Upon inmate/detainee transfer to another facility, CFG shall provide a copy of the inmate's/detainee's full medical record to the receiving facility. When a detainee is released, the detainee shall receive a copy of his/her complete medical record, according to PBNDS 2011 standards.

6. EHR Maintenance, Development, and Support

a. CFG shall support timely change requests to the EHR, performed on an as-needed basis, as requested by the County to comply with NCCHC, ACA, and PBNDS 2011 standards. Change requests may include (at a minimum) form creation, form modification, report creation, report modification, and custom development of the GE system. All work shall be performed by a certified vendor of the EHR.

b. CFG shall make technical support available to the ECCF twenty-four (24) hours per day, seven (7) days per week, 365 days per year. CFG shall also provide on-site emergency support within two (2) hours of a technical emergency (such as the system going down).

6. EHR Staffing

CFG shall proactively participate in meeting all EHR project deliverables and deadlines, including assigning staff and resources, as required. CFG shall commit two staff members (1.5 FTEs) to support, maintain, and enhance the EHR and Medical IT. The breakdown of the 1.5 FTE IT positions shall be as follows:

- **On-Site Medical IT/EHR Helpdesk Support (forty [40] hours/week)**
  - Maintain computer images and re-image.
  - Maintain/repair all hardware utilized by medical staff (i.e. computers, printers, scanners, phones, faxes... etc.).
  - Maintain an up-to-date inventory of all hardware.
  - Ensure time clock functionality.
  - Resolve EHR Interface Link Logic errors.
  - Maintain EHR downtime forms to match EHR forms.
  - Manage and resolve duplicate inmate records.
  - Serve as first-line support to troubleshoot reported EHR andhardware issues.
  - Escalation and management of any EHR related issues to EHR vendor.
  - Create and update EHR user accounts.
  - Manage all helpdesk requests through the ticketing system.
  - Provide EHR training to end-users.
  - Create and maintain training materials.
  - Attend and organize EHR steering committee meetings.
  - Attend ECCF Administration meetings, as required.
  - Meet with EHR users to receive system feedback.

- **On-Site Medical IT Project Manager (twenty [20]hours/week)**
  - Manage change requests and assign technical resources.
  - Provide project status reports and changelog reports to the EHR steering committee.
  - All work shall be performed by Fusion EHR certified system engineers. Skill sets required include SQL DBA, HL7 Programming, Crystal Reports, Logical Innovation's Visual Form Editor Software, and MEL ProgrammingLanguage.
  - Develop EHR change requests to modify/create new processes or components.
  - Develop software modifications to improve efficiency, reduce costs, and improve accountability.
  - Development and maintenance of various forms, reports, and custom modules.
  - Development and maintenance of all interfaces to and from EHR.
  - Maintenance of database backups.
  - Implementation of all project deliverables must be conducted onsite as there is no VPN or remote access allowed per ECCF IT Policy. Oversee 24x7x365 support services to ECCF.

J. Policy Development and Procedures

As the incumbent provider, CFG has developed uniform policies and procedures for the ECCF, designed to meet the site's individual needs. CFG is aware all proposed policies are subject to final approval from the Director (or the Director's designee).

K. Exclusions

CFG shall be under no obligation to provide or pay for the following services:

- Cosmetic surgery
- Initiation of gender reassignment surgery (sex change operation)
- Elective vasectomy
- Tubal ligation
- Newborn care
- Organ donation

L. Standards and Accreditation

CFG shall continue to maintain both NCCHC and ACA accreditation and compliance with current PBNDS standards throughout the tenure of the contract. CFG shall also be responsible for 100% of all NCCHC and any other medical accreditation costs, including application and renewal fees.

M. Performance and Reporting Requirements

CFG is aware that Essex County intends to monitor CFG's performance in an on-going effort to ensure all requirements of the bid/contract are fully met and to ensure all health services provided remain in compliance with the former Medical Consent Order, NCCHC standards, ACA standards, and current PBNDS standards. CFG has reviewed the additional required performance standards and reports outlined in Exhibit A of the RFB and agrees to maintain compliance with these specifications, as well.

N. Reports

CFG shall provide periodic reports to the Director, or the Director's designee, concerning the utilization and administration of the program as set forth within the RFB. CFG agrees to submit the following reports within the allotted timeframes:

1. Hospital Trip Reports

CFG shall prepare monthly hospital trip reports for the Director/the Director's designee. These reports shall list all hospital trips for an emergency, inpatient, and outpatient care within the prior month, and shall include the inmate's/detainee's name, the date of the trip, the medical reason necessitating the trip, as well as any other items deemed necessary by the Director or the Director's designee.

2. Litigation Reports

Litigation reports detailing allegations and legal actions made against CFG, pertinent to healthcare services, shall be provided to the Director (or the Director's designee) quarterly. Litigation reports involving CFG's performance in other venues shall be provided to the Director (or the Director's designee) quarterly, as well. These reports shall list the status of all unresolved cases and the outcome of all cases that were resolved in the interim between reports.

3. Regulatory Agency Reports

All citations from outside regulatory agencies shall be reported immediately to the Director or the Director's designee upon occurrence.

4. Annual Reports

An annual management plan that includes CFG's short- and long-range goals shall be submitted to the Director (or the Director's designee) upon the anniversary of the contract's date of commencement. Quarterly progress reports shall be provided that list the status of any relevant items currently in progress.

O. Maintenance of Accreditation and Healthcare Standards

In addition to all remedies to which the County may be entitled, CFG is aware the County may penalize CFG $25,000 per calendar quarter for any period in which healthcare standards are not properly maintained at the levels required by the contract, including, but not limited to, the former Medical Consent Order. If any accreditation is lost, CFG understands the County may immediately terminate the contract, in which event CFG shall be responsible for all damages incurred by the county relating to termination and replacement.

Additionally, any monetary penalty ICE assesses Essex County for medical reasons may be attributed to CFG.

P. Contractor Performance

CFG shall continue to maintain a high quality, comprehensive healthcare management system at the ECCF for the contract's entire duration.

CFG is aware the County of Essex reserves the right to deduct a penalty from CFG's monthly compensation for any performance deficiencies. The ECCF shall provide CFG with such designated office space and utilities as needed for CFG to perform its obligations and duties under this contract.

Q. General ECCF Vendor Support

1. The ECCF will provide the vendor with designated office space and utilities to enable the vendor to perform its obligations and duties under the contract.
2. The ECCF will provide the appropriate level of security as determined by the Warden for ail medical areas.
3. The ECCF will provide security staff for off-site supervision and transportation of inmates/detainees for health services.
4. The vendor staff will have access to inmate/detainee jail records on a need-to-know basis. Unless otherwise determined by the Warden, they will not have access to ECCF investigative reports.

R. CFG's Relationship with Contract Monitor Staff

CFG shall fully cooperate with the Director's contract monitoring agents, responding to requests promptly. CFG shall also be responsive to all audits performed at the institution.

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X. MOBILIZATION AND IMPLEMENTATION PLAN

As the incumbent medical services provider, CFG Health Systems, LLC, has not included a mobilization and implementation transition plan, in accordance with specifications of the RFB.

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XI. OFFICIAL PRICING AND PAYMENTS

As part of its bid, CFG has submitted a fully-loaded and firm fixed price for each of the three (3) years of the contract period. CFG has also completed all five (5) pricing components requested by Essex County, including:

- Cost of staffing
- Cost of pharmacy services, calculated using the cost per inmate per day
- Cost of ancillary services
- All other costs
- Medical Billing

CFG has also completed the Cost Summary Matrix (included as Exhibit H of the RFB) for the entire three (3) year period, with the total cost of all three (3) years representing the bid price.

****All pricing information, including the Bid Signature Form; Proposed Staffing Matrix Costs for all three (3) contract periods (Exhibit E); the Bid Price Quotation Form and Total Price Bid (Exhibit H); and a worksheet summarizing all other costs can be found at the end of this section.****

A. Cost of Staffing

As requested in the RFB, CFG has provided hourly costs by position title (as identified in Exhibit E) for each year of the contract. CFG is aware the County will not allow annual cost of living adjustments to be made in pricing for the first three (3) years of the contract after the bid has been awarded.

CFG acknowledges that our contract can be extended for two (2) one-year options, exercisable solely at the county's discretion, for the fourth and fifth contract years. CFG realizes that should the County exercise either one or both of these options, staff pricing shall be determined using third year pricing proposed by CFG, increased by the percentage change in the index rate for the twelve (12) months preceding the most recent quarterly calculations of the New Jersey Department of Community Affairs that is available on the date the County decides to exercise such options (the DCA index).

It should be noted that the cost of staffing for this proposal is significantly greater than that submitted for the previous contract in 2015. With the enhancement of services noted in the executive summary, there was a need for increased staffing to meet the objectives of the programs. There were increases in FTE to support ICE detainee requirements, increased mental health services, addition of nurse sick call program and dedicated pre-booking and booking nurses and the addition of the ACA coordinator. In 2015, there were 86.1 FTE compared to 105.25 FTE in 2020. Many of these additional positions have been filled during

the 5 year contract period. Currently, the real addition to the current matrix is the 1.0 Discharge planner, and the QI Coordinator plus the MAT positions which are grant funded.

B. Cost of Pharmacy

Charges for pharmacy services have been based on the cost per inmate per day. For the purposes of this bid, an average of 1,500 inmates per month has been used for all relevant calculations, though it is understood that the actual number changes every month.

CFG acknowledges that the cost per inmate per day shall remain a fixed price for the first three (3) years of the contract and shall not include the detainee count. Should the County agree to extend the contract to year four or year five, the increase in pharmaceuticals shall be limited to the increase in CPI for medications/prescriptions.

C. Cost of Ancillary Services

Pricing for ancillary services shall include costs for the following: on-site laboratory services, radiology and EKG testing for inmates up to $52,000.00 per month. CFG shall be responsible for paying monthly costs and shall bill the ECCF for actual monthly costs, up to $52,000.00 per month (this is the total monthly amount to be reimbursed to CFG).

As per the current agreement, please note that dialysis nursing hours will be billed as ancillary services.

Ancillary services reimbursement is also anticipated to be increased due to the cost of COVID-19 testing.

D. All Other Costs

Other costs include those costs incurred in association with the provision of services under this contract, including, but not limited to: insurance, management fees, travel, etc. All individual components of this category have been listed and priced out separately for each contract year and have been submitted as part of this bid, per RFB specifications – **please see the end of this section.**

Of note is the increased cost of medical supplies (PPE) due to the comprehensive COVID-19 plan in place at ECCF.

E. Cost of Medical Bills

Medical bills shall include physician bills, and hospital bills which will be paid by CFG. In addition to local hospital and physician bills from local providers, CFG shall pay hospital and offsite provider bills for ECCF patients sent to the hospital or physician from Trenton Psychiatric Hospital and Ann Klein Forensic Center. It is understood that the county will reimburse CFG for all offsite physician and hospital payments.

F. Invoice Processing Requirements

1. Time Clock

CFG has installed and shall continue to maintain, at its own expense, a time clock apparatus to track each employee's start and stop times on a twenty-four (24) hour, seven (7) days per week basis. Changes in device installation, location or operational processes shall be developed and agreed upon between CFG and ECCF staff prior to implementation. The time clock used by CFG has already been installed at ECCF. Time reports generated by this system shall be included with monthly invoices for payment. CFG is aware that hours not recorded using this system shall not be compensated.

2. Staff Invoices

CFG acknowledges that the vendor shall be paid on a positive reporting basis; therefore, each monthly invoice shall be presented by the first week of each month and shall be accompanied by daily time sheets for each employee and staff member whose time is being billed on the invoice. CFG is aware that only hours worked the previous month should appear on the invoice.

When presenting invoices to the County, CFG shall provide copies of daily time sheets (broken down by shift) that document staff hours worked on-site. Invoices shall be presented in a format that includes the following details:

- Number of hours by employee and skill set (e.g. – MD, LPN, NP, PA, etc.)
- Number of employees in each skill set
- The contractual hourly rate for each skill set
- Total hours worked by skill set
- Grand total of all skill sets, the total number of employees, and the total number of hours being billed per invoice

Invoices shall include paid benefit hours, total hours required by the Staffing Matrix, and the variance between hours worked and required contract hours. Reporting requirements shall apply to all personnel, including independent vendors and any CFG sub-contractors.

CFG shall provide a report summarizing each job category, the aggregate total hours worked, total hours required by the approved Staffing Matrix, and the variance between hours worked and hours required. CFG is aware that invoices that do not provide these details and/or invoices submitted without supporting documentation substantiating the number of hours being billed may not be paid in full. CFG is cognizant that the vendor shall be paid following the submission of monthly invoices for the duration of the three (3) year contract, according to County policies and procedures.

G. Failure to Maintain a Full Complement of Staff

CFG shall maintain a full complement of staff capable of providing high quality care and supporting the former Medical Consent Decree. CFG is aware that should CFG be unable to maintain a complete complement of staff for any fifteen (15) shifts within a thirty (30) day period, CFG may be deemed non-compliant with contract terms and shall be required to meet with the Director for a review of performance that may result in contract termination. CFG understands that noncompliance may result in liquidated damages, based on the number of days missed, salary, plus an additional penalty.

CFG is also aware that if the positions of Medical Director, Mental Health Director, Health Services Administrator (HSA), Director of Nursing (DON) or Dentist are vacant for over sixty (60) days, CFG shall be penalized, even if providing replacement hours. It is understood that full-time replacements must be hired within sixty (60) days.

EXHIBIT E

PROPOSED STAFFING MATRIX COSTS FOR CONTRACT PERIODS

1/1/21-12/31/21

1/1/22-12/31/22

1/1/23-12/31/23

STAFFING MATRIX 01/01/21-12/31/21

(a) POSITION:	(b) WEEKLY FACILITY HOURS	(c) COST PER HOUR	(d) EXTENDED COST Col. (b) x Col. (c)
Medical Director	40	144.57	5,782.80
Health Services Admin. (RN)	40	73.80	2,952.00
Ice Program Admin. (RN/LPN)	40	50.15	2,006.00
Director of Nursing	40	61.70	2,468.00
Administrator Assistant	40	26.01	1,040.40
Staff Physicians	152	117.00	17,784.00
NPs/PAs	304	72.25	21,964.00
NP/PA - ICE	56	79.25	4,438.00
RN's	336	49.20	16,531.20
Sick Call RN's	112	47.99	5,374.88
Infection Control RN	40	47.14	1,885.60
Quality Improvement (QI) Coordinatior RN	40	51.92	2,076.80
LPN's	1,064	39.11	41,613.04
LPN's (ICE)	68	40.45	2,750.60
* LPN (MAT Program)	35	39.11	1,368.85
C N A 's	224	24.60	5,510.40
C M A's	152	22.90	3,480.80
Psychiatrist	40	161.07	6,442.80
Psychiatric APN	56	83.65	4,684.40
Psychologist	40	89.93	3,597.20
Mental Health Counselors	184	33.41	6,147.44
Mental Health - Admin Asst	20	20.65	413.00
Drug/Alcohol Counselor	40	37.34	1,493.60
Discharge Planner	40	46.29	1,851.60
Dentist	56	83.53	4,677.68
Dental Assistant	56	26.93	1,508.08
Dental Hygenist	20	40.81	816.20
Pharmacy Technicians	152	24.86	3,778.72
Phlebotomists	56	23.83	1,334.48
Unit Clerks	136	20.19	2,745.84
Medical Records Director	40	33.45	1,338.00
Medical Records Clerks	128	20.78	2,659.84
Affordable Care Act Coordinator	40	34.10	1,364.00
Billing Analayst	40	28.89	1,155.60

(a) POSITION:	(b) WEEKLY FACILITY HOURS	(c) COST PER HOUR	(d) EXTENDED COST Col. (b) x Col. (c)
Onsite Help Desk Technician	40	33.82	1,352.80
Onsite Project/Technical Resource Manager	20	57.66	1,153.20
OB/GYN	12	193.36	2,320.32
Orthopedist	12	227.18	2,726.16
Oral Surgoen	4	189.26	757.04
MAT Program			
* Program Coordinator	40	57.14	2,285.60
* Discharge Planner	40	50.28	2,011.20
* Drug Consultant	40	51.39	2,055.60
GRAND TOTAL	**4,135**		**199,698**

* Grant funded positions - please refer to Setion J.20 for details regarding set costs

STAFFING MATRIX 01/01/22-12/31/22

(a) POSITION:	(b) WEEKLY FACILITY HOURS	(c) COST PER HOUR	(d) EXTENDED COST Col. (b) x Col. ('c)
Medical Director	40	148.91	5,956.40
Health Services Admin. (RN)	40	76.01	3,040.40
Ice Program Admin. (RN/LPN)	40	51.65	2,066.00
Director of Nursing	40	63.55	2,542.00
Administrator Assistant	40	26.79	1,071.60
Staff Physicians	152	120.51	18,317.52
NPs/PAs	304	74.42	22,623.68
NP/PA - ICE	56	81.63	4,571.28
RN's	336	50.68	17,028.48
Sick Call RN's	112	49.43	5,536.16
Infection Control RN	40	48.55	1,942.00
Quality Improvement (QI) Coordinatior RN	40	53.48	2,139.20
LPN's	1,064	40.28	42,857.92
LPN's (ICE)	68	41.66	2,832.88
* LPN (MAT Program)	35	40.28	1,409.80
C N A 's	224	25.34	5,676.16
C M A's	152	23.59	3,585.68
Psychiatrist	40	165.90	6,636.00
Psychiatric APN	56	86.16	4,824.96
Psychologist	40	92.63	3,705.20
Mental Health Counselors	184	34.41	6,331.44
Mental Health - Admin Asst	20	21.27	425.40
Drug/Alcohol Counselor	40	38.46	1,538.40
Discharge Planner	40	47.68	1,907.20
Dentist	56	86.04	4,818.24
Dental Assistant	56	27.74	1,553.44
Dental Hygenist	20	42.03	840.60
Pharmacy Technicians	152	25.61	3,892.72
Phlebotomists	56	24.54	1,374.24
Unit Clerks	136	20.80	2,828.80
Medical Records Director	40	34.45	1,378.00
Medical Records Clerks	128	21.40	2,739.20
Affordable Care Act Coordinator	40	35.12	1,404.80
Billing Analayst	40	29.76	1,190.40

(a) POSITION:	(b) WEEKLY FACILITY HOURS	(c) COST PER HOUR	(d) EXTENDED COST Col. (b) x Col. ('c)
Onsite Help Desk Technician	40	34.83	1,393.20
Onsite Project/Technical Resource Manager	20	59.39	1,187.80
OB/GYN	12	199.16	2,389.92
Orthopedist	12	234.00	2,808.00
Oral Surgoen	4	194.94	779.76
MAT Program			
* Program Coordinator	40	58.85	2,354.00
* Discharge Planner	40	51.79	2,071.60
* Drug Consultant	40	52.93	2,117.20
GRAND TOTAL	**4,135**		**205,687.68**

* Grant funded positions - please refer to Setion J.20 for details regarding set costs

STAFFING MATRIX 01/01/23-12/31/23

(a) POSITION:	(b) WEEKLY FACILITY HOURS	(c) COST PER HOUR	(d) EXTENDED COST Col. (b) x Col. ('c)
Medical Director	40	153.38	6,135.20
Health Services Admin. (RN)	40	78.29	3,131.60
Ice Program Admin. (RN/LPN)	40	53.20	2,128.00
Director of Nursing	40	65.46	2,618.40
Administrator Assistant	40	27.59	1,103.60
Staff Physicians	152	124.13	18,867.76
NPs/PAs	304	76.65	23,301.60
NP/PA - ICE	56	84.08	4,708.48
RN's	336	52.20	17,539.20
Sick Call RN's	112	50.91	5,701.92
Infection Control RN	40	50.01	2,000.40
Quality Improvement (QI) Coordinatior RN	40	55.08	2,203.20
LPN's	1064	41.49	44,145.36
LPN's (ICE)	68	42.91	2,917.88
* LPN (MAT Program)	35	41.49	1,452.15
C N A 's	224	26.10	5,846.40
C M A's	152	24.30	3,693.60
Psychiatrist	40	170.88	6,835.20
Psychiatric APN	56	88.74	4,969.44
Psychologist	40	95.41	3,816.40
Mental Health Counselors	184	35.44	6,520.96
Mental Health - Admin Asst	20	21.91	438.20
Drug/Alcohol Counselor	40	39.61	1,584.40
Discharge Planner	40	49.11	1,964.40
Dentist	56	88.62	4,962.72
Dental Assistant	56	28.57	1,599.92
Dental Hygenist	20	43.29	865.80
Pharmacy Technicians	152	26.38	4,009.76
Phlebotomists	56	25.28	1,415.68
Unit Clerks	136	21.42	2,913.12
Medical Records Director	40	35.48	1,419.20
Medical Records Clerks	128	22.04	2,821.12
Affordable Care Act Coordinator	40	36.17	1,446.80
Billing Analayst	40	30.65	1,226.00

(a) POSITION:	(b) WEEKLY FACILITY HOURS	(c) COST PER HOUR	(d) EXTENDED COST Col. (b) x Col. ('c)
Onsite Help Desk Technician	40	35.87	1,434.80
Onsite Project/Technical Resource Manager	20	61.17	1,223.40
OB/GYN	12	205.13	2,461.56
Orthopedist	12	241.02	2,892.24
Oral Surgoen	4	200.79	803.16
MAT Program			
* Program Coordinator	40	60.62	2,424.80
* Discharge Planner	40	53.34	2,133.60
* Drug Consultant	40	54.52	2,180.80
GRAND TOTAL	**4,135**	**2,819**	**211,858.23**

* Grant funded positions - please refer to Setion J.20 for details regarding set costs

EXHIBIT H

BID PRICE QUOTATION FORM AND TOTAL PRICE BID
1/1/21-12/31/21
1/1/22-12/31/22
1/1/23-12/31/23

BID #20-195 - BID PRICE QUOTATION FORM
AND
TOTAL PRICE BID

YEAR	STAFFING	ANCILLARY SERVICES ^	OTHER	PHARMACY *	MEDICAL BILLS **	TOTAL
1/01/21-12/31/21	$10,218,524	$624,000	$3,789,545	$2,244,750	$380,000	**$17,256,819**
1/01/22-12/31/22	$10,525,080	$624,000	$3,963,574	$2,244,750	$380,000	**$17,737,404**
1/01/23-12/31/23	$10,840,832	$624,000	$4,141,324	$2,244,750	$380,000	**$18,230,906**
TOTAL BID PRICE						**$53,225,129**

^ ECCF is responsible for ancillary services and will pay the vendor for the cost thereof, upon receipt of original invoices, in an aggregate amount not to exceed $52,000/month. The vendor is responsible for any costs above that amount.

*The PHARMACY FIGURE must be the same number for each year as no increase over the first year pricing is permitted. The number should be based on cost per inmate per day. 1,500 inmates/month should be used for the purposes of this calculation. Actual number of inmates changes every month.

**The vendor will be reimbursed for the cost of medical bills paid (physicians, hospitals)

PRICES QUOTED SHALL BE FIRM, NET EXCLUSIVE OF ANY SALES OR USE TAXES, IF APPLICABLE, AND MUST INCLUDE ALL COSTS, EXPENSE AND CHARGES OF EVERY NATURE WHATSOEVER.

IN THE EVENT OF TIE BIDS, THE COUNTY OF ESSEX SOLELY RESERVES THE RIGHT TO AWARD THE CONTRACT AT ITS DISCRETION TO ANY ONE OF THE TIE BIDDERS.

VENDOR'S COMPANY NAME CPG Health Systems, LLC

AUTHORIZED SIGNATURE _____ DATE 10/27/20

(Signature must be of Authorized Representative, Executive Officer or General Partner)

PRINT NAME: Les Paschall TITLE: CEO

TELEPHONE NUMBER: 856-797-4803 FAX NUMBER: 856-797-4813

TAX I.D. OR SOCIAL SECURITY NUMBER: 22-3659031

ADDRESS: 765 East Route 70, Building A-100, Marlton NJ, 08053

BID #20-195 - BID PRICE QUOTATION FORM
SUPPORTING SCHEDULE
OTHER COSTS

	1/01/21-12/31/21	1/01/22-12/31/22	1/01/23-12/31/23
MALPRACTICE INSURANCE	338,024	341,415	344,907
MEDICAL SUPPLIES	145,934	150,312	154,821
MALPRACTICE LEGAL	205,000	208,900	212,917
COVID TESTS	650,880	670,406	690,519
PPE	150,000	154,500	159,135
ON-SITE MEDICAL SERVICES	83,000	85,490	88,055
WASTE DISPOSAL MEDICAL	21,727	22,379	23,050
MEDICAL EQUIPMENT	15,000	15,450	15,914
DENTAL SUPPLIES	18,655	19,215	19,791
OUTSIDE PROFESSIONAL SERVICES	114,891	118,338	121,888
OFFICE SUPPLIES	29,334	30,214	31,121
MEDICAL EQUIPMENT LEASE	6,000	6,180	6,365
MEDICAL LICENSES	8,500	8,755	9,018
MEALS & ENTERTAINMENT	1,000	1,030	1,061
LICENSE & PERMITS	12,324	12,694	13,075
IT CONSULTING	100,455	103,469	106,573
REPAIRS & MAINTENANCE	20,500	20,665	20,835
OTHER	144,192	218,311	293,153
MANAGEMENT FEE/OVERHEAD	1,724,129	1,775,852	1,829,128
TOTAL	**3,789,545**	**3,963,574**	**4,141,324**

Cost Proposal Summary

When reviewing CFG's cost proposal, it is important to note our 2021 proposal is reflective of program enhancements made since our last proposal, such as FTE additions as well as changes made in the RFP specs to now include PPE, Covid testing and MAT budget. Additional details can be found in our technical submission.

Description		Dollars
Current month invoice and open positions (annualized)	$	**15,429,193.67**
Pharmacy adj due to increase drug cost	$	312,570
Cost estimate 2021	$	**15,741,764**
$ Essex is currently paying via pass thru that are now in the RFP		
PPE	$	150,000
COVID TESTS	$	650,880
MAT Budget	$	714,175
Cost estimate 2021 with new RFP specs	$	**17,256,819**

Appendix 7

Staffing Matrix for the Essex County Correctional Facility (ECCF)									
Positions	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Sun**	**Total Hrs.**	**Total FTEs**
Day Shift 7:00 AM - 3:30 PM									
Health Services Administrator (HSA)	8	8	8	8	8			40	1
Assistant HSA (ICE Nurse)	8	8	8	8	8			40	1
Medical Director	8	8	8	8	8			40	1
*Physicians	16	16	16	16	16	8	8	96	2.4
Director of Nursing (Don)	8	8	8	8	8			40	1
QI RN	8	8	8	8	8			40	1
Infection Control	8	8	8	8	8			40	1
*Nurse Practitioners (NPs)/Physician Assistants (PAs)	32	32	32	32	32	8	8	176	4.4
*NP/PA – ICE	8	8	8	8	8	8	8	56	1.4
*Registered Nurses (RNs)	24	24	24	24	24	24	24	168	4.2
*Licensed Practical Nurses (LPNs)	64	64	64	64	64	64	64	448	11.2
*Certified Nursing Assistants (CNAs)	16	16	16	16	16	16	16	112	2.8
*Certified Medical Assistants (CMAs)	8	8	8	8	8			40	1
*Psychiatrist (possibly Director of MH)	8	8	8	8	8			40	1
*Psychiatric APN	8	8	8	8	8	8	8	56	1.4
*Psychologist (Mental Health Supervisor or Director of MH)	8	8	8	8	8			40	1
*Mental Health Counselors	24	16	16	16	24	16	16	128	3.2
Discharge Planner	8	8	8	8	8			40	1
Mental Health Administrative Assistant	4	4	4	4	4			20	0.5
Scheduler	4	4	4	4	4			20	0.5
Drug/Alcohol Counselor	8	8	8	8	8			40	1
Administrative Assistant	8	8	8	8	8			40	1
*Unit Clerks	8	8	8	8	8	8	8	56	1.4
Medical Record Coordinator (Director)	8	8	8	8	8			40	1
Medical Record Clerks	8	8	8	8	8	16	16	72	1.8
Affordable Care Act Coordinator	8	8	8	8	8			40	1
Billing Analyst	8	8	8	8	8			40	1
Dentist	8	8	8	8	8	8	8	56	1.4
*Dental Assistant	8	8	8	8	8	8	8	56	1.4
*Dental Hygienist	4	4	4	4	4			20	0.5
*Pharmacy Techs	8	8	8	8	8	8	8	56	1.4
Phlebotomist	8	8	8	8	8	8	8	56	1.4
Support Analyst (Level 1) EHR	8	8	8	8	8			40	1
Development Analyst (Level 2) EHR	4	4	4	4	4			20	0.5
Total Day								**2,312**	**57.8**
Evening Shift 3:00 PM - 11:30 PM									
*Physicians	8	8	8	8	8	8	8	56	1.4
*NPs/PAs	8	8	8	8	8	8	8	56	1.4
*RNs	24	24	24	24	24	24	24	168	4.2

Staffing Matrix for the Essex County Correctional Facility (ECCF)									
Positions	**M**	**T**	**W**	**Th**	**F**	**Sa**	**Sun**	**Total Hrs.**	**Total FTEs**
*LPNs	64	64	64	64	64	64	64	448	11.2
*LPNs (ICE)	12	8	12	8	12	8	8	68	1.7
*CNAs	8	8	8	8	8	8	8	56	1.4
*CMAs	8	8	8	8	8	8	8	56	1.4
*Mental Health Counselors	8	8	8	8	8	8	8	56	1.4
Pharmacy Techs	8	8	8	8	8	8	8	56	1.4
Medical Record Clerks	8	8	8	8	8	8	8	56	1.4
*Unit Clerk	8	8	8	8	8			40	1
Total Evening								1,116	27.9
Night Shift 11:00 PM - 7:30 AM									
*NPs/PAs	8	8	8	8	8	8	8	56	1.4
*RNs	16	16	16	16	16	16	16	112	2.8
*LPNs	32	32	32	32	32	32	32	224	5.6
*CNAs	8	8	8	8	8	8	8	56	1.4
Pharmacy Techs	8	8	8	8	8			40	1
*Unit Clerk	8	8	8	8	8			40	1
Total Night								528	13.2
MAT (Grant Reimbursed)									
Program Coordinator	8	8	8	8	8			40	1
Discharge Planner	8	8	8	8	8			40	1
*LPN	5	5	5	5	5	5	5	35	0.875
Substance Abuse Counselor	8	8	8	8	8			40	1
Total MAT								155	3.875
On Site Specialists									
OB/GYN			6		6			12	0.3
Orthopedist		6		6				12	0.3
Oral Surgeon						4		4	0.1
(Billed through Ancillary Services)*Dialysis RN	12	12	12	12	12	12		72	1.8
Optometry				3				3	0.075
Physical Therapy							PRN		
Total Specialists								103	2.575
Grand Totals								4,214	105.35

* Denotes Backfilled positions

**Time may vary based on facility needs.

Appendix 8

COUNTY OF ESSEX

DEPARTMENT OF CORRECTIONS
ESSEX COUNTY CORRECTIONAL FACILITY
354 Doremus Avenue – Newark, New Jersey 07105
973-274-7800 --- 973-274-6193 (Fax)

Joseph N. DiVincenzo, Jr.
Essex County Executive

Alfaro Ortiz, Jr.
Director

TO: Essex County Civilian Task Force

FROM: Alfaro Ortiz, Director

DATE: October 30, 2020

RE: Answers to Medical Questions from Dr. C. Pernell

Please note that these responses are a compilation of answers from our staff including Dr. Anicette, Medical Director; Madeline Bell, Health Services Administrator; and Heidi Reifenberg, Coordinator of Monitoring and Evaluation.

1. **Questions regarding inspections**
   It was presented that the ACA, NCCHC, NJDOC, ICE/PBNDS, and the federal Office of Detention Oversight assess the facility on some regular basis. May you provide what the schedule/frequency is and the process of review including the specific criteria that each agency uses to evaluate the facility as well as the most recent performance on any assessments/evaluations that ECC may have undergone? How does the most recent performance compare to past trends? On Slide 4 in the Medical Monitoring Presentation this was alluded to but no specifics were provided.

Accreditation Agencies	**Frequency of Audits**	**Most recent dates audited**	**Upcoming dates scheduled**	**Describe the process of review, including specific criteria used to evaluate**	**Provide the most recent performance on assessments/evaluations**	**Compare the most recent performance to past trends**
ACA	***Every 3 years***	***June, 2019***	*Approx. 9/2022*	ACA Medical Stds	Passed w/ full accreditation	Same as past inspections
NCCHC	***Every 3 years***	***April, 2017***	***Nov/Dec 2020 undetermined due to Covid***	NCCHC.ORG	Passed w/full compliance	Same as past inspections

NJDOC	***Every year***	*2019*	*2020/2021 Undetermined due to Covid*	NJDOC JAIL STDS	Passed w/full compliance	Same as past inspections
ICE/PBNDS	***Yearly and ongoing***	Office of Detention Over-site (ODO) 6/2020 Nakamoto 9/2020	***To be determined by ICE***	ICE PBNDS	Meets Standards	Same as past inspections

2. Medical area description

a. "It is my understanding that each building has its own medical unit with a provider for that particular building, in addition to 2 medical stations in central processing and a 42-bed infirmary in building 5. Is this accurate?"

RESPONSE: ***Yes***

b. "Please be specific on which provider types/titles are in each building and hours of access. And, do inmates and detainees receive medical care by the same staff though inmates may be housed separately from the non-detainee population?"

RESPONSE: ***Medical providers include Physicians, Nurse Practitioners and Physician's Assistants. They treat both inmates and detainees. There are 8 physicians/NPs/PAs (providers) in the facility on the weekday daytime shift; 2 providers on the weekday evening shift; and 1 provider on the weekday night shift. On weekends, there are 2 providers on the day shift; 2 providers on the evening shift and 1 provider on the night shift.***

An administrator, physician, RN, psychiatrist and a dentist on-call 24 hours per day, seven days per week.

3. Population

a. Breakdown

	Population	Male	Female	% English not first language
Detainee	256	256	None	Unknown
Non-detainee	1993	1896	97	Unknown
Totals	2249	2152	97	

Age	Total
18-23	362
24-30	604
31-40	703
41-50	368
51-60	182

>60	30

Race/Ethnicity	Total
Asian Pacific	12
Black	1512
Hispanic	335
Am Indian/Alaska	1
Unknown	2
White	380
Other	7

b. Gender identity
   i. Are inmates/detainees able to identify as non-binary?

   RESPONSE: ***Yes***

   ii. Does the facility currently house transgendered persons or has in the past?

   RESPONSE: ***Yes***

c. Languages
   i. Are medical services provided in the preferred language?

   RESPONSE: ***Yes***

   ii. Is there access to interpretation/translation services as needed?

   RESPONSE: ***Yes***

   iii. How often are translation/interpretation services used?

   RESPONSE: ***Translation/interpretation services are used whenever needed.***

   iv. How many individual languages does the language line include? What is the percentage of inmates who speak a language other than English?

   RESPONSE: ***60 languages are available and other languages can be accessed as needed. Approximately 10-15% of patients speak a language other than English.***

4. Medical delivery of care

Medical intake screenings

a. It is my understanding that every inmate/detainee must complete an intake screen performed by a nurse, including a questionnaire and mandatory TB, RPR and COVID Antibody testing. Please advise if this is complete and accurate.

RESPONSE: ***Yes (RPR is done within 30 days)***

b. Provide copy of nursing intake form

RESPONSE: ***Please see Attachment A.***

c. Do all female inmates/detainees undergo pregnancy testing during their initial intake? What gynecological/women health care services are offered at the facility?

RESPONSE: ***Yes, an Ob/Gyn is on staff and sees patients three days/week.***

d. Who performs the History and Physical <within 24 hours>?

RESPONSE: ***Physician, Nurse Practitioner or Physician's Assistant***

e. Why on Slide 5 in the Medical Monitoring Presentation are nurse screens reported to be about 1460/month and physical assessments are about 815/month. Based on the avg census on total population stats provided in the Safety and Security Protocols presentation, there is a discrepancy. Please advise.

RESPONSE: ***Numbers were taken from January-March. The numbers differ because many inmates are released before they can have their History and Physical.***

5. Other medical stats (Medical Monitoring Presentation)

a. Do those numbers represent unique visits or are they inclusive of persons who may have had multiple encounters?

RESPONSE: ***The numbers are inclusive of persons who may have had multiple encounters.***

b. Can you provide a report that summarizes the numbers with a breakdown by inmates vs. detainees?

RESPONSE: ***We do not break down this data according to inmate type.***

c. Top 5 medical diagnoses

RESPONSE: ***Diabetes, Hypertension, COPD, HIV, Substance Abuse***

d. Top 3 mental health diagnoses

RESPONSE: ***Depression, Anxiety Disorder, Adjustment Disorder***

e. What are the top 5 prevalent medical conditions, inclusive of mental/behavioral health diagnoses?

RESPONSE: ***Hypertension, COPD, Depression/Anxiety, Substance Abuse, Diabetes***

It was reported that approx 1200-1400 have chronic conditions hence the prior question. It was also reported that 20-30% of the population has mental health conditions.

f. It was presented that the medical vendor is required to supply monthly statistical reports. What data is contained in the report and may we receive regular updates?

RESPONSE: ***Please see Attachment B (Monthly Statistical Report)***

Is this report distinct from the monthly CQI report?

RESPONSE: ***Yes***

If they are separate documents, then what data is contained in the monthly CQI report and again, may we have access to this report on a regular basis?

RESPONSE: ***Please see Attachment C for a sample agenda from a monthly meeting.***

6. **Continuous Quality Improvement (CQI)**
It was mentioned that studies are done on various key performance indicators such as timeliness of sick calls, physical assessments and chronic conditions which are under control/uncontrolled. Are there standard KPIs that are run with some regular frequency or is the data that is pulled more episodic in nature?

RESPONSE: ***Studies are performed regularly and presented at monthly CQI meetings. There are studies performed with regular frequency and others performed episodically. Studies performed in the last year include:***

Nurse Sick call
Expiring psychotropic medications renewed
E-sign electronic consent and refusals
EMR orders for suicide watches
Intake process
Withdrawal protocol
Emergency room transfers
Timeliness of MH referrals and visits
HTN chronic clinic
Medical record accuracy

7. **Sick calls**

Sick call requests	Average per day	Average per month	Average per quarter	Average per Year
	46	*1,338*	*4,015*	*16,000*

a. How many sick visits occur in one month, on average?

RESPONSE: ***2,200***

b. What demographic information is captured about the person submitting the sick call request? Stratifying the data would be useful by REAL data at least (Race/Ethnicity, Age and Language) as well as Sex. (I'm assuming SOGI data isn't collected, i.e., sex, orientation and gender identity.)

RESPONSE: ***Demographic information is imported into the electronic medical record from custody data including Age, Race, Gender ID, and Language spoken.***

c. Can you trend the most common complaints/reasons for sick calls?

RESPONSE: ***Generalized pain, headaches, dental complaints, medication requests***

d. What other trend data is available about the sick calls?

RESPONSE: ***Areas within sick calls which are looked at include timeliness of sick calls; referrals to higher level provider; treatment provided as prescribed.***

e. Which buildings or units do the majority of the calls come from?

RESPONSE: ***Generally speaking, Buildings 2 and 3.***

f. How do these numbers break down by demographic data? Via inmates vs. detainees?

RESPONSE: ***We don't collect this type of information.***

g. The standard is that the concern should be triaged within 8 hours and evaluated by a nurse who can refer to a mid-level provider or MD within 24 hours unless the concern is deemed urgent/emergent. Is this accurate?

RESPONSE: **Yes,** ***Sick call requests are triaged on all three shifts.***

h. Who triages the sick calls and determines what is urgent or emergent?

RESPONSE: ***Registered nurses triage sick calls and determine what is urgent or emergent based upon nurse sick-call protocols..***

i. What percentage of calls are urgent/emergent?

RESPONSE: ***Approx. less than 3% based upon random sampling.***

j. How often is the standard of 8 hrs and 24 hours met? When it is not met, has the facility done a root-cause analysis to understand the contributing factors to the delay?

RESPONSE: ***Studies and audits are performed regularly on the timeliness of sick call visits. Daily root-cause analysis is done to determine contributing factors and work to correct them.***

k. How many sick calls are generated by the individual via the tablet vs. by contact with a nurse or officer?

RESPONSE: ***Approx. 90% are via Tablet.***

l. Is the electronic device equipped in the preferred language of the person using it?

RESPONSE: ***Yes***

8. Chronic care services

Please provide a copy of the evidence-based medical screening guide developed by the Medical Department which outlines guidelines for determining "controlled" versus "uncontrolled" diagnoses of incarcerated individuals.

RESPONSE: ***Please see attachment D.***

9. Medical staffing

a. FTEs broken down by type

RESPONSE: ***Please see Attachment E.***

b. Comments were made that the staffing was changed to reflect gaps in care. What is the context for those statements? We don't have access to those reports/performance-based outcomes that may have prompted a different staffing model.)

RESPONSE: ***Staffing can be changed, based on results of repeated CQI studies. For example, if sick calls are high over a period of time, sick call nurses may be added.***

c. Who is available in the facility (exact site) and across which hours?

RESPONSE: ***Please see Attachment F.***

Who is available on a 24hr basis (exact site/location)?

RESPONSE: ***An administrator, physician, RNs, psychiatrist and a dentist on-call 24 hours per day, seven days per week. There are always at least 1 provider and2 nurses in Main Medical and the Infirmary at all times.***

Also, please summarize/confirm how many hours per week the specialists are on duty.

RESPONSE:

OB/GYN	***12 hours/week***
Orthopedist	***12 hours/week***
Oral Surgeon	***4 hours/week***
Podiatry	***4-8 hours/mo***
Optometry	***4 hours/mo***
Nephrologist	***On-call***

10. Access to care

Please provide data on how frequently (# of visits) inmates/detainees are referred to outside facilities for medical care, including to local hospitals and state forensic hospitals.

RESPONSE:
ER visits - about 22/month
ER/MH crisis - about 2/month
Admissions - about 6/month
Outpatient services - about 23/month

11. Medications

It was reported that approximately 1600/2000 inmates are on meds. Is this accurate?

RESPONSE: ***This is accurate and is reflective of response to COVID-19, including vitamins prescribed to all inmates/detainees. The ECCF has a robust preventative health program, which includes a detox program and MAT program. Additionally, vitamins and supplements are provided to all inmates as a response to COVID-19.***

How many meds is each inmate on average?

RESPONSE: ***About 2***

12. COVID-19 response

a. Please provide the list of criteria for determining which ICE detainees are most vulnerable to contracting COVID-19 and should be recommended for expedited release.

RESPONSE: ***Please see Attachment G.***

b. COVID-19 testing protocols
   i. Please confirm the criteria that leads to the performance of a PCR test since the testing strategy that is largely used is the serological testing of all inmates/detainees.

RESPONSE: ***COVID-19 response plan is based on CDC guidelines. PCR testing has been indicated for pre-ops, transfers, forensic placements, deportations, inmate worker clearances. Also PCR test may be given on a case-by-case basis.***

ii. Please confirm infection prevention protocols in place to ensure a safe environment for all inmates/detainees and staff. For instance, please confirm whether staff undergo temperature screening at the start of each shift and if the temperature is elevated, are these persons queried for other symptoms?

RESPONSE: ***All persons entering the facility are temperature screened. There is medical follow up for anyone with an elevated temp who is employed here. Others are refused entry into the facility.***

13. Immigration detainee-specific

a. How often are ICE medical determinations appealed by the facility?

RESPONSE: ***ICE doesn't allow us to release this information***

b. Please provide records of use of translation services for ICE detainees encountering mental health services.

RESPONSE: ***ICE doesn't allow us to release this information***

c. Please provide brief report on the ICE detainee death that occurred under facility incarceration, including the year, month, and cause of death.

RESPONSE: ***ICE doesn't allow us to release this information***

14. Transitions of Care

What processes (i.e. handoff measures) are in place to ensure safe and effective transitions of care whenever an inmate/detainee moves from one care setting to another, especially upon reentry to community, as well as transitions from the facility to an outside facility?

RESPONSE: The transfer form captures the necessary data to maintain a continuum of care when needed. We have an MAT discharge planner, ACA Discharge Coordinator, ICE liaison and re-entry discharge planning.

15. Staff Training

How often do medical staff and all facility staff complete cultural competency training? How soon will medical staff and all staff undergo implicit bias training? I understand this may just be in the planning/exploration phases.

RESPONSE: ***Cultural competency training is done on an annual basis. ECCF is preparing to implement implicit bias training which will be incorporated into current training curriculum.***

16. Grievances

a. Please provide a breakdown of daily/monthly/weekly averages, common types, and submission demographics.

RESPONSE: ***About 140 medical grievances/sick-calls are received per month. Common reasons include clerical issues (ie., accounts i.e., co-pays), dental complaints, medication requests.***

b. If a person files a grievance related to the care they received or a sick call that was issued, typically how long is the grievance process and what are the KPIs to measure performance?

RESPONSE: ***Grievances are answered within 5 days. Nurses check the grievance database everyday to make sure sick calls are not inadvertently submitted as grievances. If grievances are found to be sick calls, they are addressed as such.***
"KPIs to measure performance?" Performance would generally be measured based on timeliness of visit and if the complaint was addressed.

17. Social Services

Please provide the following data from social services classes:

a. Capacity of classes versus overall interest

RESPONSE: ***6-12 students depending on location of group***

b. Funding status

RESPONSE: ***County and state funding***

c. Demographics of participates (i.e. inmate being resentenced)

RESPONSE: ***Unknown; not being tracked***

d. Waiting list existence or capacity

RESPONSE: ***We maintain a waiting list when needed. However, there is no one on a waiting list at this time.***

18. Custodial Questions

ll it being mentioned that only half of a unit's population is permitted outside of their cells at one time. Roughly how many people is that?

RESPONSE: 32 due to social distancing requirements.

FEMALE GRIEVANCES JANUARY 1ST, 2021 - PRESENT

AVERAGE DAILY POPULATION 94

GRIEVANCE TYPE	NUMBER SUBMITTED	STATUS OF GRIEVANCE	AVERAGE PER MONTH
Account Grievance	10	All Closed	1.6
Classification/Appeal	6	All Closed	1
Commissary	31	All Closed	5.1
Custody	46	1 Pending	7.6
Phones	4	All Closed	0.6
Kitchen	4	All Closed	0.6
Laundry	2	All Closed	0.3
Mail room	6	All Closed	1
Medical	22	All Closed	3.6
Mental Health	0	NA	NA
Religious	7	All Closed	1.1
Social Services	11	All Closed	1.8
Visits	0	NA	0
Total	**149**		

Appendix 9

	Essex County Correctional Facility					Inmate Menu Cycle 1	
	MAIN MENU Enhanced Halal Menu (items in red)					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Sliced Turkey Ham	4 oz		Sirlion Burger (Halal)	4 oz
	Grits	10 oz	Macaroni Salad	8 oz		Mashed Potatoes	8 oz
	Pancakes	3 each	Corn Bread 1/48	1 each		Beef Gravy	2 oz
	Syrup	3 oz	Rice Pudding	4 oz		Mixed Vegetables	4 oz
	Margarine	2 each	Maragrine	2 each		Cookies	1 pack
	Sugar Packet	3 each	Salt & Pepper	1 ech		Bread	2 slice
	Milk	8 oz	Fruit Drink w/ vit C	8 oz		Salt & Pepper	1 each
	Coffee	8 oz				Iced Tea	8 oz
SUNDAY	Banana	1 each	Vegetarian Chili w/ barley (Halal)	12 oz		Baked Chicken	1/4
	Cold Cereal	8 oz	Barley	3 oz		Gravy	2 oz
	Waffles	3 each	Steamed Rice	8 oz		Scalloped Potatoes	8 oz
	Syrup	3 oz	Cake 1/60	1 each		Green Beans	4 oz
	Margarine	2 each	Soft 4.5" taco shell	2 each		Cookies	1 pack
	Sugar Packets	2 each	Fruit Drink w/ vit C	8 oz		Bread	2 slice
	Milk	8 oz	Salt & Pepper	1 each		Margarine	2 each
	Coffee	8 oz				Salt & Pepper	1 each
						Iced Tea	8 oz
MONDAY	Fruit Juice	4 oz	Chicken Franks (Halal)	2 each		Roast Turkey	4 oz
	Grits	10 oz	Sauerkraut	2 oz		Turkey Gravy	2 oz
	Scrambled Eggs	4 oz	Vegetarian Beans	8 oz		Mixed Vegetable	4 oz
	Bread	2 slice	Cake 1/60	1 each		Mashed Potatoes	8 oz
	Margarine	2 each	Hot Dog Rolls	2 each		Cookies	1 pack
	Sugar Packets	2 each	Fruit Drink w/ vit C	8 oz		Corn Bread 1/48	1 each
	Milk	8 oz				Margarine	2 each
	Coffee	8 oz				Iced Tea	8 oz
	Jelly	2 each				Salt & Pepper	1 each
TUESDAY	Fruit Juice	4 oz	Salisbury Steak	4 oz		Chicken Patty (Halal)	3 oz
	Oatmeal	10 oz	Buttered Noodles	8 oz		Scalloped Potatoes	8 oz
	Turkey Sausage Links	2 each	Carrots	4 oz		Carrots	4 oz
	Hash Brown Potatoes	4 oz	Cake 1/60	1 each		Cake 1/60	1 each
	Bread	2 slice	Bread	2 slice		Bread	2 slice
	Margarine	2 each	Margarine	2 each		Margarine	2 each
	Sugar Packets	3 each	Fruit Drink w/ vit C	8 oz		Fruit Drink w/ vit C	8 oz
	Milk	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
WEDNESDAY	Banana	1 each	Curry Chicken (Halal)	4 oz		Baked Ziti w/ meatsauce	12 oz
	Farina	10 oz	Peas	4 oz		Tossed Salad	1/4 C
	French Toast Stcks	3 each	Rice	4 oz		Dressing	1/2 oz
	Syrup	3 oz	Fruit	1 each		Cookies	1 pack
	Syugar Packets	3 each	Bread	2 slice		Corn Bread 1/48	1 each
	Milk	8 oz	Margarine	2 each		Margarine	2 each
	Margarine	2 each	Fruit Drink w/ vit C	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each			
THURSDAY	Fruit Drink	4 oz	Dinner Loaf	4 oz		Meatballs (Halal)	3 oz
	Farina	10 oz	Tossed Salad	4 oz		Brown (Gravy)	2 oz
	Hard Boiled Eggs	2 each	Scalloped Potatoes	4 oz		Peas	4 oz
	Bread	2 slice	Corn Bread 1/48	1 each		Steamed Rice	8 oz
	Margarine	2 each	Cookies	1 pack		Cake 1/60	1 each
	Jelly	2 each	Margarine	2 each		Bread	2 slice
	Sugar Packets	3 each	Fruit Drink w/ vit C	8 oz		Margarine	2 each
	Milk	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each
FRIDAY	Fruit Drink	8 oz	Bean Casserole (Halal)	12 oz		BBQ Chicken (Halal)	4 oz
	Oatmeal	10 oz	Mixed Vegetables	4 oz		Scalloped Potato	8 oz
	Pancakes	3 each	Cottage Fries	4 oz		Tossed Salad	4 oz
	Margarine	2 each	Cake 1/60	1 each		Cookies	1 pack
	Syrup	3 oz	Bread	2 slice		Corn Bread 1/48	1 each
	Sugar Packets	3 each	Fruit Drink w/ vit C	8 oz		Margarine	2 each
	Milk	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each

All items in red are Halal certified friendly meals. 7:00 pm evening Snacks are subject to change on a daily basis

Client Signature		Date		GD Corrections	Date

	Essex County Correctional Facility					Inmate Menu Cycle 2	
	MAIN MENU Enhanced Halal Menu (items in red)					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Meatballs (Halal)	3 oz		Country Patty	3 oz
	Grits	10 oz	Red sauce	2 oz		Scalloped Potatoes	8 oz
	Hard Boiled Eggs	2 each	Mixed Vegatables	4 oz		Carrots	4 oz
	Bread	2 slice	Pasta	8 oz		Cookies	1 pack
	Margarine	2 each	Cake 1/60	1 each		Corn Bread 1/48	1 each
	Sugar Packets	3 each	Bread/Margarine	2 each		Margarine	2 each
	Milk	8 oz	Margarine	2 each		Iced Tea	8 oz
	Coffee	8 oz	Fruit Drink w/C	8 oz		Salt & Pepper	1 each
SUNDAY	Banana	1 each	Sliced Turkey Ham	3 oz		Baked Chicken (bone in)	1 each
	Dry Cereal	8 oz	Potato Salad	8 oz		BBQ Sauce	2 oz
	Pancakes	3 each	Tossed Salad	4 oz		Black-eyed Peas	8 oz
	Margarine	2 each	Salad Dressing	1/2 oz		Rice	8 oz
	Syrup	3 oz	Rice Pudding	4 oz		Cake 1/60	1 each
	Sugar Packets	3 each	Bread	2 slice		Bread	2 slice
	Milk	8 oz	Mustard pc	2 each		Margarine	2 each
	Coffee	8 oz	Fruit Drink w/C	8 oz		Iced Tea	8 oz
			Salt & Pepper	1 each		Salt & Pepper	1 each
MONDAY	Fruit Juice	4 oz	Chicken Franks (Halal)	2 each		Chicken Patty	3 oz
	Farina	10 oz	Sauerkraut	2 oz		Peas	4 oz
	Turkey Sausage Links	2 each	Vegetarian Beans	8 oz		Au Graten Potatoes	8 oz
	Hash Brown Potatoes	4 oz	Mixed Vegatables	4 oz		Cookies	1 pack
	Bread	2 slice	Cake 1/60	1 each		Corn Bread 1/48	1 each
	Margarine	2 each	Hot Dog Rolls	2 each		Iced Tea	8 oz
	Sugar Packets	3 each	Mustard/Ketchup	1 each		Salt & Pepper	1 each
	Milk	8 oz	Fruit Drink w/ vit C	8 oz			
	Coffee	8 oz					
TUESDAY	Fruit Juice	4 oz	Salisbury Steak	4 oz		Sliced Turkey (Halal)	4 oz
	Hot Cereal	10 oz	Gravy	2 oz		Gravy	2 oz
	Waffles	3 each	Carrots	4 oz		Green Beans	4 oz
	Margarine	2 each	Cottage Fries	8 oz		Stuffing	4 oz
	Syrup	3 oz	Cookies	4 oz		Rice Pudding	4 oz
	Sugar Packets	3 each	Bread/Margarine	2 slice		Bread/Margarine	2 slice
	Milk	8 oz	Iced Tea	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
WEDNESDAY	Fruit Juice	4 oz	Seasoned Chicken (Halal)	4 oz		Turkey Sausage	4 oz
	Oatmeal	10 oz	Baked Potato	1 each		Rice/Beans	8 oz
	Scrambled Eggs	4 oz	Tossed Salad	4 oz		Mixed Vegetables	4 oz
	Corn Bread 1/48	1 each	Salad dressing	1/2 oz		Cake 1/60	1 each
	Margarine/Jelly	2 each	Fruit	1 each		Hot Dog Rolls	2 each
	Sugar Packets	2 each	Bread	2 slice		Iced Tea	8 oz
	Milk	8 oz	Margarine	2 each			
	Coffee	8 oz	Fruit Drink w/C	8 oz			
			Salt & Pepper	1 each			
THURSDAY	Fruit Juice	4 oz	Chicken Patty	1 each		Chili	8 oz
	Farina	10 oz	Cottage Fries	8 oz		Peas	4 oz
	Turkey Sausage Links	2 each	Green Beans	4 oz		Seasoned Rice	8 oz
	Hash Brown Potatoes	4 oz	Rice Pudding	4 oz		4 " Tortilla wrap	2 each
	Bread	2 slice	Corn Bread 1/48	1 each		Margarine	2 each
	Margarine	2 each	Ketchup	2 each		Iced Tea	8 oz
	Sugar Packets	3 each	Iced Tea	8 oz		Salt & Pepper	1 each
	Milk	8 oz	Salt & Pepper	1 each			
	Coffee	8 oz					
FRIDAY	Banana	1 each	Baked Ziti W/Meatsauce	12 oz		BBQ Chicken (Halal)	4 oz
	Grits	10 oz	Mozzarella Cheese)	2 oz		Scalloped Potatoes	8 oz
	French Toast Stcks	3 each	Sauce	2 oz		Carrots	4 oz
	Syrup	3 oz	Tossed Salad	4 oz		Cookies	1 pack
	Syugar Packets	3 each	Cake 1/60	1 each		Corn Bread 1/48	1 each
	Milk	8 oz	Bread	2 slice		Margarine	2 each
	Margarine	2 each	Margarine	2 each		Iced Tea	8 oz
	Coffee	8 oz	Iced Tea	8 oz		Salt & Pepper	1 each

All items in red are Halal certified friendly meals. 7:00pm evening Snacks are subject to change on a daily basis

Client Signature	Date	GD Corrections	Date

	Essex County Correctional Facility					Inmate Menu Cycle 3	
	MAIN MENU Enhanced Halal Items (Items in Red)					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Sliced Turkey (Halal)	3 oz		Chicken Patty	4 oz
	Oatmeal	10 oz	Macaroni Salad	8 oz		Gravy	2 oz
	Turkey Sausage Links	2 each	Tossed Salad	4 oz		Peas	4 oz
	Hash Brown Potatoes	4 oz	Salad Dressing	1/2 oz		Cottage Fries	8 oz
	Corn Bread 1/48	1 each	Cake 1/60	1 each		Cookies	1 pack
	Margarine	2 each	Bread	2 slice		Bread	2 slice
	Sugar Packets	3 each	Mustard	2 each		Margarine	2 each
	Milk/Coffee	8 oz	Fruit Drink w/C	8 oz		Iced Tea	8 oz
SUNDAY	Fruit Juice	4 oz	Hamburger	3 oz		Baked Chicken (Halal)	1 each
	Farina	10 oz	Mixed Vegetables	4 oz		Gravy	2 oz
	Waffles	3 each	Scalloped Potatoes	8 oz		Mac & Cheese	8 oz
	Syrup	3 oz	Rice Pudding	4 oz		Green Beans	4 oz
	Margarine	2 each	Hamburger Roll	1 each		Cake 1/60	1 each
	Sugar Packets	3 each	Ketchup	2 each		Bread	2 slice
	Milk	8 oz	Fruit Drink w/ C	8 oz		Margarine	2 each
	Coffee	8 oz				Iced Tea	8 oz
						Salt & Pepper	1 each
MONDAY	Banana	1 each	Meatballs	3 oz		Beef Stew	8 oz
	Dry Cereal	8 oz	Mashed Potatoes	8 oz		Rice	8 oz
	Corn Bread 1/48	1 each	Beef Gravy	2 oz		Carrots	4 oz
	Margarine	2 each	Mixed Vegetables	4 oz		Mixed Vegetables	4 oz
	Jelly	2 each	Cookies	1 pack		Fruit	1 each
	Sugar Packets	3 each	Bread	2 slice		Corn Bread 1/48	1 each
	Milk	8 oz	Margarine	2 each		Margarine	2 each
	Coffee	8 oz	Iced Tea	8 oz		Iced Tea	8 oz
			Salt & Pepper	1 each		Salt & Pepper	1 each
TUESDAY	Fruit Juice	4 oz	Macaron &Cheese w/Ground Chicken	12 oz		Sirlion Beef Burger (Halal)	3 oz
	Grits	10 oz	Green Beans	4 oz		Rice	8 oz
	Scrambled Eggs	4 oz	Cake 1/60	1 each		Carrots	4 oz
	Bread	2 slice	Bread	2 slice		Cookies	1 pack
	Margarine	2 each	Margarine	2 each		Hamburger Roll	1 each
	Sugar Packets	2 each	Fruit Drink w/ C	8 oz		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
	Coffee	8 oz					
WEDNESDAY	Fruit Juice	4 oz	Terryaki Chicken (Halal)	1 each		Salisbury Steak	3 oz
	Oatmeal	10 oz	Baked Potato	1 each		Gravy	2 oz
	French Toast Stcks	3 each	Tossed Salad	4 oz		Peas	4 oz
	Syrup	3 oz	Salad Dressing	1/2 oz		Mashed Potatoes	8 oz
	Syugar Packets	3 each	Corn Bread 1/48	1 each		Cookies	1 pack
	Milk	8 oz	Fruit	1 each		Bread	2 slice
	Margarine	2 each	Margarine	2 each		Margarine	2 each
	Coffee	8 oz	Fruit Drink w/ C	8 oz		Iced Tea	8 oz
			Salt & Pepper	1 each		Salt & Pepper	1 each
THURSDAY	Fruit Juice	4 oz	Chicken Franks (Halal)	2 each		Country Patty	3 oz
	Farina	10 oz	Sauerkraut	2 oz		Rotini	8 oz
	Turkey Sausage Links	2 each	Vegetarian Beans	8 oz		Carrots	4 oz
	Hash Brown Potatoes	4 oz	Fruit	1 each		Rice Pudding	4 oz
	Bread	2 slice	Hot Dog Rolls	2 each		Margarine	2 each
	Margarine	2 each	Mustard	1 each		Iced Tea	8 oz
	Sugar Packets	3 each	Ketchup	1 each		Salt & Pepper	1 each
	Milk	8 oz	Fruit Drink w/ vit C	8 oz			
	Coffee	8 oz					
FRIDAY	Fruit Juice	4 oz	Turkey Sausage (Halal)	3 oz		Curry Chicken (Halal)	4 oz
	Oatmeal	10 oz	Green Beans	4 oz		Rice	8 oz
	Pancakes	3 each	Rice	8 oz		Tossed Salad	4 oz
	Syrup	3 oz	Fruit	1 each		Cookies	1 pack
	Margarine	2 each	Bread	2 each		Bread	2 slice
	Sugar Packet	3 each	Mustard	1 each		Margarine	2 each
	Milk	8 oz	Fruit Drink w/ vit C	8 oz		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each

All items in red are Halal certified friendly meals. 7:00 pm evening Snacks are subject to change on a daily basis

Client Signature		Date		GD Corrections	Date

	Essex County Correctional Facility					Inmate Menu Cycle 4	
	MAIN MENU Enhanced Halal Menu (items in Red)					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Sliced Turkey (Halal)	3 oz		Meatloaf	4 oz
	Oatmeal	10 oz	Peas	4 oz		Mashed Potatoes	8 oz
	Turkey Sausage Links	2 each	Cottage Fries	8 oz		Gravy	2 oz
	Hash Brown Potatoes	4 oz	Cake 1/60	1 each		Mixed Vegatbles	4 oz
	Corn Bread 1/48	1 each	Mayo Packets	2 each		Cookies	1 pack
	Sugar Packets	3 each	Bread	2 slice		Bread	2 slice
	Milk	8 oz	Fruit Drink w/ C	8 oz		Margarine	2 each
	Coffee	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
SUNDAY	Banana	1 each	Macaroni & Cheese	12 oz		BBQ Chicken (Halal)	4 oz
	Dry Cereal	8 oz	Carrots	4 oz		Green Beans	4 oz
	Pancakes	3 each	Tossed Salad	4 oz		Scalloped Potatoes	8 oz
	Syrup	3 oz	Cookies	1 pack		Rice Pudding	4 oz
	Sugar Packets	3 each	Corn Bread 1/48	1 each		Bread	2 slice
	Milk	8 oz	Margarine	2 each		Margarine	2 each
	Coffee	8 oz	Fruit Drink w/ C	8 oz		Iced Tea	8 oz
			Salt & Pepper	1 each		Salt & Pepper	1 each
MONDAY	Fruit Juice	4 oz	Chicken Patty (Halal)	3 oz		Hot Turkey	3 oz
	Grits	10 oz	Steamed Rice	8 oz		Gravy	2 oz
	Hard Boiled Eggs	2 each	Mixed Vegetables	4 oz		Peas	4 oz
	Bread	2 slice	Corn Bread 1/48	1 each		Scalloped Potatoes	8 oz
	Margarine	2 each	Fruit	1 each		Cookies	1 pack
	Sugar Packets	3 each	Fruit Drink w/ C	8 oz		Bread	2 slice
	Milk	8 oz	Salt & Pepper	1 each		Margarine	2 each
	Coffee	8 oz				Iced Tea	8 oz
						Salt & Pepper	1 each
TUESDAY	Banana	1 each	Beef Goulash	10 oz		Turkey Sausage (Halal)	2 each
	Farina	10 oz	Pasta	8 oz		Rice	8 oz
	Pancakes	3 each	Green Beans	4 oz		Carrots	4 oz
	Syrup	3 oz	Fruit	1 each		Cookies	1 paack
	Syugar Packets	3 each	Bread	2 slice		Bread	2 each
	Milk	8 oz	Margarine	2 each		Mustard	2 each
	Margarine	2 each	Fruit Drink w/ C	8 oz		Fruit Drink w/ C	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
WEDNESDAY	Fruit Juice	4 oz	Baked Chicken (Halal)	1/4		Meatballs/gravy	4 oz
	Oatmeal	10 oz	Cottage Fries	8 oz		Mashed Potatoes	8 oz
	Hard Boiled Eggs	2 each	Tossed Salad	4 oz		Carrots	4 oz
	Bread	2 slice	Salad Dressing	1/2 oz		Cake 1/48	1 each
	Margarine	2 each	Cookies	1 pack		Bread	2 slice
	Jelly	2 each	Corn Bread 1/48	1 each		Margarine	2 each
	Sugar Packets	3 each	Fruit Drink w/ C	8 oz		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
	Coffee	8 oz					
THURSDAY	Fruit Juice	4 oz	Sirlion Beef Burger (Halal)	4 oz		Bean Casserole (Vegetarian)	12 oz
	Farina	10 oz	Gravy	2 oz		Summer Medley	4 oz
	Waffles	3 each	Peas	4 oz		Rice	8 oz
	Margarine	2 each	Scalloped Potatoes	8 oz		Cookies	1 pack
	Syrup	3 oz	Cake 1/60	1 each		Corn Bread 1/48	1 each
	Sugar Packets	3 each	Bread	2 slice		Margarine	2 each
	Milk	8 oz	Margarine	2 each		Iced Tea	8 oz
	Coffee	8 oz	Iced Tea	8 oz		Salt & Pepper	1 each
			Salt & Pepper	1 each			
FRIDAY	Fruit Juice	4 oz	Hot Turkey w/gravy	4 oz		Chicken (Halal)	4 oz
	Grits	10 oz	Cottage Fries	8 oz		Curry Sauce	2 oz
	French Toast Stcks	3 each	Tossed Salad/ dressing	4 oz		Mashed Potatoes	8 oz
	Syrup	3 oz	Fruit	1 each		Carrots	4 oz
	Syugar Packets	3 each	Bread	2 slice		Cookies	1 pack
	Milk	8 oz	Margarine	2 each		Corn Bread 1/48	1 each
	Margarine	2 each	Iced Tea	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each

All items in red are Halal certified friendly meals.7:00 pm evening Snacks are subject to change on a daily basis

Client Signature	Date	GD Corrections	Date

ility						Inmate Menu Cycle 5	
N MENU			Enhanced Halal Meals (in red)			Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
S	Fruit Juice	4 oz	Chicken Franks (Halal)	2 each		Chicken Patty	4 oz
A	Oatmeal	10 oz	Sauerkraut	2 oz		Gravy	2 oz
T	Turkey Sausage Links	2 each	Vegetarian Beans	8 oz		Green Beans	4 oz
U	Hash Brown Potatoes	4 oz	Fruit	1 each		Cottage Fries	8 oz
R	Bread	2 slice	Hot Dog Rolls	2 each		Cookies	1 pack
D	Margarine	2 each	Mustard/Ketchup	1 each		Corn Bread 1/48	1 each
A	Sugar Packets	3 each	Tossed Salad	1 each		Iced Tea	8 oz
Y	Milk	8 oz	Fruit Drink w/ vit C	8 oz		Salt & Pepper	1 each
S	Banana	1 each	Baked Ziti	10 oz		Baked Chicken W/ Meatsauc	4 oz
U	Farina	10 oz	Sauce	2 oz		Au Graten Potatoes	8 oz
N	Waffles	3 each	Tossed Salad	4 oz		Peas	4 oz
D	Syrup	3 oz	Dressing	1/2 oz		Cake 1/60	1 each
A	Sugar Packets	3 each	Corn Bread 1/48	1 each		Margarine	2 each
Y	Milk	8 oz	Fruit	1 each		Bread	2 slice
	Coffee	8 oz	Fruit Drink w/ vit C	8 oz		Iced Tea	8 oz
						Salt & Pepper	1 each
M	Fruit Juice	4 oz	Chicken Patty	1 each		Vegetarian Chili	8 oz
O	Grits	10 oz	Sweet Potato	1 each		Rotini	8 oz
N	Scrambled Eggs	4 oz	Seasoned Carrots	4 oz		Mixed Vegetables	4 oz
D	Bread	2 slice	Salt & Pepper	1 each		Salt & Pepper	1 each
A	Margarine	2 each	Cookies	1 pack		Nachos	1/2 cup
Y	Jelly	2 each	Corn Bread 1/48	1 each		Corn Bread 1/48	1 each
	Sugar Packets	3 each	Fruit Drink	8 oz		Fruit Drink	8 oz
	Milk	8 oz					
T	Fruit Juice	4 oz	Turkey Sausage (Halal)	4 oz		Salisbury Steak	4 oz
U	Oatmeal	10 oz	Baked Beans	8 oz		Buttered Noodles	8 oz
E	Turkey sausage Links	2 each	Rice	8oz		Green Beans	4 oz
S	Hash Brown Potatoes	4 oz	Cake 1/60	1 each		Cookies	1 pack
D	Corn Bread 1/48	1 each	Bread	2 slice		Bread	2 slice
A	Margarine	2 each	Tossed Salad	4 oz		Margarine	2 each
Y	Sugar Packets	3 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	2 each		Salt & Pepper	1 each
W	Banana	1 each	BBQ Chicken (Halal)	4 oz		Meatballs	3 oz
E	Dry Cereal	8 oz	Carrots	4 oz		Scallopped Potatoes	8 oz
D	French Toast Sticks	3 each	Rice	8 oz		Beef Gravy	2 oz
N	Margarine	2 each	Fruit	1 each		Mixed Vegetables	4 oz
E	Syrup	3 oz	Corn Bread 1/48	1 each		Rice Pudding	4 oz
S	Sugar Packets	3 each	Fruit Drink	8 oz		Bread	2 slice
D	Milk	8 oz	Salt & Pepper	1 each		Margarine	2 each
A	Coffee	8 oz				Iced Tea	8 oz
Y						Salt & Pepper	1 each
T	Fruit Juice	4 oz	Mac &Cheese w/Ground Chicken	10 oz		Chicken Patty (Halal)	3 oz
H	Grits	10 oz	Green Beans	4 oz		Parsley Potatoes	8 oz
U	Hard Cooked Eggs	2 each	Tossed Salad	1/4 C		Peas	4 oz
R	Bread	2 slice	Corn Bread 1/48	1 each		Bread	2 slice
S	Margarine	2 each	Cookies	1 pack		Cake 1/60	1 each
D	Sugar Packets	3 each	Margarine	2 each		Margarine	2 each
A	Milk	8 oz	Fruit Juice	8 oz		Iced Tea	8 oz
Y	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
			Dressing	1/2 oz			
F	Fruit Juice	4 oz	BBQ Beef Patty	3 oz		Terryaki Chicken (Halal)	4 oz
R	Farina	10 oz	Mixed Vegetables	4 oz		Carrots	4 oz
I	Pancakes	3 each	Seasoned Noodles	8 oz		Mashed Potatoes	8 oz
D	Syrup	3 oz	Fruit	1 each		Cookies	1 pack
A	Sugar Packets	3 each	Hamburger Bun	1 each		Bread	2 slice
Y	Milk	8 oz	Ketchup	2 each		Margarine	2 each
	Margarine	2 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each

All items in red are Halal certified friendly meals. 7:00 pm evening Snacks are subject to change on a daily basis

Client Signature		Date		GD Corrections	Date

	Essex County Correctional Facility					Inmate Menu Cycle 6	
	MAIN MENU Enhanced Halal Menu (items in red)					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Sliced Turkey (Halal)	4 oz		Dinner Loaf	3 oz
	Oatmeal	10 oz	Pasta Salad	8 oz		Seasoned Rice	8 oz
	Turkey Sausage Links	2 each	Rice Pudding	4 oz		Mixed Vegetables	4 oz
	Hash Brown Potatoes	4 oz	Bread	2 slice		Cookies	1 pack
	Bread	2 slice	Fruit Drink	8 oz		Corn Bread 1/48	1 each
	Margarine	2 each	Salt & Pepper	1 each		Margarine	2 each
	Sugar Packets	3 each				Iced Tea	8 oz
	Milk	8 oz				Salt & Pepper	1 each
SUNDAY	Banana	1 each	Beef Patty	4 oz		BBQ Baked Chicken (Halal)	4 oz
	Farina	10 oz	Cottage Fries	8 oz		Chicken Gravy	2 oz
	French Toast Sticks	3 each	Green Beans	4 oz		Mashed Potatoes	8 oz
	Margarine	2 each	Cookies	1 pack		Peas	4 oz
	Syrup	3 oz	Hamburger Bun	1 each		Cake 1/60	1 each
	Sugar Packets	3 each	Ketchup	2 each		Bread	2 slice
	Milk	8 oz	Fruit Drink	8 oz		Margarine	2 each
	Coffee	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
						Salt & Ppper	1 each
MONDAY	Fruit Juice	4 oz	Chicken Patty (Halal)	4 oz		Country Patty	3 oz
	Grits	10 oz	Mixed Vegetables	4 oz		Carrots	4 oz
	Turkey Sausage Links	2 each	Rice	8 oz		Rice	8 oz
	Hash Brown Potatoes	4 oz	Corn Bread 1/48	1 each		Ketchup	2 each
	Bread	2 slice	Cookies	1 pack		Cookies	1 pack
	Margarine	2 each	Fruit Drink	8 oz		Bread	2 slice
	Sugar Packets	3 each	Margarine	2 each		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
	Coffee	8 oz					
TUESDAY	Banana	1 each	Chicken Supreme (6oz chicken 2 oz Sauce)	8 oz		Meatballs (Halal)	3 oz
	Dry Cereal	8 oz	Rice	8 oz		Beef Gravy	2 oz
	Waffles	3 each	Green Beans	4 oz		Green Beans	4 oz
	Margarine	2 each	Corn Bread 1/48	1 each		Noodles	8 oz
	Syrup	3 oz	Fruit	1 each		Rice Pudding	4 oz
	Sugar Packets	3 each	Fruit Drink	8 oz		Bread	2 slice
	Milk	8 oz	Margarine	2 each		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each
WEDNESDAY	Fruit Juice	4 oz	Herb Chicken (Halal)	4 oz		Baked Ziti W/Meatsauce	10 oz
	Grits	10 oz	Rice	8 oz		Tossed Salad	4 oz
	Scrambled Eggs	4 oz	Carrots	4 oz		Salad Dressing	1/2 oz
	Corn Bread 1/48	1 each	Chicken Gravy	2 oz		Cookies	1 pack
	Margarine	2 each	Fruit	1 each		Bread	2 slice
	Jelly	2 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Sugar Packets	3 each	Corn Bread 1/48	1 each		Salt & Pepper	1 each
	Milk	8 oz	Salt & Pepper	1 each			
	Coffee	8 oz					
THURSDAY	Fruit Juice	4 oz	Chicken Franks (Halal)	2 each		Chicken Patty	3 oz
	Oatmeal	10 oz	Sauerkraut	2 oz		Tomato Sauce	2 oz
	Pancakes	3 each	Vegetarian Beans	8 oz		Rotini	8 oz
	Syrup	3 oz	Cottage Fries	8 oz		Mixed Vegetables	4 oz
	Margarine	2 each	Fruit	1 each		Cookies	1 pack
	Sugar Packets	3 each	Hot dog Rolls	2 each		Bread	2 slice
	Milk	8 oz	Ketchup/Mustard	2 each		Iced Tea	8 oz
	Coffee	8 oz	Fruit Drink	8 oz			
			Tossed Salad / Dressing	4 oz			
FRIDAY	Fruit Juice	4 oz	Turkey	4 oz		Curry Chicken (Halal)	4 oz
	Farina	10 oz	Gravy	2 oz		Rice	8 oz
	Hard Cooked Eggs	2 each	Peas	4 oz		Curry Sauce	2 oz
	Bread	2 slice	Mashed Potatoes	8 oz		Carrots	4 oz
	Margarine	2 each	Rice Pudding	4 oz		Cake 1/60	1 each
	Sugar Packets	3 each	Bread	2 slice		Bread	2 slice
	Milk	8 oz	Margarine	2 each		Margarine	2 each
	Coffee	8 oz	Fruit Drink	8 oz		Iced Tea	8 oz

All items in red are Halal certified friendly meals. 7:00 pm evening Snacks are subject to change on a daily basis

Client Signature	Date	GD Corrections	Date

Correctional Food Service

Essex County Correctional Facility

KOSHER FRIDAY DINNER GRAPE JUICE — **Kosher**

Meals are subject to change, this is just a guideline — **1/4/2022**

	Breakfast		Lunch		Dinner	
SATURDAY	**Cold Cereal**	**1 each**	**Boiled Chicken Dinner Meal**	**1 each**		
	Peanut Butter pc	**2oz**	**Grape Juice**	**4 oz**	**Stuffed Shells Dinner Meal**	**1 each**
	Sliced Bread	**2ea**	**Fresh Fruit**	**1 each**	**Grape Juice**	**4 oz**
	Sugar Packets	**3 @**	**Wrapped Challah Roll**	**1 each**	**Fresh Fruit**	**1 each**
	Milk	**2 each**	**Matzoh Crackers**	**2 each**	**Wrapped Challah Roll**	**1 each**
	Coffee pc	**8 oz**	**Tea**	**1**	**Matzoh Crackers**	**2 each**
	Jelly pc	**4ea**	**Honey Packet**	**1**	**Tea**	**1**
			Lemon Packet	**1**	**Lemon Packet**	**1**
			Kosher Soup	**1**	**Honey Packet**	**1**
SUNDAY	**Cold Cereal**	**1 each**				
	Hot Omlette Breakfast Meal	**1**	**Pot Roast Dinner Meal**	**1 each**	**Roasted Chicken Dinner Meal**	**1 each**
	Sliced Bread	**2ea**	**Salt & pepper**	**1 each**	**Salt & pepper**	**1 each**
	Sugar Packets	**3 @**	**Sun cup**	**4 oz**	**Sun cup**	**4 oz**
	Milk	**2 each**	**Fresh Fruit**	**1 each**	**Fresh Fruit**	**1 each**
	Coffee pc	**8 oz**	**Wrapped Challah Roll**	**1 each**	**Wrapped Challah Roll**	**1 each**
	Jelly pc	**4ea**	**Tea**	**1**	**Tea**	**1**
			Lemon Packet	**1**	**Lemon Packet**	**1**
			Honey Packet	**1**	**Honey Packet**	**1**
MONDAY	**Cold Cereal**	**1 each**			**Lasagna**	**1 each**
	Peanut Butter pc	**2oz**	**Manicotti Dinner Meal**	**1 each**	**Salt & pepper**	**1 each**
	Sliced Bread	**2ea**	**Salt & pepper**	**4 oz**	**Sun cup**	**4 oz**
	Sugar Packets	**3 @**	**Sun cup**	**1 each**	**Fresh Fruit**	**1 each**
	Milk	**2 each**	**Fresh Fruit**		**Wrapped Challah Roll**	**1 each**
	Coffee pc	**8 oz**	**Wrapped Challah Roll**	**1 each**	**Tea**	**1**
	Jelly pc	**4ea**	**Tea**	**1**	**Lemon Packet**	**1**
			Lemon Packet	**1**	**Honey Packet**	**1**
			Honey Packet	**1**		
TUESDAY	**Cold Cereal**	**1 each**				
	French Toast Breakfast Meal	**1**	**Braised Veal Dinner Meal**	**1 each**	**Roasted Turkey Dinner Meal**	**1 each**
	Sliced Bread	**2ea**	**Salt & pepper**	**1 each**	**Salt & pepper**	**1 each**
	Sugar Packets	**3 @**	**Sun cup**	**4 oz**	**Sun cup**	**4 oz**
	Milk	**2 each**	**Fresh Fruit**	**1 each**	**Fresh Fruit**	**1 each**
	Coffee pc	**8 oz**	**Wrapped Challah Roll**	**1 each**	**Wrapped Challah Roll**	**1 each**
	Jelly pc	**4ea**	**Tea**	**1**	**Tea**	**1**
			Lemon Packet	**1**	**Lemon Packet**	**1**
			Honey Packet	**1**	**Honey Packet**	**1**
WEDNESDAY	**Cold Cereal**	**1 each**				
	Peanut Butter pc	**2oz**	**Spaghetti & Meatball Meal**	**1 each**	**Stuffed Cabbage Dinner Meal**	**1 each**
	Sliced Bread	**2ea**	**Salt & pepper**	**1 each**	**Salt & pepper**	**1 each**
	Sugar Packets	**3 @**	**Sun cup**	**4 oz**	**Sun cup**	**4 oz**
	Milk	**2 each**	**Fresh Fruit**	**1 each**	**Fresh Fruit**	**1 each**
	Coffee pc	**8 oz**	**Wrapped Challah Roll**	**1 each**	**Wrapped Challah Roll**	**1 each**
	Jelly pc	**4ea**	**Tea**	**1**	**Tea**	**1**
			Lemon Packet	**1**	**Lemon Packet**	**1**
			Honey Packet	**1**	**Honey Packet**	**1**
THURSDAY	**Cold Cereal**	**1 each**				
	Peanut Butter pc	**2oz**	**Roasted Chicken Dinner Meal**	**1 each**	**Pot Roast Dinner Meal**	**1 each**
	Sliced Bread	**2ea**	**Salt & pepper**	**1 each**	**Salt & pepper**	**1 each**
	Sugar Packets	**3 @**	**Sun cup**	**4 oz**	**Sun cup**	**4 oz**
	Milk	**2 each**	**Fresh Fruit**	**1 each**	**Fresh Fruit**	**1 each**
	Coffee pc	**8 oz**	**Wrapped Challah Roll**	**1 each**	**Wrapped Challah Roll**	**1 each**
	Jelly pc	**4ea**	**Tea**	**1**	**Tea**	**1**
			Lemon Packet	**1**	**Lemon Packet**	**1**
			Honey Packet	**1**	**Honey Packet**	**1**
					Roasted Chicken Dinner	**1 each**
FRIDAY	**Cold Cereal**	**1 each**	**Fish Dinner Meal**	**1 each**	**Salt & pepper**	**1 each**
	Omlette Breakfast Meal	**1**	**Salt & pepper**	**1 each**	**Grape Juice**	**4 oz**
	Sliced Bread	**2ea**	**Grape Juice**	**4 oz**	**Fresh Fruit**	**1 each**
	Sugar Packets	**3 @**	**Fresh Fruit**	**1 each**	**Wrapped challah Roll**	**1 each**
	Milk	**2 each**	**Wrapped Challah Roll**	**1 each**	**Matzoh Crackers**	**2 each**
	Coffee pc	**8 oz**	**Matzoh Crackers**	**2 each**	**Kosher Soup**	**1 each**
	Jelly pc	**4ea**	**Tea**	**1**	**Tea**	**1**
			Lemon Packet	**1**	**Lemon Packet**	**1**
			Honey Packet	**1**	**Honey Packet**	**1**

All Entrée portions including casseroles are cooked weight measurements. Side dishes are volume measurements. All combination dishes are ground turkey unless otherwise indicated. All starches, vegetables and cooked cereal are prepared with margarine unless indicated as LF (low fat). No pork is used.

Client Signature — Date — Date

Appendix 10

Cycle Day: 1

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 1

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Ham	4 oz	X	X	X	Sirloin Burger	Sirloin Burger	X	1 Each Grilled Cheese
Macaroni Salad	8 oz	X	4 Oz	4 Oz	X	X	X	X
Tossed Salad	4 oz	X	X	X	X	X	X	X
Italian Dressing	1/2 Fl Oz	X	X	X	X	X	X	X
White Bread	4 Slices	Wheat Bread	2 Slices Wheat Bread	2 Slices Wheat Bread	2 Slices	2 Slices Wheat Bread	X	No
Mustard PC	2 Each	X	X	X	1 Each	1 Each	X	No
Cake	1/60 Slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 1

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Sirloin Burger	4 oz	X	X	X	X	X	X	8 oz Navy Beans
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	Rice	X	X	X
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Potato Chip	1 Each	No	No	No	No	No	No	No

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 2

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chili Con Carne	8 Oz	X	6 Oz	6 Oz	3 oz Hamburger	X	X	12 Oz Veg Chili
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Tortilla	2 Each	X	1 Each	1 Each	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 2

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Baked Chicken Quarter	8 oz	X	X	X	X	X	X	No
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Scalloped Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1/2 cup Frt Cocktail	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Brownie	1 Each	No	No	No	No	No	No	No

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 3

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 3

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Franks	2 Each	1 Each	1 Each	1 Each	4 oz Dcd Chicken	X	X	No
Sauerkraut	2 Oz	X	X	X	4 Oz Mxd Vegetables	X	X	1 Cup Rice
Vegetarian Beans	8 Oz	X	X	X	Rice	X	X	X
Hot Dog Bun	2 Each	1 Each	1 Each	1 Each	2 Slices White Bread	X	X	2 Slices White Bread
Mustard PC	1 Each	X	X	X	No	X	X	2 Each Margarine PC
Ketchup PC	1 Each	No	No	No	No	X	X	No
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 3

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Roll	4 oz	X	X	X	X	X	X	1 Each Veggie Burger
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	Rice	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Duplex Cookies	4 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 4

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Grits PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 4

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Salisbury Patty	4 oz	X	X	X	X	X	X	No
Buttered Noodles	8 oz	X	4 oz	4 oz	X	X	X	10 oz
Carrots	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 4

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	3 oz	X	X	X	4 oz Dcd Chicken	X	X	No
Scalloped Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Pretzels	1 Each	No	No	No	No	No	No	No

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No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 5

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 5

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Curry Baked Chicken Quarters	8 oz	X	X	X	X	X	X	Navy Beans
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 5

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Poultry Patty	No	No	No	No	3 Oz	No	No	No
Ziti with Meat Sauce	8 Oz	X	6 Oz	6 Oz	1 Cup Ziti	X	X	12 Oz Baked Ziti
Broccoli	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Muffin	1 Each	No	No	No	No	No	No	No

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No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 6

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 6

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Dinner Loaf	4 oz	X	X	X	3 oz Hamburger	X	X	1 Each Veggie Burger
Scalloped Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
California Blend Vegetables	4 oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 6

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Meatballs	3 Oz	X	X	X	X	X	X	1 Each Grilled Cheese
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Margarine PC	2 Each	X	X	X	X	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Ice Cream Cup	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 7

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 7

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Vegetarian Beans	12 Oz	X	6 Oz	6 Oz	3 oz Hamburger	X	X	X
Spanish Rice	4 Oz	X	X	X	X	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 7

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
BBQ Chicken Quarter	8 oz	Bkd Chicken	X	X	Bkd Chicken	X	X	Navy Beans
Scalloped Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Broccoli	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Donut	1 Each	No	No	No	No	No	No	No

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No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 8

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 8

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Country Patty	3 oz	3 Oz Meatballs	3 Oz Meatballs	3 Oz Meatballs	3 Oz Poultry Patty	X	X	2 Oz Cheese Mozzar
Marinara Sauce	1/4 cup	X	X	X	No	X	X	X
Spaghetti	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 8

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Nuggets	3 oz	X	X	X	4 oz Dcd Chicken	X	X	8 oz 3 Bn Sld
Scalloped Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Potato Chip	1 Each	No	No	No	No	No	No	No

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 9

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Ham	3 oz	X	X	X	Hamburger	Hamburger	X	1 Each Grilled Cheese
Potato Salad	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Tossed Salad	4 oz	X	X	X	X	X	X	X
Italian Dressing	1/2 Fl Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Mustard PC	2 Each	X	X	X	1 Each	X	X	No
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 9

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
BBQ Chicken Quarter	8 oz	Bkd Chicken	X	X	Bkd Chicken	X	X	No
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Black Eyed Peas	8 oz	X	4 Oz	4 Oz	4 Oz Carrots	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 Slice	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Brownie	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 10

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 10

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Franks	2 Each	1 Each	1 Each	1 Each	3 oz Hamburger	X	X	No
Sauerkraut	2 Oz	X	X	X	No	X	X	8 Oz Rice
Vegetarian Beans	8 Oz	X	4 Oz	4 Oz	Rice	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Hot Dog Bun	2 Each	1 Each	1 Each	1 Each	2 Slices White Bread	X	X	2 Slices White Bread
Mustard PC	1 Each	X	X	X	X	X	X	2 Each Margarine PC
Ketchup PC	1 Each	No	No	No	No	X	X	No
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 10

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	3 oz	X	X	X	4 oz Dcd Chicken	X	X	1 Each Veggie Burger
Au Gratin Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Duplex Cookies	4 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 11

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Grits PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 11

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Cottage Fried Potatoes	8 oz	No	No	No	No	No	No	X
Salisbury Patty	4 oz	X	X	X	X	X	X	8 oz 3 Bn Sld
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Cottage Fried Potatoes	No	8 oz	4 oz	4 oz	8 Oz Rice	8 oz	8 oz	No
Carrots	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 11

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Roll	4 oz	X	X	X	X	X	X	No
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Buttered Noodles	8 oz	X	4 oz	4 oz	X	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Pretzels	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 12

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 12

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Baked Chicken Quarter	8 oz	X	X	X	X	X	X	1 Each Grilled Cheese
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	8 oz Btrd Noodles	X	X	X
Broccoli	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Margarine PC	2 Each	X	X	X	X	X	X	No
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 12

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Sausage	4 oz	X	X	X	3 oz Hamburger	X	X	No
Red Beans w/ Rice	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	10 oz
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Hot Dog Bun	1 Each	X	X	X	2 Slices White Bread	X	X	2 Slices White Bread
Mustard PC	1 Each	X	X	X	X	X	X	2 Each Margarine PC
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Muffin	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 13

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 13

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	3 oz	X	X	X	4 oz Dcd Chicken	X	X	1 Each Veggie Burger
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Ketchup PC	1 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 13

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chili Con Carne	8 Oz	X	6 Oz	6 Oz	3 Oz Poultry Patty	X	X	12 Oz Veg Chili
Seasoned Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
Tortilla	2 Each	X	1 Each	1 Each	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Ice Cream Cup	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 14

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 14

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Poultry Patty	No	No	No	No	3 Oz	No	No	No
Ziti with Meat Sauce	8 Oz	X	6 Oz	6 Oz	8 oz Ziti	X	X	X
California Blend Vegetables	4 oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 14

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
BBQ Chicken Quarter	8 oz	Bkd Chicken	X	X	Bkd Chicken	X	X	3 Bn Sld
Scalloped Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Donut	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 15

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 15

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Roll	3 oz	X	X	X	X	X	X	1 Each Grilled Cheese
Macaroni Salad	8 oz	X	4 Oz	4 Oz	X	X	X	X
Tossed Salad	4 oz	X	X	X	X	X	X	X
Italian Dressing	1/2 Fl Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Mustard PC	1 Each	X	X	X	X	X	X	No
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 15

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	4 oz	X	X	X	Dcd Chicken	X	X	8 oz Navy Beans
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Potato Chip	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 16

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Hamburger	3 oz	X	X	X	X	X	X	1 Each Veggie Burger
Scalloped Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Hamburger Bun	1 Each	X	X	X	X	X	X	X
Ketchup PC	1 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 16

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Baked Chicken Quarter	8 oz	X	X	X	X	X	X	No
Baked Macaroni and Cheese	8 oz	X	X	X	X	X	X	10 oz
Beans Green	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 Slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Brownie	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 17

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 17

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Meatballs	3 Oz	X	X	X	X	X	X	8 Oz Pinto Beans
Brown Gravy	2 Oz	No	X	X	8 oz Btrd Noodles	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	No	X	X	X
Broccoli	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 17

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Beef Stew	8 oz	X	X	X	X	X	X	Veg Stew
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Duplex Cookies	4 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 18

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Grits PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 18

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Goulash	12 Oz	X	6 Oz	6 Oz	6 Oz	X	X	V. Goulash
Beans Green	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 18

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Sirloin Burger	3 oz	X	X	X	X	X	X	1 Each Veggie Burger
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
California Blend Vegetables	4 oz	X	X	X	X	X	X	X
Hamburger Bun	1 Each	X	X	X	X	X	X	X
Ketchup PC	2 Each	X	X	X	1 Each Mustard PC	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Pretzels	1 Each	No	No	No	No	No	No	No

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No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 19

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 19

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Teriyaki Chicken Quarter	8 oz	X	X	X	X	X	X	1 Each Grilled Cheese
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Broccoli	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	No
Margarine PC	2 Each	X	X	X	X	X	X	No
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 19

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Salisbury Patty	3 oz	X	X	X	X	X	X	8 Oz Pinto Beans
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	8 oz Btrd Noodles	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Muffin	1 Each	No	No	No	No	No	No	No

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 20

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 20

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Franks	2 Each	1 Each	1 Each	1 Each	4 oz Dcd Chicken	X	X	8 Oz Rice
Sauerkraut	2 Oz	X	X	X	4 Oz Carrots	X	X	No
Vegetarian Beans	8 Oz	X	4 Oz	4 Oz	Rice	X	X	X
Hot Dog Bun	2 Each	1 Each	1 Each	1 Each	2 Slices White Bread	X	X	2 Slices White Bread
Mustard PC	1 Each	X	X	X	No	X	X	2 Each Margarine PC
Ketchup PC	1 Each	No	No	No	No	X	X	No
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 20

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Country Patty	3 oz	X	X	X	Hamburger	X	X	1 Each Veggie Burger
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Rotini	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Ice Cream Cup	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 21

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 21

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Sausage	4 oz	X	X	X	3 oz Hamburger	X	X	8 oz Navy Beans
Scalloped Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
Hot Dog Bun	1 Each	X	X	X	2 Slices White Bread	X	X	X
Mustard PC	1 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 21

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Curry Baked Chicken Quarters	8 oz	X	X	X	X	X	X	3 Bn Sld
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Donut	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 22

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 22

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Roll	3 oz	X	X	X	X	X	X	1 Each Grilled Cheese
Pasta Salad	8 oz	X	4 Oz	4 Oz	X	X	X	X
Tossed Salad	4 oz	X	X	X	X	X	X	X
Italian Dressing	1/2 Fl Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Mustard PC	1 Each	X	X	X	X	X	X	No
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 22

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Meatloaf	4 Oz	X	X	X	3 oz Hamburger	X	X	8 Oz Pinto Beans
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	Rice	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Potato Chip	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 23

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Meat Mac & Cheese	12 Oz	X	6 Oz	6 Oz	X	X	X	12 oz Mac & Cheese
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 23

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
BBQ Chicken Quarter	8 oz	Bkd Chicken	X	X	Bkd Chicken	X	X	3 Bn Sld
Scalloped Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 Slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Brownie	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 24

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 24

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	4 oz	X	X	X	Dcd Chicken	X	X	1 Each Veggie Burger
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 24

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Roll	3 oz	X	X	X	X	X	X	8 oz Navy Beans
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	8 oz Btrd Noodles	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Duplex Cookies	4 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 25

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Grits PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 25

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Goulash	12 Oz	X	X	X	X	X	X	V. Goulash
Beans Green	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Sausage	4 oz	X	X	X	Dcd Chicken	X	X	1 Each Grilled Cheese
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
Hot Dog Bun	1 Each	X	X	X	2 Slices White Bread	X	X	No
Mustard PC	1 Each	X	X	X	No	X	X	No
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 25

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Pretzels	1 Each	No	No	No	No	No	No	No

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 26

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 26

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Baked Chicken Quarter	8 oz	X	X	X	X	X	X	8 Oz Pinto Beans
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Broccoli	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Dietary Manager _____ Approval Date _____

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 26

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Meatballs	3 Oz	X	X	X	X	X	X	8 oz 3 Bn Sld
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	8 oz Btrd Noodles	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Muffin	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 27

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 27

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Sirloin Burger	4 oz	X	X	X	X	X	X	1 Each Veggie Burger
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Scalloped Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 27

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Vegetarian Beans	12 Oz	X	6 Oz	6 Oz	4 oz Dcd Chicken	X	X	X
Spanish Rice	4 Oz	X	X	X	X	X	X	X
California Blend Vegetables	4 oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Ice Cream Cup	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 28

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 28

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Roll	3 oz	X	X	X	X	X	X	8 oz 3 Bn Sld
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	Rice	X	X	X
Broccoli	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 28

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Curry Baked Chicken Quarters	8 oz	X	X	X	X	X	X	1 Each Veggie Burger
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Donut	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 29

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 29

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Franks	2 Each	1 Each	1 Each	1 Each	3 oz Hamburger	X	X	8 Oz Rice
Sauerkraut	2 Oz	X	X	X	4 Oz Grn Bns	X	X	X
Vegetarian Beans	8 Oz	X	4 Oz	4 Oz	8 oz Btrd Noodles	X	X	X
Hot Dog Bun	2 Each	1 Each	1 Each	1 Each	2 Slices White Bread	X	X	2 Slices White Bread
Mustard PC	1 Each	X	X	X	X	X	X	Margarine PC
Ketchup PC	1 Each	No	No	No	No	X	X	No
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 29

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	4 oz	X	X	X	Dcd Chicken	X	X	1 Each Veggie Burger
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Potato Chip	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 30

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Poultry Patty	No	No	No	No	3 Oz	No	No	No
Ziti with Meat Sauce	8 Oz	X	6 Oz	6 Oz	8 oz Ziti	X	X	12 Oz Baked Ziti
California Blend Vegetables	4 oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 30

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Baked Chicken Quarter	8 oz	X	X	X	X	X	X	8 Oz Pinto Beans
Au Gratin Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Brownie	1 Each	No	No	No	No	No	No	No

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Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 31

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	3 oz	X	X	X	Hamburger	X	X	No
Red Beans w/ Rice	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	10 oz
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 31

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chili Con Carne	8 Oz	X	6 Oz	6 Oz	4 oz Dcd Chicken	X	X	12 Oz Veg Chili
Rotini	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Duplex Cookies	4 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 32

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Grits PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 32

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Sausage	4 oz	X	X	X	3 oz Hamburger	X	X	1 Each Veggie Burger
Scalloped Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
Hot Dog Bun	1 Each	X	X	X	2 Slices White Bread	X	X	2 Slices White Bread
Mustard PC	1 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 32

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Salisbury Patty	3 oz	X	X	X	X	X	X	No
Buttered Noodles	8 oz	X	4 oz	4 oz	X	X	X	10 oz
Beans Green	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Pretzels	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 33

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
BBQ Chicken Quarter	8 oz	Bkd Chicken	X	X	Bkd Chicken	X	X	Navy Beans
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 33

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Meatballs	3 Oz	X	X	X	X	X	X	1 Each Grilled Cheese
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	8 oz Btrd Noodles	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Margarine PC	2 Each	X	X	X	X	X	X	No
Cake	1/60 Slice	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Muffin	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 34

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 34

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Poultry Patty	No	No	No	No	3 Oz	No	No	No
Chili Macaroni	10 oz	X	6 Oz	6 Oz	8 oz Macaroni	X	X	12 Oz Veg Chili
Beans Green	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 34

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	4 oz	X	X	X	Dcd Chicken	X	X	8 Oz Pinto Beans
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	8 Oz Rice	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Ice Cream Cup	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 35

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 35

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Sirloin Burger	4 oz	X	X	X	X	X	X	1 Each Veggie Burger
BBQ Sauce	1 Oz	No	X	X	No	X	X	No
Buttered Noodles	8 oz	X	4 oz	4 oz	X	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Hamburger Bun	1 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 35

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Teriyaki Chicken Quarter	8 oz	X	X	X	X	X	X	3 Bn Sld
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Donut	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 36

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Coleslaw	4 Oz	X	X	X	X	X	X	X
Turkey Roll	3 oz	X	X	X	X	X	X	1 Each Grilled Cheese
Pasta Salad	8 oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Mustard PC	1 Each	X	X	X	X	X	X	No
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 36

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Dinner Loaf	4 oz	X	X	X	Dcd Chicken	X	X	8 Oz Pinto Beans
Seasoned Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
California Blend Vegetables	4 oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Potato Chip	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 37

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 37

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Sirloin Burger	4 oz	X	X	X	X	X	X	1 Each Veggie Burger
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
Hamburger Bun	1 Each	X	X	X	X	X	X	X
Ketchup PC	2 Each	X	X	X	1 Each Mustard PC	X	X	X
Duplex Cookies	2 Each	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 37

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
BBQ Chicken Quarter	8 oz	Bkd Chicken	X	X	Bkd Chicken	X	X	Navy Beans
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	Rice	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Brownie	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 38

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 38

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	4 oz	X	X	X	Dcd Chicken	X	X	1 Each Grilled Cheese
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	No
Margarine PC	2 Each	X	X	X	X	X	X	No
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 38

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Country Patty	3 oz	X	X	X	Hamburger	X	X	1 Each Veggie Burger
Cottage Fried Potatoes	8 oz	X	4 oz	4 oz	Btrd Noodles	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Ketchup PC	2 Each	X	X	X	1 Each Mustard PC	X	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Duplex Cookies	4 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 39

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Grits PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 39

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken A La King	8 Oz	X	X	X	X	X	X	Pinto Beans
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Beans Green	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 39

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Meatballs	3 Oz	X	X	X	X	X	X	No
Brown Gravy	2 Oz	No	X	X	No	X	X	No
Buttered Noodles	8 oz	X	4 oz	4 oz	X	X	X	10 oz
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 Slice	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Pretzels	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 40

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Coffee Cake	2 1/48	X	1/48 Slice	1/48 Slice	X	X	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 40

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Baked Chicken Quarter	8 oz	X	X	X	X	X	X	3 Bn Sld
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
Cornbread	1/48 Slice	X	1 Slice Wheat Bread	2 Slices Wheat Bread	X	X	X	X
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	**No. 16 Scoop**	**2-2 1/4 oz**	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 40

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Poultry Patty	No	No	No	No	3 Oz	No	No	No
Ziti with Meat Sauce	8 Oz	X	6 Oz	6 Oz	8 oz Ziti	X	X	12 Oz Baked Ziti
Broccoli	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Muffin	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 41

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Peanut Butter PC	2 Each	X	X	X	X	X	X	X
Fruit	1 Each	X	X	X	Apple	X	X	X
Cold Cereal	1 1/2 Cup	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	X	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 41

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Franks	2 Each	X	X	X	3 oz Hamburger	X	X	8 Oz Rice
Sauerkraut	2 Oz	X	X	X	4 Oz Mxd Vegetables	X	X	No
Vegetarian Beans	8 Oz	X	X	X	Rice	X	X	X
Hot Dog Bun	2 Each	X	X	X	2 Slices White Bread	X	X	2 Slices White Bread
Mustard PC	1 Each	X	X	X	X	X	X	2 Each Margarine PC
Ketchup PC	1 Each	X	X	X	No	X	X	No
Fruit	1 Each	X	X	X	X	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 41

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Chicken Patty	3 oz	X	X	X	4 oz Dcd Chicken	X	X	No
Mozzarella Cheese	1 Oz	X	X	X	No	X	X	2 Oz
Rotini	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Marinara Sauce	1/4 cup	X	X	X	No	X	X	X
Mixed Vegetables	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Duplex Cookies	2 Each	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	1/2 Cup Applesauce	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Ice Cream Cup	1 Each	No	No	No	No	No	No	No

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Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle 1/4 cup		4 oz Ladle/Spoodle 1/2 cup		8 oz Ladle/Spoodle 1 cup	
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle 1/3 cup		6 oz Ladle/Spoodle 3/4 cup			

Cycle Day: 42

Breakfast

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Fruit Juice	4 Oz	X	X	X	X	X	X	X
Oatmeal PC	1 Each	X	X	X	X	X	X	X
Boiled Eggs	2 Each	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Jelly PC	2 Each	X	1 Each Diet Jelly PC	Diet Jelly PC	X	X	X	X
Milk 1%	1 Each	X	X	X	No	X	X	X
Coffee	1 Cup	X	X	X	X	X	X	X
Sugar PC	2 Each	X	Sugar Sub	Sugar Sub	X	X	X	X

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Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 42

Lunch

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Turkey Roll	3 oz	X	X	X	X	X	X	1 Each Grilled Cheese
Poultry Gravy	2 oz	No	X	X	No	X	X	No
Mashed Potatoes	8 Oz	X	4 Oz	4 Oz	8 oz Btrd Noodles	X	X	X
Peas	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	No
Margarine PC	2 Each	X	X	X	X	X	X	No
Duplex Cookies	2 Each	1 Each Apple	1 Each Apple	1 Each Apple	1 Each Apple	X	X	X
Beverage	8 Oz	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

Cycle Day: 42

Dinner

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Curry Baked Chicken Quarters	8 oz	X	X	X	X	X	X	1 Each Veggie Burger
Rice	8 Oz	X	4 Oz	4 Oz	X	X	X	X
Carrots	4 Oz	X	X	X	X	X	X	X
White Bread	2 Slices	Wheat Bread	1 Slice Wheat Bread	Wheat Bread	X	Wheat Bread	X	X
Margarine PC	2 Each	X	X	X	X	X	X	X
Cake	1/60 slice	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	1/2 cup Frt Cocktail	X	X	X
Iced Tea	1 Cup	X	X	X	X	1 Each Milk 1%	X	X
Salt PC	1 Each	No	X	X	No	X	X	X
Pepper PC	1 Each	X	X	X	X	X	X	X

Evening Snack

	Regular	Cardiac LFat	DB1800	DB2200	Renal	Pregnancy	High Proi Hi	Vegetarian
Donut	1 Each	No	No	No	No	No	No	No

Dietary Manager _____ Approval Date _____

Dietary Consultant Megan Peterson, MS, RD Approval Date 2/10/2022

Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size	Scoop	Size
No. 6 Scoop	6 oz	No. 10 Scoop	3-4 oz	No. 16 Scoop	2-2 1/4 oz	2 oz Ladle/Spoodle	1/4 cup	4 oz Ladle/Spoodle	1/2 cup	8 oz Ladle/Spoodle	1 cup
No. 8 Scoop	4-5 oz	No. 12 Scoop	2 1/2-3 oz	No. 30 Scoop	1-1 1/2 oz	3 oz Ladle/Spoodle	1/3 cup	6 oz Ladle/Spoodle	3/4 cup		

	Essex County Correctional Facility					Inmate Menu Cycle 2	
	COMMON FARE MENU					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Pasta/Beans	8 oz		3 Bean Salad	8 oz
	Grits	10 oz	Mixed Vegatables	4 oz		Scalloped Potatoes	8 oz
	Peanut Butter	2 oz	Mashed Potatoes	8 oz		Carrots	4 oz
	Bread	2 slice	Cake 1/60	1 each		Cookies	1 pack
	Margarine	2 each	Bread/Margarine	2 each		Corn Bread 1/48	1 each
	Sugar Packets	3 each	Margarine	2 each		Margarine	2 each
	Milk	8 oz	Fruit Drink w/C	8 oz		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each
SUNDAY	Banana	1 each	Grilled Cheese (2 slices of cheese)	1 sand		Black-eyed Peas	8 oz
	Dry Cereal	8 oz	Potato Salad	8 oz		Rice	8 oz
	Pancakes	3 each	Tossed Salad	4 oz		Cake 1/60	1 each
	Margarine	2 each	Salad Dressing	1/2 oz		Bread	2 slice
	Syrup	3 oz	Rice Pudding	4 oz		Margarine	2 each
	Sugar Packets	3 each	Bread	2 slice		Iced Tea	8 oz
	Milk	8 oz	Mustard pc	2 each		Salt & Pepper	1 each
	Coffee	8 oz	Fruit Drink w/C	8 oz			
			Salt & Pepper	1 each			
MONDAY	Fruit Juice	4 oz	Vegetarian Beans	8 oz		Vegetable Burger	3 oz
	Farina	10 oz	Mixed Vegatables	4 oz		Corn	4 oz
	Peanut Butter	2 oz	Rice	8 oz		Au Graten Potatoes	8 oz
	Hash Brown Potatoes	4 oz	Cake 1/60	1 each		Cookies	1 pack
	Bread	2 slice	Hot Dog Rolls	2 each		Corn Bread 1/48	1 each
	Margarine	2 each	Mustard/Ketchup	1 each		Iced Tea	8 oz
	Sugar Packets	3 each	Fruit Drink w/ vit C	8 oz		Salt & Pepper	1 each
	Milk	8 oz					
	Coffee	8 oz					
TUESDAY	Fruit Juice	4 oz	3 bean Salad	8 oz		Peanut Butter	4 oz
	Hot Cereal	10 oz	Carrots	4 oz		Summer Medley	4 oz
	Waffles	3 each	Rice	8 oz		Cottage Fries	8 oz
	Margarine	2 each	Cookies	1 pack		Rice Pudding	4 oz
	Syrup	3 oz	Corn Bread 1/60	1 each		Bread/Jelly	4 each
	Sugar Packets	3 each	Margarine	2 each		Iced Tea	8 oz
	Milk	8 oz	Fruit Drink w/C	8 oz		Salt & Pepper	1 each
	Coffee	8 oz	Salt & Pepper	1 each			
WEDNESDAY	Fruit Juice	4 oz	Cheese Sauce	8 oz		Rice/Beans	10 oz
	Oatmeal	10 oz	Baked Potato	1 each		Green Beans	4 oz
	Peanut Butter	2 oz	Tossed Salad	4 oz		Cake 1/60	1 each
	Corn Bread 1/48	1 each	Salad dressing	1/2 oz		Hot Dog Rolls	2 each
	Margarine/Jelly	2 each	Fruit	1 each		Iced Tea	8 oz
	Sugar Packets	2 each	Bread	2 slice			
	Milk	8 oz	Margarine	2 each			
	Coffee	8 oz	Fruit Drink w/C	8 oz			
			Salt & Pepper	1 each			
THURSDAY	Fruit Juice	4 oz	Vegetable Burger	3 oz		Grilled Cheese (2 slices)	1 sand
	Farina	10 oz	Cottage Fries	8 oz		Peas	4 oz
	Peanut Butter	2 oz	Summer Medley	4 oz		Seasoned Rice	8 oz
	Hash Brown Potatoes	4 oz	Rice Pudding	4 oz		Nachos	1 oz
	Bread	2 slice	Hamburger Roll	1 each		Corn Bread 1/60	1 each
	Margarine	2 each	Ketchup	2 each		Margarine	2 each
	Sugar Packets	3 each	Iced Tea	8 oz		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
	Coffee	8 oz					
FRIDAY	Banana	1 each	Pasta Salad	8 oz		Black Beans	6 oz
	Grits	10 oz	Green Beans	4 oz		Scalloped Potatoes	8 oz
	French Toast Stcks	3 each	Cake 1/60	1 each		Carrots	4 oz
	Syrup	3 oz	Bread	2 slice		Cookies	1 pack
	Syugar Packets	3 each	Margarine	2 each		Corn Bread 1/60	1 each
	Milk	8 oz	Iced Tea	8 oz		Margarine	2 each
	Margarine	2 each	Salt & Pepper	1 each		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each

All Entrée portions including casseroles are cooked weight measurements. Side dishes are volume measurements. All combination dishes are ground turkey unless otherwise indicated. All starches, vegetables and cooked cereal are prepared with margarine unless indicated as LF (low fat). No pork is used.

Client Signature		Date		GD Corrections	Date

	Essex County Correctional Facility					Inmate Menu Cycle 4	
	COMMON FARE MENU					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Grilled Cheese (2 slices of cheese)	1 each		Beans	8 oz
	Oatmeal	10 oz	Peas	4 oz		Mashed Potatoes	8 oz
	Peanut Butter	2 oz	Cottage Fries	8 oz		Mixed Vegatbles	4 oz
	Hash Brown Potatoes	4 oz	Cake 1/60	1 each		Cookies	1 pack
	Corn Bread 1/48	1 each	Bread	2 slice		Bread	2 slice
	Sugar Packets	3 each	Fruit Drink w/ C	8 oz		Margarine	2 each
	Milk	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
	Coffee	8 oz					
SUNDAY	Banana	1 each	Macaroni & Cheese	10 oz		3 Bean Salad	8 oz
	Dry Cereal	8 oz	Carrots	4 oz		Green Beans	4 oz
	Pancakes	3 each	Cookies	1 pack		Sweet Potatoes	8 oz
	Syrup	3 oz	Corn Bread 1/48	1 each		Rice Pudding	4 oz
	Sugar Packets	3 each	Margarine	2 each		Bread	2 slice
	Milk	8 oz	Fruit Drink w/ C	8 oz		Margarine	2 each
	Coffee	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
						Salt & Pepper	1 each
MONDAY	Fruit Juice	4 oz	Vegetable Burger	3 oz		Peanut Butter	3 oz
	Grits	10 oz	Steamed Rice	8 oz		Peas	4 oz
	Peanut Butter	2 oz	Corn	4 oz		Scalloped Potatoes	8 oz
	Bread	2 slice	Corn Bread 1/48	1 each		Cookies	1 pack
	Margarine	2 each	Fruit	1 each		Bread	2 slice
	Sugar Packets	3 each	Fruit Drink w/ C	8 oz		Margarine	2 each
	Milk	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each
TUESDAY	Banana	1 each	Beans	6 oz		Pasta Salad	8 oz
	Farina	10 oz	Rice	8 oz		Pasta	8 oz
	Pancakes	3 each	Carrots	4 oz		Peas	4 oz
	Syrup	3 oz	Cookies	1 paack		Bread Pudding	4 oz
	Syugar Packets	3 each	Bread	2 slice		Bread	2 slice
	Milk	8 oz	Corn Bread 1/48	1 each		Margarine	2 each
	Margarine	2 each	Fruit Drink w/ C	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
WEDNESDAY	Fruit Juice	4 oz	Grilled Cheese (2 slices of cheese)	1 each		Beans	8 oz
	Oatmeal	10 oz	Cottage Fries	8 oz		Mashed Potatoes	8 oz
	Peanut Butter	2 oz	Tossed Salad	4 oz		Carrots	4 oz
	Bread	2 slice	Salad Dressing	1/2 oz		Cake 1/48	1 each
	Margarine	2 each	Cookies	1 pack		Bread	2 slice
	Jelly	2 each	Corn Bread 1/48	1 each		Margarine	2 each
	Sugar Packets	3 each	Fruit Drink w/ C	8 oz		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
	Coffee	8 oz					
THURSDAY	Fruit Juice	4 oz	Veggie Burger	3 oz		Tomato Sauce	8 oz
	Farina	10 oz	Carrots	4 oz		Pasta	8 oz
	Waffles	3 each	Scalloped Potatoes	8 oz		Summer Medley	4 oz
	Margarine	2 each	Cake 1/60	1 each		Cookies	1 pack
	Syrup	3 oz	Bread	2 slice		Corn Bread 1/48	1 each
	Sugar Packets	3 each	Margarine	2 each		Margarine	2 each
	Milk	8 oz	Iced Tea	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
FRIDAY	Fruit Juice	4 oz	Bulk Peanut Butter	4 oz		3 Bean Salad	8 oz
	Grits	10 oz	Cottage Fries	8 oz		Gravy	2 oz
	French Toast Stcks	3 each	Tossed Salad/ dressing	4 oz		Mashed Potatoes	8 oz
	Syrup	3 oz	Fruit	1 each		Carrots	4 oz
	Syugar Packets	3 each	Bread	2 slice		Cookies	1 pack
	Milk	8 oz	Margarine	2 each		Corn Bread 1/48	1 each
	Margarine	2 each	Iced Tea	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each

All Entrée portions including casseroles are cooked weight measurements. Side dishes are volume measurements. All combination dishes are ground turkey unless otherwise indicated. All starches, vegetables and cooked cereal are prepared with margarine unless indicated as LF (low fat). No pork is used.

Client Signature	Date	GD Corrections	Date

	Essex County Correctional Facility					Inmate Menu Cycle 5	
	COMMON FARE MENU					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Pasta Veg Salad	8 oz		Beans	8 oz
	Oatmeal	10 oz	Rice Pudding	4 oz		Cottage Fries	8 oz
	Peanut Butter	2 oz	Bread	2 slice		Cookies	1 pack
	Hash Brown Potatoes	4 oz	Mustard/Mayo	2 each		Corn Bread 1/48	1 each
	Bread	2 slice	Fruit Drink w/ C	8 oz		Iced Tea	8 oz
	Margarine	2 each				Salt & Pepper	1 each
	Sugar Packets	3 each					
	Milk	8 oz					
SUNDAY	Banana	1 each	Grilled Cheese (2 slices of cheese)	1 each		Black Beans	8 oz
	Farina	10 oz	Sauerkraut	2 oz		Au Graten Potatoes	8 oz
	Waffles	3 each	Vegetarian Beans	8 oz		Peas	4 oz
	Syrup	3 oz	Fruit	1 each		Cake 1/60	1 each
	Sugar Packets	3 each	Hamburger Roll	1 each		Margarine	2 each
	Milk	8 oz	Ketchup pc	1 pack		Bread	2 slice
	Coffee	8 oz	Fruit Drink w/ vit C	8 oz		Iced Tea	8 oz
						Salt & Pepper	1 each
MONDAY	Fruit Juice	4 oz	Tomato Sauce	8 oz		Beans	8 oz
	Grits	10 oz	Rotini	8 oz		Mashed Potatoes	8 oz
	Peanut Butter	2 oz	Tossed Salad	4 oz		Seasoned Carrots	4 oz
	Bread	2 slice	Dressing	1/2 oz		Rice Pudding	4 oz
	Margarine	2 each	Nachos	1/2 cup		Bread	2 slice
	Jelly	2 each	Corn Bread 1/48	1 each		Margarine	2 each
	Sugar Packets	3 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	1 each		Salt & Pepper	1 each
TUESDAY	Fruit Juice	4 oz	Veggie Burger	3 oz		Tomato Sauce	8 oz
	Oatmeal	10 oz	Baked Beans	8 oz		Buttered Noodles	8 oz
	Peanut Butter	2 oz	Cottage Fries	8 oz		Green Beans	4 oz
	Hash Brown Potatoes	4 oz	Cake 1/60	1 each		Cookies	1 pack
	Corn Bread 1/48	1 each	Hamburger Bun	1 each		Bread	2 slice
	Margarine	2 each	Ketchup	2 each		Margarine	2 each
	Sugar Packets	3 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Milk	8 oz	Salt & Pepper	2 each		Salt & Pepper	1 each
WEDNESDAY	Banana	1 each	3 Bean Salad	8 oz		Peanut Butter	3 oz
	Dry Cereal	8 oz	Carrots	4 oz		Scallopped Potatoes	8 oz
	French Toast Sticks	3 each	Rice	8 oz		Mixed Vegetables	4 oz
	Margarine	2 each	Fruit	1 each		Rice Pudding	4 oz
	Syrup	3 oz	Corn Bread 1/48	1 each		Bread	2 slice
	Sugar Packets	3 each	Fruit Drink	8 oz		Margarine	2 each
	Milk	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
	Coffee	8 oz					
THURSDAY	Fruit Juice	4 oz	Mac & Cheese	10 oz		Beans	8 oz
	Grits	10 oz	Carrots	4 oz		Parsley Potatoes	8 oz
	Peanut Butter	2 oz	Cookies	1 pack		Peas	4 oz
	Bread	2 slice	Corn Bread 1/48	1 each		Bread	2 slice
	Margarine	2 each	Margarine	2 each		Cake 1/60	1 each
	Sugar Packets	3 each	Fruit Juice	8 oz		Margarine	2 each
	Milk	8 oz	Salt & Pepper	1 each		Iced Tea	8 oz
	Coffee	8 oz				Salt & Pepper	1 each
FRIDAY	Fruit Juice	4 oz	Grilled Cheese (2 slices of cheese)	1 each		Green Beans	4 oz
	Farina	10 oz	Mixed Vegetables	4 oz		Mashed Potatoes	8 oz
	Pancakes	3 each	Seasoned Noodles	8 oz		Cookies	1 pack
	Syrup	3 oz	Fruit	1 each		Bread	2 slice
	Sugar Packets	3 each	Fruit Drink	8 oz		Margarine	2 each
	Milk	8 oz				Iced Tea	8 oz
	Margarine	2 each				Salt & Pepper	1 each
	Coffee	8 oz					

All Entrée portions including casseroles are cooked weight measurements. Side dishes are volume measurements. All combination dishes are ground turkey unless otherwise indicated. All starches, vegetables and cooked cereal are prepared with margarine unless indicated as LF (low fat). No pork is used.

Client Signature		Date		GD Corrections	Date

	Essex County Correctional Facility					Inmate Menu Cycle 6	
	COMMON FARE MENU					Weekly Average 3000 calories per day	
	Breakfast		Lunch			Dinner	
SATURDAY	Fruit Juice	4 oz	Grilled Cheese (2 slices of cheese)	1 each		Vegetable Rice	10 oz
	Oatmeal	10 oz	Pasta Salad	8 oz		Mixed Vegetables	4 oz
	Peanut Butter	2 oz	Rice Pudding	4 oz		Cookies	1 pack
	Hash Brown Potatoes	4 oz	Bread	2 slice		Corn Bread 1/48	1 each
	Bread	2 slice	Fruit Drink	8 oz		Margarine	2 each
	Margarine	2 each	Salt & Pepper	1 each		Iced Tea	8 oz
	Sugar Packets	3 each				Salt & Pepper	1 each
	Milk	8 oz					
SUNDAY	Banana	1 each	Vegetable Burger	3 oz		Beans	6 oz
	Farina	10 oz	Cottage Fries	8 oz		Mashed Potatoes	8 oz
	French Toast Sticks	3 each	Green Beans	4 oz		Peas	4 oz
	Margarine	2 each	Cookies	1 pack		Cake 1/60	1 each
	Syrup	3 oz	Hamburger Bun	1 each		Bread	2 slice
	Sugar Packets	3 each	Ketchup	2 each		Margarine	2 each
	Milk	8 oz	Fruit Drink	8 oz		Iced Tea	8 oz
	Coffee	8 oz	Salt & Pepper	1 each		Salt & Ppper	1 each
MONDAY	Fruit Juice	4 oz	Baked Potato	1 each		Bulk Peanut Butter	3 oz
	Grits	10 oz	Tossed Salad	8 oz		Carrots	4 oz
	Peanut Butter	2 oz	Salad Dressing	1/2 oz		Rice	8 oz
	Hash Brown Potatoes	4 oz	Corn Bread 1/48	1 each		Cookies	1 pack
	Bread	2 slice	Fruit	1 each		Bread	2 slice
	Margarine	2 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Sugar Packets	3 each	Margarine	2 each		Salt & Pepper	1 each
	Milk	8 oz	Salt & Pepper	1 each			
	Coffee	8 oz					
TUESDAY	Banana	1 each	Beans	6 oz		Cornchip & Bean salad	10 oz
	Dry Cereal	8 oz	Mixed Vegetables	4 oz		Taco	
	Waffles	3 each	Rice	8 oz		Green Beans	
	Margarine	2 each	Corn Bread 1/48	1 each		Mashed Potatoes	4 oz
	Syrup	3 oz	Cookies	1 pack		Rice Pudding	4 oz
	Sugar Packets	3 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Milk	8 oz				Salt & Pepper	1 each
	Coffee	8 oz					
WEDNESDAY	Fruit Juice	4 oz	Vegetarian Beans	6 oz		Sauce	3 oz
	Grits	10 oz	Rice	8 oz		Pasta	8 oz
	Peanut Butter	2 oz	Carrots	4 oz		Peas	4 oz
	Corn Bread 1/48	1 each	Chicken Gravy	2 oz		Cookies	1 pack
	Margarine	2 each	Fruit	1 each		Bread	2 slice
	Jelly	2 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Sugar Packets	3 each	Corn Bread 1/48	1 each		Salt & Pepper	1 each
	Milk	8 oz	Salt & Pepper	1 each			
	Coffee	8 oz					
THURSDAY	Fruit Juice	4 oz	Vegetarian Beans	6 oz		Veggie Burger	3 oz
	Oatmeal	10 oz	Cottage Fries	8 oz		Rotini	8 oz
	Pancakes	3 each	Fruit	1 each		Mixed Vegetables	4 oz
	Syrup	3 oz	Hot dog Rolls	2 each		Cookies	1 pack
	Margarine	2 each	Ketchup/Mustard	2 each		Bread	2 slice
	Sugar Packets	3 each	Fruit Drink	8 oz		Iced Tea	8 oz
	Milk	8 oz					
	Coffee	8 oz					
FRIDAY	Fruit Juice	4 oz	Grilled Cheese (2 slices of cheese)	1 each		Bulk Peanut Butter	3 oz
	Farina	10 oz	Peas	4 oz		Rice	8 oz
	Peanut Butter	2 oz	Mashed Potatoes	8 oz		Jelly	2 each
	Bread	2 slice	Rice Pudding	4 oz		Carrots	4 oz
	Margarine	2 each	Bread	2 slice		Cake 1/60	1 each
	Sugar Packets	3 each	Margarine	2 each		Bread	2 slice
	Milk	8 oz	Fruit Drink	8 oz		Margarine	2 each
	Coffee	8 oz				Iced Tea	8 oz

All Entrée portions including casseroles are cooked weight measurements. Side dishes are volume measurements. All combination dishes are ground turkey unless otherwise indicated. All starches, vegetables and cooked cereal are prepared with margarine unless indicated as LF (low fat). No pork is used.

Client Signature		Date		GD Corrections	Date

Appendix 11

CFG HEALTH SYSTEMS, LLC

ESSEX COUNTY DEPARTMENT OF CORRECTIONS
MEDICALLY ASSISTED TREATMENT PROGRAM
354 DOREMUS AVENUE
NEWARK, NJ 07105
973-274-7780 (P) ~ 973-274-6996 (F)

Dr. Lionel Anicette
Medical Director

Alfaro Ortiz, Jr.
Director

Medication Assistant Treatment (MAT) – Medication Opioid Use Disorder (MOUD)

Essex County Corrections Medication Assisted Treatment program began in April 2020. This program was implemented to provide treatment to the inmates who have been identified to have an Opiate use disorder or Alcohol use disorder. Prior to the implementation of the MAT program ECCF was treating individuals who had an OUD or AUD with the detoxification medicine.

Intake:
As part of the incarceration process at Essex County Jail the medical department conducts a rigorous medical evaluation on all new admissions. The clients are greeted by our nursing staff who is either a Licensed Practical Nurse or Registered Nurse. The Nursing staff complete Nursing

Screening Tool which consist of the following sections;

- Vital Signs
- Review of Symptoms
- Post medical
- Mental health Questions
- Covid – 19 testing
- Pregnancy testing for all female inmates
- Clinical Institute Withdrawal Assessment for Alcohol (CIWA) and Clinical Opiate Withdrawal Scale (COW's) screening tool

The Nursing screening tool assist the medical practitioner to determine the proper medication to prescribe the clients during their incarceration. Upon completion of the Nurse intake the nurses will notify the medical practitioner with the clients name and information, so they can schedule an appointment with the client.

The Medical practitioner has within 3 days to meet with the referral unless it is an emergency, the client will be met immediately. The medical practitioners will complete the Practitioners Intake/Assessment form which consist of;

- Social History
- Medical Screening
- Review of CIWA's and COWS screening tool
- General Health Assessment

The clients that have scored 5 or more on the CIWA's Or COW's will be placed on the withdrawal protocol and will be referred to the MAT Department for further evaluation for admission into their program. The MAT team has with 3 days to meet with the clients and determine program eligibility for either MAT/ MOUD program.

Screening:

The MAT Department receives and reviews all referrals on the next business day. Prior to meeting with the clients the treatment team reviews the nurse's assessment and the Practitioners assessment. After reviewing the documentation the MAT/ MOUD staff will meet with the client and complete a questionnaire that consists of;

- Basic Demographics
- Addiction History
- Treatment history
- Mental history
- Medical History
- Consent forms
- Treatment goals
- Treatment needs
- Urine drug screen will be requested

The clients that have meet criteria for the MAT/ MOUD program will be referred to the Medical practitioner for medication consultation. The medical practitioner will discussed the MAT/MOUD medications, the side effects of the prescribing medication, and dosage. The clients will sign

a consent form stating they understand the medication being prescribed to them, and will are informed they can request to be removed from the medication at any time.

Those that do not meet criteria or have requested to be removed from the MAT/MOUD program will be referred to the non-medication assisted program, where they will receive counseling, groups and case management services.

Medication practices:

Essex County MAT program are able to provide the following medication to assist clients cope with the withdrawal symptoms they may be experiencing from the not using the following substances:

- Alcohol
- Benzodiazepine
- Opiate

The medications that are administered at ECCF are;

- Suboxone oral / injectable
- Vivtrol oral/injectable
- Gabapentin

The clients that are pregnant or on high dose of methadone are referred to Khalidescope Methadone clinic for treatment. The Medical Director reviews the case and will schedule the referral, and monitor the client's treatment during their incarceration.

The medical practitioners meet with the clients and will determine the proper medication dosage to prescribe. The medical doctor reviews the following information;

- Information gathered from the CIWA's and/or COWS
- Information gathered from their assessment
- Information gathered from the Urine Drug Screen
- Information gathered from the MAT staff
- Additional information from outside prescriber or pharmacy confirming client's medication dosage, treatment, and last prescription.

Once the clients are enrolled in the program, they are then placed on the MAT roster and they will be meeting with the MAT Officer who will formally introduce himself and explain the medication process. The MAT officer will gather information from the client, to further assist and prepare the clients discharge plan.

Essex County Correctional Facility (ECCF) Medication Assistant Treatment Program is currently medicating 119 participants with Suboxone. In an effort, to increase recovery and decrease relapse potential the MAT program has partnered with ECCF Addiction programs to increase activities for the participants. The participants receive Narcan training, access to the 24/7 free recovery hotline and recovery movie which are located on the Tablet. The addiction program has provided the participants with access to Self-help meetings via pamphlets. Currently the MAT program have 75 participants that meet the Co-Occurring Criteria. These participants meet with both the Mental Health Department and MAT Department staff to treat their Co-occurring disorder. These participants receive the following services;

- Individual Counseling
- Co-Occurring Worksheets
- Continuing Care plan
- Random Urine Drug Test
- Narcan Training
- Treatment team Intervention

January 1, 2021 the Medication Opioid Use Disorder (MOUD) program was implemented, this program is geared towards servicing individuals that meet the criteria for Opioid Use Disorder. This program was implemented to provide services to individuals who meet criteria for MAT medication but are not receiving full services as those who are in the MAT Full program. The participants still follow the admission guide lines as those who are enrolled in the MAT full program. The Medical Staff use the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) and Clinical Opiate Withdrawal Scale (COW's) to assess the severity of the participant's withdrawal symptoms. If the participant scores between 3 and 5 on either screening tool they can be placed in the MOUD program. These participants will receive the following services during treatment;

- Random Urine drug test
- Continuing care plan
- Addiction Worksheets
- Medication monitoring
- Narcan Training
- Treatment Team Intervention

In Addition to the MOUD program, ECCF has implemented the treatment team intervention program. The purpose of the intervention program is to meet with individuals who have tested positive for illicit substances, cheeked their medication, and displayed some negative behaviors during their involvement in the program. The intervention team consist of;

- Director Ortiz of Essex County Jail
- Dr. Anicette Medical Director of Essex County Jail
- Ms. Augustin Medication Assistant Treatment Program Coordinator

- Officer Morgan Medication Assistant Treatment officer and Patient Navigator

Each team member speaks to the participants and allows them the opportunity to share their concerns, and struggles with addiction. At the end of each intervention the participants receive a treatment plan modification that can consist of housing change, medication review, and clinical intervention by mental health or MAT program.

Upon release the participants are monitored for 9 months by our Discharge planner and MAT Officer/ Patient Navigator. The Discharge planner and Patient Navigator work with the community partners to assure that the participants are compliant with treatment, medication compliant, employed, stable living environment and have a positive support network. The MAT/MOUD program primary focus is to reduce relapse, drug overdose and recidivism.

Other Community Programs for MAT

1. Drug Court
2. Eden 8
3. NJCRI
4. Northwest Essex Counseling
5. Northern NJ Medication-Assisted Treatment
6. Trinitas Regional Medical Center
7. Victims of Crime
8. Suburban Medical Services
9. Lennard Clinic
10. American Habitare Counseling
11. Dr. Churman – Private Doctor for bupe prescription
12. Homeless Solutions
13. Partners Prevention

Appendix 12

Order Form : UNASSIGNED ORDER FORM
Friday, September 11, 2020 10:53

Name : _____ CIN : _____ Balance : _____

Block : _____ Tier : _____ Cell : _____

PERSONAL CARE PRODUCTS			
0010	____	ALBERTO VO5 SHAMPOO	1.67
0011	____	ALBERTO VO5 CONDITIO	2.00
0020	____	4OZ DANDRUFF SHAMPOO	0.69
0045	____	AFRICAN CROWN HAIRDR	2.12
0051	____	HAIRDRESS & PRESS OI	1.92
0055	____	PRO GLO GEL POMADE	1.92
0106	____	P-UP WOMENS A/P DEOD	1.81
0121	____	1.5 OZ FRESHSCENT RO	0.54
0200	____	4OZ BABY POWDER	1.15
0214	____	COCOA & SHEA COND LO	2.16
0249	____	HYDROCORTISONE CREAM	1.50
0251	____	GEN TINACTIN(TOLNAFT	1.43
0273	____	LIP BALM	1.11
0320	____	REG MAGIC CREAM SHAV	3.08
0331	____	PRO-TECTION SHAVE CR	1.05
0350	____	AFTER SHAVE	1.15
0397	____	NEXT1 COCOA BTTR SOA	0.85
0424	____	MOISTURIZING SOAP 5	0.85
0426	____	SPORT BAR SOAP	0.85
0500	____	8-OZ MOUTHWASH ORAL	1.54
0510	____	CAVITY TOOTHPASTE MI	2.38
0530	____	COOL WAVE CLR TOOTHP	1.69
0557	____	ANTISHANK TOOTHBRUSH	0.62
0572	____	COLD, COUGH, FLU	0.46
0577	____	MEDI-SELTZER	0.51
0580	____	TOOTHBRUSH HOLDER	0.38
0581	____	APAP(LIKE X STGTH TY	0.31
0583	____	IBUPROFEN 2 PK	0.31
0590	____	DENTURE TABLET	2.35
0596	____	ORAFIX DENTURE BATH	2.00
0636	____	MILK OF MAGNESIA	3.08
0680	____	MN MULTIVITAMIN NO I	2.10
0685	____	VITAMIN C 500 MG	2.10
0700	____	DOUCHE VINEGAR & WAT	2.31
0711	____	MAXI PAD-SUPER	2.54
0713	____	PANTY LINERS 22CT.	1.62
0720	____	FOOT POWDER	2.15
0731	____	DIPHEN (LIKE BENADRY	0.38
0750	____	NAIL CLIPPER NO FILE	0.38
0760	____	COTTON SWABS 100CT B	1.54
0835	____	WAVE ENFORCER WAVE C	2.31
0854	____	FOAM ROLLERS LRG.	1.43
0855	____	PONYTAIL HOLDER	0.19
TABLET TIME**			
9801	____	TELMATE TABLET TIME	1.00
MISCELLANEOUS			
0216	____	COCOA BUTTER STICK 1	1.47
0490	____	SOAP DISH	0.38
0595	____	2.5OZ EFFERGRIP	3.65
1001	____	LARGE STAMPED ENVELO	0.70
1010	____	#10 WHITE ENVELOPE	0.04
1015	____	MANILLA ENVELOPE	0.25
1049	____	1 EACH 1ST CLASS STA	0.61
1060	____	8.5 X 11 LETTER PAD	1.10
1068	____	SECURITY PEN-BLACK	0.88
1070	____	SKETCH PAD 8.5 X 11	0.81
1087	____	SPANISH ENGLISH DICT	1.54
1100	____	BIRTHDAY CARD W/O ST	1.50
1101	____	JUVENILE BIRTHDAY CA	1.50
1105	____	GET WELL CARD - ACET	1.50
1110	____	FRIENDSHIP CARD - AC	1.50
1115	____	ANNIVERSARY CARD W/O	1.50
1120	____	THANK YOU CARD W/O S	1.50
1121	____	SEASONAL GREETING CA	1.50
1123	____	SPANISH BIRTHDAY CAR	1.50
1124	____	SPANISH FRIENDSHIP C	1.50
1150	____	BIBLE	10.38
1152	____	PRAYER RUG	13.08
1166	____	EAR BUD	1.92
1206	____	AAA 1/EA ION3 BATTER	0.65
1213	____	AA BATTERY 1EA	0.66
1217	____	KOSS HEADPHONES	3.50
1249	____	RADIO DIGITAL AM FM	26.40
1300	____	AVIATOR PLAYING CARD	1.46
1305	____	PINOCHLE CARDS	1.46
1400	____	GEN BOWL W/ID 24 OZ	0.65
1401	____	BOWL 1.6 QT	2.12
1411	____	COFFEE CUP W/ HANDLE	0.85
1415	____	CUP W/LID 22 OZ WHIT	0.94
1430	____	WASHCLOTH WHITE	0.45
1440	____	BATH TOWEL BEIGE	6.08
1450	____	SM. SHOWER SHOE	0.95
1451	____	MED. SHOWER SHOE	0.95
1452	____	LG. SHOWER SHOE	0.95
1470	____	LAUNDRY DETERGENT	0.54
1498	____	MEN BRIEFS 3XL	3.73
1499	____	MEN''S BRIEFS 4XL	3.73
1504	____	SMALL T-SHIRT	2.96
1505	____	MED T-SHIRT	2.96
1506	____	LG T-SHIRT	2.96
1507	____	XLG T-SHIRT	2.96
1508	____	XXLG T-SHIRT	5.38
1509	____	3X LARGE T-SHIRT	5.38
1514	____	MEN BRIEFS SMALL	2.00
1515	____	MEN BRIEFS MED	2.00
1516	____	MEN BRIEFS LRG	2.00
1517	____	MEN BRIEFS XL	2.00
1518	____	MEN BRIEFS 2XL	3.73
1529	____	SM BOXER SHORTS WHIT	3.08
1530	____	MED BOXER SHORTS WHI	3.08
1531	____	LG BOXER SHORTS WHIT	3.08
1532	____	XLG BOXER SHORTS WHI	3.08
1533	____	2XLG BOXER SHORTS WH	3.08
1534	____	3XLG BOXER SHORTS WH	5.38
1540	____	TUBE SOCK (ONE SIZE	1.60
1551	____	MED THERMAL TOP	3.85
1552	____	LRG THERMAL TOP	3.85
1553	____	XL THERMAL TOP	3.85
1554	____	2XL THERMAL TOP	4.62
1555	____	3XL THERMAL TOP	4.62
1556	____	THERMAL TOP 4XLG	4.62
1561	____	MED THERMAL BOTTOMS	3.85
1562	____	LRG THERMAL BOTTOMS	3.85
1563	____	XLRG THERMAL BOTTOMS	3.85
1564	____	MEN THERMAL BOTTOM 2	4.62
1565	____	MEN 3XL THERMAL BOTT	4.62
1567	____	THERMAL BOTTOM 4XLG	4.62
1582	____	MED. SWEATSHIRT GRAY	10.38
1583	____	LRG. SWEATSHIRT GRAY	10.38
1584	____	XLRG SWEATSHIRT GRAY	10.38
1585	____	2X SWEATSHIRT GRAY	13.85
1586	____	3X SWEATSHIRT GRAY	13.85
1588	____	MED SWEATPANTS GRAY	10.38
1589	____	LRG SWEATPANTS GRAY	10.38
1590	____	XLRG SWEATPANTS GRAY	10.38
1591	____	2X SWEATPANTS GRAY	14.23
1592	____	SWEATPANTS 3XL GRAY	14.23
1599	____	SWEATSHIRT GRAY 4XLG	13.85
1625	____	SPORTS BRA SMALL	8.39
1626	____	SPORTS BRA MEDIUM	9.23
1627	____	SPORTS BRA LARGE	6.39
1628	____	SPORTS BRA XLARGE	8.39
1650	____	SZ 6 WOMENS PANTIES	2.15
1651	____	SZ 8 WOMENS PANTIES	2.15
1652	____	SZ 10 WOMENS PANTIES	2.15
1653	____	SZ 11 WOMENS PANTIES	2.62
1675	____	SWEATPANTS GREY 4XLG	14.23
1697	____	WOMEN''S PANTIES 2XL	2.62
1751	____	SZ 7 RAWLINGS MARC I	17.48
1752	____	SZ 7.5 RAWLINGS MARC	17.48
1753	____	SZ 8 RAWLINGS MARC I	17.48
1754	____	SZ 8.5 RAWLINGS MARC	17.48
1757	____	SZ 9.5 RAWLINGS MARC	17.48
1758	____	SZ 10.5 RAWLINGS MAR	17.48
1759	____	SZ 11 RAWLINGS MARC	17.48
1761	____	SZ 13 RAWLINGS MARC	17.48
1853	____	SZ 9 RAWLINGS MARC I	17.48
1854	____	SZ 10 RAWLINGS MARC	17.48
1855	____	SZ 11.5 RAWLINGS MAR	17.48
1856	____	SZ 12 RAWLINGS MARC	17.48
1857	____	SZ 14 RAWLINGS MARC	17.48
3652	____	5XL CREWNECK T-SHIRT	6.92
3669	____	6XL CREWNECK T-SHIRT	6.92
3679	____	SF COUGH DROPS	1.73
5191	____	EARBUD W/MICROPHONE	11.00
5273	____	1.25 READING GLASSES	6.54
5274	____	1.50 READING GLASSES	6.54
5276	____	READING GLASSES 2.0	6.54
5277	____	2.25 READING GLASSES	6.54
5278	____	2.5 READING GLASSES	6.54
5280	____	3.00 READING GLASSES	6.54
5727	____	4XL MENS CREWNECK T-	6.15
BEVERAGES			
2000	____	SINGLE SERVE KEEFE C	0.21
2006	____	DECAF COFFEE (1-STIC	0.27
2015	____	100% COLOMBIAN FREEZ	4.51
2021	____	8 OZ CREAMER CLEARPA	2.62
2028	____	(BX) KF TEA BAGS 48	1.65
2041	____	FRENCH VANILLA CAPPU	2.20
2071	____	10 OZ. HOT COCOA CLR	2.09
2084	____	SUGAR PACKETS 20/PAC	0.88
2100	____	N/S SS ORANGE DRNK	0.30
2120	____	N/S SS LEMONADE	0.27
2134	____	CHOC HEALTH SHAKE	1.54
2136	____	VANILLA HEALTH SHAKE	1.54
2283	____	KEEFE COLOMBIAN BLEN	2.69
2304	____	GA PEACH DRNK CLRPK	3.00
2311	____	6OZ GRAPE KOOL-AID C	1.27
2320	____	12OZ ORANGE DRINK	2.00
2550	____	PDF NONFAT DRY MILK	3.46
COOKIES/CRACKERS/PASTRIES			
2594	____	DOLLY MADISON CHOC C	1.15
3004	____	ZC PB CREME COOKIES	1.08
3010	____	GRANDMAS COOKIES CHO	0.65
3015	____	GRANDMAS COOKIES OAT	0.65
3020	____	OREO COOKIES	0.82
3030	____	ZC VNILLA CRM COOKIE	1.08
3035	____	ZC CHOC CHIP COOKIES	1.08
3039	____	MARIAS COOKIES	0.69
3040	____	ZC ICED OATML COOKIE	1.08
3045	____	ZC DUPLEX CREMES 6OZ	1.08
3107	____	(BOX) SALTINE CRACKER	2.38
3114	____	(BOX) SNACK CRACKERS	2.86
3175	____	SMORES POPTARTS	0.96
3192	____	CREAM CHEESE COFFEE	0.92
3193	____	2/PK FRSTD STRWBRY P	0.96
3309	____	RICE KRISPIE TREATS	0.88
3331	____	ZC(BOX) SWISS ROLLS 6	2.50
3332	____	ZC(BOX) D-DUNX 6/PK	2.50
3333	____	ZC(BOX) PB WAFERS 6-	2.50
4041	____	DOLLY MADISON VANILL	1.38
4044	____	DOLLY MADISON POWDER	1.12
4048	____	DOLLY MADISON GLAZED	1.12

Order Form : UNASSIGNED ORDER FORM
Friday, September 11, 2020 @10:53

4049	____	APPLE PIE	1.15	6600	____	FLOUR TORTILLAS	1.00
CANDY				6606	____	SALTED PEANUTS 1.25	0.73
4019	____	CHICK O STICK	0.35	6607	____	HOT PEANUTS 1.75 OZ	0.73
4100	____	BUTTERSCOTCH CANDY	0.81	6711	____	HOT CHILI REFRI BEAN	1.36
4135	____	JOLLY RANCHERS ASST.	1.12	6721	____	FISH STEAKS IN HOT S	1.38
4146	____	ATOMIC FIREBALL CAND	0.81	6826	____	FRESH CATCH TUNA 4.2	1.96
4150	____	SOUR FRUIT BALLS 4.2	0.81	**COMMISSARY ONLY ITEMS**			
4168	____	LEMONHEADS REDRIFIC	1.00	9810	____	BEEF CHEESE STEAK	8.00
4310	____	(EA)MILKY WAY MINI P	1.62	9811	____	BONELESS BUFFALO CHI	8.00
4315	____	TOOTSIE POPS	0.31	9812	____	PERSONAL 8" PIZZA	8.00
TOBACCO				9813	____	BURGER	8.00
4080	____	(BAG)SNICKERS MINITU	2.19	9814	____	SOUTH WESTERN SALAD	8.00
4081	____	(BAG)HRSHY MINI ASSO	2.77	9815	____	POTATO COINS	2.00
FOOD/SNACK ITEMS				9816	____	KOSHER SOUP	2.25
0921	____	HONEY TURKEY STUCK 1	1.65	9817	____	3 COOKIES	1.75
2053	____	(10/PK) FRENCH VANIL	2.64				
2063	____	(10/PK) CARAMEL MACC	2.64				
2216	____	(BX)PINK SUGAR SUBST	2.00				
2437	____	(EA) REGULAR FLAVOR	0.58				
2438	____	(EA) MAPLE BROWN SUG	0.58				
2596	____	CREAM CHEESE W/JALAP	0.96				
2615	____	BC REG SUMMER SAUSAG	1.15				
2624	____	TRKY HNY&BRN SGR SAU	2.86				
2630	____	BC BLACK BEANS 10OZ	1.92				
2737	____	CHILI CHEESE FRITOS	0.99				
3581	____	BC SUMMER SAUSAGE HO	1.15				
3584	____	BC HOT & SPICY SUMME	2.73				
4056	____	PEANUT BUTTER SQUEEZ	1.10				
4321	____	DORITOES CLR BAG	0.99				
4396	____	GRANOLA BAR_MAPLE BR	0.58				
4431	____	STRAWBERRY CHEESE DA	1.00				
4520	____	HOT CHICKEN VIENNA S	2.86				
4863	____	DORITOS_TORTILLA CHI	0.99				
6013	____	CAJUN CHICKEN RAMEN	0.72				
6018	____	TEXAS BEEF RAMEN SOU	0.72				
6026	____	CHILI RAMEN	0.72				
6046	____	CHICKEN RAMEN	0.72				
6050	____	KK INSTANT RICE	1.42				
6051	____	KK BROWN RICE 6.5 OZ	1.65				
6074	____	MACKERAL FILLET IN B	1.46				
6079	____	WHOLE SHABANG 1.5 OZ	0.77				
6083	____	WHITE CHEDDAR POPCOR	1.58				
6100	____	POTATO CHIPS	0.77				
6102	____	1.5OZ STUFD JALP CHI	0.77				
6103	____	HABANERO TORTILLA CH	0.77				
6105	____	BBQ POTATO CHIPS	0.77				
6114	____	HOT FRIES (ANDY CAPP	0.69				
6116	____	CHEESE PUFFS	0.77				
6120	____	NACHO TORTILLA CHIPS	0.77				
6125	____	HOT CHIPS 1.5 OZ	0.77				
6126	____	SOUR CREAM ONION 1.5	0.77				
6153	____	CHIPS-BUFFALO WING B	0.77				
6159	____	CHEETOS FLMN HOT 1.7	0.88				
6167	____	CHEETOS 2-OZ	0.88				
6173	____	BC CHILI W/ BEANS	1.81				
6174	____	BC HOT CHILI W/ BEAN	1.81				
6176	____	BC BEEF STEW	3.85				
6179	____	FC SARDINES IN OIL	1.27				
6183	____	SMOKED CLAMS IN OIL	4.46				
6191	____	FC SALMON FLAKES	1.50				
6195	____	PREMIUM CHICKEN BREA	5.34				
6206	____	STUDENT SNACK MIX	1.35				
6213	____	HEALTHY SNACK MIX	1.04				
6345	____	MM SS RAISIN BRAN BO	0.58				
6412	____	GRAPE JELLY 1 OZ.	0.27				
6428	____	CA SHARP CHDR CHS SQ	0.65				
6429	____	CA JALAP CHEESE SQUE	0.65				
6430	____	SS FROSTED FLAKES	0.58				
6432	____	SS TOOTIE FRUITIES	0.58				
6449	____	JALAPENO CHEESE BAR	1.92				
6501	____	PICKLE (MILD)	0.05				
6515	____	MAYO SINGLE SERVE 1	0.19				

Signature: _____

Date: _____