AN UNRECOGNIZED HEALTH HAZARD IN OUR COMMUNITY

A PROPOSAL TO IMMUNIZE THE SENTENCED ADULTS IN THE COUNTY DETENTION FACILITIES

SUMMARY

In order to protect our community against the threat of communicable diseases, society has developed the practice of immunizing as much of the population as possible in accordance with the standards set by the Centers for Disease Control (CDC).

The 2012-2013 San Diego County Grand Jury (Grand Jury) decided to examine the immunization policies and practices followed in our County detention facilities. Our purpose was to determine the extent to which they administer the CDC recommended vaccines to the inmates living in the close quarters typical of these detention facilities.

San Diego County Probation Department Institutional Services (IS), which oversees the juvenile detention facilities, has an active immunization policy and practice that identifies the juvenile detainees who lack the full complement of immunizations and brings them in line with CDC recommendations. IS fully immunizes all juveniles in their detention facilities. Unfortunately, the same cannot be said for the inmates in the County's adult detention facilities, which are overseen by the San Diego County Sheriff's Detention Services Bureau (DSB). DSB's current policy is to immunize inmates only when they or a physician requests it. Even then they only provide immunization against influenza and Hepatitis B.

Attachment B of this report details the CDC recommended immunizations for adults. When compared with the CDC recommendations and the Federal Bureau of Prisons guidelines, DSB fails to provide many of these screenings and immunizations. Of the missing immunizations, those of greatest concern are those for pregnant women and women of childbearing age. During the five years 2008-2012, 67 babies were born while the mothers were in the San Diego Sheriff's custody.

This lack of conformity with recommended immunizations, combined with the 70% recidivism rate of adult inmates and the resultant recycling of this population between confinement and the general population, constitutes an unrecognized serious health hazard for our community.

California has a statewide immunization tracking system, California Immunization Registry-San Diego Regional Immunization Registry (CAIR-SDIR). CAIR-SDIR complies with Federal regulations for Meaningful Use. Under Meaningful Use, the Federal Government pays incentives to organizations whose Electronic Healthcare Record (EHR) is certified and able to report communicable diseases to the public health department. Currently DSB uses a local computer system not compliant with Federal regulations for Meaningful Use. The Grand Jury recommends that DSB convert to the use of the CAIR-SDIR system.

The Grand Jury recognizes that there are many obstacles to immunizing adult inmates, not the least of which is cost. The Grand Jury recommends that DSB establish a goal and plan the steps necessary to provide the CDC recommended screenings and immunizations for all inmates. The first step should be to immunize all pregnant women and all women of childbearing age by January 2014. DSB should plan additional steps to expand this program year by year until they have achieved a 90% level of screening and immunization for all adult inmates. These steps will prevent the development of some tragic epidemic, born in our detention facilities, that creates widespread illness and death in our community.

PURPOSE AND BACKGROUND

The Grand Jury has had a long-standing interest in the condition and management of County detention facilities and annually issues a report on this subject. This proposal to immunize adult detainees is separate from that series of annual reports and arises out of the Grand Jury's concern about public health matters.

Because the youths in the juvenile facilities managed by IS are fully immunized in conformance with CDC recommendations, the focus of this study is on adults in County detention facilities.

DSB is one of the largest detention systems in the United States.[1] It is responsible for all seven of the County's adult facilities. DSB defines jails as locked adult detention facilities that hold prisoners awaiting trial, convicted prisoners awaiting sentencing, and offenders who are serving their sentences. The focus of this report is on sentenced adult detainees only. The recidivism rate for this group of offenders is 70%.[2]

PROCEDURE

The Grand Jury visited County detention facilities for adults, County Probation Department juvenile halls and juvenile rehabilitation camps. The Grand Jury conducted interviews of medical personnel for both departments, submitted additional questions to the IS and the DSB regarding future immunization plans, reviewed past Grand Jury reports, and obtained published information from cited web sites.

DISCUSSION

Although inmate overcrowding in California prisons was a major concern of the Federal District Court and the U.S. Supreme Court affirmed the ruling, the pivotal issue in the Court's decision was the lack of adequate access to health care and mental health services. In 1976, the U.S. Supreme Court (Estelle vs. Gamble) established a constitutional standard for inmate healthcare. In May 2011, the U.S. Supreme Court decision which began as a Federal court class action lawsuit known as Plata vs. Schwarzenegger, challenged prisoners' access to care.[3] It resulted in the Public Safety Realignment Act, AB 109. The Supreme Court ordered the reduction in prison

[1] http://www.sdsheriff.net/about_history.html
[2] http://www.sdcounty.ca.gov/Portal/News/2010/Oct/101210reentry.html/.
[3] *http://www.corrections.com/articles/29234*

population, citing shortage of medical attention, exacerbated conditions in mentally ill prisoners, and danger to prison employees.[4]

DSB is responsible for providing professional detention services for adult detainees in a safe and humane environment. Medical oversight of the adult detention facilities is by the Medical Services Division's Medical Director. DSB contracts with UCSD for on-site physician care. DSB medical decisions are based on Title 15, Department of Corrections and Rehabilitation, Article 8, Medical and Dental Services. It does not follow CDC recommendations.

The mission statement of the DSB Medical Services Division states, "…ensuring the provision of emergency, acute, and basic medical/mental health care to all inmates in a timely manner; taking all necessary precautions **to prevent the spread of communicable and contagious diseases**.."[5] DSB's immunization policies and procedures do not seem to conform to this Mission Statement.

Of greatest concern is the failure of DSB to provide the following screenings and immunizations:

- Automatic screening for all inmates for Hepatitis A, B, C, and HIV
- Tetanus, Diphtheria, Pertussis (Tdap) booster for all inmates
- Screening and immunization where needed for pregnant women for
    - Hepatitis B
    - Tdap
- Screening and immunization of all non-pregnant women of child-bearing age for Measles/Mumps/Rubella (MMR)
- Pneumococcal immunization for inmates over 65
- Shingles immunization for those inmates over 60
- Meningococcal immunization for all inmates under 21
- HPV immunization for males and females under 26

During the calendar years 2008 through 2011, 67 babies were born to mothers who were in custody with DSB. **The information supplied by DSB shows that during this period there were no pregnant women immunized with Tdap and no women of childbearing age were immunized with MMR**.

Attachment A displays the immunizations provided to County adult detainees. It details the lack of CDC recommended immunizations.

When a sufficient number of individuals have been vaccinated to create "herd immunity", the spread and ultimate elimination of communicable diseases is achieved. The herd immunity threshold (the number of immune individuals in a herd at which level the disease cannot persist) varies depending on how contagious the disease in question is,

[4] http://www.corrections.com/articles/29234
[5] http://www.sdsheriff.net/jailinfo/medical.html

how efficacious the vaccine is, the exposure rates etc. For example, the herd immunity "threshold" for Pertussis is 92--94%, whereas for diphtheria it is 85%.[6]

The Grand Jury Report, *Medical Care in the San Diego County Detention Facilities*, May 4, 1989, recommended study and consideration of transferring administration of the medical care in the detention facilities from the Sheriff's Department to the San Diego County Health Department. The Grand Jury does not know the response to this recommendation. **There is no evidence of this occurring.**

Demographics

The population of the detention facilities is always in flux. During calendar year 2011, the average inmate population was 4,630 (86% male, 14% female) spread among seven sites. DSB updated this figure on July 23, 2012 to show an increase to 5,281. On October 3, 2012, because of the Public Safety Realignment, the adult population of the jails in San Diego County continued to increase by 1,601[7]. On average, DSB books approximately 90,000 inmates a year.[8]

Average length of stay is 65 days. Currently the furthest release date is June 4, 2017. With the implementation of AB 109, sentences will increase in length, ranging from 16 months to 10 years. The youngest inmate is 18, the oldest 76. Currently, DSB incarcerates all female inmates at Las Colinas. [9]

National health disparity is a particular type of health difference that National Health and Human Services closely link with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to healthcare and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location or other characteristics historically linked to discrimination or exclusion. [10] Inmates are included in this group.

Inmates are generally less educated than the public and score below the public in basic reading literacy.[11] Inmates generally are unable to seek literature to improve their health or medical condition. It is unlikely that an inmate would seek immunization information but would rely on recommendations from the medical staff.

Immunizations

Attachment B displays the CDC and San Diego Public Health Department (SDPHD)[12] recommended immunization for adults. Individuals not immunized during childhood for

[6] http://www.vaccinetimes.com/how-do-we-know-that-herd-immunity-exists/
[7] www.SDsheriff.net/AB109/AB109_counts.pdf.
[8] Interview 10/25/2012 DSB.
[9] 2011 San Diego Sheriff's Department handout.
[10] *National Partnership for Action to end Health Disparities*. U.S. Department of Health & Human Services. www.hhs.gov.
[11] Cellblocks to Classrooms: Reforming Inmate Education to Improve Public Safety, February 2008, pg 3. http://lao.ca.gov/2008/crim/inmate_education_021208.aspx.
[12] http://www.cdc.gov/vaccines/schedules/hcp/adult.html

polio are rarely immunized as adults. The recently published Federal Bureau of Prisons guidelines[13] follows closely the CDC adult "catch-up" immunization recommendations.

The medical community bases vaccine recommendations for adolescents and adults on a variety of factors including age, overall health status, and medical history. There are no legally mandated vaccinations for adults, except for persons entering military service.[14] DSB should fully inform inmates about the risks and benefits of vaccination and encourage them to take advantage of the protection immunization provides.
DSB currently offers two immunizations when requested by the physician or the inmate (Hepatitis B and Influenza).[15] For the long-term population, DSB may develop a preventive medicine program that would expand immunizations beyond the two now offered. These immunizations would be for inmates remaining in custody more than one year. Not under consideration for the expansion, but recommended by CDC, are immunizations against Hepatitis A, Meningococcal Disease, HPV for males and females under 26 and Pneumococcal.[16]

The Morbidity and Mortality Weekly Report (MMWR), July 19, 2002, discusses the San Diego Viral Hepatitis Prevention Project (VHPP) which ran from 1998-2001, focusing on vaccination for potentially high-risk adolescents and adults. There were 2,010 men and 221 women inmates vaccinated in county jails because of the Project.

CDC recommends a series of three Hepatitis B immunizations. However, research from the CDC National Vaccine Program Office has shown that among healthy young adults, protective levels of antibody develop in 30% to 55% following a single dose of Hep B vaccine. **During the four fiscal years 2009 through 2012, DSB provided only 19 Hepatitis immunizations.** (Attachment A)

Women of Childbearing Age
The national strategy to eliminate Hepatitis B transmission is based on:

- Screening all pregnant women for Hepatitis B surface antigen and post-exposure vaccination of infants of infected mothers
- Vaccinating all infants as part of the childhood vaccination schedule
- Vaccinating children and adolescents not vaccinated previously
- Vaccinating adolescents and adults in groups at increased risk for infection.

CDC has the same recommendations. **DSB complies with Title 15 but does not follow CDC guidelines.** During the four fiscal years 2009 through 2012, DSB provided seven Hepatitis B immunizations to women of childbearing age. (Attachment A)

CDC and the Federal Bureau of Prisons Guidelines, both recommend that pregnant women receive a Tdap booster that contains Tetanus, Diphtheria, and Pertussis vaccine.

[13] Preventive Health Care, Federal Bureau of Prisons, Clinical Practice Guidelines, August 2012. Appendix 3, E Immunizations, pp. 20-22. Http://www.bop.gov.news/medresources.jsp.
[14] CDC National Vaccine Program Office: *Immunization Laws*. http://www.hhs.gov/nvpo/law.htm
[15] Letter to the Grand Jury, from San Diego County Sheriff's Department, August 24, 2012.
[16] Letter to the Grand Jury, from San Diego County Sheriff's Department, August 24, 2012.

In addition to pregnant women, CDC recommends administration of Tdap vaccine to all adults as a substitute for one of the recommended Tetanus/Diphtheria booster immunizations. On October 27, 2010, the Advisory Committee on Immunization Practices (ACIP) voted to recommend the use of Tdap regardless of interval since the last tetanus or diphtheria containing vaccine. **DSB complies with Title 15 but does not follow CDC guidelines.**

During the four fiscal years 2009 through 2012, DSB did not administer any Tdap boosters (Attachment A). Surprisingly, during the four-year period DSB administered 1,175 doses of Tetanus/Diphtheria vaccinations to male and female inmates. It is difficult to understand why no Tdap immunizations occurred when the County experienced increasing numbers of Pertussis cases. The question also arises why the communications from DSB state they only provided Hepatitis B and Influenza immunizations. When the Grand Jury requested a report of every vaccine given, however, it showed the administration of the Tetanus/Diphtheria vaccine.

Federal Bureau of Prisons guidelines [17] recommends, at intake, one dose of MMR for all women of childbearing age after testing for pregnancy. This follows the CDC guidelines on catch-up vaccinations. DSB does not follow this policy. **During the four fiscal years 2009 through 2012, DSB did not administer MMR to any female inmates** (Attachment A).

Testing for Immunity

Checking an individual's immunization status[18] can be accomplished by blood tests for nine of the diseases in question. DSB does not screen for immunization status. SDPHD does not recommend universal screening due to cost, but does recommend screening for high-risk individuals such as diabetics, those who have injected illegal drugs, and those who received tattoos while in jail. Screening is also recommended for those who have a history of STD, males who have had sex w/males, HIV or HCV infection, or are on immunosuppressants, etc.

Tracking Immunizations – Who has been immunized?

Tracking Juvenile Records to Adulthood

The San Diego Regional Immunization Registry (SDIR) is part of the California Immunization Registry (CAIR). CAIR-SDIR is a confidential, computerized immunization information system connected with SDPHD Immunization Branch. It allows health care providers and other authorized users to update an individual's record and/or access an individual's record of immunization. Twenty-nine states use a similar state system. The health care providers at the Juvenile facilities use this system to view and enter immunizations.

Adult Records

Prior to 2000, adult detention information was in paper form. In 2000, the San Diego County Sheriff's Department began using the Jail Information

[17] *Federal Bureau of Prisons*, pg 23

[18] Serologic testing to verify the immune status of int…[Vaccine. 2010] Pub Med - NCBI

Management System (JIMS). The information in this system is not available to other counties.

CAIR-SDIR is compliant with all of the Federal Government's regulations for Meaningful Use. The Government is incentivizing providers to report immunizations and to report communicable diseases to the public health department. If one is looking at records from the late 1990s to the present, the CAIR-SDIR immunization records will already contain some inmate data for those individuals who attended California schools or those housed in San Diego Juvenile Detention.[19] **Currently, DSB does not use the statewide CAIR-SDIR system.**

WHY VACCINATE

"From July through September, 2010, an outbreak of 28 confirmed cases of mumps occurred in the Bexar County Jail in San Antonio, TX."[20] This outbreak raises a compelling issue regarding disease prevention measures among the inmate population. Outbreaks in correctional facilities are costly in terms of staff overtime, staff sick days, supplies and space restrictions.[21] **Public health and correctional professionals now recognize the significance of including incarcerated populations in community-based disease prevention and control strategies.[22]**

Two outbreaks of Varicella (chicken pox) occurred in the San Diego County Detention Facilities since 2011 to present. Management of the chicken pox cases and the affected inmates was coordinated with the San Diego Public Health Epidemiology and Immunization Services. DSB used isolation, negative pressure rooms, and the antiviral Acyclovir (Attachment A).

Improved access to medical care and prevention services for incarcerated populations benefits communities by reducing disease transmission and medical costs. Inmates who participate in health-related programs while incarcerated have lower recidivism rates and are more likely to maintain health-conscious behaviors. Some of the inmates did not attend California schools and did not receive recommended immunizations. Some are illegal aliens who have not had access to health care.[23] Finally, because incarcerated persons have a high frequency of infection with hepatitis viruses, community efforts to prevent and control these infections requires inclusion of the correctional population. However, implementation of preventive health programs for incarcerated persons has substantial challenges.[24]

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[19] http://cairweb.org/wheres-my-immunization-record/

[20] http://www.ncchc.org/pubs/CC/mumps.html Fall 2010 Issue *CorrectCare*. Mumps! A Jail Outbreak and Public Health Response *by Lillian Ringsdorf, MD, Bret Heerema, MD, MPH, Jessica Ruiz, BSN, RN, and Roger Sanchez*

[21] Op. cit.

[22] CDC *MMWR Weekly* July 19, 2002 / 51(28);618-621. Hepatitis B Vaccination Among High-Risk Adolescents and Adults --- San Diego, California, 1998—2001.

[23] Presentation, August 10, 2012, South Bay Correctional Facility.

[24] CDC MMWR Weekly, March 3, 2003 / 52(10);205

Vaccinations of inmates protect the deputies, their spouses, children, visiting medical workers, or anyone else entering the jail, from infections by unvaccinated inmates. SDPHD provided vaccine for DSB during the H1N1 influenza outbreak. Some individuals are asymptomatic carriers for disease such as Meningococcal disease. These individuals serve as hosts for an infectious agent but do not show any apparent signs of the illness.

Transmission of Disease

This report has focused on diseases preventable by immunization. Inhalation or mucus-laden aerosols transmit most of these diseases. Some are also transmittable by direct contact with infected objects such as doorknobs, or direct contact with an individual. Hepatitis A is transmissible through the sexual or fecal/oral route. Contaminated food is a common source of transmission. Sexual contact transmits Hepatitis A, Hepatitis B, Hepatitis C, and HPV. These viruses may cause cancer in men and women.

This report has not addressed the new CDC recommendation of one-time testing of all individuals born between 1945 and 1965 for Hepatitis C virus. Currently, there is no vaccine to prevent this disease but there are new treatment methods that have been successful. The age-specific universal testing recommendation is based on the fact that one in 30 baby boomers have been infected with Hepatitis C, often because of illicit drug-using experiences and medical procedures performed decades earlier before there were universal blood and body fluids precautions. Most individuals discover they are infected with Hepatitis C when they are diagnosed with liver cancer or when they need a liver transplant.[25]

Science has not discovered a vaccine for HIV. Federal Bureau of Prisons guidelines[26] recommends routine preventive health screening for HIV for all sentenced inmates. DSB will screen inmates who make a request. The Grand Jury was not told how screening information is communicated to the inmates.

Cost of Immunization

DSB estimated the cost for providing the recommended CDC immunizations for 91,515 inmates booked during the fiscal year 2011-2012 to be $63,055,402 (Attachment A, Figure 1). Cost of vaccines, supplies and staffing were included in the estimate. Dividing the estimate by the number of booked inmates gives us an immunization cost of approximately $689 per **booked** inmate.

As stated previously, DSB may develop a preventive medicine program for the long-term population. Using the Federal Guidelines of immunizing **sentenced** inmates, this report assumes that the average population of 4,421 in 2012 would be equivalent to sentenced inmates. Immunizations are voluntary. Only 442, or 10%, accepted the influenza immunizations in 2012, a rate much lower than that needed for "herd immunity". Assuming that the same percentage of inmates would request the broader CDC recommendations, multiplying the cost per inmate fee of $689 times 442 inmates, the cost estimate for a robust immunization program for sentenced inmates would be

[25] http://hepmag.com/articles/hepatitis_testing_boomers_2501_22851.shtml
[26] Federal Bureau of Prisons, pg 23.

$304,538. This cost would drop as SDIR accumulates immunization records for sentenced inmates that identify them as immune. Immunization without screening does not appear to have a downside and is the current practice for some institutions.

Although there are many obstacles to immunizing adult inmates including cost, it is important for DSB to plan the steps necessary to provide all CDC recommended screenings and immunizations for all sentenced inmates, expanding the immunizations yearly until they reach the acceptable level of approximately 90% for all vaccine preventable diseases. As discussed earlier, this level of vaccination creates a status of "herd protection".

Cost of Illness

- For every day one inmate is in the hospital, it costs the County $5,000.
- Inmate immunizations are voluntary.[27]
- Five-minute counseling session about Hepatitis B vaccination increased the acceptance rate from 44%--70% to 80%.[28]
- In 2012, if an inmate is on Medical/Medicare, it stops once the inmate is processed and incarcerated. At that point, the County is responsible for the cost of healthcare for the inmate.[29] It is not clear how Patient Protection and Affordable Care Act will affect these costs.

Immunization is one of the most successful and cost-effective public health interventions.[30]

FACTS AND FINDINGS

Fact: Federal Bureau of Prisons guidelines recommend immunization for 11 preventable diseases, when age and risk appropriate.

Fact: CDC and SDPHD recommend immunization for 15 preventable diseases, when age and risk appropriate.

Fact: Federal Bureau of Prisons guidelines recommend the administration of the Tdap vaccine to all pregnant women who have not received it, as well as the immunization of all inmates in accordance with CDC recommendations.

Fact: DSB currently immunizes against two diseases, Hepatitis B and Influenza.

Fact: For women of childbearing age, DSB does not follow the recommendations of CDC and Federal Bureau of Prisons guidelines to check for missing MMR immunizations, confirm the non-pregnant status and provide the immunization.

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[27] www.vaccinesafety.edu/exemptreview101503.pdf

[28] CDC MMWR Weekly July 19, 202 / 51(28);618-621. *Hepatitis B Vaccination Among High-Risk Adolescents and Adults* --- San Diego, California, 1998—2001.

[29] Interview during Grand Jury tour of San Diego Central Jail visit 7/25/12

[30] CDC MMWR May 12, 2006 / 55(18); 511-515, *Vaccine Preventable Deaths and the Global Immunization Vision and Strategy 2006-2015.*

Fact: For those inmates remaining in long-term custody, DSB may develop a preventive medicine program that will expand the number of immunizations from the two now offered to 11.

Fact: DSB does not identify or screen inmates for immunization status.

Finding 01: DSB's current policy and practice fails to meet accepted national immunization standards, including those of the CDC and Federal Bureau of Prisons guidelines for inmates. DBS does not follow the most basic and widely accepted public health standards for women in developed countries.

Fact: After counseling, inmates' participation in immunization programs increases.

Fact: Inmates are generally less educated than the public and score below the public in basic reading literacy.

Fact: Inmates are members of the national health disparities. They experience greater social and/or economic obstacles to health and are adversely affected.

Fact: Inmates who participate in health-related programs while incarcerated have lower recidivism rates and are more likely to maintain health-conscious behaviors.

Finding 02: DSB failure to provide effective counseling about the benefits of specific immunizations ensures that the inmates will underutilize the immunization program.

Fact: San Diego Regional Immunization Registry (SDIR), part of the California Immunization Registry (CAIR):

- Meets the requirements for Meaningful Use
- Is a web-based, immunization tracking system
- Allows health care providers and other authorized users to access an individual's State record of immunizations
- Allows health care providers to determine the need for other immunizations.

Fact: The Jails Information Management System (JIMS) is limited to information from jails in San Diego County. It does not comply with the Federal Government's regulations for Meaningful Use.

Finding 3: DSB's failure to track immunizations using the CAIR-SDIR system increases the cost of tracking and causes delays in evaluating inmate immunization status and implementing an effective immunization program.

Fact: Due to the often-rapid turnover of adults in detention, inmates may not complete the series of immunizations before discharge.

Fact: DSB's current health assessment is for inmates who remain in custody beyond one year.

Fact: *The 1988/89 San Diego County Grand Jury Report* recommended study and consideration of transferring administration of the medical care in the detention facilities from the Sheriff's Department to the San Diego County Health Department.

Fact: SDPHD provided vaccine to DSB during the H1N1 influenza outbreak.

Fact: Maximum capacity for inmates, aged 19 to 75, housed by DSB in seven facilities, is over 5,000.

Finding 4: Developing a robust immunization program for DSB will be very complicated. It will require training and input from multiple sources and disciplines to identify workable logistics.

RECOMMENDATIONS

The 2012-2013 San Diego County Grand Jury recommends that the San Diego County Sheriff and the Chief Administrative Officer of the County of San Diego build a partnership to implement the following by January 1, 2014:

13-27: **Develop a robust catch-up immunization program for the County jails using recommendations from the CDC, SDPHD, Medical Services Division County Jails and the Federal Bureau of Prisons guidelines.**

13-28: **Develop a counseling program to educate and promote the benefits of immunizations among inmates. Provide information for inmates to share with their visitors. Discuss the benefits of preventing sexually transmitted diseases through immunization for Hepatitis A, Hepatitis B, Hepatitis C and for those under 26 for HPV.**

13-29: **In partnership with SDPHD, seek funding from the recently released CDC grant to expand testing of Hepatitis B and Hepatitis C, and to increase earlier diagnosis and linkage to care, treatment and preventive services.**

13-30: **With training from SDPHD, begin use of CAIR- SDIR to enter and review immunizations as part of the Federal Government's Meaningful Use program by July 1, 2013.**

The 2012-2013 San Diego County Grand Jury recommends that the San Diego County Sheriff by January 1, 2014:

13-31: **Establish a goal and plan the steps necessary to provide the CDC recommended screenings and immunizations for all inmates. Expand this goal year by year to achieve an acceptable 90% level of screening and immunization for all adult inmates.**

13-32: **Begin the catch-up immunization of sentenced inmates within their first month of custody after sentencing.**

13-33: In compliance with CDC recommendations, immunize pregnant inmates against Hepatitis B and Tdap within their first month of custody after sentencing.

13-34: Provide Tdap vaccine to all inmates except those identified as being immune.

13-35: In compliance with CDC recommendations, vaccinate with MMR all non-pregnant women who report never having received an MMR vaccine as an adult.

13-36: In compliance with the recent CDC recommendations, screen all inmates born between 1945 and 1965 for Hepatitis C.

13-37: Screen all inmates for HIV.

REQUIREMENTS AND INSTRUCTIONS

The California Penal Code §933(c) requires any public agency which the Grand Jury has reviewed, and about which it has issued a final report, to comment to the Presiding Judge of the Superior Court on the findings and recommendations pertaining to matters under the control of the agency. Such comment shall be made *no later than 90 days* after the Grand Jury publishes its report (filed with the Clerk of the Court); except that in the case of a report containing findings and recommendations pertaining to a department or agency headed by an elected County official (e.g. District Attorney, Sheriff, etc.), such comment shall be made *within 60 days* to the Presiding Judge with an information copy sent to the Board of Supervisors.

Furthermore, California Penal Code §933.05(a), (b), (c), details, as follows, the manner in which such comment(s) are to be made:

(a) As to each grand jury finding, the responding person or entity shall indicate one of the following:
    (1) The respondent agrees with the finding
    (2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

(b) As to each grand jury recommendation, the responding person or entity shall report one of the following actions:
    (1) The recommendation has been implemented, with a summary regarding the implemented action.
    (2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
    (3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for

discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the grand jury report.

(4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

(c) If a finding or recommendation of the grand jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the Board of Supervisors shall respond if requested by the grand jury, but the response of the Board of Supervisors shall address only those budgetary or personnel matters over which it has some decision making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.

Comments to the Presiding Judge of the Superior Court in compliance with the Penal Code §933.05 are required from the:

Responding Agency	**Recommendations**	**Date**
San Diego County Sheriff	**13-27 through 13-37**	**7/8/13**
Chief Administrative Officer County of San Diego	**13-27 through 13-30**	**8/7/13**

ATTACHMENT A

IMMUNIZATIONS GIVEN
SAN DIEGO COUNTY ADULT DETAINEES
FISCAL YEARS 2008 – 2012*

Year	08/09											09/10											10/11											11/12											
Gender	Male 1262					Female 771					2033	Male NA					Female NA						Male 2818					Female 690					3508	Male 3658					Female 763					4421	
Age at Vac.	18 or -	18 to 49	50 to 59	60 to 65	65 +	18 or -	19 to 49	50 to 59	60 to 65	65 +	Total Yr	18 or -	19 to 49	50 to 59	60 to 65	65 +	18 or -	19 to 49	50 to 59	60 to 65	65 +	Total Yr	18 or -	19 to 49	50 to 59	60 to 65	65 +	18 or -	19 to 49	50 to 59	60 to 65	65 +	Total Yr	18 or -	19 to 49	50 to 59	60 to 65	65 +	18 or -	19 to 49	50 to 59	60 to 65	65 +	Total Yr	**Total All**
Diseases																																													
Flu	4	152	62	32	22	1	117	29	5	0	424	0	116	67	29	18	1	83	11	2	1	328	6	495	91	36	10	0	188	21	1	0	848	2	137	46	37	21	0	153	21	4	1	422	2022
Hepatitis A		1									1		1									1		2									2		1								1	5
Hepatitis B		2		2			3				7		2									2		3	1				4				8		2								2	19
HPV											0											0											0										0	0
Meningo.											0											0											0										0	0
Measles/ Mumps /Rubella											0											0											0										0	0
Pneumo.											0											0											0										0	0
Polio											0																																	
Shingles											0											0											0										0	0
Tet/Dipth	3	242	23	5	0	0	52	5	1	0	331	0	144	16	6	2	2	64	5	0	0	239	2	176	27	5	4	0	71	6	1	0	292	0	186	32	8	1	0	74	10	1	1	313	1175
Tet/Dipth/ Pertussis																																												0
Varicella											0											0											0										0	0

*Information provided by San Diego County Sheriff's Detention Services Bureau

FIGURE 1

Estimated Cost Immunizations		
#Booked Inmates		91,525
Cost Per Inmate	$	689
Estimated Inmates Accepting Vaccines		442
Estimated Cost 1st year of full immunization	$	304,538

ATTACHMENT B

Recommended Adult Immunization Schedule—United States - 2013

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

VACCINE ▼ AGE GROUP ▶	19-21 years	22-26 years	27-49 years	50-59 years	60-64 years	≥ 65 years
Influenza [2,*]	1 dose annually					
Tetanus, diphtheria, pertussis (Td/Tdap) [3,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs					
Varicella [4,*]	2 doses					
Human papillomavirus (HPV) Female [5,*]	3 doses					
Human papillomavirus (HPV) Male [5,*]	3 doses					
Zoster [6]					1 dose	
Measles, mumps, rubella (MMR) [7,*]	1 or 2 doses					
Pneumococcal polysaccharide (PPSV23) [8,9]	1 or 2 doses					1 dose
Pneumococcal 13-valent conjugate (PCV13) [10]	1 dose					
Meningococcal [11,*]	1 or more doses					
Hepatitis A [12,*]	2 doses					
Hepatitis B [13,*]	3 doses					

*Covered by the Vaccine Injury Compensation Program

- For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection; zoster vaccine recommended regardless of prior episode of zoster
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indication)
- No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.
Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005, telephone, 202-357-6400.
Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday - Friday, excluding holidays.
Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

ATTACHMENT B (CONTINUED)

Footnotes — Recommended Adult Immunization Schedule—United States - 2012

1. **Additional information**
   - Advisory Committee on Immunization Practices (ACIP) vaccine recommendations and additional information are available at: http://www.cdc.gov/vaccines/pubs/acip-list.htm.
   - Information on travel vaccine requirements and recommendations (e.g., for hepatitis A and B, meningococcal, and other vaccines) available at http://wwwnc.cdc.gov/travel/page/vaccinations.htm.
2. **Influenza vaccination**
   - Annual vaccination against influenza is recommended for all persons 6 months of age and older.
   - Persons 6 months of age and older, including pregnant women, can receive the trivalent inactivated vaccine (TIV).
   - Healthy, nonpregnant adults younger than age 50 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) (FluMist), or TIV. Health-care personnel who care for severely immunocompromised persons (i.e., those who require care in a protected environment) should receive TIV rather than LAIV. Other persons should receive TIV.
   - The intramuscular or intradermal administered TIV are options for adults aged 18–64 years.
   - Adults aged 65 years and older can receive the standard dose TIV or the high-dose TIV (Fluzone High-Dose).
3. **Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination**
   - Administer a one-time dose of Tdap to adults younger than age 65 years who have not received Tdap previously or for whom vaccine status is unknown to replace one of the 10-year Td boosters.
   - Tdap is specifically recommended for the following persons:
     - pregnant women more than 20 weeks' gestation,
     - adults, regardless of age, who are close contacts of infants younger than age 12 months (e.g., parents, grandparents, or child care providers), and
     - health-care personnel.
   - Tdap can be administered regardless of interval since the most recent tetanus or diphtheria containing vaccine.
   - Pregnant women not vaccinated during pregnancy should receive Tdap immediately postpartum.
   - Adults 65 years and older may receive Tdap.
   - Adults with unknown or incomplete history of completing a 3-dose primary vaccination series with Td-containing vaccines should begin or complete a primary vaccination series. Tdap should be substituted for a single dose of Td in the vaccination series with Tdap preferred as the first dose.
   - For unvaccinated adults, administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second.
   - If incompletely vaccinated (i.e., less than 3 doses), administer remaining doses. Refer to the ACIP statement for recommendations for administering Td/Tdap as prophylaxis in wound management (See footnote 1).
4. **Varicella vaccination**
   - All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose.
   - Special consideration for vaccination should be given to those who
     - have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or
     - are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).
   - Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.
   - Evidence of immunity to varicella in adults includes any of the following:
     - documentation of 2 doses of varicella vaccine at least 4 weeks apart;
     - U.S.-born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity);

- history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or having an atypical case, a mild case, or both, healthcare providers should seek either an epidemiologic link to a typical varicella case or to a

5. Human papillomavirus (HPV) vaccination

- Two vaccines are licensed for use in females, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine for use in males (HPV4).
- For females, either HPV4 or HPV2 is recommended in a 3-dose series for routine vaccination at 11 or 12 years of age, and for those 13 through 26 years of age, if not previously vaccinated.
- For males, HPV4 is recommended in a 3-dose series for routine vaccination at 11 or 12 years of age, and for those 13 through 21 years of age, if not previously vaccinated. Males 22 through 26 years of age may be vaccinated.
- HPV vaccines are not live vaccines and can be administered to persons who are immunocompromised as a result of infection (including HIV infection), disease, or medications. Vaccine is recommended for immunocompromised persons through age 26 years who did not get any or all doses when they were younger. The immune response and vaccine efficacy might be less than that in immunocompetent persons.
- Men who have sex with men (MSM) might especially benefit from vaccination to prevent condyloma and anal cancer. HPV4 is recommended for MSM through age 26 years who did not get any or all doses when they were younger.
- Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, persons who are sexually active should still be vaccinated consistent with age-based recommendations. HPV vaccine can be administered to persons with a history of genital warts, abnormal Papanicolaou test, or positive HPV DNA test.
- A complete series for either HPV4 or HPV2 consists of 3 doses. The second dose should be administered 1–2 months after the first dose; the third dose should be administered 6 months after the first dose (at least 24 weeks after the first dose).
- Although HPV vaccination is not specifically recommended for health-care personnel (HCP) based on their occupation, HCP should receive the HPV vaccine if they are in the recommended age group.

6. Zoster vaccination

- A single dose of zoster vaccine is recommended for adults 60 years of age and older
- regardless of whether they report a prior episode of herpes zoster. Although the vaccine is
- licensed by the Food and Drug Administration (FDA) for use among and can be administered to
- persons 50 years and older, ACIP recommends that vaccination begins at 60 years of age.
- Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication, such as pregnancy or severe immunodeficiency.
- Although zoster vaccination is not specifically recommended for health-care personnel (HCP), HCP should receive the vaccine if they are in the recommended age group.

7. Measles, mumps, rubella (MMR) vaccination

- Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, laboratory evidence of immunity to each of the three diseases, or documentation of provider-diagnosed measles or mumps disease. For rubella, documentation of provider-diagnosed disease is not considered acceptable evidence of immunity.

Measles component:

- A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who
- are students in postsecondary educational institutions;
  - work in a health-care facility; or plan to travel internationally.
- Persons who received inactivated (killed) measles vaccine or measles vaccine of unknown type from 1963 to 1967 should be revaccinated with 2 doses of MMR vaccine.

Mumps component:

- A routine second dose of MMR vaccine, administered a minimum of 28 days after the first dose, is recommended for adults who
- are students in postsecondary educational institutions;
  - work in a health-care facility; or
- plan to travel internationally.
- Persons vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type who are at high risk for mumps infection (e.g., persons who are working in a health-care facility) should be considered for revaccination with 2 doses of MMR vaccine.

- persons working with HAV-infected primates or with HAV in a research laboratory setting; persons with chronic liver disease and persons who receive clotting factor concentrates; persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A; and unvaccinated persons who anticipate close personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity. (See footnote 1 for more information on travel recommendations). The first dose of the 2-dose hepatitis A vaccine series should be administered as soon as adoption is planned, ideally 2 or more weeks before the arrival of the adoptee.
- Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix), or 0 and 6–18 months (Vaqta). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule may be used, administered on days 0, 7, and 21–30 followed by a booster dose at month 12.

Rubella component:

- For women of childbearing age, regardless of birth year, rubella immunity should be determined. If there is no evidence of immunity, women who are not pregnant should be vaccinated. Pregnant women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility.
- Health-care personnel born before 1957:
- For unvaccinated health-care personnel born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider routinely vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.

8. Pneumococcal polysaccharide (PPSV) vaccination

- Vaccinate all persons with the following indications:
  - age 65 years and older without a history of PPSV vaccination;
  - adults younger than 65 years with chronic lung disease (including chronic obstructive pulmonary disease, emphysema, and asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver disease (including cirrhosis); alcoholism; cochlear implants; cerebrospinal fluid leaks; immunocompromising conditions; and functional or anatomic asplenia (e.g., sickle cell disease and other hemoglobinopathies, congenital or acquired asplenia, splenic dysfunction, or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]);
  - residents of nursing homes or long-term care facilities; and adults who smoke cigarettes.
- Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after their diagnosis.
- When cancer chemotherapy or other immunosuppressive therapy is being considered, the interval between vaccination and initiation of immunosuppressive therapy should be at least 2 weeks. Vaccination during chemotherapy or radiation therapy should be avoided.
- Routine use of PPSV is not recommended for American Indians/Alaska Natives or other persons younger than 65 years of age unless they have underlying medical conditions that are PPSV indications. However, public health authorities may consider recommending PPSV for American Indians/Alaska Natives who are living in areas where the risk for invasive pneumococcal disease is increased.

9. Revaccination with PPSV

- One-time revaccination 5 years after the first dose is recommended for persons 19 through 64 years of age with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions.
- Persons who received PPSV before age 65 years for any indication should receive another dose of the vaccine at age 65 years or later if at least 5 years have passed since their previous dose.
- No further doses are needed for persons vaccinated with PPSV at or after age 65 years.

10. Meningococcal vaccination

- Administer 2 doses of meningococcal conjugate vaccine quadrivalent (MCV4) at least 2 months apart to adults with functional asplenia or persistent complement component deficiencies.
- HIV-infected persons who are vaccinated should also receive 2 doses.
- Administer a single dose of meningococcal vaccine to microbiologists routinely exposed to isolates of *Neisseria meningitidis*, military recruits, and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic.
- First-year college students up through age 21 years who are living in residence halls should be vaccinated if they have not received a dose on or after their 16th birthday.

- MCV4 is preferred for adults with any of the preceding indications who are 55 years old and younger; meningococcal polysaccharide vaccine (MPSV4) is preferred for adults 56 years and older.
- Revaccination with MCV4 every 5 years is recommended for adults previously vaccinated with MCV4 or MPSV4 who remain at increased risk for infection (e.g., adults with anatomic or functional asplenia or persistent complement component deficiencies).

11. Hepatitis A vaccination

- Vaccinate any person seeking protection from hepatitis A virus (HAV) infection and persons with any of the following indications:
  - men who have sex with men and persons who use injection drugs;
- laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease);
  - history of herpes zoster based on diagnosis or verification of herpes zoster by a health-care provider; or
  - laboratory evidence of immunity or laboratory confirmation of disease.

12. Hepatitis B vaccination

1. Vaccinate persons with any of the following indications and any person seeking protection from hepatitis B virus (HBV) infection:
   - sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease (STD); current or recent injection-drug users; and men who have sex with men;
   - health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids;
   - persons with diabetes younger than 60 years as soon as feasible after diagnosis; persons with diabetes who are 60 years or older at the discretion of the treating clinician based on increased need for assisted blood glucose monitoring in long-term care facilities, likelihood of acquiring hepatitis B infection, its complications or chronic sequelae, and likelihood of immune response to vaccination;
   - persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease;
   - household contacts and sex partners of persons with chronic HBV infection; clients and staff members of institutions for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of chronic HBV infection; and
   - all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; healthcare settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities.
   - Administer missing doses to complete a 3-dose series of hepatitis B vaccine to those persons not vaccinated or not completely vaccinated. The second dose should be administered 1 month after the first dose; the third dose should be given at least 2 months after the second dose (and at least 4 months after the first dose). If the combined hepatitis A and hepatitis B vaccine (Twinrix) is used, give 3 doses at 0, 1, and 6 months; alternatively, a 4-dose Twinrix schedule, administered on days 0, 7, and 21–30 followed by a booster dose at month 12 may be used.
   - Adult patients receiving hemodialysis or with other immunocompromising conditions should receive 1 dose of 40 μg/mL (Recombivax HB) administered on a 3-dose schedule or 2 doses of 20 μg/mL (Engerix-B) administered simultaneously on a 4-dose schedule at 0, 1, 2, and 6 months.

13. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used

- 1 dose of Hib vaccine should be considered for persons who have sickle cell disease, leukemia, or HIV infection, or who have anatomic or functional asplenia if they have not previously received Hib vaccine.

14. Immunocompromising conditions

- Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, and influenza [inactivated influenza vaccine]), and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at http://www.cdc.gov/vaccines/pubs/acip-list.htm.