TORRANCE COUNTY
SPECIAL COMMISSION
MEETING
MAY 15, 2019
9:00 A.M.

FOR PUBLIC VIEW, DO NOT REMOVE

Torrance County

BOARD OF COUNTY COMMISSIONERS (BCC)
Ryan Schwebach, Chair
Kevin McCall, District 1
Javier Sanchez, District 3

Wayne Johnson, County Manager

SPECIAL ADMINISTRATIVE MEETING AGENDA

WEDNESDAY, May 15, 2019 @ 9:00 AM

1. **Call to Order**

2. **DISCUSSION**

3. **APPROVALS**

   A. **MANAGER:** Motion to authorize the County Manager to execute all agreements related to the Intergovernmental Service Agreement, Between the United States Department of Homeland Security U.S. Immigration and Customs Enforcement Office of Enforcement and Removal Operations and Torrance County.

   B. **ROAD:** Motion to approve Capital Outlay funding from FY19 Budget to complete paving of Torrance County Admin Building parking lot.

   C. **FY20 Budget Continued**

4. **EXECUTIVE SESSION**

   A. **Threatened & Pending Litigation** regarding Dispatch, Section 10-15-1(H)(3)

5. **Adjourn**

Agenda Item
No. 1

Agenda Item
No. 2

Agenda Item
No. 3-A

70CDCR19DIG000009
INTERGOVERNMENTAL SERVICE AGREEMENT
BETWEEN THE
UNITED STATES DEPARTMENT OF HOMELAND SECURITY
U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
OFFICE OF ENFORCEMENT AND REMOVAL OPERATIONS
AND
TORRANCE COUNTY, NEW MEXICO

This Intergovernmental Service Agreement ("Agreement") is entered into between United States Department of Homeland Security Immigration and Customs Enforcement ("**ICE**"), and Torrance County, NM, ("**Service Provider**") for the detention and care of aliens ("**detainees**"). The term "Parties" is used in this Agreement to refer jointly to ICE and the Service Provider.

FACILITY LOCATION:

The Service Provider shall provide detention services for detainees at the following institution(s):

Torrance County Detention Facility
209 County Road A049
Estancia, NM 87016

The following documents constitute the complete agreement and are hereby incorporated directly or by reference:

- Bilaterally Signed Intergovernmental Service Agreement (IGSA)
- Attachment 1 – IHSC Formulary FY 2016
- Attachment 2 – Torrance County and CoreCivic Agreement
- Attachment 3 – Jail Cost Statement for Torrance County, dated April 2019
- Attachment 4 – Title 29, Part 4 Labor Standards for Federal Service Contracts
- Attachment 5 – Wage Determination 2015-5443, Revision 7 Dated 12/26/2018
- Attachment 6 – Quality Control Plan
- Attachment 7 – Quality Assurance Surveillance Plan
  - Attachment 7(a) – Performance Requirements Summary
  - Attachment 7(b) – Sample Contract Deficiency Report
- Attachment 8 – Performance Work Statement (PWS)
- Attachment 9 – Staffing Plan
- Attachment 10 – Intake Screening Form Template
- Attachment 11 – Trauma Informed Care Guidance
- Attachment 12 – Clinical Practice Guidelines
- Attachment 13 – Quality Improvement Audit Tool
- Attachment 15 – Torrance Recreation Schedule
- Attachment 16 – Torrance Visitation Schedule
- Attachment 17 – Torrance Ramp Plan
- Attachment 18 – DHS PREA Standards
- Attachment 19 – G-391 Data Collection Categories and Descriptions

- Attachment 19(a) – G-391 Transportation Data Template

IN WITNESS WHEREOF, the undersigned, duly authorized officers, have subscribed their names on behalf of the [Name of Service Provider] and Department of Homeland Security, U.S. Immigration and Customs Enforcement.

ACCEPTED:

U.S. Immigration and Customs Enforcement

Broderick Morris,
Contracting Officer

Signature: _____

Date: _____

ACCEPTED:

Torrance County, New Mexico

Wayne Johnson,
County Manager

Signature: _____

Date: _____

Intergovernmental Service Agreement (IGSA)

Table of Contents:

Article 1. Purpose

A. Purpose: The purpose of this Inter-Governmental Service Agreement (IGSA) is to establish an Agreement between ICE and the Service Provider for the provision of the necessary physical structure, equipment, facilities, personnel, and services to provide a program of care in a properly staffed and secure environment under the authority of the Immigration and Nationality Act, as amended. All persons in the custody of ICE are "Administrative Detainees." This term recognizes that ICE detainees are not charged with criminal violations and are only held in custody to ensure their presence throughout the administrative hearing process and to assure their presence for removal from the United States pursuant to a lawful final order by the Immigration Court, the Board of Immigration Appeals or other Federal judicial body.

B. Responsibilities: This Agreement sets forth the responsibilities of ICE and the Service Provider. The Service Provider shall provide all personnel, management, equipment, supplies, and services necessary for performance of all aspects of the Agreement and ensure that the safekeeping, housing, subsistence, medical, and other program services provided to ICE detainees housed in the facility is consistent with ICE's civil detention authority, the PWS, IGSA requirements and ICE standards referenced in this agreement. The Agreement states the services the Service Provider shall perform satisfactorily to receive payment from ICE at the rate prescribed in Article I C.

C. Rates: This is a fixed rate agreement, not a cost reimbursable agreement, with respect to the bed day rate for up to 892 detainees. ICE agrees to maintain a minimum population of at least 714 detainees, subject to the provisions contained within this Agreement. ICE will be responsible for reviewing and approving the costs associated with this Agreement and subsequent modifications utilizing all applicable federal procurement laws, regulations and standards in arriving at the bed day rate.

Year 1 Fixed Monthly Payment (714 bed Guarantee)	$1,950,130.35 per month, plus
Year 1 Bed Day Rate (Detainees 715+)	$ 89.55 per detainee
Year 2 Fixed Monthly Payment (714 bed Guarantee)	$1,993,449.32 per month, plus
Year 2 Bed Day Rate (Detainees 715+)	$ 91.79 per detainee
Year 3 Fixed Monthly Payment (714 bed Guarantee)	$2,043,182.40 per month, plus
Year 3 Bed Day Rate (Detainees 715+)	$ 94.08 per detainee
Year 4Fixed Monthly Payment (714 bed Guarantee)	$2,094,218.52 per month, plus
Year 4 Bed Day Rate (Detainees 715+)	$ 96.43 per detainee
Year 5 Fixed Monthly Payment (714 bed Guarantee)	$2,152,438.68 per month, plus
Year 5 Bed Day Rate (Detainees 715+)	$ 98.84 per detainee

* Escort Services at Regular Rate $ 36.99 per hour

* Stationary Guard at Regular Rate	$	36.99 per hour
Detainee Work Program Reimbursement	$	1.00 per day

*Transportation Mileage rate to be in accordance with GSA rates at the time of incurrence

***For medical and other transportation and guard services pursuant to Articles 16 and 17.**

Pricing for Transportation per Article 16.P is to be determined and will be incorporated by modification to this IGSA.

If this IGSA contains a population guarantee, ICE will not be liable for any failure to meet the population guarantee if such failure directly results from an occurrence that impairs the ability to use the facility's capacity, and such occurrence arises out of causes beyond the control and without the fault or negligence of ICE. Such causes may include, but are not limited to, acts of God or the public enemy, fires, floods, freight embargoes, court orders and extraordinarily severe weather. This provision shall become effective only if ICE immediately notifies the Provider of the extent and nature of the occurrence resulting in the failure and takes all reasonable steps to limit any adverse effects required by the occurrence.

Article 2. General

A. Commencement of Services: ICE is under no obligation to utilize the facilities identified herein until the need for detention services has been identified, funding has been identified and made available, and the Facility meets ICE requirements, and is in compliance with ICE 2011 Performance-Based National Detention Standards (PBNDS). Therefore, ICE may perform numerous assessments to ensure compliance prior to presenting detainees for housing.

**Should there be a need for a ramp-up plan, the effective start of the plan is from the date of the first detainee presented for housing.*

B. Funding: The obligation of ICE to make payments to the Service Provider is contingent upon the availability of Federal funds. ICE will neither present detainees to the Service Provider nor direct performance of any other services until ICE has the appropriate funding. Orders will be placed under this Agreement when specific requirements have been identified and funding obligated. Performance under this Agreement is not authorized until the Contracting Officer issues an order in writing. The effective date of the services will be negotiated and specified in this Agreement. The Service Provider shall be prepared to accept detainees immediately upon issuance of task order in accordance with the agreed upon ramp-up plan.

C. Subcontractors: The Service Provider shall notify and obtain approval from the ICE Contracting Officer if it intends to house ICE detainees in a facility other than the Torrance County Detention Facility. If either the Facility or any future facility is operated by an entity other than the Service Provider, ICE will treat the entity as a subcontractor to the Service Provider. The Service Provider shall obtain the Contracting Officer's approval before subcontracting the detention and care of detainees to another entity. The Contracting Officer has the right to deny, withhold, or withdraw approval of the proposed subcontractor. Upon approval by the Contracting Officer, the Service Provider shall ensure that any subcontract includes all provisions of this Agreement, and shall provide ICE with copies of all subcontracts. All payments will be made to the Service Provider. ICE will not accept invoices from, or make payments to, a subcontractor. Subcontractors that perform under this agreement are subject to the terms and conditions of this IGSA.

D. Staffing: The number, type and distribution of staff as described in the 714- ICE detainee contract staffing plan shall be maintained throughout the term of the contract. Written requests to change the number, type and/or distribution of staff described in the staffing plan must be submitted to the CO, through the COR, for approval prior to implementation. Beginning 90 days after the facility's receipt of the first detainee under this Agreement, Staffing levels shall not fall below a monthly average of 95% of the approved staffing plan each month.

Each month, the contractor shall submit to the COR the current average monthly vacancy rate, and indicate any individual positions that have been vacant more than 120 days. Failure to fill any individual position within 120 days of the vacancy may result in a deduction from the monthly invoice, if the vacancy in combination with other vacancies regardless of duration brings staffing levels below 95%. ICE may calculate the deduction retroactive to day one of the vacancy, excluding the days for ICE's conditional approval process, starting on the day of receipt and concluding on the day conditional approval is granted.

E. Consistent with Law: This is a firm fixed rate Agreement, not a cost reimbursable Agreement. This Agreement is permitted under applicable statutes, regulations, policies and judicial mandates. Any provision of this Agreement contrary to applicable statutes, regulation, policies or judicial mandates is null and void and shall not necessarily affect the balance of the Agreement.

Article 3. Covered Services

A. Bedspace: The Service Provider shall provide and operate a 892 bed adult male civil detention facility. The facility shall be located within appropriate proximity and access to emergency services (medical, fire protection, law enforcement, etc.) ICE will be financially liable only for the actual detainee days as defined in Paragraph C of Article 3.

B. Basic Needs: The Service Provider shall provide ICE detainees with safekeeping, housing, subsistence, medical and other services in accordance with this Agreement. In

providing these services, the Service Provider shall ensure compliance with all applicable laws, regulations, fire and safety codes, policies and procedures. The types and levels of services shall be consistent with ICE polices and detention standards. If the Service Provider determines that ICE has delivered a person for custody who is under the age of eighteen (18), the Service Provider shall not house that person with adult detainees and shall immediately notify the ICE COR or designated ICE official. ICE will remove the juvenile within seventy-two (72) hours.

C. Unit of Service and Financial Liability: The unit of service is called a "Bed Day" and is defined as one person per day. The bed day begins on the date of arrival. The Service Provider may bill ICE for the date of arrival but not the date of departure. The Service Provider shall not charge for costs that are not directly related to the housing and detention of detainees. Such unallowable costs include but are not limited to:

1) Salaries of elected officials
2) Salaries of employees not directly engaged in the housing and detention of detainees
3) Indirect costs in which a percentage of all local government costs are pro-rated and applied to individual departments unless, those cost are allocated under an approved Cost Allocation Plan
4) Detainee services which are not provided to, or cannot be used by, Federal detainees
5) Operating costs of facilities not utilized by Federal detainees
6) Interest on borrowing (however represented), bond discounts, costs of financing/refinancing, except as prescribed by OMB Circular A-87.
7) Legal or professional fees (specifically legal expenses for prosecution of claims against the Federal Government, legal expenses of individual detainees or inmates)
8) Contingencies

D. Language Access Services: The Service Provider shall provide language access services, which include interpretation and translation services, for limited English proficient (LEP) detainees. This should be accomplished through professional interpretation and translation or qualified bilingual personnel for necessary communication with detainees who do not read, speak, write, or understand English. Oral interpretation should be provided for detainees who are illiterate. Other than in emergencies, and even then only for that period of time before appropriate language services can be procured, detainees shall not be used for interpretation or translation services. The Service Provider shall also make special provisions for detainees who are illiterate. The Service Provider should utilize commercial phone language interpretive services to ensure fulfillment of this requirement. Upon request, ICE will assist the Service Provider in obtaining interpretation and translation services through a toll-free line. The Service Provider shall provide all instructions verbally, either in English or the detainees' language, as appropriate, to detainees who cannot read.

E. Disability-Related Services: The Service Provider shall comply with Section 504 of the Rehabilitation Act of 1973 (Section 504), Title II of the Americans with Disabilities Act of 1990 (Title II), their implementing federal regulations, any other applicable disability-related federal law and state law, and its obligations under ICE 2011 PBNDS. Specifically, the Service Provider shall ensure that its building and transportation services are physically accessible for detainees with disabilities. Also, as required under applicable federal and state law and under ICE 2011 PBNDS, the Service Provider shall provide detainees with disabilities with accommodations, auxiliary aids, and modifications to policies, practices, and/or procedures to allow them an equal opportunity to access, participate in, or benefit from detention programs, services, and activities. The Service Provider shall allow for effective communication with detainees with disabilities through the provision of reasonable accommodations and auxiliary aids, such as access to sign language interpretation services, as necessary. In addition, deaf detainees shall have access to a TTY telephone sign language interpretation services.

F. Escort and Transportation Services: The Service Provider shall provide, upon request and as scheduled by ICE, necessary escort and transportation services for ICE detainees to and from designated locations. Escort services shall be required for escorting detainees to court hearings; escorting detainees who are witnesses to the courtroom and staged with the ICE Judge during administrative proceedings. Transportation Services shall be performed by at least two (2) qualified sworn law enforcement or correctional officer personnel employed by the Service Provider under their policies, procedures and authorities.

G. No ICE Liability for Failure to Meet Minimum Guarantee: ICE will not be liable for any failure to meet the minimum or population guarantee if such failure results directly from an occurrence that impairs the ability of ICE to use the facility's capacity, and such occurrence arises out of causes beyond the control and without the fault or negligence of ICE. Such causes may include, but are not limited to, acts of God or the public enemy, fires, floods, freight embargoes, court orders and extraordinarily severe weather. This provision becomes effective only if ICE immediately notifies the Provider of the extent and nature of the occurrence resulting in the failure and takes all reasonable steps to limit any adverse effects required by the occurrence.

Article 4. Receiving and Discharging Detainees

A. Required Activity: The Service Provider shall receive and discharge detainees only to and from properly identified ICE/ERO personnel or other properly identified Federal law enforcement officials with prior authorization from ICE/ERO. Presentation of U.S. Government identification will constitute "proper identification." The Service Provider shall furnish receiving and discharging services twenty-four (24) hours per day, seven (7) days per week. ICE will furnish the Service Provider with reasonable notice of receiving and discharging detainees. The Service Provider shall ensure positive identification and recording of detainees and ICE officers. The Service Provider shall not permit medical or emergency discharges except through coordination with on-duty ICE officers.

B. Emergency Situations: ICE detainees shall not be released from the Facility into the custody of other Federal, state, or local officials for any reason, except for medical or emergency situations, without express authorization of ICE.

C. Restricted Release of Detainees: The Service Provider shall not release ICE detainees from its physical custody to any persons other than those described in Paragraph A of Article IV for any reason, except for either medical, other emergency situations, or in response to a federal writ of habeas corpus. If an ICE detainee is sought for federal, state, or local proceedings, only ICE may authorize release of the detainee for such purposes. The Service Provider shall contact the ICE COR or designated ICE official immediately regarding any such requests.

D. Safe Release: The time, point and manner of release from a facility shall be consistent with safety considerations and shall take into account special vulnerabilities. Facilities that are not within a reasonable walking distance of, or that are more than one mile from, public transportation shall transport detainees to local bus/train/subway stations prior to the time the last bus/train leaves such stations for the day. If public transportation is within walking distance of the detention facility, detainees shall be provided with an information sheet that gives directions to and describes the types of transportation services available. However, facilities must provide transportation for any detainee who is not reasonably able to walk to public transportation due to age, disability, illness, mental health or other vulnerability, or as a result of weather or other environmental conditions at the time of release that may endanger the health or safety of the detainee. Upon release, detainees shall also be provided with a list of shelter services available in the immediate area along with directions to each shelter. Prior to their release, detainees shall be given the opportunity to make a free phone call to a friend or relative to arrange for pick up from the facility. As practicable, detainees shall be provided with a laundered set of their own clothing, or one set of non-institutional clothing and footwear, weather appropriate, for their final destination.

E. Service Provider Right of Refusal. The Service Provider retains the right to refuse acceptance of any detainee if such refusal is supported by a valid justification and agreed to by the COR. Examples of such justification are: any detainee exhibiting violent or disruptive behavior, or any detainee found to have a medical condition that requires medical care beyond the scope of the Service Provider's health care provider. In the case of a detainee already in custody, the Service Provider shall notify ICE and request such removal of the detainee from the Facility. The Service Provider shall allow ICE reasonable time to make alternative arrangements for the detainee.

F. Emergency Evacuation: In the event of an emergency requiring evacuation of the Facility, the Service Provider shall evacuate ICE detainees in the same manner, and with the same safeguards, as it employs for persons detained under the Service Provider's authority. The Service Provider shall notify the ICE COR or designated ICE official within two (2) hours of evacuation.

Article 5. ICE Performance-Based National Detention Standards and Other Applicable Standards

A. The Service Provider shall house detainees and perform related detention services at a minimum in accordance with the 2011 edition of ICE Performance Based National Detention Standards (PBNDS), Minimal Level, unless otherwise specified in this agreement. The complete set of standards applicable to this procurement is available from the following website: http://www.ice.gov/detention-standards/2011/ and are incorporated herein. The Minimal Level PBNDS are required under this Agreement. The Service Provider is not required to provide services at the Optimal Level. ICE Inspectors will conduct periodic inspections of the Facility to assure compliance with the ICE PBNDS.

B. If a change in the standards identified herein results in a documentable financial impact to the Service Provider, the Service Provider must notify the Contracting Officer within thirty (30) days of receipt of the change and request either 1) a waiver to the Standards or, 2) to negotiate a change in per diem.

C. The Service provider shall also comply with the American Correctional Association (ACA) Standards for Adult Local Detention Facilities (ALDF), and Standards Supplement, Standards for Health Services in Jails, National Commission on Correctional Health Care (NCCHC). Some ACA standards are augmented by ICE Policy and/or procedure. The Service Provider shall also comply with the requirements of Subpart A of the U.S. Department of Homeland Security Regulation titled "*Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities*," title 6 Code of Federal Regulation (C.F.R.) part 115 (DHS PREA)/79 Fed. Reg. 13100 (Mar. 7, 2014), and Attachment 5 to this agreement. If any requirements of the DHS PREA standards conflict with the terms of the 2011 PBNDS, the DHS PREA standards shall prevail.

D. In cases where other standards conflict with ICE Policy or Standards, ICE Policy and Standards will prevail.

Article 6. Medical Services

A. If it is determined that ICE Health Service Corps will not provide direct patient care services at this location then; the Service Provider shall be responsible for providing health care services for ICE detainees at the Facility in accordance with the applicable 2011 PBNDS, NCCHC and/or ACA standards, including but not limited to: intake arrival screening, infectious disease screening and treatment, emergent, acute and chronic care, on-site sick call, dental services, and mental health services. Also required is over-the-counter and prescription medications per the current ICE Health Service Corps (IHSC) Formulary along with all required vaccinations per the CDC recommendations and IHSC policy for certain populations. On site routine labs and CLIA waived testing will be a requirement of the Service Provider. Off-site labs must be approved through the Medpar system and will be paid for by IHSC. Medical supplies will also be provided at

no additional cost to the government or the ICE detained alien. Except as otherwise noted, all of the above costs will be included in the bed day rate for this contract.

The exception would be any approved prescription medications that must be filled at a retail pharmacy location, to include; approved non-formulary meds, or any approved newly marketed med not currently available at the on-site pharmacy, as well as durable medical equipment identified as necessary by a medical provider. The mechanism for payment for retail purchases of medications and durable medical equipment will be made available through the IHSC Field Medical Coordinator (FMC).

B. In the event of a medical emergency, the Service Provider shall proceed immediately to provide necessary emergency medical treatment, including initial on-site stabilization and off-site transport, if needed. The Service Provider shall notify ICE immediately regarding the nature of the transferred detainee's illness or injury and the type of treatment provided. The cost of all emergency medical services provided off-site will be the responsibility of ICE Health Service Corps (IHSC). At no time shall the Service Provider or detainee incur any financial liability related to such services. The primary point of contact for obtaining pre-approval for non-emergent care as well as the post approval for emergent care will be the IHSC FMC assigned to this location.

C. The Service Provider shall furnish a twenty-four (24) hour/seven day per week emergency medical care contact list which must include local hospitals and other offsite service providers. The Service Provider shall ensure they have access to an offsite emergency medical provider at all times.

D. The Service Provider must make available a facility emergency evacuation procedure guide that includes any patients currently housed in a medical/mental health housing area including any isolation rooms as well as other special housing areas within the facility. The service provider must provide training on all emergency plans to the on-site medical staff.

E. A true copy of a detainee's medical records shall be transferred with the detainee upon request of the detainee. Otherwise a medical transfer summary shall accompany the detainee outlining necessary care during transit that includes current medications, medical precautions, tuberculosis testing and evaluation status, equipment needed, and appropriately authorized methods of travel.

F. The Service Provider shall ensure that all health care providers utilized for ICE detainees hold current licenses, certifications, and/or registrations within the State and/or City where they treat our detained population. The Service Provider shall retain, at a minimum, staffing levels as approved by IHSC at the time of implementation of this contract.

G. The Service Provider shall furnish onsite health care under this Agreement as defined by the Facility Local Health Authority (usually the Health Administrator) and as approved by the ICE Health Authority on the effective date of this Agreement. The Service

Provider shall not charge any ICE detainee a fee or co-payment for medical services or treatment provided at the Facility. The Service Provider shall ensure that ICE detainees receive no lower level of onsite medical care and services than those it provides to local inmates, and as spelled out in 2011 PBNDS.

H. Onsite health care personnel shall perform **initial medical screening** within (12) hours of arrival to the Facility. Arrival screening shall include, at a minimum, all questions captured on the IHSC 795-A or equivalent. Required testing for TB infection and/or disease using any Food and Drug Administration (FDA) approved method and recording the history of past and present illnesses (mental and physical, dental, pregnancy status, history of substance abuse, screening questions for other infectious disease, and current health status). Initial screening will also contain height, weight, and a complete set of vital signs (BP, P, T). Blood sugar and O2 readings may be necessary dependent upon specified diagnosis or current medical concern.

I. The Service Provider shall furnish mental health evaluations as determined by the Facility local health authority and in accordance with detention, 2011 PBNDS, National Commission on Correctional Health Care (NCCHC), and ACA standards with the expectation to provide custody oversight and medication as needed.

J. **A full health assessment to include a history and hands on physical examination shall be completed within the first 14 days of detainee arrival unless the clinical situation dictates an earlier evaluation.** Detainees with chronic medical and/or mental health conditions shall receive prescribed treatment and follow-up care with the appropriate level of provider and in accordance with the PBNDS 2011, the, National Commission on Correctional Health Care (NCCHC) and American Correctional Association Standards based on which standards are applicable under this agreement. In addition, **any juvenile (pediatric or adolescent) seen for a scheduled medical, dental or mental health appointment will have a weight, blood pressure, temperature, and pulse taken and recorded in the record.** This does not include the weekly mental health wellness check conducted for each juvenile.

K. If the Service Provider determines that an ICE detainee has a medical condition which renders that person unacceptable for detention under this Agreement, (for example, serious contagious disease, condition needing life support, uncontrollable violence, or serious mental health condition), the Service Provider shall notify ICE through the Field Office representative. Upon such notification, the Service Provider shall allow ICE reasonable time to make the proper arrangements for further disposition of that detainee.

L. The Service Provider shall release any and all medical information for ICE detainees to the IHSC representatives upon request.

The Service Provider shall submit a Medical Payment Authorization Request (MedPAR) to IHSC for payment for off-site medical care (e.g. offsite specialty care, offsite lab testing, eyeglasses, prosthetics, hospitalizations, emergency visits). The Service Provider

shall enter payment authorization requests electronically as outlined in the MedPAR User Guide:
https://medpar.ehr-icehealth.org/.

M. The Health Authority of the Service Provider shall notify the ICE contact and/or FMC as soon as possible if emergency care was obtained off site; and in no case more than seventy-two (72) hours after detainee is in receipt of such care. Authorized payment for all offsite medical services for the initial emergency need and for medical and/or mental health care required beyond the initial emergency situation will be made by the Veterans Administration Franchise Service Center (VA FSC) on behalf of IHSC directly to the medical provider(s).

IHSC VA Financial Services Center
PO Box 149345
Austin, TX 78714-9345
Phone: (800) 479-0523
Fax: (512) 460-5538

N. The Service Provider shall allow IHSC Field Medical Coordinators, Managed Care Coordinators or any ICE personnel reasonable access to its facility and medical records of ICE detainees for the purpose of liaison activities with the local IGSA Health Authority and associated Service Provider departments in accordance with HIPAA privacy exception at 45 C.F.R. §§ 164.512 (k)(5)(i).

O. The Service Provider shall provide ICE detainee medical records to ICE whether created by the Service Provider or its sub-Service Provider/vendor upon request from the Contracting Officer's Representative or Contracting Officer in accordance with HIPAA privacy exception at 45 C.F.R. §§ 164.512 (k)(5)(i), which allows disclosure without consent to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual if the correctional institution or such law enforcement official represents that such protected health information is necessary for:

a. The provision of health care to such individuals;
b. The health and safety of such individual or other inmates;
c. The health and safety of the officers or employees of or others at the correctional institution;
d. The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;
e. Law enforcement on the premises of the correctional institution;
f. The administration and maintenance of the safety, security, and good order of the correctional institution; and

g. Conducting a quality improvement / quality of care review consistent with an established quality improvement (medical quality management) program and interfacing with the IHSC quality improvement program consistent with federal, state, and local laws.

P. Tuberculosis Screening

The Service Provider will perform TB screening as part of the routine intake screening, within 12 hours of detainee admission, early detection of any detainee suspected of having TB disease. TB screening will include, at a minimum, TB symptom screening and testing for TB infection and/or disease using any Food and Drug Administration (FDA) approved method. Detainees who have symptoms suggestive of TB disease will be immediately placed in an airborne infection isolation room and promptly evaluated for suspected TB disease. Detainees who are initially tested using a test for TB infection [TB skin test (TST) or interferon gamma release assay (IGRA)] and result with a TST interpretation or IGRA positive for TB infection and no symptoms suggestive of TB disease must be evaluated with a chest radiograph within 5 days after the TST is interpreted or IGRA result is received.

Detainees who are identified with confirmed or suspected active TB (e.g., symptoms suggestive of TB or chest radiograph suggestive of TB) will be placed in a functional airborne infection isolation room and managed in accordance with the PBNDS and all applicable CDC guidelines: http://www.cdc.gov/tb/publications/guidelines/default.htm. It is not necessary to house detainees separately from the general population unless there is clinical or radiographic evidence suggestive of TB disease. If chest x-rays are performed on-site, they will be performed by a trained and qualified health care provider and interpreted by a credentialed radiologist. There will be a non-punitive process in place for detainees who refuse the screening assessment for TB.

The Service Provider will notify IHSC and the local health department of all detainees with confirmed or suspected TB disease, including detainees with clinical or radiographic evidence suggestive of TB. Notification shall occur within one working day of identifying a detainee with confirmed or suspected TB disease. Notification to local health departments shall identify the detainee as being in ICE custody and shall include the alien number with other identifying information. For detainees with confirmed or suspected TB disease, the Service Provider will coordinate with IHSC and the local health department prior to release to facilitate release planning and referrals for continuity of care.

The service provider will evaluate detainees annually for symptoms, consistent with TB, within one year of the previously documented TB evaluation. For detainees initially screened with a TST or IGRA with a negative result, annual evaluation will include testing with the same method as previously used. For detainees initially evaluated with a chest radiograph interpreted as not suggestive of TB disease, routine annual chest radiograph is not recommended.

Q. Radiology Service Provider

If the service provider utilizes tele-radiology for Tuberculosis screening, the requirement should be built into the established bed day rate for this IGSA.

R. Airborne precautions

In order to prevent the spread of airborne infectious disease or cross contamination of zones within the facility, the HVAC system in the intake screening area will be designed to exhaust to the exterior and prevent air exchange between the intake screening area and any other area within the facility (see CDC guidelines http://www.cdc.gov/tb/publications/guidelines/Correctional.htm).

Other areas of concern:

Language Access – The Service Provider is responsible for providing meaningful access to all programs and services (e.g. medical, intake, classification, sexual assault reporting) for individuals with limited English proficiency. This should be accomplished through professional interpretation and translation or qualified bilingual personnel for necessary communication with residents who do not speak or understand English. Oral interpretation should be provided for residents who are illiterate. Other than in emergencies, and even then only for that period of time before appropriate language services can be procured, residents shall not be used for interpretation or translation services. The Service Provider should utilize commercial phone language interpretive services to ensure fulfillment of this requirement. Telephones that can be used for this purpose must be available.

It is the obligation of the Service Provider that residents with disabilities (e.g. physical, mental, intellectual, developmental) are housed/served in the least restrictive environment and that reasonable modifications be provided to allow individuals with disabilities to have equal opportunity to participate in programs and services. The Service Provider will use auxiliary aids and necessary assistive devices for residents who because of a disability need additional communication support.

Employee Health:

Employee health files for each employee must be maintained on site, in a locked cabinet by the Health Services Administrator or the employer's designee. Health files are maintained in accordance with DHS and ICE Privacy Policies and the Privacy Act of 1974 and contain the following documents:

a. Initial and annual TB infection screening results.
b. Vaccination records including results, titers, and Immunization Declination Form(s).
c. OSHA 301 Incident forms.
d. Blood borne pathogen exposure documentation.
e. Annual respirator medical clearance.

f. Fit test results.

g. Other employee health documents .

The Service Provider may initiate employment of an individual who has initiated the required vaccines and the individual may be hired and begin performing work on the contract as long as they meet all subsequent booster dates until fully vaccinated.

All contract personnel must provide documentation regarding the following:

1. History of testing for tuberculosis (TB) within the last 12 months:

a. Chest x-ray if employee has a history of LTBI, treatment history for LTBI or TB disease, if applicable; and

b. Additionally, on an annual basis and at own expense, contractor shall provide a current TST or IGRA test result if the employee previously tested negative for LTBI, evaluation for TB symptoms if the employee previously tested positive for LTBI, and follow up as appropriate in accordance with Centers for Disease Control and Prevention (CDC) guidelines.

2. Hepatitis B

The Occupational Safety and Health Administration (OSHA) Blood-borne Pathogens (BBP) Standard requires employers to provide employees at risk of occupational exposure to blood and other potentially infectious material (OPIM) with the Hepatitis B vaccination series. Health staff must do one of the following:

a. Complete the Hepatitis B vaccination series; and provide documentation of the vaccination series or titer results that confirm immunity to HBV; or

b. Refuse the vaccination series for medical reasons and complete the Immunization Declination Form.

Highly recommended vaccinations for custody staff in the detention environment; Custody workers are considered to be at significant risk for acquiring or transmitting Hepatitis B, measles, mumps, rubella, varicella and seasonal influenza. All of these diseases are vaccine-preventable. Therefore, the following vaccinations are highly recommended for custody staff. If staff decline or refuse any of these recommended vaccines, an Immunization Declination Form is required.

a. Hepatitis A;

b. Hepatitis B;

c. Varicella;

d. Measles, Mumps, Rubella (MMR);

e. Diphtheria, tetanus, a-cellular pertussis (DTAP); and

f. Annual seasonal influenza.

Custody staff will provide immunization documentation or titer results to the Health Services Administrator or the employer's designee for placement in the employee health file. CDCs Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC)

Article 7. Employment Screening Requirements

General: Performance under this Intergovernmental Service Agreement requires access to sensitive DHS information and will involve direct contact with ICE Detainees. The Service Provider shall adhere to the following.

Contractor Employee Fitness Screening: Screening criteria under DHS Instruction 121-01-007-001 (Personnel Security, Suitability and Fitness Program), or successor thereto, that may exclude contractor employees from consideration to perform under this agreement includes:

- Misconduct or negligence in employment;
- Criminal or dishonest conduct;
- Material, intentional false statement or deception of fraud in examination or appointment;
- Refusal to furnish testimony as required by 5 CFR § 5.4 (i.e., a refusal to provide testimony to the Merit Systems Protection Board or the Office of Special Counsel);
- Illegal use of narcotics, drugs, or other controlled substances without evidence of substantial rehabilitation.
- Alcohol abuse, without evidence of substantial rehabilitation, of a nature and duration that suggests that the applicant or appointee would be prevented from performing the duties of the position in question, or would constitute a direct threat to the property or safety of the applicant or appointee or others;
- Illegal use of narcotics, drugs, or other controlled substances, without evidence of substantial rehabilitation;
- Knowing and willful engagement in acts or activities designed to overthrow the U.S. Government by force;
- Any statutory or regulatory bar which prevents the lawful employment of the person involved in the position in question (for Excepted Service employees); and
- Any other nondiscriminatory reason that an individual's employment (or work on a contract) would not protect the integrity of promote the efficiency of the service.

Contractor Employee Fitness Screening: Screening criteria under 6 CFR § 115.117 (Sexual Abuse and Assault Prevention Standards) implemented pursuant to Public Law 108-79 (Prison Rape Elimination Act (PREA) of 2003) or successor thereto, that WILL exclude contractor employees from consideration to perform under this agreement includes:

- Engaged in Sexual Abuse in a Prison, Jail, Holding Facility, Community Confinement Facility, Juvenile Facility, or other Institution as defined under 42 USC 1997;
- Convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse;
- Civilly or administratively adjudicated to have in engaged in such activity.

Subject to existing law, regulations and/or other provisions of this Agreement, illegal or undocumented aliens shall not be employed by the Service Provider.

GENERAL

The United States Immigration and Customs Enforcement (ICE) has determined that performance of the tasks as described in contract agreement (#)70CDCR19DIG000009 requires that the Contractor, subcontractor(s), vendor(s), etc. (herein known as Contractor) have access to sensitive DHS information and ICE Detainees, and that the Contractor will adhere to the following:

PRELIMINARY FITNESS DETERMINATION

ICE will exercise full control over granting, denying, withholding or terminating unescorted government facility and/or sensitive Government information access for contractor employees, based upon the results of a Fitness screening process. ICE may, as it deems appropriate, authorize and make a favorable expedited preliminary Fitness determination based on preliminary security checks. The preliminary Fitness determination will allow the contractor employee to commence work temporarily prior to the completion of a Full Field Background Investigation. The granting of a favorable preliminary Fitness shall not be considered as assurance that a favorable final Fitness determination will follow as a result thereof. The granting of preliminary Fitness or final Fitness shall in no way prevent, preclude, or bar the withdrawal or termination of any such access by ICE, at any time during the term of the contract. No employee of the Contractor shall be allowed to enter on duty and/or access sensitive information or systems without a favorable preliminary Fitness determination or final Fitness determination by the Office of Professional Responsibility, Personnel Security Unit (OPR-PSU). No employee of the Contractor shall be allowed unescorted access to a Government facility without a favorable preliminary Fitness determination or final Fitness determination by OPR-PSU. Contract employees are processed under DHS Instruction 121-01-007-001 (Personnel Security, Suitability and Fitness Program), or successor thereto; those having direct contact with Detainees will also have 6 CFR § 115.117 considerations made as part of the Fitness screening process.

BACKGROUND INVESTIGATIONS

Contractor employees (to include applicants, temporaries, part-time and replacement employees) under the contract, needing access to sensitive information and/or ICE Detainees, shall undergo a position sensitivity analysis based on the duties each individual will perform on the contract. The results of the position sensitivity analysis shall identify the appropriate background investigation to be conducted. Background investigations will be processed through the Personnel Security Unit. Contractor employees nominated by a Contracting Officer

Representative for consideration to support this contract shall submit the following security vetting documentation to OPR-PSU, through the Contracting Officer Representative (COR), within 10 days of notification by OPR-PSU of nomination by the COR and initiation of an Electronic Questionnaire for Investigation Processing (e-QIP) in the Office of Personnel Management (OPM) automated on-line system.

1. Standard Form 85P (Standard Form 85PS (With supplement to 85P required for armed positions)), "Questionnaire for Public Trust Positions" Form completed on-line and archived by the contractor employee in their OPM e-QIP account.

2. Signature Release Forms (Three total) generated by OPM e-QIP upon completion of Questionnaire (e-signature recommended/acceptable – instructions provided to applicant by OPR-PSU). Completed on-line and archived by the contractor employee in their OPM e-QIP account.

3. Two (2) SF 87 (Rev. December 2017) Fingerprint Cards. **(Two Original Cards sent via COR to OPR-PSU)**

4. Foreign National Relatives or Associates Statement. (This document sent as an attachment in an e-mail to contractor employee from OPR-PSU – must be signed and archived into contractor employee's OPM e-QIP account prior to electronic "Release" of data via on-line account)

5. DHS 11000-9, "Disclosure and Authorization Pertaining to Consumer Reports Pursuant to the Fair Credit Reporting Act" (This document sent as an attachment in an e-mail to contractor employee from OPR-PSU – must be signed and archived into contractor employee's OPM e-QIP account prior to electronic "Release" of data via on-line account)

6. Optional Form 306 Declaration for Federal Employment (This document sent as an attachment in an e-mail to contractor employee from OPR-PSU – must be signed and archived into contractor employee's OPM e-QIP account prior to electronic "Release" of data via on-line account)

7. Questionnaire regarding conduct defined under 6 CFR § 115.117 (Sexual Abuse and Assault Prevention Standards) (This document sent as an attachment in an e-mail to contractor employee from OPR-PSU – must be signed and archived into contractor employee's OPM e-QIP account prior to electronic "Release" of data via on-line account)

8. One additional document may be applicable if contractor employee was born abroad. If applicable, additional form and instructions will be provided to contractor employee. (If applicable, the document will be sent as an attachment in an e-mail to contractor employee from OPR-PSU – must be signed and archived into contractor employee's OPM e-QIP account prior to electronic "Release" of data via on-line account)

Contractor employees who have an adequate, current investigation by another Federal Agency may not be required to submit complete security packages; the investigation may be accepted under reciprocity. The questionnaire related to 6 CFR § 115.117 listed above in item 7 will be required for positions designated under PREA.

An adequate and current investigation is one where the investigation is not more than five years old, meets the contract risk level requirement, and applicant has not had a break in service of more than two years. (Executive Order 13488 amended under Executive Order 13764/DHS Instruction 121-01-007-01)

Required information for submission of security packet will be provided by OPR-PSU at the time of award of the contract. Only complete packages will be accepted by the OPR-PSU as notified by the COR.

To ensure adequate background investigative coverage, contractor employees must currently reside in the United States or its Territories. Additionally, contractor employees are required to have resided within the Unites States or its Territories for three or more years out of the last five (ICE retains the right to deem a contractor employee ineligible due to insufficient background coverage). This time-line is assessed based on the signature date of the standard form questionnaire submitted for the applied position. Contractor employees falling under the following situations may be exempt from the residency requirement: 1) work or worked for the U.S. Government in foreign countries in federal civilian or military capacities; 2) were or are dependents accompanying a federal civilian or a military employee serving in foreign countries so long as they were or are authorized by the U.S. Government to accompany their federal civilian or military sponsor in the foreign location; 3) worked as a contractor employee, volunteer, consultant or intern on behalf of the federal government overseas, where stateside coverage can be obtained to complete the background investigation; 4) studied abroad at a U.S. affiliated college or university; or 5) have a current and adequate background investigation (commensurate with the position risk/sensitivity levels) completed for a federal or contractor employee position, barring any break in federal employment or federal sponsorship.

Only U.S. Citizens and Legal Permanent Residents are eligible for employment on contracts requiring access to DHS sensitive information unless an exception is granted as outlined under DHS Instruction 121-01-007-001. Per DHS Sensitive Systems Policy Directive 4300A, only U.S. citizens are eligible for positions requiring access to DHS Information Technology (IT) systems or positions that are involved in the development, operation, management, or maintenance of DHS IT systems, unless an exception is granted as outlined under DHS Instruction 121-01-007-001.

TRANSFERS FROM OTHER DHS CONTRACTS:

Contractor employees may be eligible for transfer from other DHS Component contracts provided they have an adequate and current investigation meeting the new assignment requirement. If the contractor employee does not meet the new assignment requirement a DHS

11000-25 with ICE supplemental page will be submitted to OPR-PSU to initiate a new investigation.

Transfers will be accomplished by submitting a DHS 11000-25 with ICE supplemental page indicating "Contract Change." The questionnaire related to 6 CFR § 115.117 listed above in item 7 will be required for positions designated under PREA.

CONTINUED ELIGIBILITY

ICE reserves the right and prerogative to deny and/or restrict facility and information access of any contractor employee whose actions conflict with Fitness standards contained in DHS Instruction 121-01-007-01, Chapter 3, paragraph 6.B or who violate standards of conduct under 6 CFR § 115.117. The Contracting Officer or their representative can determine if a risk of compromising sensitive Government information exists or if the efficiency of service is at risk and may direct immediate removal of a contractor employee from contract support. The OPR-PSU will conduct periodic reinvestigations every 5 years, or when derogatory information is received, to evaluate continued Fitness of contractor employees.

REQUIRED REPORTS

The Contractor will notify OPR-PSU, via the COR, of all terminations/resignations of contractor employees under the contract within five days of occurrence. The Contractor will return any expired ICE issued identification cards and building passes of terminated/ resigned employees to the COR. If an identification card or building pass is not available to be returned, a report must be submitted to the COR referencing the pass or card number, name of individual to whom issued, the last known location and disposition of the pass or card. The COR will return the identification cards and building passes to the responsible ID Unit.

The Contractor will report any adverse information coming to their attention concerning contractor employees under the contract to the OPR-PSU, via the COR, as soon as possible. Reports based on rumor or innuendo should not be made. The subsequent termination of employment of an employee does not obviate the requirement to submit this report. The report shall include the contractor employees' name and social security number, along with the adverse information being reported.

The Contractor will provide, through the COR a Quarterly Report containing the names of contractor employees who are active, pending hire, have departed within the quarter or have had a legal name change (Submitted with documentation). The list shall include the Name, Position and SSN (Last Four) and should be derived from system(s) used for contractor payroll/voucher processing to ensure accuracy.

CORs will submit reports to psu-industrial-security@ice.dhs.gov

Contractors, who are involved with management and/or use of information/data deemed "sensitive" to include 'law enforcement sensitive" are required to complete the DHS Form 11000-6-Sensitive but Unclassified Information NDA for contractor access to sensitive information. The NDA will be administered by the COR to the all contract personnel within 10

calendar days of the entry on duty date. The completed form shall remain on file with the COR for purpose of administration and inspection.

Sensitive information as defined under the Computer Security Act of 1987, Public Law 100-235 is information not otherwise categorized by statute or regulation that if disclosed could have an adverse impact on the welfare or privacy of individuals or on the welfare or conduct of Federal programs or other programs or operations essential to the national interest. Examples of sensitive information include personal data such as Social Security numbers; trade secrets; system vulnerability information; pre-solicitation procurement documents, such as statements of work; and information pertaining to law enforcement investigative methods; similarly, detailed reports related to computer security deficiencies in internal controls are also sensitive information because of the potential damage that could be caused by the misuse of this information. All sensitive information must be protected from loss, misuse, modification, and unauthorized access in accordance with DHS Management Directive 11042.1, *DHS Policy for Sensitive Information* and ICE Policy 4003, *Safeguarding Law Enforcement Sensitive Information*."

Any unauthorized disclosure of information should be reported to ICE.ADSEC@ICE.dhs.gov.

SECURITY MANAGEMENT

The Contractor shall appoint a senior official to act as the Corporate Security Officer. The individual will interface with the OPR-PSU through the COR on all security matters, to include physical, personnel, and protection of all Government information and data accessed by the Contractor.

The COR and the OPR-PSU shall have the right to inspect the procedures, methods, and facilities utilized by the Contractor in complying with the security requirements under this contract. Should the COR determine that the Contractor is not complying with the security requirements of this contract, the Contractor will be informed in writing by the Contracting Officer of the proper action to be taken in order to effect compliance with such requirements.

INFORMATION TECHNOLOGY SECURITY CLEARANCE

When sensitive government information is processed on Department telecommunications and automated information systems, the Contractor agrees to provide for the administrative control of sensitive data being processed and to adhere to the procedures governing such data as outlined in DHS MD 4300.1, *Information Technology Systems Security.* or its replacement. Contractor employees must have favorably adjudicated background investigations commensurate with the defined sensitivity level.

Contractor employees who fail to comply with Department security policy are subject to having their access to Department IT systems and facilities terminated, whether or not the failure results in criminal prosecution. Any person who improperly discloses sensitive information is subject to criminal and civil penalties and sanctions under a variety of laws (e.g., Privacy Act).

INFORMATION TECHNOLOGY SECURITY TRAINING AND OVERSIGHT

In accordance with Chief Information Office requirements and provisions, all contractor employees accessing Department IT systems or processing DHS sensitive data via an IT system will require an ICE issued/provisioned Personal Identity Verification (PIV) card. Additionally, Information Assurance Awareness Training (IAAT) will be required upon initial access and annually thereafter. IAAT training will be provided by the appropriate component agency of DHS.

Contractor employees, who are involved with management, use, or operation of any IT systems that handle sensitive information within or under the supervision of the Department, shall receive periodic training at least annually in security awareness and accepted security practices, systems rules of behavior, to include Unauthorized Disclosure Training, available on PALMS or by contacting ICE.ADSEC@ICE.dhs.gov. Department contractor employees, with significant security responsibilities, shall receive specialized training specific to their security responsibilities annually. The level of training shall be commensurate with the individual's duties and responsibilities and is intended to promote a consistent understanding of the principles and concepts of telecommunications and IT systems security.

All personnel who access Department information systems will be continually evaluated while performing these duties. System Administrators should be aware of any unusual or inappropriate behavior by personnel accessing systems. Any unauthorized access, sharing of passwords, or other questionable security procedures should be reported to the local Security Office or Information System Security Officer (ISSO).

Article 8. Period of Performance

This Agreement becomes effective upon the date of final signature by the ICE Contracting Officer and the authorized signatory of the Service Provider and will remain in effect for a period not to exceed 60 months unless extended by bi-lateral modification or terminated in writing by either party. Either party must provide written notice of intention to terminate the agreement, 120 days in advance of the effective date of formal termination, or the Parties may agree to a shorter period under the procedures prescribed in Article 11. If this Agreement is terminated by either party under this Article, ICE will be under no financial obligation for any costs after the date of termination. The Service Provider will only be paid for services provided to ICE up to and including the day of termination.

Article 9. Inspections, Audit, Surveys, and Tours

A. Facility Inspections: The Service Provider shall allow ICE or an entity or organization approved by ICE to conduct inspections of the Facility, as required, to ensure an acceptable level of services and acceptable conditions of confinement as determined by ICE. No notice to the Service Provider is required prior to an inspection. ICE will share findings of the inspection with the Service Provider's Facility Administrator. The Inspection Report will state any improvements to facility operation, conditions of confinement, and level of service that will be required by the Service Provider.

B. ICE will not house detainees in any facility that has received two consecutive overall ratings of less than acceptable. Upon notice that the second overall rating is less than acceptable, ICE will remove all detainees from the Facility within seven (7) calendar days. Any minimum guarantee stated elsewhere in this Agreement is no longer applicable if detainees are removed as a result of two overall ratings less than acceptable. No further funds will be obligated and no further payments will be made.

C. Possible Termination: If the Service Provider, after being afforded reasonable time of at least 30 days to comply, fails to remedy deficient service identified through an ICE inspection, ICE may terminate this Agreement without regard to any other provisions in this Agreement.

D. Share Findings: The Service Provider shall provide ICE copies of facility inspections, reviews, examinations, and surveys performed by accreditation sources. The Service Provider shall cooperate fully with the Detention Service Manager (DSM).

E. Access to Detainee and Facility Records: The Service Provider shall, upon request, grant ICE access to any record in its possession, regardless of whether the Service Provider created the record, concerning any detainee held pursuant to this Agreement. This right of access includes, but is not limited to, incident reports, records relating to suicide attempts, and behavioral assessments and other records relating to the detainee's behavior while in the Service Provider's custody; provided, however that access to medical and mental health record information be provided in accordance with Article VI. Furthermore, the Service Provider shall retain all records where this right of access applies for a period of two (2) years from the date of the detainee's discharge from the Service Provider's custody. This right of access specifically applies to all inspections and other Facility reports.

Article 10. Modifications and Disputes

A. Modifications: Actions other than those designated in this Agreement will not bind or incur liability on behalf of either Party. Either Party may request a modification to this Agreement by submitting a written request to the other Party. A modification will become a part of this Agreement only after the ICE Contracting Officer has approved the modification in writing.

B. Change Orders:

1. The Contracting Officer may at any time, by written order, and without notice to the Service Provider, make changes within the general scope of this Agreement in any one or more of the following:
   (a) Description of services to be performed, including revisions to the applicable Detention Standards.
   (b) Place of performance of the services.

2. If any such change causes an increase or decrease in the cost of the services under the Agreement, the Contracting Officer will make an equitable adjustment in the agreement price and will modify the Agreement accordingly.

3. The Service provider must assert its right to an adjustment under this Article within 30 days from the date of receipt of the written order including a proposal addressing the cost impacts and detailed supporting data.

4. If the Service Provider's proposal includes costs that are determined unreasonable and/or unsupportable, as determined by the Contracting Officer, the Contracting Officer will disallow those costs when determining a revised rate, if any.

5. Failure to agree to any adjustment will be a dispute under the Disputes section of the Agreement. However, nothing in this Article excuses the Service Provider from proceeding with the Agreement as changed.

C. Disputes: The ICE Contracting Officer and the authorized signatory of the Service Provider will settle disputes, questions and concerns arising from this Agreement. Settlement of disputes will be memorialized in a written modification between the ICE Contracting Officer and authorized signatory of the Service Provider. In the event a dispute is not able to be resolved between the Service Provider and the ICE Contracting Officer, the ICE Contracting Officer will make the final decision. If the Service Provider does not agree with the final decision, the matter may be appealed to the ICE Head of the Contracting Activity (HCA) for resolution. The ICE HCA may employ all methods available to resolve the dispute including alternative dispute resolution techniques. The Service Provider shall proceed diligently with performance of this Agreement pending final resolution of any dispute.

Article 11. Adjusting the Bed Day Rate

ICE will reimburse the Service Provider at the fixed detainee bed day rate shown in Article I paragraph C. The Service Provider may request a rate adjustment no less than thirty-six (36) months after the effective date of the Agreement unless required by law (see Article 19). After thirty-six (36) months, the Service Provider may request a rate by submitting a new Jail Services Cost Statement with a summary of the rate adjustment, break-out of the requested increase amount, and back-up documentation necessary to support the request. The Parties agree to base the cost portion of the rate adjustment on the principles of allowability and allocability as set forth in OMB Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments, federal procurement laws, regulations, and standards in arriving at the bed day rate. If ICE does not receive an official request for a bed day rate adjustment that is supported by the information provided, the fixed bed day rate as stated in this Agreement will be in place indefinitely.

ICE reserves the right to audit the actual and/or prospective costs upon which the rate adjustment is based. All rate adjustments are prospective. As the bed day rate is fixed, there are no retroactive adjustment(s).

Article 12. Enrollment, Invoicing, and Payment

A. Enrollment in Electronic Funds Transfer: The Service Provider shall provide ICE with the information needed to make payments by electronic funds transfer (EFT). The Service Provider shall identify their financial institution and related information on Standard Form 3881, Automated Clearing House (ACH) Vendor Miscellaneous Payment Enrollment Form http://www.fms.treas.gov/pdf/3881.pdf. The Service Provider shall submit a completed SF 3881 to ICE payment office prior to submitting its initial request for payment under this Agreement. If the EFT data changes, the Service Provider shall be responsible for providing updated information to the ICE payment office.

B. Consolidated Invoicing: The Service Provider shall submit an original monthly itemized invoice within the first ten (10) working days of the month following the calendar month when it provided the services via one of the following three methods:

1. By mail:

   DHS, ICE
   Burlington Finance Center
   P.O. Box 1620
   Williston, VT 05495-1620
   Attn: ICE-ERO-FOD-FEP

2. By fax: (include a cover sheet with point of contact and number of pages)

   802-288-7658

3. By e-mail:

   Invoice.Consolidation@dhs.gov

Invoices submitted by other than these three methods will be returned. The Service Provider's Taxpayer Identification Number (TIN) must be registered in the Central Contractor Registration (http://www.ccr.gov) prior to award and shall be notated on every invoice submitted to ICE to ensure prompt payment provisions are met. The ICE program office shall also be notated on every invoice.

Each invoice submitted shall contain the following information:

1. Name and address of the Facility;
2. Invoice date and number;
3. Agreement number, line item number and, if applicable, the Task Order number;
4. Terms of any discount for prompt payment offered;
5. Name, title, and phone number of person to notify in event of defective invoice;
6. Taxpayer Identification Number (TIN).

7. Total number of bed days; total number of miles.
8. Bed day rate;
9. Number of bed days multiplied by the bed day rate;
10. Name of each detainee;
11. Resident's/detainee's A-number;
12. Specific dates of detention for each resident/detainee;
13. An itemized listing of all other charges;
14. For stationary guard services, the itemized monthly invoice shall state the number of hours being billed, the duration of the billing (times and dates) and the name of the resident(s)/detainee(s) that was guarded.
15. For Mileage, the itemized monthly invoice shall include a copy of the GSA webpage that shows the mileage rate being applied for that invoice.

Items 1 through 14 above shall be included in the invoice. Invoices without the above information may be returned for resubmission.

C. Payment: ICE will transfer funds electronically through either an Automated Clearing House subject to the banking laws of the United States, or the Federal Reserve Wire Transfer System. The Prompt Payment Act applies to this Agreement. The Prompt Payment Act requires ICE to make payments under this Agreement the thirtieth (30th) calendar day after the Burlington Finance Office receives a complete invoice. Either the date on the Government's check, or the date it executes an electronic transfer of funds, constitutes the payment date. The Prompt Payment Act requires ICE to pay interest on overdue payments to the Service Provider. ICE will determine any interest due in accordance with the Prompt Payment Act provided the Service Provider maintains an active registration in Central Contractor Registration (CCR) and all information is accurate.

Article 13. ICE Furnished Property

A. ICE Property Furnished to the Service Provider: ICE may furnish Federal Government property and equipment to the Service Provider. Accountable property remains titled to ICE and shall be returned to the custody of ICE upon termination of the Agreement. The suspension of use of bed space made available to ICE is agreed to be grounds for the recall and return of any or all ICE furnished property.

B. Service Provider Responsibility: The Service Provider shall not remove ICE property from the Facility without the prior written approval of ICE. The Service Provider shall report any loss or destruction of any ICE property immediately to ICE.

Article 14. Hold Harmless Provisions

Unless specifically addressed by the terms of this Agreement, the parties agree to be responsible for the negligent or wrongful acts or omissions of their respective employees.

A. Service Provider Held Harmless: ICE liability for any injury, damage or loss to persons or property arising in the performance of this Agreement and caused by the negligent or tortuous conduct of its own officers, employees, and other persons provided coverage pursuant to federal law is governed by the Federal Tort Claims Act, 28 USC 2691 *et seq.*(FTCA). Compensation for work related injuries for ICE's officers, employees and covered persons is governed by the Federal Employees Compensation Act (FECA). ICE agrees to the extent permitted under Federal law, to waive all claims and causes of action it may have against the Service Provider for any injury, damage or loss to the Government, not otherwise provided for in this agreement, as a result of claims paid or judgments incurred under either the FTCA or FECA. The Service Provider shall promptly notify ICE of any claims or lawsuits filed against any ICE employees of which Service Provider is notified.

B. Federal Government Held Harmless: Service Provider liability for any injury, damage or loss to persons or property arising out of the performance of this Agreement and caused by the negligence of its own officers, employees, agents and representatives is governed by the applicable State tort claims act. ICE will promptly notify the Service Provider of any claims filed against any of Service Provider's employees of which ICE is notified. The Federal Government will be held harmless for any injury, damage or loss to persons or property caused by a Service Provider employee arising in the performance of this Agreement.

C. Defense of Suit: In the event a detainee files suit against the Service Provider contesting the legality of the detainee's incarceration by ICE under this Agreement and/or immigration/citizenship status, or a detainee files suit as a result of an administrative error or omission of the Federal Government, ICE will request that the Department of Justice, as appropriate, move either to have the Service Provider dismissed from such suit; to have ICE substituted as the proper party defendant; or to have the case removed to a court of proper jurisdiction. Regardless of the decision on any such motion, ICE will request that the Department of Justice be responsible for the defense of any suit on these grounds.

D. ICE Recovery Right: The Service Provider shall do nothing to prejudice ICE's right to recover against third parties for any loss, destruction of, or damage to U.S. Government property. Upon request of the Contracting Officer, the Service Provider shall furnish to ICE all reasonable assistance and cooperation, including assistance in the prosecution of suit and execution of the instruments of assignment in favor of ICE in obtaining recovery.

Article 15. Financial Records

A. Retention of Records: All financial records, supporting documents, statistical records, and other records pertinent to contracts or subordinate agreements under this Agreement shall be retained by the Service Provider for three (3) years for purposes of federal examinations and audit. The three (3) year retention period begins at the end of the first year of completion of service under the Agreement. If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the

three (3) year period, the records must be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular three (3) year period, whichever is later.

B. Access to Records: ICE and the Comptroller General of the United States, or any of their authorized representatives, have the right of access to any pertinent books, documents, papers or other records of the Service Provider or its subcontractors, which are pertinent to contract compliance, in order to make audits, examinations, excerpts, and transcripts. The rights of access must not be limited to the required retention period, but shall last as long as the records are retained.

Delinquent Debt Collection: ICE will hold the Service Provider accountable for any overpayment, or any breach of this Agreement that results in a debt owed to the Federal Government. ICE will apply interest, penalties, and administrative costs to a delinquent debt owed to the Federal Government by the Service Provider pursuant to the Debt Collection Improvement Act of 1982, as amended.

Article 16. Transportation

A. All transportation of ICE detainees shall be conducted in accordance with the ICE 2011 PBNDS. Furthermore, except in emergency situations, a single officer may not transport a single detainee of the opposite gender and if there is an expectation that a pat search will occur during transport, an officer of the same gender as the detainee(s) must be present.

B. In the event of transportation services involving distances that exceed a twelve (12) hour workday to complete, the Service Provider shall be reimbursed for related costs of lodging and meals commensurate with the U.S. General Services Administration rates for such within the geographical area of occurrence. Any incurred overtime pay for such services will be reimbursed at the applicable overtime rate for the transportation officer position specified in Article I. C., Rates. Overnight lodging resulting from transportation services shall be approved in advance by the COR or designated ICE official. All transportation services shall be accomplished in an appropriate and economical manner.

C. The Service Provider personnel provided for the above services shall be of the same qualifications, receive the same training, complete the same security clearances, and wear the same uniforms as those Service Provider personnel provided in the other areas of this Agreement. Transportation officers shall have the required state licenses for commercial drivers with the proper endorsement limited to vehicles with Automatic Transmission and the state Department of Motor Vehicles (DMV) (or Motor Vehicles Department (MVD)) Medical Certification.

D. Transport/Escort/Stationary Services Rate: The Service Provider agrees, upon request of ICE in whose custody an ICE detainee is held, to provide all such ground transportation/escort/stationary services as may be required to transport detainees securely, in a timely manner, to locations as directed by the ICE COR or designated ICE official. At least two (2) qualified law enforcement or correctional officer personnel

employed by the Service Provider under their policies, procedures and practices shall perform transport services. Furthermore, except in emergency situations, a single officer may not transport a single detainee of the opposite gender and if there is an expectation that a pat search will occur during transport, an officer of the same gender as the detainee(s) must be present.

E. Medical/Legal Transportation: The Service Provider shall provide transportation and escort guard services for ICE detainees to and from a medical facility for outpatient care and attending off-site court proceedings. An officer or officers shall keep the detainee under constant supervision twenty-four (24) hours per day until the detainee is ordered released from the hospital, or at the order of the COR. The number of escorts will be determined by the COR. The Service Provider agrees to augment such practices as may be requested by ICE to enhance specific requirements for security, detainee monitoring, visitation, and contraband control.

F. The Service Provider shall, upon order of the COR, or upon its own decision in an urgent medical situation with notification to the COR immediately thereafter, transport a detainee to a hospital location. An officer(s) shall keep the detainee under supervision 24 hours per day until the detainee is ordered released from the hospital, or at the order of the COR. The Service Provider shall then return the detainee to the Facility. The Service Provider shall ensure that at least one officer responsible for the security of the detainee while he/she is an in-patient at the hospital will be of the same sex as the detainee.

G. Indemnities: Furthermore, the Service Provider agrees to hold harmless and indemnify DHS/ICE and its officials in their official and individual capacities from any liability, including third-party liability or worker's compensation, arising from the conduct of the Service Provider and its employees during the course of transporting ICE detainees.

H. Service Provider Furnished Vehicles: If the Service Provider is to use its own vehicles, the following requirements apply to this agreement.

1. The Service Provider shall not allow employees to use their personal vehicles to transport detainees.
2. The Service Provider shall furnish suitable vehicles in good condition, approved by the Government, to safely provide the required transportation services. The Service Provider shall comply with all federal and state laws with regard to inspections, licensing, and registration for all vehicles used for transportation.

3. The Service Provider shall furnish vehicles equipped with interior security features including physical separation of detainees from guards. The Service Provider shall provide interior security specifications of the vehicles to ICE for review and approval prior to installation.

4. Nothing in this Agreement shall restrict the Service Provider from acquiring additional vehicles as deemed necessary by the Service Provider at no cost to the Government.

I. Training and Compliance: The Service Provider shall comply with ICE transportation standards related to the number of hours the Service Provider's employee may operate a vehicle. The transportation shall be accomplished in the most economical manner. The Service Provider personnel provided for the above services shall be of the same qualifications, receive training, complete the same security clearances, and wear the same uniforms as those personnel provided for in other areas of this Agreement.

J. Miscellaneous Transportation: The COR may direct the Service Provider to transport detainees to unspecified, miscellaneous locations.

K. When the COR provides documents to the Service Provider concerning the detainee(s) to be transported and/or escorted, the Service Provider shall deliver these documents only to the named authorized recipients. The Service Provider shall ensure the material is kept confidential and not viewed by any person other than the authorized recipient.

L. The Service Provider shall establish a fully operational communication system compatible with ICE communication equipment that has direct and immediate contact with all transportation vehicles and post assignments. Upon demand, the COR shall be provided with current status of all vehicles and post assignment employees.

M. Failure on the Service Provider's part to comply fully with the detainee(s) departure as pre-scheduled may result in the Service Provider having deductions made for non-performance.

N. Armed Transportation Officers: All transportation Detention Officers shall be armed in the performance of these duties.

O. Billing Procedures: The itemized monthly invoice for such stationary guard services shall state the number of hours being billed, the duration of the billing (times and dates) and the name of the detainee(s) that was guarded.

P. Anticipated Transportation Routes: The following transportation routes and/or destinations are anticipated requirements for this Agreement. The following requirements are **one way routes from the Facility**. Mileage may vary from the table depending on the starting point of the destination. These routes are not all inclusive and should not be limited to the following:

Mileage From FACILITY	Locations	City	Frequency
	N/A AT THIS TIME		

Q. Transportation Reporting Requirements: The Service Provider shall document all Transportation movements in accordance with Attachments 19 and 19(a). This data will be collected through form G-391 (Attachment 19(a)) in excel-based format and submitted to the COR every month, with every invoice. Additionally, Quarterly Status Reports shall be provided as indicated below:

Reporting Requirements	Description
1. Monthly Status Report	The report will include at a minimum the information required for each G-391 for every trip as indicated in the G-391 Data Collection Categories and Descriptions (Attachment 19). An electronic excel based template for data collection will be provided to the contractor upon award to submit as a part of the Monthly Status Report. A breakdown of hours and personnel will also be provided and divided into Transportation Guard Hours (time spent performing transportation related activities) and Stationary Guard Hours (time spent performing detention related stationary guard activities). A breakdown of the total number of vehicles used (year, model, and capacity) will also be required if the contractor is using contractor owned vehicles. A list of government vehicles used will be required if the contractor uses government owned vehicles. This information will be available electronically to government users and submitted monthly with each Service Provider invoice.
2. Quarterly Status Report	This report will be produced every three months to document and provide the vehicle telematics data collected from all movement of ERO serviced contract hours for the previous quarter. It will include a summation of the previous Monthly Status reports and document any fluctuations in demand or trends in provided service. Recommendations for surges or lulls will also be included in the quarterly performance report along with the Service Provider's capability to respond.

Article 17. Guard Services

A. The Service Provider agrees to provide stationary guard services, at a separately agreed hourly rate, on demand by the COR and shall include, but not limited to, escorting and guarding detainees to medical or doctor's appointments, hearings, ICE interviews, and any other remote location requested by the COR. Qualified detention officer personnel employed by the Service Provider under its policies, procedures, and practices will

perform such services. The Service Provider agrees to augment such practices as may be requested by CO or COR to enhance specific requirements for security, detainee monitoring, visitation, and contraband control. Public contact is prohibited unless authorized in advance by the COR.

B. The Service Provider shall be authorized two officers for each such remote location, unless additional officers are required, per the direction of the COR or designated ICE officer. Except in cases of an emergency, one of the two above referenced officers shall be of the same sex as the detainees being assigned to the remote location.

C. The itemized monthly invoice for such stationary guard services shall state the number of hours being billed, the duration of the billing (times and dates) and the names of the detainees that were guarded. Such services shall be denoted as a separate item on submitted invoices. ICE agrees to reimburse the Service Provider for actual stationary guard services provided during the invoiced period.

Article 18. Contracting Officer's Representative (COR)

A. The COR will be designated by the Contracting Officer. When and if the COR duties are reassigned, an administrative modification will be issued to reflect the changes. This designation does not include authority to sign contractual documents or to otherwise commit to, or issue changes, which could affect the price, quantity, or performance of this Agreement.

B. Should the Service Provider believe it has received direction that is not within the scope of the agreement; the Service Provider shall not proceed with any portion that is not within the scope of the agreement without first contacting the Contracting Officer. The Service Provider shall continue performance of efforts that are deemed within the scope.

Article 19. Labor Standards and Wage Determination

A. The Service Contract Act, 41 U.S.C. 351 et seq., Title 29, Part 4 Labor Standards for Federal Service Contracts, is hereby incorporated as Attachment 2. These standards and provisions are included in every contract and IGSA entered into by the United States or the District of Columbia, in excess of $2,500, or in an indefinite amount, the principal purpose of which is to furnish services through the use of service employees.

B. Wage Determination: Each service employee employed in the performance of this Agreement shall be paid not less than the minimum monetary wages and shall be furnished fringe benefits in accordance with the wages and fringe benefits determined by the Secretary of Labor or authorized representative, as specified in any wage determination attached to this Agreement. (See Attachment 3 - Wage Determination)

C. FAR 52.222-43 Fair Labor Standards Act and the Service Contract Act-Price Adjustment (Multiyear and Option Contracts) is incorporated by reference.

D. FAR 52.222-62 Paid Sick Leave Under Executive Order 13706 is incorporated by reference.

Article 20. Notification and Public Disclosures

A. Information obtained or developed as a result of this IGSA is under the control of ICE and is subject to public disclosure only pursuant to the provisions of applicable federal laws, regulations, and executive orders or as ordered by a court. Insofar as any documents created by the Service Provider contain information developed or obtained as a result of this IGSA, such documents shall be subject to public disclosure only pursuant to the provisions of applicable federal laws, regulations, and executive orders or as ordered by a court. To the extent the Service Provider intends to release the IGSA or any information relating to, or exchanged under, this IGSA, the Service Provider agrees to coordinate with the ICE Contracting Officer prior to such release. The Service Provider may, at its discretion, communicate the substance of this IGSA when requested. ICE understands that this IGSA will become a public document when presented to the Service Provider's governing body for approval.

B. The CO shall be notified in writing of all litigation pertaining to this IGSA and provided copies of any pleadings filed or said litigation within five working days of receipt of service. The Service Provider shall cooperate with Government legal staff and/or the United States Attorney regarding any requests pertaining to federal or Service Provider litigation.

C. The Service Provider shall notify the CO when a member of the United States Congress requests information or makes a request to visit the facility. The Service Provider shall coordinate all public information related issues pertaining to ICE detainees with the CO. All press statements and releases shall be cleared, in advance, with the ICE Office of Public Affairs. The Service Provider shall promptly make public announcements stating the facts of unusual or newsworthy incidents to local media. Examples of such events include, but are not limited to: deaths, escapes from custody, and facility emergencies.

D. With respect to public announcements and press statements, the Service Provider shall ensure employees agree to use appropriate disclaimers clearly stating the employees' opinions do not necessarily reflect the position of the United States Government in any public presentations they make or articles they write that relate to any aspect of contract performance or the facility operations.

Article 21. Incident Reporting

A. The COR shall be notified immediately in the event of all serious incidents. The COR will provide after-hours contact information to the Service Provider at the time of award.

B. Serious incidents include, but are not limited to: activation of disturbance control

team(s); disturbances (including gang activities, group demonstrations, food boycotts, work strikes, work-place violence, civil disturbances/protests); staff use of force including use of lethal and less-lethal force (includes inmates in restraints more than eight hours); assaults on staff/inmates resulting in injuries requiring medical attention (does not include routine medical evaluation after the incident); fights resulting in injuries requiring medical attention; fires; full or partial lock down of the Facility; escape; weapons discharge; suicide attempts; deaths; declared or non-declared hunger strikes; adverse incidents that attract unusual interest or significant publicity; adverse weather (e.g., hurricanes, floods, ice/snow storms, heat waves, tornadoes); fence damage; power outages; bomb threats; detainee admitted to a community hospital; witness security cases taken outside the Facility; significant environmental problems that impact the facility operations; transportation accidents (i.e. airlift, bus) resulting in injuries, death or property damage; and sexual assaults.

C. The Service Provider agrees to cooperate with any Federal investigation concerning incidents and treatment involving ICE detainees to the full extent of its authorities, including providing access to any relevant databases, personnel, and documents.

Article 22. Detainee Privacy

A. The Service Provider agrees to comply with the Privacy Act of 1974 ("Act") and the agency rules and regulations issued under the Act in the design, development, or operation of any system of records on individuals to accomplish an agency function when the Agreement specifically identifies (i) the systems of records; and (ii) the design, development, or operation work that the Service Provider is to perform. The Service Provider shall also include the Privacy Act into any and all subcontracts when the work statement in the proposed subcontract requires the redesign, development, or operation of a system of records on individuals that is subject to the Act; and

B. In the event of violations of the Act, a civil action may be brought against the agency involved when the violation concerns the design, development, or operation of a system of records on individuals to accomplish an agency function, and criminal penalties may be imposed upon the officers or employees of the agency when the violation concerns the operation of a system of records on individuals to accomplish an agency function. For purposes of the Act, when the agreement is for the operation of a system of records on individuals to accomplish an agency function, the Service Provider is considered to be an employee of the agency.

1. "Operation of a system of records," as used in this Article, means performance of any of the activities associated with maintaining the system of records, including the collection, use, and dissemination of records.

2. "Record," as used in this Article, means any item, collection, or grouping of information about an individual that is maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and that contains the person's name, or the identifying number,

symbol, or other identifying particular assigned to the individual, such as a fingerprint or voiceprint or a photograph.

3. "System of records on individuals," as used in this Article, means a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

Article 23. Zero Tolerance for Sexual Harassment, Abuse, and Assault

A. The Service Provider shall develop and implement a comprehensive sexual abuse/assault prevention and intervention program in accordance with the DHS PREA standards referenced in Article 5 above. This program shall include training that is given separately to both staff and detainees, in accordance with the Prison Rape Elimination Act (PREA) (Attachment 5) and 2011 PBNDS 2.11.

B. The Service Provider will ensure that information regarding the facility's policy on sexual abuse/assault is included in the detainee handbook; that the facility articulates to staff and to detainees and adheres to a standard of zero tolerance for incidents of sexual abuse or assault; that detainees shall be encouraged to promptly report acts of harassment of a sexual nature, or abuse or signs of abuse observed; that victims of sexual abuse are given timely access to emergency medical treatment and crisis intervention services; that training is included for all staff to ensure that they fulfill their responsibilities under the Service Providers' Sexual Abuse and Assault Prevention and Intervention Program; that the facility reports immediately all sexual abuse and/or assault to ICE/ERO; that the Service Provider develops and implements a policy that includes: an evidence protocol for sexual assault, including access to a forensic medical exam, an internal administrative investigation process that will not compromise a criminal investigation. The Service Provider will also maintain a policy that requires medical staff to report allegations or suspicions of sexual assault to appropriate facility staff, how the victim's medical, mental health and future safety needs will be addressed; appropriate disciplinary sanctions, how a detainee may contact the Office of the Inspector General to confidentially report sexual abuse or assault.

Article 24. Detainee Telephone Services (DTS)

A. The Service Provider shall provide detainees with reasonable and equitable access to telephones as specified in the ICE 2011 Performance-Based National Detention Standard on Telephone Access. Telephones shall be located in an area that provides for a reasonable degree of privacy and a minimal amount of environmental noise during phone calls.

B. If authorized to do so under applicable law, the Service Provider shall monitor and record detainee conversations. If detainee telephone conversations can be monitored under applicable law, the Service Provider shall provide notice to detainees of the

potential for monitoring. However, the Service Provider shall also provide procedures at the facility for detainees to be able to place unmonitored telephone calls to their attorneys.

C. Telephone rates shall not exceed the FCC rates for inmate telephone service, as well as State established rates where applicable, and shall conform to all applicable federal, state, and local telephone regulations.

D. Video phones, portable electronics or other enhanced telecommunications features provided by the DTS contractor to ICE detainees, based upon concurrence between ICE and the Service Provider, may be added in the future subject to negotiation at no cost to ICE. These features may not in any way compromise the safety and security of the detainees, staff or the facility. Any new or enhanced telecommunications features must be integrated within the DTS service and can NOT be a separate system or software from the DTS service. Such capabilities may now or in the future include; video visitation, limited web access for law library, email, kites, commissary ordering, educational tools, news, sports, and video games. Pricing for the use of these technologies will be set by the DTS provider, subject to negotiations with ICE, and shall be negotiated at a future time and date if required.

E. ICE recognizes the Service Provider may have an existing contract with a Telecommunications Company to provide telephone service to ICE detainees and other inmates. Notwithstanding any existing Telecommunications contract, the Service Provider shall require the Telecommunications Company to provide connectivity to the DTS Contractor for ICE detainee pro bono telephone calls. The Service Provider (and the Telecommunications Company) shall make all arrangements with the DTS Contractor independently from this Agreement. If the Service Provider has an existing contract with a Telecommunications Company, ICE requires that ICE detainees have direct access to the DTS Contractor for collect and prepaid calls at the expiration of any current contract. The DTS Contractor shall then be allowed to install vending debit machines and shall receive 100 percent of all revenues collected by sale of prepaid debit services to ICE detainees. The DTS Contractor shall be responsible for the costs incurred to provide the pro bono services, and the maintenance and operation of the system, including a standard compensation to the Telecommunications Company. The Service Provider shall not be entitled to any commissions, fees, or revenues generated by the use of the DTS.

F. The Service Provider shall inspect telephones for serviceability, in accordance with ICE 2011 Performance-Based National Detention Standards and ICE policies and procedures. The Service Provider shall notify the COR or ICE designee of any inoperable telephones.

CC. ICE DTS Contractor Information:

Talton Communications
910 Ravenwood Dr.

Selma, AL 36701

Robin Hall	Mike Oslund
Customer Relations Manager	Operations Manager
(334) 375-7842	(334) 375-4200
robin@taltoncommunications.com	michael@taltoncommunications.com

Article 25. Government Use of Wireless Communication Devices

All personnel that have been issued a Federal Government owned wireless communication device, including but not limited to, cellular telephones, pagers or wireless Internet devices, are authorized to possess and use those items in all areas of the facility in which ICE detainees are present.

Article 26. Certified Cost and Pricing Data

A) Requirements for Certified Cost or Pricing Data and Data Other Than Certified Cost or Pricing Data

(a) *Exceptions from certified cost or pricing data.*

(1) In lieu of submitting certified cost or pricing data, offerors may submit a written request for exception by submitting the information described in the following subparagraphs. The Contracting Officer may require additional supporting information, but only to the extent necessary to determine whether an exception should be granted, and whether the price is fair and reasonable.

(i) *Identification of the law or regulation establishing the price offered.* If the price is controlled under law by periodic rulings, reviews, or similar actions of a governmental body, attach a copy of the controlling document.

(ii) *Commercial item exception.* For a commercial item exception, the offeror shall submit, at minimum, information on prices at which the same item or similar items have previously been sold in the commercial market that is adequate for evaluating the reasonableness of the price for this acquisition. Such information may include –

(A) For catalog items, a copy of or identification of the catalog and its date, or the appropriate pages for the offered items, provide a copy or describe current discount policies and price lists (published or unpublished), *e.g.*, wholesale, original equipment manufacturer, or reseller. Also explain the basis of each offered price and its relationship to the established catalog price, including how the proposed price relates to the price of recent sales in quantities similar to the proposed quantities;

(B) For market-priced items, the source and date or period of the market quotation or other basis for market price, the base amount, and applicable discounts. In addition, describe the nature of the market;

© For items included on an active Federal Supply Service Multiple Award Schedule contract, proof that an exception has been granted for the schedule item.

(2) The offeror grants the Contracting Officer or an authorized representative the right to examine, at any time before award, books, records, documents, or other directly pertinent records to verify any request for an exception under this provision, and the reasonableness of price. For items priced using catalog or market prices, or law or regulation, access does not extend to cost or profit information or other data relevant solely to the offeror's determination of the prices to be offered in the catalog or marketplace.

(b) *Requirements for certified cost or pricing data.* If the offeror is not granted an exception from the requirement to submit certified cost or pricing data, the following applies:

(1) The offeror shall prepare and submit certified cost or pricing data, and data other than certified cost or pricing data, and supporting attachments.

(2) As soon as practicable after agreement on price, but before IGSA award, the offeror shall submit a Certificate of Current Cost or Pricing Data, the format of which is at the end of this Article.

B) Requirements for Certified Cost or Pricing Data and Data Other Than Certified Cost or Pricing Data – Modifications

(a) *Exceptions from certified cost or pricing data.*

(1) In lieu of submitting certified cost or pricing data for modifications under this IGSA, for price adjustments expected to exceed $700,000 on the date of the agreement on price or the date of the award, whichever is later, the Service Provider may submit a written request for exception by submitting the information described in the following subparagraphs. The Contracting Officer may require additional supporting information, but only to the extent necessary to determine whether an exception should be granted, and whether the price is fair and reasonable –

(i) *Identification of the law or regulation establishing the price offered.* If the price is controlled under law by periodic rulings, reviews, or similar actions of a governmental body, attach a copy of the controlling document.

(2) The Service Provider grants the Contracting Officer or an authorized representative the right to examine, at any time before award, books, records, documents, or other directly pertinent records to verify any request for an exception under this clause, and the reasonableness of price. For items priced using catalog or market prices, or law or regulation, access does not extend to cost or profit information or other data relevant solely to the Service Provider's determination of the prices to be offered in the catalog or marketplace.

(b) *Requirements for certified cost or pricing data.* If the Service Provider is not granted an exception from the requirement to submit certified cost or pricing data, the following applies:

(1) The Service Provider shall submit certified cost or pricing data, data other than certified cost or pricing data, and supporting attachments.

(2) As soon as practicable after agreement on price, but before award, the Service Provider shall submit a Certificate of Current Cost or Pricing Data. The form is included at the end of this Article.

C) Subcontractor Certified Cost or Pricing Data

(a) Before awarding any subcontract expected to exceed $700,000 on the date of agreement on price or the date of award, whichever is later; or before pricing any subcontract modification involving a pricing adjustment expected to exceed $700,000, the Service Provider shall require the subcontractor to submit certified cost or pricing data (actually or by specific identification in writing), to include any information reasonably required to explain the subcontractor's estimating process such as the judgmental factors applied and the mathematical or other methods used in the estimate, including those used in projecting from known data, and the nature and amount of any contingencies included in the price, unless (1) the prices are based upon adequate price competition, or (2) if a waiver has been granted.

(b) The Service Provider shall require the subcontractor to certify in substantially the form at the end of this Article that, to the best of its knowledge and belief, the data submitted under paragraph (a) of this clause were accurate, complete, and current as of the date of agreement on the negotiated price of the subcontract or subcontract modification.

(c) In each subcontract that exceeds $700,000, when entered into, the Service Provider shall insert either -

(1) The substance of this clause, including this paragraph (c), if paragraph (a) of this clause requires submission of certified cost or pricing data for the subcontract; or

(2) The substance of the Section below entitled "Subcontractor Certified Cost or Pricing Data - Modifications."

D) Subcontractor Certified Cost or Pricing Data – Modifications

(a) The requirements of paragraphs (b) and (c) of this Section shall –

(1) Become operative only for any modification to this IGSA involving a pricing adjustment expected to exceed $700,000; and

(2) Be limited to such modifications.

(b) Before awarding any subcontract expected to exceed $700,000, on the date of agreement on price or the date of award, whichever is later; or before pricing any subcontract modification involving a pricing adjustment expected to exceed $700,000, the Service Provider shall require the subcontractor to submit certified cost or pricing data (actually or by specific identification in

writing), to include any information reasonably required to explain the subcontractor's estimating process such as the judgmental factors applied and the mathematical or other methods used in the estimate, including those used in projecting from known data, and the nature and amount of any contingencies included in the price, unless (1) prices of the modification are based upon adequate price competition, or (2) if a waiver has been granted.

© The Service Provider shall require the subcontractor to certify in substantially the form at the end of this Article that, to the best of its knowledge and belief, the data submitted under paragraph (b) of this clause were accurate, complete, and current as of the date of agreement on the negotiated price of the subcontract or subcontract modification.

(d) The Service Provider shall insert the substance of this Article, including this paragraph (d), in each subcontract that exceeds $700,000 on the date of agreement on price or the date of award, whichever is later.

E) Price Reduction for Defective Certified Cost or Pricing Data

(a) If any price, including profit or fee, negotiated in connection with this IGSA, or any cost reimbursable under this IGSA, was increased by any significant amount because –

(1) The Service Provider or a subcontractor furnished certified cost or pricing data that were not complete, accurate, and current as certified in its Certificate of Current Cost or Pricing Data;

(2) A subcontractor or prospective subcontractor furnished the Service Provider certified cost or pricing data that were not complete, accurate, and current as certified in the Service Provider's Certificate of Current Cost or Pricing Data; or

(3) Any of these parties furnished data of any description that were not accurate, the price or cost shall be reduced accordingly and the IGSA shall be modified to reflect the reduction.

(b) Any reduction in the IGSA price under paragraph (a) of this clause due to defective data from a prospective subcontractor that was not subsequently awarded the subcontract shall be limited to the amount, plus applicable overhead and profit markup, by which (1) the actual subcontract or (2) the actual cost to the Service Provider, if there was no subcontract, was less than the prospective subcontract cost estimate submitted by the Service Provider; provided, that the actual subcontract price was not itself affected by defective certified cost or pricing data.

(c)

(1) If the Contracting Officer determines under paragraph (a) of this clause that a price or cost reduction should be made, the Service Provider agrees not to raise the following matters as a defense:

(i) The Service Provider or subcontractor was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the IGSA would not have been modified even if accurate, complete, and current certified cost or pricing data had been submitted.

(ii) The Contracting Officer should have known that the certified cost or pricing data in issue were defective even though the Service Provider or subcontractor took no affirmative action to bring the character of the data to the attention of the Contracting Officer.

(iii) The IGSA was based on an agreement about the total cost of the IGSA and there was no agreement about the cost of each item procured under the IGSA.

(iv) The Service Provider or subcontractor did not submit a Certificate of Current Cost or Pricing Data.

(2)

(i) Except as prohibited by subdivision ©(2)(ii) of this clause, an offset in an amount determined appropriate by the Contracting Officer based upon the facts shall be allowed against the amount of a IGSA price reduction if –

(A) The Service Provider certifies to the Contracting Officer that, to the best of the Service Provider's knowledge and belief, the Service Provider is entitled to the offset in the amount requested; and

(B) The Service Provider proves that the certified cost or pricing data were available before the "as of" date specified on its Certificate of Current Cost or Pricing Data, and that the data were not submitted before such date.

(ii) An offset shall not be allowed if –

(A) The understated data were known by the Service Provider to be understated before the "as of" date specified on its Certificate of Current Cost or Pricing Data; or

(B) The Government proves that the facts demonstrate that the IGSA price would not have increased in the amount to be offset even if the available data had been submitted before the "as of" date specified on its Certificate of Current Cost or Pricing Data.

(d) If any reduction in the IGSA price under this clause reduces the price of items for which payment was made prior to the date of the modification reflecting the price reduction, the Service Provider shall be liable to and shall pay the United States at the time such overpayment is repaid –

(1) Simple interest on the amount of such overpayment to be computed from the date(s) of overpayment to the Service Provider to the date the Government is repaid by the Service Provider at the applicable underpayment rate effective for each quarter prescribed by the Secretary of the Treasury under 26 U.S.C. 6621(a)(2); and

(2) A penalty equal to the amount of the overpayment, if the Service Provider or subcontractor knowingly submitted certified cost or pricing data that were incomplete, inaccurate, or noncurrent.

F) Price Reduction for Defective Certified Cost or Pricing Data - Modifications

(a) This Article shall become operative only for any modification to this IGSA involving a pricing adjustment expected to exceed $700,000, except that this Article does not apply to any modification (1) where prices of the modification are based upon adequate price competition, or (2) when a waiver has been granted.

(b) If any price, including profit or fee, negotiated in connection with any modification under this clause, or any cost reimbursable under this IGSA, was increased by any significant amount because

(1) the Service Provider or a subcontractor furnished certified cost or pricing data that were not complete, accurate, and current as certified in its Certificate of Current Cost or Pricing Data,

(2) a subcontractor or prospective subcontractor furnished the Service Provider certified cost or pricing data that were not complete, accurate, and current as certified in the Service Provider's Certificate of Current Cost or Pricing Data, or

(3) any of these parties furnished data of any description that were not accurate, the price or cost shall be reduced accordingly and the IGSA shall be modified to reflect the reduction. This right to a price reduction is limited to that resulting from defects in data relating to modifications for which this clause becomes operative under paragraph (a) of this clause.

(c) Any reduction in the IGSA price under paragraph (b) of this clause due to defective data from a prospective subcontractor that was not subsequently awarded the subcontract shall be limited to the amount, plus applicable overhead and profit markup, by which (1) the actual subcontract or (2) the actual cost to the Service Provider, if there was no subcontract, was less than the prospective subcontract cost estimate submitted by the Service Provider; provided, that the actual subcontract price was not itself affected by defective certified cost or pricing data.

(d)

(1) If the Contracting Officer determines under paragraph (b) of this clause that a price or cost reduction should be made, the Service Provider agrees not to raise the following matters as a defense:

(i) The Service Provider or subcontractor was a sole source supplier or otherwise was in a superior bargaining position and thus the price of the IGSA would not have been modified even if accurate, complete, and current certified cost or pricing data had been submitted.

(ii) The Contracting Officer should have known that the certified cost or pricing data in issue were defective even though the Service Provider or subcontractor took no affirmative action to bring the character of the data to the attention of the Contracting Officer.

(iii) The IGSA was based on an agreement about the total cost of the IGSA and there was no agreement about the cost of each item procured under the IGSA.

(iv) The Service Provider or subcontractor did not submit a Certificate of Current Cost or Pricing Data.

(2)

(i) Except as prohibited by subdivision (d)(2)(ii) of this clause, an offset in an amount determined appropriate by the Contracting Officer based upon the facts shall be allowed against the amount of a IGSA price reduction if -

(A) The Service Provider certifies to the Contracting Officer that, to the best of the Service Provider's knowledge and belief, the Service Provider is entitled to the offset in the amount requested; and

(B) The Service Provider proves that the certified cost or pricing data were available before the "as of" date specified on its Certificate of Current Cost or Pricing Data, and that the data were not submitted before such date.

(ii) An offset shall not be allowed if -

(A) The understated data were known by the Service Provider to be understated before the "as of" date specified on its Certificate of Current Cost or Pricing Data; or

(B) The Government proves that the facts demonstrate that the IGSA price would not have increased in the amount to be offset even if the available data had been submitted before the "as of" date specified on its Certificate of Current Cost or Pricing Data.

(e) If any reduction in the IGSA price under this clause reduces the price of items for which payment was made prior to the date of the modification reflecting the price reduction, the Service Provider shall be liable to and shall pay the United States at the time such overpayment is repaid -

(1) Simple interest on the amount of such overpayment to be computed from the date(s) of overpayment to the Service Provider to the date the Government is repaid by the Service Provider at the applicable underpayment rate effective for each quarter prescribed by the Secretary of the Treasury under 26 U.S.C. 6621(a)(2); and

(2) A penalty equal to the amount of the overpayment, if the Service Provider or subcontractor knowingly submitted certified cost or pricing data that were incomplete, inaccurate, or noncurrent.

Certificate of Current Cost or Pricing Data

This is to certify that, to the best of my knowledge and belief, the cost or pricing data submitted, either actually or by specific identification in writing, to the Contracting Officer or to the Contracting Officer's representative in support of ____* are accurate, complete, and current as of ____**. This certification includes the cost or pricing data supporting any advance agreements and forward pricing rate agreements between the offeror and the Government that are part of the proposal.

Service Provider _____

Signature _____

Name _____

Title _____

Date of execution*** _____

* Identify the proposal, request for price adjustment, or other submission involved, giving the appropriate identifying number (*e.g.*, RFP No.).

** Insert the day, month, and year when price negotiations were concluded and price agreement was reached or, if applicable, an earlier date agreed upon between the parties that is as close as practicable to the date of agreement on price.

*** Insert the day, month, and year of signing, which should be as close as practicable to the date when the price negotiations were concluded and the contract price was agreed to.

Article 27. Combating Trafficking in Persons

(a) *Definitions*. As used in this clause—

"Coercion" means—

(1) Threats of serious harm to or physical restraint against any person;

(2) Any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or

(3) The abuse or threatened abuse of the legal process.

"Commercial sex act" means any sex act on account of which anything of value is given to or received by any person.

"Debt bondage" means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied

toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

"Employee" means an employee of the Contractor directly engaged in the performance of work under the contract who has other than a minimal impact or involvement in contract performance.
"Forced Labor" means knowingly providing or obtaining the labor or services of a person—
(1) By threats of serious harm to, or physical restraint against, that person or another person;
(2) By means of any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform such labor or services, that person or another person would suffer serious harm or physical restraint; or
(3) By means of the abuse or threatened abuse of law or the legal process.

"Involuntary servitude" includes a condition of servitude induced by means of—
(1) Any scheme, plan, or pattern intended to cause a person to believe that, if the person did not enter into or continue in such conditions, that person or another person would suffer serious harm or physical restraint; or
(2) The abuse or threatened abuse of the legal process.

"Severe forms of trafficking in persons" means—
(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.
"Sex trafficking" means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

(b) *Policy.* The United States Government has adopted a zero tolerance policy regarding trafficking in persons. Contractors and contractor employees shall not—

(1) Engage in severe forms of trafficking in persons during the period of performance of the contract;
(2) Procure commercial sex acts during the period of performance of the contract; or
(3) Use forced labor in the performance of the contract.

(c) *Contractor requirements.* The Contractor shall—

(1) Notify its employees of—

(i) The United States Government's zero tolerance policy described in paragraph (b) of this clause; and

(ii) The actions that will be taken against employees for violations of this policy. Such actions may include, but are not limited to, removal from the contract, reduction in benefits, or termination of employment; and

(2) Take appropriate action, up to and including termination, against employees or subcontractors that violate the policy in paragraph (b) of this clause.

(d) *Notification.* The Contractor shall inform the Contracting Officer immediately of—

(1) Any information it receives from any source (including host country law enforcement) that alleges a Contractor employee, subcontractor, or subcontractor employee has engaged in conduct that violates this policy; and

(2) Any actions taken against Contractor employees, subcontractors, or subcontractor employees pursuant to this clause.

(e) *Remedies.* In addition to other remedies available to the Government, the Contractor's failure to comply with the requirements of paragraphs (c), (d), or (f) of this clause may result in—

(1) Requiring the Contractor to remove a Contractor employee or employees from the performance of the contract;

(2) Requiring the Contractor to terminate a subcontract;

(3) Suspension of contract payments;

(4) Loss of award fee, consistent with the award fee plan, for the performance period in which the Government determined Contractor non-compliance;

(5) Termination of the contract for default or cause, in accordance with the termination clause of this contract; or

(6) Suspension or debarment.

(f) *Subcontracts.* The Contractor shall include the substance of this clause, including this paragraph (f), in all subcontracts.

(g) *Mitigating Factor.* The Contracting Officer may consider whether the Contractor had a Trafficking in Persons awareness program at the time of the violation as a mitigating factor when determining remedies. Additional information about Trafficking in Persons and examples of awareness programs can be found at the website for the Department of State's Office to Monitor and Combat Trafficking in Persons at http://www.state.gov/g/tip.

Article 28. Order of Precedence

Should there be a conflict between the 2011 PBNDS and other any other term and/or condition of the IGSA, the Service Provider shall contact the Contracting Officer for clarification.

Article 29. Reporting Executive Compensation and First-Tier Subcontract Awards

a) *Definitions*. As used in this article:

"Executive" means officers, managing partners, or any other employees in management positions.

"First-tier subcontract" means a subcontract awarded directly by the Contractor for the purpose of acquiring supplies or services (including construction) for performance of a prime contract. It does not include the Contractor's supplier agreements with vendors, such as long-term arrangements for materials or supplies that benefit multiple contracts and/or the costs of which are normally applied to a Contractor's general and administrative expenses or indirect costs.

"Months of award" means the month in which a contract is signed by the Contracting Officer or the month in which a first-tier subcontract is signed by the Contractor.

"Total compensation" means the cash and noncash dollar value earned by the executive during the Contractor's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

(1) *Salary and bonus*.

(2) *Awards of stock, stock options, and stock appreciation rights*. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Financial Accounting Standards Board's Accounting Standards Codification (FASB ASC) 718, Compensation-Stock Compensation.

(3) *Earnings for services under non-equity incentive plans*. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives, and are available generally to all salaried employees.

(4) *Change in pension value*. This is the change in present value of defined benefit and actuarial pension plans.
(5) *Above-market earnings on deferred compensation which is not tax-qualified.*

(6) Other compensation, if the aggregate value of all such other compensation (*e.g.*, severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds $10,000.

(b) Section 2(d)(2) of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109-282), as amended by section 6202 of the Government Funding Transparency Act of

2008 (Pub. L. 110-252), requires the Contractor to report information on subcontract awards. The law requires all reported information be made public, therefore, the Contractor is responsible for notifying its subcontractors that the required information will be made public.

(c) Nothing in this article requires the disclosure of classified information

(d)

(1) *Executive compensation of the prime contractor.* As a part of its annual registration requirement in the Central Contractor Registration (CCR) database, the Contractor shall report the names and total compensation of each of the five most highly compensated executives for its preceding completed fiscal year, if—

(i) In the Contractor's preceding fiscal year, the Contractor received—

(A) 80 percent or more of its annual gross revenues from Federal contracts (and subcontracts), loans, grants (and subgrants), cooperative agreements, and other forms of Federal financial assistance; and

(B) $25,000,000 or more in annual gross revenues from Federal contracts (and subcontracts), loans, grants (and subgrants), cooperative agreements, and other forms of Federal financial assistance; and

(ii) The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.)

(2) *First-teir subcontract information.* Unless otherwise directed by the contracting officer, or as provided in paragraph (h) of this clause, by the end of the month following the month of award of a first-tier subcontract with a value of $25,000 or more, the Contractor shall report the following information at http://www.fsrs.gov for that first-tier subcontract. (The Contractor shall follow the instructions at http://www.fsrs.gov to report the data.)

(i) Unique identifier (DUNS Number) for the subcontractor receiving the award and for the subcontractor's parent company, if the subcontractor has a parent company.

(ii) Name of the subcontractor.

(iii) Amount of the subcontract award.

(iv) Date of the subcontract award.

(v) A description of the products or services (including construction) being provided under the subcontract, including the overall purpose and expected outcomes or results of the subcontract.

(vi) Subcontract number (the subcontract number assigned by the Contractor).

(vii) Subcontractor's physical address including street address, city, state, and country. Also include the nine-digit zip code and congressional district.

(viii) Subcontractor's primary performance location including street address, city, state, and country. Also include the nine-digit zip code and congressional district.

(ix) The prime contract number, and order number if applicable.

(x) Awarding agency name and code.

(xi) Funding agency name and code.

(xii) Government contracting office code.

(xiii) Treasury account symbol (TAS) as reported in FPDS.

(xiv) The applicable North American Industry Classification System code (NAICS).

(3) *Executive compensation of the first-tier subcontractor.* Unless otherwise directed by the Contracting Officer, by the end of the month following the month of award of a first-tier subcontract with a value of $25,000 or more, and annually thereafter (calculated from the prime contract award date), the Contractor shall report the names and total compensation of each of the five most highly compensated executives for that first-tier subcontractor for the first-tier subcontractor's preceding completed fiscal year at http://www.fsrs.gov , if—

(i) In the subcontractor's preceding fiscal year, the subcontractor received—

(A) 80 percent or more of its annual gross revenues from Federal contracts (and subcontracts), loans, grants (and subgrants), cooperative agreements, and other forms of Federal financial assistance; and

(B) $25,000,000 or more in annual gross revenues from Federal contracts (and subcontracts), loans, grants (and subgrants), cooperative agreements, and other forms of Federal financial assistance; and

(ii) The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at http://www.sec.gov/answers/execomp.htm.)

(e) The Contractor shall not split or break down first-tier subcontract awards to a value less than $25,000 to avoid the reporting requirements in paragraph (d).

(f) The Contractor is required to report information on a first-tier subcontract covered by paragraph (d) when the subcontract is awarded. Continued reporting on the same subcontract is not required unless one of the reported data elements changes during the performance of the subcontract. The Contractor is not required to make further reports after the first-tier subcontract expires.

(g)

(1) If the Contractor in the previous tax year had gross income, from all sources, under $300,000, the Contractor is exempt from the requirement to report subcontractor awards.

(2) If a subcontractor in the previous tax year had gross income from all sources under $300,000, the Contractor does not need to report awards for that subcontractor.

(h) The FSRS database at http://www.fsrs.gov will be prepopulated with some information from CCR

Article 30. Information Governance and Privacy

ICE Information Governance and Privacy Requirements Clause (JUL 2017)

Guidance: In addition to FAR 52.224-1 Privacy Act Notification (APR 1984), 52.224-2 Privacy Act (APR 1984), FAR 52.224-3 Privacy Training (JAN 2017), and HSAR Clauses, the following IGP clause must be included in its entirety in all contracts. No section of this clause may be read as self-deleting unless the terms of the contract meet the requirements for self-deletion as specified in this clause.

A. Limiting Access to Privacy Act and Other Sensitive Information

(1) Privacy Act Information
In accordance with FAR 52.224-1 Privacy Act Notification (APR 1984), and FAR 52.224-2 Privacy Act (APR 1984), if this contract requires contractor personnel to have access to information protected by the Privacy Act of 1974 the contractor is advised that the relevant DHS system of records notices (SORNs) applicable to this Privacy Act information may be found at www.dhs.gov/privacy. Applicable SORNS of other agencies may be accessed through the agencies' websites or by searching FDsys, the Federal Digital System, available at http://www.gpo.gov/fdsys/. SORNs may be updated at any time.

(2) Prior Approval Required to Hire Subcontractors

The Contractor is required to obtain the Contracting Officer's approval prior to engaging in any contractual relationship (Subcontractor) in support of this contract requiring the disclosure of information, documentary material and/or records generated under or relating to this contract. The Contractor (and any Subcontractor) is required to abide by Government and Agency guidance for protecting sensitive and proprietary information.

(3) Separation Checklist for Contractor Employees
Contractor shall complete a separation checklist before any employee or Subcontractor employee terminates working on the contract. The separation checklist must verify: (1) return of any Government-furnished equipment; (2) return or proper disposal of sensitive personally identifiable information (PII), in paper or electronic form, in the custody of the employee or Subcontractor employee including the sanitization of data on any computer systems or media as appropriate; and (3) termination of any technological access to the Contractor's facilities or systems that would permit the terminated employee's access to sensitive PII.

In the event of adverse job actions resulting in the dismissal of an employee or Subcontractor employee, the Contractor shall notify the Contracting Officer's Representative (COR) within 24 hours. For normal separations, the Contractor shall submit the checklist on the last day of employment or work on the contract.

As requested, contractors shall assist the ICE Point of Contact (ICE/POC), Contracting Officer, or COR with completing ICE Form 50-005/Contractor Employee Separation Clearance Checklist by returning all Government-furnished property including but not limited to computer equipment, media, credentials and passports, smart cards, mobile devices, PIV cards, calling cards, and keys and terminating access to all user accounts and systems.

B. Privacy Training, Safeguarding, and Remediation
If the Safeguarding of Sensitive Information (MAR 2015) and Information Technology Security and Privacy Training (MAR 2015) clauses are included in this contract, section B of this clause is deemed self- deleting.

(1) Required Security and Privacy Training for Contractors
Contractor shall provide training for all employees, including Subcontractors and independent contractors who have access to sensitive personally identifiable information (PII) as well as the creation, use, dissemination and/or destruction of sensitive PII at the outset of the employee's work on the contract and every year thereafter. Training must include procedures on how to properly handle sensitive PII, including security requirements for the transporting or transmission of sensitive PII, and reporting requirements for a suspected breach or loss of sensitive PII. All Contractor employees are required to take the *Privacy at DHS: Protecting Personal Information* training course. This course, along with more information about DHS security and training requirements for Contractors, is available at www.dhs.gov/dhs-security-and-training-requirements-contractors. The Federal Information Security Management Act (FISMA) requires all individuals accessing ICE information to take the annual Information Assurance Awareness Training course. These courses are available through the ICE intranet site or the Agency may also make the training available through hypertext links or CD. The

Contractor shall maintain copies of employees' certificates of completion as a record of compliance and must submit an annual e-mail notification to the ICE Contracting Officer's Representative that the required training has been completed for all the Contractor's employees.

(2) Safeguarding Sensitive PII Requirement
Contractor employees shall comply with the Handbook for Safeguarding sensitive PII at DHS at all times when handling sensitive PII, including the encryption of sensitive PII as required in the Handbook. This requirement will be flowed down to all subcontracts and lower tiered subcontracts as well.

(3) Non-Disclosure Agreement Requirement
All Contractor personnel that may have access to PII or other sensitive information shall be required to sign a Non-Disclosure Agreement (DHS Form 11000-6) prior to commencing work. The Contractor shall maintain signed copies of the NDA for all employees as a record of compliance. The Contractor shall provide copies of the signed NDA to the Contracting Officer's Representative (COR) no later than two (2) days after execution of the form.

(4) Prohibition on Use of PII in Vendor Billing and Administrative Records
The Contractor's invoicing, billing, and other financial/administrative records/databases may not store or include any sensitive Government information, such as PII that is created, obtained, or provided during the performance of the contract. It is acceptable to list the names, titles and contact information for the Contracting Officer, Contracting Officer's Representative, or other ICE personnel associated with the administration of the contract in the invoices as needed.

(5) Reporting Suspected Loss of Sensitive PII
Contractors must report the suspected loss or compromise of sensitive PII to ICE in a timely manner and cooperate with ICE's inquiry into the incident and efforts to remediate any harm to potential victims.

1. The Contractor must develop and include in its security plan (which is submitted to ICE) an internal system by which its employees and Subcontractors are trained to identify and report the potential loss or compromise of sensitive PII.

2. The Contractor must report the suspected loss or compromise of sensitive PII by its employees or Subcontractors to the ICE Security Operations Center (480-496-6627), the Contracting Officer's Representative (COR), and the Contracting Officer within one (1) hour of the initial discovery.

3. The Contractor must provide a written report to ICE within 24 hours of the suspected loss or compromise of sensitive PII by its employees or Subcontractors. The report must contain the following information:

a. Narrative or detailed description of the events surrounding the suspected loss or compromise of information.
b. Date, time, and location of the incident.
c. Type of information lost or compromised.

d. Contractor's assessment of the likelihood that the information was compromised or lost and the reasons behind the assessment.
e. Names of person(s) involved, including victim, Contractor employee/Subcontractor and any witnesses.
f. Cause of the incident and whether the company's security plan was followed and, if not, which specific provisions were not followed.
g. Actions that have been or will be taken to minimize damage and/or mitigate further compromise.
h. Recommendations to prevent similar situations in the future, including whether the security plan needs to be modified in any way and whether additional training may be required.

4. The Contractor shall provide full access and cooperation for all activities determined by the Government to be required to ensure an effective incident response, including providing all requested images, log files, and event information to facilitate rapid resolution of sensitive information incidents.

5. At the Government's discretion, Contractor employees or Subcontractor employees may be identified as no longer eligible to access sensitive PII or to work on that contract based on their actions related to the loss or compromise of sensitive PII.

(6) Victim Remediation
The Contractor is responsible for notifying victims and providing victim remediation services in the event of a loss or compromise of sensitive PII held by the Contractor, its agents, or its Subcontractors, under this contract. Victim remediation services shall include at least 18 months of credit monitoring and, for serious or large incidents as determined by the Government, call center help desk services for the individuals whose sensitive PII was lost or compromised. The Contractor and ICE will collaborate and agree on the method and content of any notification that may be required to be sent to individuals whose sensitive PII was lost or compromised.

C. Government Records Training, Ownership, and Management
(1) Records Management Training and Compliance
(a) The Contractor shall provide DHS basic records management training for all employees and Subcontractors that have access to sensitive PII as well as to those involved in the creation, use, dissemination and/or destruction of sensitive PII. This training will be provided at the outset of the Subcontractor's/employee's work on the contract and every year thereafter. This training can be obtained via links on the ICE intranet site or it may be made available through other means (e.g., CD or online). The Contractor shall maintain copies of certificates as a record of compliance and must submit an e-mail notification annually to the Contracting Officer's Representative verifying that all employees working under this contract have completed the required records management training.

(b) The Contractor agrees to comply with Federal and Agency records management policies, including those policies associated with the safeguarding of records covered by the Privacy Act of 1974. These policies include the preservation of all records created or received regardless of format, mode of transmission, or state of completion.

(2) Records Creation, Ownership, and Disposition

(a) The Contractor shall not create or maintain any records not specifically tied to or authorized by the contract using Government IT equipment and/or Government records or that contain Government Agency data. The Contractor shall certify in writing the destruction or return of all Government data at the conclusion of the contract or at a time otherwise specified in the contract.

(b) Except as stated in the Performance Work Statement and, where applicable, the Contractor's Commercial License Agreement, the Government Agency owns the rights to all electronic information (electronic data, electronic information systems or electronic databases) and all supporting documentation and associated metadata created as part of this contract. All deliverables (including all data and records) under the contract are the property of the U.S. Government and are considered federal records, for which the Agency shall have unlimited rights to use, dispose of, or disclose such data contained therein. The Contractor must deliver sufficient technical documentation with all data deliverables to permit the agency to use the data.

(c) The Contractor shall not retain, use, sell, disseminate, or dispose of any government data/records or deliverables without the express written permission of the Contracting Officer or Contracting Officer's Representative. The Agency and its contractors are responsible for preventing the alienation or unauthorized destruction of records, including all forms of mutilation. Willful and unlawful destruction, damage or alienation of Federal records is subject to the fines and penalties imposed by 18 U.S.C. § 2701. Records may not be removed from the legal custody of the Agency or destroyed without regard to the provisions of the Agency records schedules.

Article 31. Quality Control

A. The Service Provider is responsible for management and quality control actions necessary to meet the quality standards set forth in the Agreement. The Service Provider must provide a Quality Control Plan (QCP) that meets the requirements specified in the Performance Requirements Summary (PRS), Attachment 7(a) to the CO for concurrence prior to award of the IGSA (or as directed by the CO). The CO will notify the Service Provider of concurrence or required modifications to the plan before the Agreement start date. If a modification to the plan is required, the Service Provider must make appropriate modifications and obtain concurrence of the revised plan by the CO before the contract start date.

B. The Service Provider shall provide an overall QCP that addresses critical operational performance standards for the services required under this contract. The QCP shall ensure that services will be maintained at a uniform and acceptable level. At a minimum, the Service Provider shall periodically review and update the QCP policies and procedures at least on an annual basis. The Service Provider shall audit facility's operations associated with ICE and ICE detainees monthly for compliance with the QCP. The Service Provider shall notify the Government 48 hours in advance of the

audit to ensure the COR is available to participate. The Service Provider's QCP shall identify deficiencies, appropriate corrective action(s), and timely implementation plans to the COR.

C. If the Service Provider proposes changes in the QCP after contract award, the Service Provider shall submit them to the COR for review. If the COR concurs with the changes, the COR shall submit the changes to the CO. The CO may modify the contract to include these changes.

Article 32. Quality Assurance Surveillance Program (QASP)

A. The Government's Quality Assurance Surveillance Program is based on the premise that the Service Provider, and not the Government, is responsible for management and quality control actions to meet the terms of the Agreement. The Quality Assurance Surveillance Plan (QASP) procedures recognize that unforeseen problems do occur. Good management and use of an adequate Quality Control Plan will allow the facility to operate within acceptable quality levels.

B. Each phase of the services rendered under this Agreement is subject to inspection both during the Service Provider's operations and after completion of the tasks.

C. When the Service Provider is advised of any unsatisfactory condition(s), the Service Provider shall submit a written report to the COR addressing corrective/preventive actions taken. The QASP is not a substitute for quality control by the Service Provider.

D. The COR may check the Service Provider's performance and document any noncompliance; only the Contracting Officer may take formal action against the Service Provider for unsatisfactory performance.

E. The Government may reduce the invoice or otherwise withhold payment for any individual item of nonconformance observed. The Government may apply various inspection and extrapolation techniques (i.e., 100 % surveillance, random sampling, planned sampling, unscheduled inspections) to determine the quality of services, the appropriate reductions, and the total payment due.

F. Attachment 4 of this Agreement sets forth the procedures and guidelines that ICE will use to inspect the technical performance of the Service Provider. It presents the financial values and mechanisms for applying adjustments to the Service Provider's invoices as dictated by work performance measured to the desired level of accomplishment.

1. The purpose of the QASP is to:

   a. Define the roles and responsibilities of participating Government officials.
   b. Define the types of work to be performed.

c. Describe the evaluation methods that will be employed by the Government in assessing the Service Provider's performance.
d. Describe the process of performance documentation.

2. Roles and Responsibilities of Participating Government Officials

a. The COR(s) will be responsible for monitoring, assessing, recording, and reporting on the technical performance of the Service Provider on a day-to-day basis. The COR(s) will have primary responsibility for completing "Quality Assurance Surveillance Forms" to document their inspection and evaluation of the Service Provider's work performance.

b. The Contracting Officer (CO) or designee has overall responsibility for evaluating the Service Provider's performance in areas of contract compliance, contract administration, and cost and property control. The CO shall review the COR's evaluation of the Service Provider's performance and invoices. If applicable, deductions will be assessed in accordance with the evaluation of the Service Provider's performance, e.g., monetary adjustments for inadequate performance.

G. The rights of the Government and remedies described in this section are in addition to all other rights and remedies set forth in this Agreement. Any reductions in the Service Provider's invoice shall reflect the contract's reduced value resulting from the Service Provider's failure to perform required services. The Service Provider shall not be relieved of full performance of the services hereunder and may be terminated for default based upon inadequate performance of services, even if a reduction was previously taken for any inadequate performance.

Article 33. Shared Facility

ICE acknowledges that Service Provider's inmates will be housed in the Facility and the Service Provider shall pay a separate bed day rate. ICE shall not be responsible for payment related to beds used by any other agency or the Service Provider.

Article 36. Physical Plant Requirements

A. Enforcement and Removal Operations Office Space

ICE ERO space will be formally identified in a modification at a later date.

National Formulary

ICE Health Service Corps

Fiscal Year 2016

U.S. Immigration and Customs Enforcement

Important Information

The IHSC formulary is a listing of medications approved for use in IHSC affiliated facilities. For facilities directly operated by IHSC, a variety of provider restrictions on medication utilization apply.

Brand names are indicated for illustrative purposes. This is not meant to imply an endorsement of any trademarked product. If "A" rated generics are available, their use is normally required over brand name products.

This formulary was last updated on August 1st, 2015.

General in Prescribing

Physician Use Only

A restriction placed on certain medications that requires a physician's approval for both initiation and renewal. If the detainee arrives with medications, a Mid-Level Provider may continue until an IHSC physician reviews the order and makes a judgment regarding the appropriateness of continuing the detainee on medications in this category.

Physician Initiation Only

A restriction placed on certain medications and requires a physician's approval for initiation. A Mid-Level Provider may continue this medication without obtaining the physician's approval. If the detainee arrives with medications, a Mid-Level Provider may continue until an IHSC physician reviews the order and makes a judgment regarding the appropriateness of continuing the detainee on medications in this category.

Newly added formulary items are designated by the red typeface.
Temporary additions to the formulary are listed below:
-Flunisolide nasal solution 0.025% (KOP)
-Fluticasone propionate nasal spray 50mcg (PL Only)

Table of Contents

Generic Monographs

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Abacavir	Ziagen	Antiretroviral Agents	Physician Initiation Only.	Pill Line		[2012 version]
Abacavir/ Lamivudine	Epzicom	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Abacavir/ Lamivudine/ Zidovudine	Trizivir	Antiretroviral Agents	Physician Initiation Only.	Pill Line		[2012 version]
Acetaminophen	Tylenol	Miscellaneous Analgesics and Antipyretics	Suppositories need to be refrigerated.		RN Use	
Acetaminophen / Aspirin/ Caffeine	Excedrin	Nonsteroidal Anti-inflammatory Agents				
Acetaminophen and Codeine	Tylenol No. 3	Opiate Agonist	PA/NP: Requires a prescription countersigned by physician/dentist unless MLP privileged to prescribe independently.	Pill Line		
		Miscellaneous Analgesics and Antipyretics	**Keep in locked cabinet. Immediate release and non-enteric coated are to be crushed prior to administration.**			
Acetaminophen and Hydrocodone	Vicodin	Opiate Agonist	Useful for patient allergic to codeine although cross allergenicity potential may exist.			
		Miscellaneous Analgesics and Antipyretics	PA/NP: Requires a prescription countersigned by physician/dentist unless MLP privileged to prescribe independently. **Keep in locked cabinet. Immediate release and non-enteric coated are to be crushed prior to administration.**	Pill Line		

Generic Monographs

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Acetaminophen and Oxycodone	Percocet	Opiate Agonists	PA/NP: Requires a prescription countersigned by physician/dentist unless MLP privileged to prescribe independently.	Pill Line		
		Miscellaneous Analgesics and Antipyretics	Immediate-release and non-enteric coated tablets are to be crushed prior to administration.			
Acetazolamide	Diamox	Carbonic Anhydrase Inhibitors	Not 1st line therapy -reserved for treatment resistant glaucoma.			
Acyclovir	Zovirax	Nucleosides and Nucleotides	Topical not approved.			
Adapalene	Differin	Skin & Mucous Membrane Agent, Anti-infectives-Miscellaneous	"Pediatric Use Only"			
Adefovir	Hepsera	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Albendazole	Albenza	Anthelmintics				
Albuterol	Ventolin HFA Proventil HFA Proair HFA	Sympathomimetic (Adrenergic) Agents	Ventolin has a counter, and it is in a foil pack with a 2 month expiration date after opening it. Recommended for regular users. ER tablet not approved. The Pro-Air has no counter, but it doesn't have the foil pack or 2 month expiration. Recommended for occasional users.			
Alcohol, Isopropyl	Rubbing Alcohol	Skin & Mucous Membrane Agent, Anti-infectives-Miscellaneous	For in clinic use only. For external use only.			
Alendronate	Fosamax	Miscellaneous Therapeutic Agents	Medication should be taken 30 minutes before the first food of the day. Stay upright for at least 30 minutes after taken medication.			[2013 version]
Allopurinol	Zyloprim	Uricosuric Agents				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Aluminum Acetate Topical	Burow's Solution	Miscellaneous Skin and Mucous Membrane Agents	For external use only.			
Aluminum Acetate and Acetic Acid Otic	Domeboro Otic	EENT Anti-Infectives, Miscellaneous				
Aluminum Hydroxide and Magnesium Trisilicate	Gaviscon	Antacid and Adsorbents	Used for gastric reflux only.			
Aluminum Hydroxide/ Magnesium Hydroxide/ Simethicone	Mylanta, Maalox	Antacids and Adsorbents	See also Simethicone.		RN Use	
Amantadine	Symmetrel	Antivirals – Adamantanes				
Amiodarone	Pacerone	Antiarrhythmic Agent Class III				
Amitriptyline	Elavil	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be reordered/renewed by Mid-Levels. MLPs may initiate/renew to treat neuropathic pain only.	Pill Line		
Amlodipine	Norvasc	Calcium Channel Blocking Agents				
Ammonia Spirit, Aromatic	Ammonia, Aromatic Spirits	Anorexigenic Agents and Respiratory and Cerebral Stimulants	For in clinic use only. For external use only.			
Ammonium lactate	Lac-Hydrin	Basic Lotions and Liniments	For severe xerosis/ichthyosis.			
Amoxicillin	Amoxil	Penicillins				
Amoxicillin and Potassium Clavulanate	Augmentin	Penicillins	875mg/125mg tablets are only available via ScripCare as of 8/1/2015			
Ampicillin, Injectable	Omnipen-N	Penicillins	Physician Initiation Only.			
Amprenavir	Agenerase	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Antipyrine and Benzocaine	Auralgan	Local Anesthetics (EENT)	For external use only.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Aripiprazole	Abilify	Atypical Antipsychotics	Physician/Psychiatrist Initiation Only; Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2014 version]
Ascorbic Acid	Vitamin C	Vitamin C				
Aspirin	Ecotrin, Chewable Aspirin	Nonsteroidal Anti-inflammatory Agents	All formulations are approved.		RN Use	
Atazanavir	Reyataz	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Atazanavir/ Cobicistat	Evotaz	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Atenolol	Tenormin	B-Adrenergic Blocking Agents				
Atorvastatin	Lipitor	HMG-CoA Reductase Inhibitors				
Atovaquone	Mepron	Antiprotozoal	Not available via VA Prime Vendor. May obtain from contracted Mail Order Pharmacy. Clinic use only.	Pill Line		
Atropine Ophthalmic	Atropisol (Ophthalmic)	Mydriatics	Injection not approved.			
Azathioprine	Imuran	Immunosuppressive agents				
Azithromycin	Zithromax	Macrolides				
B vitamins, vitamin C with folic acid	Nephrocaps Capsules	Vitamins	Use for renal failure patients.			
Bacitracin	Baciguent	Antibacterials (Skin and Mucous Membrane)			RN Use	
Baclofen	Lioresal	Skeletal Muscle Relaxants				
Barium Sulfate			Diagnostic agent for computed tomography or x-ray examinations			
Benzocaine	Orabase-B and Toothache Gel	Local Anesthetics (EENT) Dental Agents Antipruritics and Local Anesthetics				
Benzonatate	Tessalon	Antitussives	Limited to five day therapy.			
Benzoyl Peroxide	Desquam-X	Keratolytic Agent	For external use only.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Benztropine Mesylate	Cogentin	Antiparkinsonian Agents		Pill Line		
Bethanechol	Urecholine	Parasympathomimetic (Cholinergic) Agent				
Bisacodyl	Dulcolax	Cathartics and Laxatives			RN Use	
Bismuth Subsalicylate	Pepto-Bismol	Antidiarrhea Agents			RN Use	
Borate/Boric Acid/H2O/NaCl	Collyrium for Fresh Eyes Eye Wash	EENT Anti-Infectives, Miscellaneous	Eye irrigation for in clinic use only – do not dispense to patients.			
Brimonidine Tartrate	Alphagan P	A-Adrenergic Agonists (EENT)				
Bromocriptine	Parlodel	Dopamine Agonist				
Budesonide/ Formoterol	Symbicort	Corticosteroid/LABA				[2010 version]
Bupivacaine Hydrochloride with Epinephrine	Marcaine	Local Anesthetics				
Bupropion	Wellbutrin	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels. Not authorized for smoking cessation. XL form is a once daily formulation and NOT equivalent to the SR formulation for twice daily dosing. Must crush immediate release formulation	Pill Line		[2014 version]
Buspirone	BuSpar	Miscellaneous Anxiolytics, Sedatives and Hypnotics	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Butorphanol	Stadol	Opiate Partial Agonists	Physician Use Only. Keep in locked cabinet. PA/NP: Requires a prescription countersigned by physician. Nasal spray formulation is not approved.	Pill Line		
Cabergoline	Cabergoline	Ergot Derivative	For hyperprolactinemia			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Calamine	Calamine Lotion	Miscellaneous Skin and Mucous Membrane Agents			RN Use	
Calcipotriene	Dovonex	Miscellaneous Skin and Mucous Membrane Agents	Use after Failure to "Very High Potency Steroids." Physician Initiation Only			
Calcium Acetate	Phos-Lo	Replacement Preparations	Restricted to use in renal dialysis patients.			
Calcium Carbonate	Titralac	Replacement Preparations				
Calcium Carbonate with Vitamin D	Os-Cal 500 + D	Replacement Preparations				
Calcium Polycarbophil	Fiber-Tabs, Fibercon	Cathartics and Laxatives				
Camphor/menthol	Vaporub	Topical Skin Product	"Pediatric Use Only"			
Capreomycin		Antituberculosis	Physician Initiation Only. The second-line regimen for MDR/XDR TB	Pill Line		
Captopril	Capoten	Renin-Angiotensin-Aldosterone System Inhibitors				
Carbamazepine	Tegretol	Miscellaneous Anticonvulsants		Pill Line		[2014 version]
Carbamide Peroxide	Debrox Otic	EENT Anti-Infectives, Miscellanous				
Carbidopa and Levodopa	Sinemet	Antiparkinsonian Agents	Medication should be taken 1 hour before or 2 hours after meals.			
Carvedilol	Coreg	B-Adrenergic Blocking Agents	For NYHA Class III or IV heart failure.			
Cefazolin	Kefzol	Cephalosporins	Physician Initiation Only.			
Cefdinir	Omnicef (brand name discontinued)	Cephalosporins	Not available via VA Prime Vendor. May obtain from contracted Mail Order Pharmacy.			
Ceftriaxone	Rocephin	Cephalosporins	Medication can be reconstituted with 1.0% lidocaine to reduce pain at injection site.			
Cephalexin	Keflex	Cephalosporins				
Cetirizine	Zyrtec	Second Generation Antihistamines			RN Use	
Charcoal, Activated	Actidose	Antacids and Adsorbents				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Chlorhexidine Gluconate	Peridex	Mouthwashes	If the product containing alcohol is used, it must be used in clinic or given via pill line. If the alcohol-free product is used, it can be given self-carry (KOP). Topical liquid formulation (4% Scrub) is approved for clinic use.	Pill Line		
Chloroquine Phosphate	Aralen	Antimalarials				
Chlorpheniramine Maleate	Chlor-Trimeton	First Generation Antihistamines			RN Use	
Chlorpromazine Hydrochloride	Thorazine	Antipsychotic Agents	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Chlorthalidone		Thiazide-like Diuretics				
Cinacalcet	Sensipar	Miscellaneous Therapeutic Agents	Dialysis Patient Use Only.			
Ciprofloxacin Hydrochloride	Cipro	Quinolones	Ophthalmic and Otic formulation not approved.			[2013 version]
Citalopram	Celexa	Antidepressants	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[4/2014 version]
Clarithromycin	Biaxin	Macrolides				
Clindamycin	Cleocin	Miscellaneous Antibiotics	Topical not approved.			
Clobetasol	Clobex	Anti-inflammatory Agents (Skin and Mucous Membrane)	Not recommended for application to face or groin.			
Clonazepam	Klonopin	Benzodiazepines	Physician/Psychiatrist Use Only-Only Physician/Psychiatrist can order (both initiation and renewal). Keep in locked cabinet. PA/NP: Requires a prescription countersigned by physician/psychiatrist.	Pill Line		[2013 version]

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Clonidine Hydrochloride	Catapres	Hypotensive Agents, Central A-Agonists	30 days or less; opioid withdrawal; Tourette syndrome; clozapine induced hypersalivation; not for blood pressure management.			
Clopidogrel Bisulfate	Plavix	Platelet-Aggregation Inhibitors	Use in aspirin intolerance or failure as antiplatelet alternative.			[2013 version]
Clotrimazole	Lotrimin	Antifungals (Skin and Mucous Membrane)			RN Use	
Colchicine	Colcrys	Nonsteroidal Anti-inflammatory Agents				[2011 version]
Crotamiton	Eurax	Scabicides and Pediculicides	For external use only.			
Cyanocobalamin	Vitamin B-12	Vitamin B complex	IM or deep SC are preferred routes of administration.			
Cyclobenzaprine	Flexeril	Skeletal Muscle Relaxants	Recommend Pill Line Only.			
Cyclopentolate	Cyclogyl	Mydriatics	Diagnostic ophthalmic aid			
Cycloserine	Seromycin	Antituberculosis	Physician Initiation Only. Not first line for MDR/XDR TB. Should be administered with pyridoxine daily to mitigate neurotoxic effect. Not available via VA Prime Vendor			
Cyclosporine	Gengraf, Neoral	Immunosuppressive agents	Ophthalmic preparation not approved.			
Dapsone	Dapsone	Miscellaneous Antimycobacterials	Physician Initiation Only.			
Darunavir	Prezista	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Darunavir/ Cobicistat	Prezcobix	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Delavirdine	Rescriptor	Antiretroviral Agents	Physician Initiation Only.	Pill Line		

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Desipramine	Norpramin	Antidepressants	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2014 version]
Dexamethasone		Anti-inflammatory Agents (EENT)	All formulations are approved.			
Dextrose 5% in normal saline	D5NS	Replacement Preparations				
Dextrose Instant	Insta-Glucose, Glucose Gel, Glucose Tabs	Caloric Agents	Gel or tablets can be given either KOP or PL per provider's discretion.		RN Use	
Dextrose in sterile water	D5W	Replacement Preparations				
Diazepam	Valium	Oral Benzodiazepines	Physician Use Only-Only Physician can order (both initiation and renewal). Keep in locked cabinet. Only MD and DDS can prescribe oral diazepam.	Pill Line		
		Injectable Benzodiazepines	NP/PA: Can use IV form for seizures in children and adults on an emergency bases, but MD must countersign a prescription ASAP.			
Dibucaine	Nupercainal	Antipruritics and Local Anesthetics				
Diclofenac ER	Voltaren XR	Nonsteroidal Anti-inflammatory Agents				[2011 version]
Dicloxacillin	Dynapen	Penicillins	Every effort should be made to avoid the suspension in children since it has a rather offensive taste and is difficult for children to swallow.			
Dicyclomine Hydrochloride	Bentyl	Antimuscarinics/ Antispasmodics				
Didanosine	Videx	Antiretroviral Agents	Physician Initiation Only. Medication must be taken on an empty stomach.	Pill Line		[2011 version]

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Dietary Supplement, Oral	Ensure, Resource, Boost	Nutritional Supplements	Physician/Dentist Initiation Only. Indicated for broken jaw or other temporary dental issue that limits proper nutritional intake, hunger strike, wasting syndrome, malabsorption, and malnutrition. Pregnancy, HIV infection without wasting, older age, and minor weight loss are usually not indications for nutritional/dietary supplements. For such situations or others not named, a NF request should be submitted to the Medical Director. Special diets should generally be utilized to provide additional calories if necessary. MUST CONSUME AT PILL LINE.	Pill Line		
Digoxin	Lanoxin	Cardiac Drugs	Oral Tablets Only			
Diltiazem	Cardizem	Calcium Channel Blocking Agents				
Diphenhydramine Hydrochloride	Benadryl	First Generation Antihistamines			RN Use	
Diphtheria and Tetanus Toxoid (DT)	Tenivac	Toxoids	According to CDC guidelines.			
Diphtheria, Tetanus Toxoid, Acellular Pertussis Vaccine (TDap, DPT)	Adacel, Boostrix, Daptacel, Infanrix	Toxoids	According to CDC guidelines.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Divalproex Sodium	Depakote	Miscellaneous Anticonvulsants	There are currently two oral formulations of divalproex sodium available. The first agent on the market (1983) was an enteric coated tablet (Divalproex-EC), which results in a delayed-release pharmacokinetic profile and requires multiple daily doses. In 2002, a sustained release formulation (Divalproex ER), allowing once daily administration, was approved.	Pill Line		[2014 version]
Docusate Sodium	Colace	Cathartics and Laxatives			RN Use	
Dolutegravir	Tivicay	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Dolutegravir/ Abacavir/ Lamivudine	Triumeq	Antiretroviral Agents	Physician Initiation Only	Pill Line		
Dorzolamide Hydrochloride	Trusopt	Carbonic Anhydrase Inhibitors				
Dorzolamide Hydrochloride/ Timolol	Cosopt	Carbonic Anhydrase Inhibitors EENT Preparations - B-Adrenergic Blocking Agents				
Doxazosin	Cardura	A-Adrenergic Blocking Agents				
Doxepin	Sinequan	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2007 version]
Doxycycline	Vibramycin	Tetracyclines				
Drospirenone - Ethinyl Estradiol	Gianvi	Contraceptives				
Duloxetine	Cymbalta	Serotonin/NE Reuptake Inhibitor	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		

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Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Efavirenz	Sustiva	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Efavirenz, Emtricitabine, Tenofovir	Atripla	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Electrolyte Solution	Pedialyte	Replacement Preparations	Note: The use of this product should be limited to 24 hours in infants and children. After 24 hours this rehydration formula can cause diarrhea worsening gastroenteritis.		RN Use	
Elvitegravir/ Cobicistat/ Emtricitabine/ Tenofovir	Stribild	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Emtricitabine	Emtriva	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Emtricitabine, Tenofovir	Truvada	Antiretroviral Agents	Physician Initiation Only.	Pill Line		[2013 version]
Emtricitabine, Rilpivirine, Tenofovir	Complera	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Enalapril	Vasotec	Renin-Angiotensin-Aldosterone System Inhibitors				
Enfuvirtide	Fuzeon	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Enoxaparin	Lovenox	Anticoagulants				
Entecavir	Baraclude	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Epinephrine	Adrenaline	Sympathomimetic (Adrenergic) Agents			RN Use	
Epoetin Alfa	Epogen, Procrit	Hematopoietic Agents	Physician Initiation Only Must be enrolled in the ESA APPRISE.	Pill Line		[2012 Version]
Ergotamine and Caffeine	Cafergot	Sympatholyic (Adrenergic Blocking) Agents				
Erythromycin and Sulfisoxazole	Pediazole	Macrolides Sulfonamides				
Erythromycin Ethylsuccinate	E.E.S.	Macrolides				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Erythromycin Stearate	Erythrocin	Macrolides	NP/PA: Pneumonia, sinusitis, NSU, adult streptococcal pharyngitis, cellulitis, folliculitis, hordeolum and otitis media.			
Erythromycin, Ophthalmic	Ilotycin	EENT Anti-infectives				
Erythromycin Topical Gel 2%	Erygel	Antibacterials (Skin and Mucous Membrane)				
Estradiol Cypionate	Depo-Estradiol	Estrogens				
Estradiol Valerate	Delestrogen, Climara	Estrogens	Estradiol is preferred over Estrogen conjugated (Premarin) *Conversion (PO) Estradiol vs Premarin 2mg 1.8mg 4mg 2.7mg 6mg 3.75mg 8mg 5mg -Use serum estradiol to adjust accordingly			
Ethambutol	Myambutol	Antituberculosis	Physician Initiation Only.	Pill Line		
Ethionamide	Trecator	Antituberculosis	Physician Initiation Only.	Pill Line		
Etravirine	Intelence	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Famciclovir	Famvir	Nucleosides and Nucleotides	Physician Initiation Only to HIV Patients.			
Fenofibrate	Lofibra	Fibric Acid Derivatives				
Ferrous Sulfate	Fer-In-Sol	Iron Preparations	Note: When prescribing in children be sure to advise caregivers to keep this medication out of reach of children. Iron overdose is a common cause of death.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Filgrastim	Neupogen	Hematopoietic Agents	Physician Initiation Only. If patient's weight is greater than or equal to 75kg, then use 480mcg dose. Restricted to Physician Initation Only or secondard to Infectious Disease.	Pill Line		
Finasteride	Proscar	5 Alpha-Reductase Inhibitor				
Fluconazole	Diflucan	Antifungals				
Fluocinonide	Lidex	Anti-inflammatory Agents (Skin and Mucous Membrane)	Medication should never be used for longer than a two-week period of time without a discontinuation prior to re-starting. This and other fluorinated compounds should never be used on the face unless instructed by a dermatologist.			
Fluoxetine	Prozac	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2014 version]
Fluphenazine	Prolixin	Antipsychotic Agents	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Fluphenazine Decanoate	Prolixin Decanoate	Antipsychotic Agents	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Fluticasone Propionate Oral Inhaler	Flovent	Adrenals				
Folic Acid	Folvite	Vitamin B Complex				
Fosamprenavir	Lexiva	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Furosemide	Lasix	Diuretics				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Gabapentin	Neurontin	Miscellaneous Anticonvulsants	Restricted to use as anticonvulsant and for pain control.	Pill Line		[2013 version]
Gemfibrozil	Lopid	Fibric Acid Derivatives	Contraindication to use with simvastatin.			
Gentian Violet		Antifungals, Miscellaneous Skin and Mucous Membrane	Not available via VA Prime Vendor. May obtain from contracted Mail Order Pharmacy. Clinic use only.			
Gentamicin Sulfate	Garamycin	Aminoglycoside EENT Anti-infectives	Injectable-Physician Initiation Only.			
Glipizide	Glucotrol	Antidiabetic Agents	The immediate release tablets are administered 30 minutes before a meal and divided doses for dosing equal or greater than 15 mg/day.			
Glucagon, Human Recombinant	Glucagen Hypokit	Glycogenolytic Agents				
Glyburide	Micronase, Diabeta	Antidiabetic Agents				
Glycerin suppository		Cathartics and Laxatives			RN Use	
Griseofulvin Suspension	Grifulvin	Antifungals	Pediatric Use Only Suspension Only			
Guaifenesin	Robitussin	Expectorants	Recommend alcohol-free formulation.		RN Use	
Haloperidol	Haldol	Antipsychotic Agents	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Haloperidol Decanoate	Haloperidol Decanoate	Antipsychotic Agents	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels. The maximum volume per injection site should not exceed 3ml. Not to be administered IV.	Pill Line		
Heparin Sodium	Heparin Lock Flush Solution	Anticoagulants	Physician Initiation Only.			
Hepatitis A Vaccine	Havrix	Vaccines				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Hepatitis B Vaccine	Engerix	Vaccines				
Hydralazine	Apresoline	Direct Vasodilators				
Hydro-chlorothiazide	Microzide	Diuretics				
Hydrocortisone Suppository	Anucort-HC, Anusol-HC	Anti-inflammatory Agents (Skin and Mucous Membrane)				
Hydrocortisone, Topical	Cortizone	Anti-inflammatory Agents (Skin and Mucous Membrane)	Hydrocortisone 1% for RN Use		RN Use	
Hydrogen Peroxide		Mouthwashes and Gargles	Main clinic and dental clinic use.		RN Use	
Hydroxy-chloroquine	Plaquenil	Antimalarials				
Hydroxyurea	Hydrea	Antineoplastic Agents				
Hydroxyzine	Atarax; Vistaril	Miscellaneous Anxiolytics, Sedatives, and Hypnotics	Atarax is the Hydrochloride salt. Vistaril is the Pamoate salt. Pill Line Only for anxiety use. For other indications such as pruritus, may be given as KOP.	Pill Line		
Ibuprofen	Motrin	Nonsteroidal Anti-inflammatory Agents			RN Use	[2007 version]
Imipramine	Tofranil	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Immune Globulin	Gamimune	Serums	Physician Initiation Only. MUST BE REFRIGERATED.			
Indinavir	Crixivan	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Indomethacin	Indocin	Nonsteroidal Anti-inflammatory Agents				[2008 version]
Influenza Virus Vaccine	Fluzone	Vaccines				
Insulin	Humulin, Novolin, Lantus	Insulins	Human Insulin Only			
	Regular, NPH, 70/30, Glargine		Insulin lispro, insulin aspartate not approved.	Pill Line		

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Ipratropium	Atrovent	Antimuscarinics/ Antispasmodics				
Ipratropium/ Albuterol oral inhaler	Combivent	Antimuscarinics/Antispasmodics Sympathomimetic Agents				
Isoniazid	INH	Antituberculosis		Pill Line		
Isosorbide Dinitrate	Isordil	Vasodilating Agents – Nitrates and Nitrites	NP/PA: Angina pectoris in adults.			
Isosorbide Mononitrate	ISMO, Monoket, Imdur					
Ivermectin	Stromectol	Anthelmintics				
Ketoconazole	Nizoral	Antifungal				[2014 version]
Ketorolac injection	Toradol	Nonsteroidal Anti-inflammatory Agents	**Do not use for greater than five continuous days.** Oral formulation not approved.			[2013 version]
Ketorolac ophthalmic	Acular, Acular LS	EENT Nonsteroidal Antiinflammatory Agents	Restricted to use only after surgery.			
Ketotifen	Zaditor	Antiallergic Agents				
Labetalol	Trandate	B-Adrenergic Blocking Agents				
Lactated Ringers	Ringer's Lactate	Replacement Preparations				
Lactobacillus	Acidophilus	Antidiarrhea Agents				
Lactulose	Kristalose	Electrolytic, Caloric, and Water Balance				
Lamivudine	Epivir	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Lamotrigine	Lamictal	Anticonvulsants, Miscellaneous	Physician Initiation Only. Lamotrigine should be discontinued at the first sign of rash, unless the rash is clearly not drug-related.	Pill Line		[2013 version]
Latanoprost	Xalatan	Prostaglandin Analogs				
Leflunomide	Arava	Disease-Modifying Antirheumatic Agents	2nd line treatment for RA.			
Leucovorin Calcium	Leucovorin	Miscellaneous Therapeutic Agents	Concomitant use with pyrimethamine to prevent hematologic toxicity.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Levetiracetam	Keppra	Anticonvulsants, Miscellaneous		Pill Line		[2013 version]
Levofloxacin Oral Solution	Levaquin	Quinolones	"Pediatric Use Only"			
Levonorgestrel	Plan B One-Step	Contraceptives, Progestins				
Levothyroxine	Synthroid	Thyroid Agents				
Lidocaine and Epinephrine	Xylocaine with Epinephrine	Local Anesthetics				
Lidocaine Hydrochloride	Xylocaine	Cardiac Drugs Local Anesthetics Antipruritics and Anesthetics				
Lisinopril	Zestril, Prinivil	Renin-Angiotensin-Aldosterone System Inhibitors				
Lisinopril/ Hydro-chlorothiazide	Prinzide, Zestoretic	Renin-Angiotensin-Aldosterone System Inhibitors Diuretics				
Lithium Carbonate	Eskalith	Antimanic Agents	Physician/Psychiatrist Initiation Only.	Pill Line		
Loperamide Hydrochloride	Imodium	Antidiarrhea Agents			RN Use	
Lopinavir/ Ritonavir	Kaletra	Antiretroviral Agents	Physician Initiation Only. Use oral solution within two months if patient stores at room temperature. Oral solution contains alcohol.	Pill Line		[2013 version]
Loratadine	Claritin	Second Generation Antihistamines				
Lorazepam	Ativan	Benzodiazepines	Lorazepam injectable needs to be refrigerated. Physician/Psychiatrist Use Only. PA/NP: Requires a prescription countersigned by physician/dentist unless MLP privileged to prescribe independently. Keep in locked cabinet.	Pill Line		

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Losartan	Cozaar	Angiotensin II Receptor Antagonists	Intolerance to ACE inhibitors and/or failure to control Rennin-Angiotensin-Aldosterone System.			
Losartan/ Hydrochlorothiazide	Hyzaar	Angiotensin II Receptor Antagonists	Intolerance to ACE inhibitors and/or failure to control Rennin-Angiotensin-Aldosterone System.			
Lurasidone	Latuda	Atypical Antipsychotics	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Magnesium Hydroxide	MOM, Milk of Magnesia	Cathartics and Laxatives			RN Use	
Magnesium Oxide	Mag-Ox	Antacids and adsorbents				
Magnesium Sulfate	Magnesium Sulfate	Miscellaneous Anticonvulsants	Injectable-Physician Initiation Only.			
Maraviroc	Selzentry	Antiretroviral Agents	Physician Initiation Only	Pill Line		[3/2014 version]
Measles, Mumps, and Rubella Vaccine	MMR	Vaccines	According to CDC guidelines.			
Measles, Mumps, Rubella, and Varicella Vaccine	MMRV	Vaccines	According to CDC guidelines.			
Meclizine	Antivert	Antiemetics				
Medroxy-progesterone	Provera	Progestins				
Megestrol Acetate	Megace	Antineoplastic Agents	Appetite stimulation for patients with HIV or cachexia.			
Meloxicam	Mobic	Nonsteroidal Anti-inflammatory Agents				
Meningococcal Conjugate Vaccine	Menactra, Menveo	Vaccines	According to CDC guidelines.			
Mepivacaine	Carbocaine	Local Anesthetics				
Mesalamine	Asacol, Lialda	Anti-inflammatory Agents (GI Drugs)				
Metformin	Glucophage	Miscellaneous Antidiabetic Agents				
Methimazole	Tapazole	Antithyroid Agents	Pregnancy Risk: D			
Methocarbamol	Robaxin	Skeletal Muscle Relaxants				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Methotrexate	Rhematrex	Antineoplastic Agents	Pregnancy Risk:X	Pill Line		
Methyldopa	Aldomet	Hypotensive Agents – Central A-Agonists	Preferred alternative for the treatment of hypertension in pregnancy.			
Methyl-prednisolone	Solu-Medrol, Medrol	Adrenals				
Metoclopramide Hydrochloride	Reglan	Gastrointestinal Agents – Prokinetic Agents				[2011 version]
Metoprolol Tartrate	Lopressor	B-Adrenergic Blocking Agents	Metoprolol Succinate (XL) restricted to use in congestive heart failure only.			
Metronidazole	Flagyl and Metrogel	Miscellaneous Anti-infective Miscellaneous Local Anti-Infectives				
Miconazole	Micatin, Monistat 7	Antifungals (Skin and Mucous Membrane)				
Minoxidil	Loniten	Direct Vasodilators				
Mirtazapine	Remeron	Antidepressants	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2014 version]
Mometasone Furoate	Nasonex	Anti-inflammatory Agents (EENT)				
Montelukast	Singulair	Leukotriene Modifiers				
Morphine Sulfate	Duramorph	Opiate Agonists	Physician Use Only-Only Physician can order (both initiation and renewal). Keep in locked cabinet. Immediate Release, non-enteric coated are to be crushed prior to administration.	Pill Line		[2014 version]
Moxifloxacin HCl	Avelox	Quinolones				[2013 version]
Multivitamin	One-A-Day	Multivitamin Preparation	Dialysis, pregnant, malnutrition, and wasting syndrome patients only.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Multivitamin, Children's	Chewable Multivitamin	Multivitamin Preparation	For pediatric use.			
Multivitamin/ Mineral/Folic Acid	Prenatal Vitamin	Multivitamin Preparation				
Mupirocin	Bactroban	Antibacterials (Skin and Mucous Membrane)	MRSA and Impetigo Use Only.			
Mycophenolate	CellCept, Myfortic	Immunosuppressive Agents				[2013 version]
Naloxone	Narcan	Opiate Antagonists				
Naproxen	Naprosyn	Nonsteroidal Anti-inflammatory Agents				[2013 version]
Nelfinavir	Viracept	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Neomycin/ Polymyxin B Sulfate/ Dexamethasone Ophthalmic drop	Maxitrol	EENT Anti-infectives				
Neomycin/ Polymyxin B/ Hydrocortisone	Cortisporin Otic	EENT Anti-infectives				
Nevirapine	Viramune	Antiretroviral Agents	Physician Initiation Only.	Pill Line		[2014 version]
Niacin	Niacin	Vitamin B Complex				
Nifedipine	Procardia XL	Calcium Channel Blocking Agents	Immediate Release not approved.			
Nitrofurantoin	Macrodantin	Urinary Anti-Infectives				
Nitroglycerin	Nitrostat, Transderm-Nitro	Vasodilating Agents - Nitrates and Nitrites	Nitrostat-keep the tablets in the original container.			
Norethindrone	Nora-BE	Contraceptives				
Norgestimate-Ethinyl Estradiol	MonoNessa, Trinessa	Contraceptives				
Normal Saline Nose Drops	Ocean Spray	EENT Preparations - Miscellaneous			RN Use	
Nystatin	Mycostatin	Antifungals				
Ofloxacin Ophthalmic Drop	Ocuflox	EENT Anti-infectives				
Ofloxacin Otic	Floxin	EENT Anti-infectives				[2011 version]

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Olanzapine	Zyprexa	Atypical Antipsychotics	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels. IM is NF. Use for Special Operation Only.	Pill Line		[2013 version]
Omeprazole	Prilosec	Gastrointestinal Agents - Antiulcer Agents and Acid Suppressants				[3/2014 version]
Ondansetron	Zofran	5-HT3 Receptor Antagonists				
Oseltamivir	Tamiflu	Antivirals – Neuraminidase Inhibitor	Therapy preferably initiated within 48 hours of symptom onset.	Pill Line		
Oxacillin	Bactocill	Penicillins	Physician Initiation Only.			
Oxcarbazepine	Trileptal	Miscellaneous Anticonvulsants		Pill Line		
Oxybutynin	Ditropan	Genitourinary Smooth Muscle Relaxant				
Oxymetazoline	Afrin	Vasoconstrictors (EENT)	Clinic use only for severe nosebleed.			
Para-Aminosalicylic Acid	Paser	Antituberculosis	Physician Initiation Only. Not available via VA Prime Vendor. May obtain from contracted Mail Order Pharmacy. Clinic use only.	Pill Line		
Papillomavirus (HPV Vaccines)	Gardasil, Gardasil 9	Vaccines	"Pediatric Use Only". Gardasil 9-Not available via VA Prime Vendor. May obtain from contracted Mail Order Pharmacy.			
Paroxetine	Paxil	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2014 version]
PEG (Polyethylene Glycol 3350 + Electrolytes Solution)	Golytely	Cathartics and Laxatives				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Penicillin G Benzathine	Bicillin Long-Acting	Penicillins	Medication must be refrigerated.			
Penicillin G Procaine	Penicillin G Procaine	Penicillins	Medication must be refrigerated.			
Penicillin V Potassium	Penicillin VK	Penicillins				
Pentamidine Isethionate	NebuPent, Pentam 300	Miscellaneous Antiprotozoals				
Permethrin	Acticin, Nix	Scabicides and Pediculicides	RN Use 1% Permethrin Per RN Guidelines.		RN Use	
Perphenazine	Trilafon	Antipsychotic Agents	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Petrolatum	Vaseline	Emollients, Demulcents and Protectants			RN Use	
Phenazopyridine	Pyridium	Antipruritics and Anesthetics				
Phenobarbital	Phenobarbital	Anticonvulsants, Barbiturates	Physician Use Only. PA/NP: Requires a prescription countersigned by physician/dentist unless MLP privileged to prescribe independently. Keep in locked cabinet.	Pill Line		
Phenylephrine	Anu-Med Suppository, oral tablets	Miscellaneous Skin and Mucous Membrane Agents	Suppositories and oral tablets only		RN Use	
Phenytoin	Dilantin	Anticonvulsants, Hydantoins	Injectable-Physician Initiation Only.	Pill Line		[2011 version]
Phytonadione	Vitamin K	Vitamin K	Physician Initiation Only.			
Piperonyl Butoxide/ Pyrethrins	RID	Scabicides and Pediculicides	For external use only.		RN Use	
Pneumococcal Vaccine	Pneumovax 13 & 23	Vaccines	Only to be administered to patients meeting criteria per CDC guideline.			
Podofilox	Condylox	Skin and Mucous Membrane Agents	Clinic use only.	Pill Line		

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Podophyllin	Podocon 25	Keratolytic Agent	For use in condyloma acuminata in adults-to be used in clinic only. Medication is not to be dispensed to patients. For external use only.	Pill Line		
Poliovirus Vaccine	Orimune	Vaccines	According to CDC guidelines.			
Polyethylene Glycol 3350	MiraLax	Cathartics and Laxatives				
Polymyxin B/ Neomycin/ Bacitracin	Neosporin Topical Ointment	EENT Anti-infectives			RN Use	
Polymyxin B/ Neomycin/ Gramicidin Ophthalmic	Neosporin Ophthalmic Solution	EENT Anti-infectives				
Potassium Chloride	Slow-K	Replacement Preparations				
Pravastatin	Pravachol	HMG CoA Reductase Inhibitors				
Prazosin	Minipress	A-Adrenergic Blocking Agents				
Prednisolone Ophthalmic	Pred Forte	Anti-inflammatory Agents (EENT)				
Prednisone	Deltasone	Adrenals	If oral steroids are to be used for greater than 5 days, they should be tapered and not abruptly stopped.			
Primaquine	Primaquine	Antimalarials	G6PD-deficient patients may be treated with lower doses over a longer period of time.			
Primidone	Mysoline	Anticonvulsants, Barbiturates		Pill Line		
Probenecid	Benemid	Uricosuric Agents				
Prochlorperazine	Compazine	Antiemetics				
Promethazine	Phenergan	Miscellaneous Anxiolytics, Sedatives, and Hypnotics				
Proparacaine Hydrochloride	Alcaine	Local Anesthetics (EENT)				
Propranolol Hydrochloride	Inderal	B-Adrenergic Blocking Agents				
Propylthiouracil	PTU	Antithyroid Agents				[2010 version]
Psyllium	Metamucil	Cathartics and Laxatives	Sugar free products only.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Pyrazinamide	PZA	Antituberculosis	Physician Initiation Only.	Pill Line		
Pyridoxine	Vitamin B-6	Vitamin B Complex				
Pyrimethamine	Daraprim, Fansidar	Antimalarials				
Quinidine Sulfate	Quinidine Sulfate	Cardiac Drugs				
Quinine	Qualaquin	Antimalarials	When treating uncomplicated malaria medication should be given in combination with either tetracycline or doxycycline.			[2014 version]
Raltegravir Potassium	Isentress	Antiretroviral Agents	Physician Initiation Only	Pill Line		
Ranitidine Hydrochloride	Zantac	Gastrointestinal Agents Antiulcer Agents and Acid Suppressants				
Rifampin	Rifadin	Antituberculosis	Physician Initiation Only.	Pill Line		
Rilpivirine	Edurant	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Risperidone	Risperdal	Atypical Antipsychotics	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Ritonavir	Norvir	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Rotavirus	Rotarix, Rota Teq	Vaccines (Live)	Live vaccines			
Salicylic Acid		Keratolytic Agents	Clinic use only.	Pill Line		
Salmeterol	Serovent Diskus	Sympathomimetic (Adrenergic) Agents	Physician Initiation Only. Use after failure with steroid inhaler and current short acting B-agonist.			[4/2014 version]
Saquinavir	Invirase	Antiretroviral Agents	Physician Initiation Only.	Pill Line		

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Selenium Sulfide	Selsun	Miscellaneous Local Anti-Infectives	OTC version-RN Use Per RN Guidelines. For external use only.		RN Use	
Sertraline Hydrochloride	Zoloft	Antidepressants	Physician/Psychiatrist Initiation Only-Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels	Pill Line		[2012 version]
Sevelamer	Renagel	Ion-removing Agent	Tablets must be swallowed intact.			
Silver Nitrate Applicator		Anti-Infectives	Not available via VA Prime Vendor. May obtain from contracted Mail Order Pharmacy. Clinic use only.			
Silver Sulfadiazine	Silvadene	Miscellaneous Local Anti-Infectives			RN Use	
Simethicone	Mylicon	Antiflatulents	See also Maalox and Mylanta (aluminum hydroxide, magnesium hydroxide and simethicone).			
Simvastatin	Zocor	HMG CoA Reductase Inhibitors	Maxium recommended dose is 40mg. Contraindicated with protease inhibitors (HIV) and gemfibrozil. See pravastatin or atorvastatin for alternative.			
Sodium Chloride	Normal Saline	Replacement Preparations	RN: May administer only upon practitioners orders. The nasal sodium chloride is OTC.			
Sodium Chloride, Irrigation Solution	Normal Saline irrigation solution	Irrigating Solutions	RN: May use for wound irrigation, but can not dispense to patient.			
Sodium Phosphate, Rectal	Fleet Enema	Cathartics and Laxatives				
Sotalol	Betapace	B-Adrenergic Blocking Agents				
Spironolactone	Aldactone	Diuretics-potassium sparing				
Stavudine	Zerit	Antiretroviral Agents	Physician Initiation Only.	Pill Line		[2011 version]
Streptomycin	Streptomycin	Antituberculosis	Physician Initiation Only.	Pill Line		

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Sucralfate	Carafate	Gastrointestinal Agents - Antiulcer Agents and Acid Suppressants	Restricted to diagnosis of duodenal ulcer as confirmed by UGI or endoscopy.			
Sulfacetamide	Sulamyd	EENT Anti-Infectives				
Sulfacetamide and Prednisolone Ophthalmic	Blephamide	EENT Anti-Infectives, Miscellanous				
Sulfamethoxazole/ Trimethoprim	Bactrim, Septra	Sulfonamides				
Sulfasalazine	Azulfidine	Sulfonamides				
Sulfur and Salicylic Acid	Fostex	Keratolytic Agents	For external use only.			
Sumatriptan Succinate	Imitrex	Antimigraine Agents - Selective Serotonin Agonists				
Tacrolimus	Prograf	Immunosuppressive Agents				
Tamsulosin	Flomax	Sympatholyic (Adrenergic Blocking) Agents				
Tar Shampoo	Ionil T	Keratinoplastic Agents	OTC versions-RN Use Per RN Guidelines. For external use only.		RN Use	
Tears, Artificial	Artificial Tears, many brands	EENT Preparations - Miscellaneous			RN Use	
Telbivudine	Tyzeka	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Tenofovir Disoproxil Fumarate	Viread	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Terazosin	Hytrin	A-Adrenergic Blocking Agents				
Terbinafine	Lamisil	Antifungal Agent	Not to be used for onychomycosis. Use for tinea capitis or tinea pedis.			
Testosterone (Depo Injection)	Depo-Testosterone	Androgen	Depo Injectable Only. Physician Initiation Only.	Pill Line		
Tetanus Toxoid	TT	Toxoids	According to CDC guidelines.			
Tetanus Toxoid Fluid		Toxoids	Diagnostic agent used for anergy testing; fluid needs to be refrigerated.			
Tetanus and Diphtheria	Td	Toxoids	According to CDC guidelines.			
Tetracycline	Achromycin, Sumycin	Tetracyclines				

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Tetrahydrozoline Ophthalmic	Visine	Vasoconstrictors (EENT)				
Theophylline	Theo-Dur	Respiratory Smooth Muscle Relaxants	Physician Initiation Only. Given the toxic side effects of theophylline and the frequency of blood monitoring, this drug should be considered a last resort drug when all other types of asthma medications have failed in children and adolescents.			
Thiamine	Vitamin B-1, Betalin S	Vitamin B Complex				
Thiothixene	Navane	Antipsychotic Agents	Physician/Psychiatrist Initiation Only. Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		
Timolol Maleate	Timoptic	EENT Preparations - B-Adrenergic Blocking Agents				
Tipranavir	Aptivus	Antiretroviral Agents	Physician Initiation Only.	Pill Line		
Titanium Dioxide	Vanicream	Sunscreen Agents	Topical Cream			
Tizanidine	Zanaflex	Centrally Acting Skeletal Muscle Relaxants				
Tobramycin Ophthalmic	Tobrex	EENT Antibacterials				
Topiramate	Topamax	Anticonvulsant	Used for epilepsy as monotherapy or adjunctive therapy; migraine prophylaxis	Pill Line		[2014 version]

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Tramadol	Ultram	Opiate Agonists	PA/NP: Requires a prescription countersigned by physician/dentist unless MLP privileged to prescribe independently. Only after documented NSAID failure or unless other NSAIDS are contraindicated. Keep in locked cabinet. Immediate release and non-enteric coated are to be crushed prior to administration.	Pill Line		
Trazodone	Desyrel	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2014 version]
Tretinoin Topical	Retin-A	Skin and Mucous Membrane Agents	Used for acne vulgaris only. Topical only.			
Triamcinolone Acetonide	Kenalog	Anti-Inflammatory Agents (Skin and Mucous Membranes)	In general topical corticosteroids should only be used on the involved areas of the skin and when treating chronic dermatitis should only be used when skin is inflamed.			
Triamcinolone Dental Paste	Kenalog in Orabase	Anti-Inflammatory Agents (Skin and Mucous Membranes)	See also Dental Agents 34:00			
Triamcinolone Hexacetonide	Aristospan	Adrenals				
Triamterene/ Hydro-chlorothiazide	Maxzide	Diuretics-potassium sparing				
Trimethobenzamide Hydrochloride	Tigan	Antiemetics				
Trihexyphenidyl	Artane	Antiparkinsonian Agents		Pill Line		
Tropicamide	Mydriacyl	Mydriatics	For diagnostic use only.			
Tuberculin Purified Protein Derivative	Tubersol	Tuberculosis (Diagnostic)	Product must be refrigerated.			

Generic	Trade Name	Therapeutic Class	Comments	Pill Line	RN Use	FDA Med Guide
Umeclidinium/ Vilanterol	Anoro Ellipta	Anticholinergic/ LABA	Long Acting Anticholinergic for COPD			[2013 version]
Ulipristal	Ella	Contraceptives				
Valsartan/Hydro-chlorothiazide	Diovan HCT	Angiotensin II Receptor Antagonists/Diuretic				
Valproic Acid		Anticonvulsant		Pill Line		
Vancomycin	Vancocin	Miscellaneous Antibiotics	Physician Initation Only. ADD-Vantage Vials.			
Varicella Vaccine	Varivax	Vaccines	According to CDC guidelines.			…
Venlafaxine	Effexor	Antidepressants	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		[2012 version]
Verapamil	Calan	Calcium Channel Blocking Agents	Injection-Physician Initiation Only.			
Vitamin A	Aquasol A	Vitamin A				
Vitamin A&D Ointment		Basic Ointments and protectants			RN Use	
Vitamin D 2 & D3	Ergocalciferol Cholecalciferol	Vitamin D				
Warfarin	Coumadin	Anticoagulants	Physician Initiation Only. See Anticoagulation Protocol.	Pill Line		[2011 version]
Zalcitabine	Hivid	Antiretroviral Agents	Physician Initiation Only	Pill Line		
Zidovudine	Retrovir	Antiretroviral Agents	Physician Initiation Only. Zidovudine has been associated with hematologic toxicity.	Pill Line		
Zidovudine and Lamivudine	Combivir	Antiretroviral Agents	Physician Initiation Only. Zidovudine has been associated with hematologic toxicity.	Pill Line		
Zinc Oxide	Desitin	Emollient,Protectants			RN Use	
Ziprasidone	Geodon	Atypical Antipsychotics	Physician/Psychiatrist Initiation Only- Physician/Psychiatrist can initiate and can be re-ordered/renewed by Mid-Levels.	Pill Line		

Dental Products

Generic	Trade Name	Indication	Price	Pill Line	Clinic Use Only
Acidulated Phosphate Fluoride (APF) 1.23%	Topex 60 Second APF Foam or Gel	Children, orthodontic, and xerostomia from medical tx.			
Articaine 4% with epinephrine	Septocaine	Local anesthetics.	$17.93 per box		Yes
Biotene Mouthwash (alcohol free)	Biotene Mouthwash (alcohol free)	Treatment of xerostomia due to medical treatment such as chemotherapy, radiation therapy and salivary gland disorders. "Physician/Dentist Initiation Only".	$3.27 per 8oz bottle		
Biotene Oral Balance Moisturizer	Biotene Oral Balance Moisturizer		$4.18 per 1.5oz		
Biotene Toothpaste	Biotene Toothpaste		$4.18 per 4.5oz tube		
Dexamethasone elixir 0.5 mg/ 5ml	Decadron	Treatment of steroid responsive disorders of the oral mucosa, including inflammatory and ulcerative lesions. "Physician/Dentist Initation Only" 7 days Use Only.	$19.66 per 240ml	Yes	
Denture Adhesive Cream	Fixodent				
Minocycline HCL 1mg syringes	Arestin	Locally administered antibiotic for use in scaling and root planning procedures for the reduction of pocket depth in patients with adult periodontitis.	$479.00 one box of 12		Yes
Neutral Sodium Fluoride 2%	Topex Neutral Foam or Gel	Children, orthodontic, and xerostomia from medical tx.			
Penciclovir cream 1%	Denavir	Treatment of oral herpes simplex. "Physician/Dentist Initiation Only".	$20.87 per 1.5gm		
Sodium Fluoride 1.1 %	PreviDent 5000	Xerostomia from medical treatment (i.e. Radiation tx).			
Sodium Fluoride 2.7% Propylaxis Paste (Fluoride Ion 1.23%)		Used for normal dental cleanings, polishing and plaque/ stain removal.	$21.05 box of 200		Yes
Sodium Fluoride Varnish 5%	Duraphat, Sultan DuraShield	Prevention of carious lesions and tooth sensitivity.	$18.22 per 10mL $155.99 per box (200 units/box)		Yes
Sulfonated Phenolics and Sulfuric Acid	Debacterol	Not available from VA Prime Vendor.			Yes

Approved Over-The-Counter Items
For Nurse Use

Generic	Trade Name	Therapeutic Class	Comments
Acetaminophen	Tylenol	Miscellaneous Analgesics and Antipyretics	Suppositories need to be refrigerated.
Aluminum Hydroxide/ Magnesium Hydroxide/ Simethicone	Mylanta, Maalox	Antacids and Adsorbents	See also Simethicone.
Bacitracin		Antibacterials (Skin and Mucous Membrane)	
Bisacodyl	Dulcolax	Cathartics and Laxatives	
Bismuth Subsalicylate	Pepto-Bismol	Antidiarrhea Agents	
Calamine	Calamine Lotion	Miscellaneous Skin and Mucous Membrand Agents	
Cetirizine	Zyrtec	Second Generation Antihistamines	
Chlorpheniramine Maleate	Chlor-Trimeton	First Generation Antihistamines	
Clotrimazole	Lotrimin	Antifungals (Skin and Mucous Membrane)	
Diphenhydramine Hydrochloride	Benadryl	First Generation Antihistamines	
Docusate Sodium	Colace	Cathartics and Laxatives	
Electrolyte Solution	Pedialyte	Replacement Preparations	For Pediatric/Children Use Only. Note: The use of this product should be limited to 24 hours in infants and children. After 24 hours, this rehydration formula can cause diarrhea worsening gastroenteritis.
Glycerin suppository		Cathartics and Laxatives	
Guaifenesin	Robitussin	Expectorants	
Hydrocortisone, Topical	Hydrotex	Anti-inflammatory Agents (Skin and Mucous Membrane)	
Hydrogen Peroxide		Mouthwashes and Gargles	Main clinic and dental clinic use.
Ibuprofen	Motrin	Nonsteroidal Anti-inflammatory Agents	
Loperamide Hydrochloride	Imodium	Antidiarrhea Agents	
Magnesium Hydroxide	MOM, Milk of Magnesia	Cathartics and Laxatives	
Normal Saline Nose Drops	Ocean Spray	EENT Preparations - Miscellaneous	
Permethrin	Acticin, Nix	Scabicides and Pediculicides	RN Use 1% Permethrin Per RN Guidelines.
Petrolatum	Vaseline	Emollients, Demulcents and Protectants	

Approved Over-The-Counter Items
For Nurse Use

Generic	Trade Name	Therapeutic Class	Comments
Phenylephrine suppository	Anu-Med	Miscellaneous Skin and Mucous Membrane Agents	
Piperonyl Butoxide/Pyrethrins	RID	Scabicides and Pediculicides	For external use only.
Polymyxin B/ Neomycin/ Bacitracin	Neosporin Topical Ointment	ENNT Anti-infectives	
Selenium Sulfide	Selsun	Miscellaneous Local Anti-Infectives	RN Use 1% Selenium Sulfide.
Simethicone	Mylicone	Antiflatulents	See also Maalox and Mylanta.
Tar Shampoo	Ionil T	Keratinoplastic Agents	OTC versions-RN Use Per RN Guidelines. For external use only.
Tears, Artificial	Artificial Tears, many brands	EENT Preparations - Miscellaneous	The previous entry with methylcellulose is not available from McKesson.
Tetrahydrozoline Ophthalmic	Visine	Vasoconstrictors (EENT)	

Category Listing

	Therapeutic Class	Generic
04:04	First Generation Antihistamines	Chlorpheniramine Maleate
04:04	First Generation Antihistamines	Diphenhydramine Hydrochloride
04:08	Second Generation Antihistamines	Cetrizine
04:08	Second Generation Antihistamines	Loratadine
08:08	Anthelmintics	Ablendazole
08:08	Anthelmintics	Ivermectic
08:12.02	Aminoglycoside	Gentamicin Sulfate
08:12.02	Aminoglycoside	Streptomycin
08:12.06	Cephalosporins	Cefazolin
08:12.06	Cephalosporins	Cefdinir
08:12.06	Cephalosporins	Ceftriaxone
08:12.06	Cephalosporins	Cephalexin
08:12.12	Macrolides	Azithromycin
08:12.12	Macrolides	Clarithromycin
08:12.12	Macrolides	Erythromycin and Sulfisoxazole
08:12.12	Macrolides	Erythromycin Ethylsuccinate
08:12.12	Macrolides	Erythromycin Stearate
08:12.16	Penicillins	Amoxicillin
08:12.16	Penicillins	Amoxicillin and Potassium Clavulanate
08:12.16	Penicillins	Ampicillin, Injectable
08:12.16	Penicillins	Dicloxacillin
08:12.16	Penicillins	Oxacillin
08:12.16	Penicillins	Penicillin G Benzathine
08:12.16	Penicillins	Penicillin G Procaine
08:12.16	Penicillins	Penicillin V Potassium
08:12.18	Quinolones	Ciprofloxacin Hydrochloride
08:12.18	Quinolones	Levofloxacin
08:12.18	Quinolones	Moxifloxacin
08:12.20	Sulfonamides	Erythromycin and Sulfisoxazole
08:12.20	Sulfonamides	Sulfamethoxazole/ Trimethoprim
08:12.20	Sulfonamides	Sulfasalazine
08:12.24	Tetracyclines	Doxycycline
08:12.24	Tetracyclines	Tetracycline
08:12.28	Miscellaneous Antibiotics	Clindamycin
08:12.28	Miscellaneous Antibiotics	Vancomycin
08:14	Antifungals	Nystatin
08:14.04	Antifungals	Terbinafine
08:14.08	Antifungals	Fluconazole
08:14.08	Antifungals	Ketoconazole
08:14.92	Antifungals	Griseofulvin
08:16.04	Antituberculosis	Capreomycin
08:16.04	Antituberculosis	Cycloserine
08:16.04	Antituberculosis	Ethambutol
08:16.04	Antituberculosis	Ethionamide

Category Listing

	Therapeutic Class	Generic
08:16.04	Antituberculosis	Isoniazid
08:16.04	Antituberculosis	Para-Aminosalicylic Acid
08:16.04	Antituberculosis	Pyrazinamide
08:16.04	Antituberculosis	Rifampin
08:16.92	Miscellaneous Antimycobacterials	Dapsone
08:18.04	Antivirals – Adamantanes	Amantadine
08:18.08	Antiretroviral Agents	Abacavir
08:18.08	Antiretroviral Agents	Abacavir/ Lamivudine
08:18.08	Antiretroviral Agents	Abacavir/ Lamivudine/ Zidovudine
08:18.08	Antiretroviral Agents	Amprenavir
08:18.08	Antiretroviral Agents	Atazanavir
08:18.08	Antiretroviral Agents	Atazanavir/Cobicistat
08:18.08	Antiretroviral Agents	Darunavir
08:18.08	Antiretroviral Agents	Darunavir/Cobicistat
08:18.08	Antiretroviral Agents	Delavirdine
08:18.08	Antiretroviral Agents	Didanosine
08:18.08	Antiretroviral Agents	Dolutegravir
08:18.08	Antiretroviral Agents	Dolutegravir/ Abacavir/ Lamivudine
08:18.08	Antiretroviral Agents	Efavirenz
08:18.08	Antiretroviral Agents	Efavirenz, Emtricitabine, Tenofovir
08:18.08	Antiretroviral Agents	Elvitegravir/ Cobicistat/ Emtricitabine/ Tenofovir
08:18.08	Antiretroviral Agents	Emtricitabine
08:18.08	Antiretroviral Agents	Emtricitabine, Tenofovir
08:18.08	Antiretroviral Agents	Emtricitabine, Rilpivirine, Tenofovir
08:18.08	Antiretroviral Agents	Enfuvirtide
08:18.08	Antiretroviral Agents	Entecavir
08:18.08	Antiretroviral Agents	Etravirine
08:18.08	Antiretroviral Agents	Fosamprenavir
08:18.08	Antiretroviral Agents	Lamivudine
08:18.08	Antiretroviral Agents	Lopinavir/ Ritonavir
08:18.08	Antiretroviral Agents	Nelfinavir
08:18.08	Antiretroviral Agents	Nevirapine
08:18.08	Antiretroviral Agents	Rilpivirine
08:18.08	Antiretroviral Agents	Ritonavir
08:18.08	Antiretroviral Agents	Saquinavir
08:18.08	Antiretroviral Agents	Stavudine
08:18.08	Antiretroviral Agents	Telbivudine
08:18.08	Antiretroviral Agents	Tenofovir Disoproxil Fumarate
08:18.08	Antiretroviral Agents	Tipranavir
08:18.08	Antiretroviral Agents	Zalcitabine
08:18.08	Antiretroviral Agents	Zidovudine
08:18.08	Antiretroviral Agents	Zidovudine and Lamivudine
08:18.08	Antiretroviral Agents	Indinavir
08:18.08.04	Antiretroviral Agents	Maraviroc

Category Listing

	Therapeutic Class	Generic
08:18.08.12	Antiretroviral Agents	Raltegravir Potassium
08:18.28	Antivirals- Neuraminidase Inhibitors	Oseltamivir
08:18.32	Nucleosides and Nucleotides	Acyclovir
08:18.32	Nucleosides and Nucleotides	Adefovir
08:18.32	Nucleosides and Nucleotides	Famciclovir
08:30.08	Antimalarials	Chloroquine Phosphate
08:30.08	Antimalarials	Hydroxychloroquine
08:30.08	Antimalarials	Primaquine
08:30.08	Antimalarials	Pyrimethamine
08:30.08	Antimalarials	Quinine
08:30.08	Antimalarials	Atovaquone
08:30.92	Miscellanous Antiprotozoals	Metronidazole
08:30.92	Miscellanous Antiprotozoals	Pentamidine Isethionate
08:36	Urinary Anti-Infectives	Nitrofurantoin
10:00	Antineoplastic Agents	Hydroxyurea
10:00	Antineoplastic Agents	Megestrol Acetate
10:00	Antineoplastic Agents	Methotrexate
12:04	Parasympathomimetic (Cholinergic) Agent	Bethanechol
12:08.04	Antiparkinsonian Agents	Benztropine Mesylate
12:08.04	Antiparkinsonian Agents	Carbidopa and Levodopa
12:08.04	Antiparkinsonian Agents	Trihexyphenidyl
12:08.08	Antimuscarinics/ Antispasmodics	Dicyclomine Hydrochloride
12:08.08	Antimuscarinics/ Antispasmodics	Umeclidinium/Vilanterol
12:08.08	Antimuscarinics/ Antispasmodics	Ipratropium
12:08.08	Antimuscarinics/Antispasmodics	Ipratropium/ Albuterol oral inhaler
12:12	Sympathomimetic (Adrenergic) Agents	Epinephrine
12:12	Sympathomimetic (Adrenergic) Agents	Salmeterol
12:12	Sympathomimetic (Adrenergic) Agents	Albuterol
12:12	Sympathomimetic (Adrenergic) Agents	Ipratropium/ Albuterol oral inhaler
12:16	Sympatholyic (Adrenergic Blocking) Agents	Ergotamine and Caffeine
12:16.04	Selective Alpha-1-Adrenergic Blocking Agent	Tamsulosin
12:20	Skeletal Muscle Relaxants	Baclofen
12:20	Skeletal Muscle Relaxants	Cyclobenzaprine
12:20	Skeletal Muscle Relaxants	Methocarbamol
12:20.04	Centrally Acting Skeletal Muscle Relaxants	Tizanidine
20:04.04	Iron Preparations	Ferrous Sulfate
20:12.04	Anticoagulants	Enoxaparin
20:12.04	Anticoagulants	Heparin Sodium
20:12.04	Anticoagulants	Warfarin
20:12.18	Platelet-Aggregation Inhibitors	Clopidogrel Bisulfate
20:16	Hematopoietic Agents	Epoetin Alfa

Category Listing

	Therapeutic Class	Generic
20:16	Hematopoietic Agents	Filgrastim
24:04	Cardiac Drugs	Digoxin
24:04	Cardiac Drugs	Lidocaine Hydrochloride
24:04	Cardiac Drugs	Quinidine Sulfate
24:04.04	Antiarrhythmic agents	Amiodarone
24:06.06	Fibric Acid Derivatives	Fenofibrate
24:06.06	Fibric Acid Derivatives	Gemfibrozil
24:06.08	HMG CoA Reductase Inhibitors	Atorvastatin
24:06.08	HMG CoA Reductase Inhibitors	Pravastatin
24:06.08	HMG CoA Reductase Inhibitors	Simvastatin
24:08.16	Hypotensive Agents – Central A-Agonists	Clonidine Hydrochloride
24:08.16	Hypotensive Agents – Central A-Agonists	Methyldopa
24:08.20	Direct Vasodilators	Minoxidil
24:08.20	Direct Vasodilators	Hydralazine
24:12.08	Vasodilating Agents – Nitrates and Nitrites	Isosorbide Dinitrate
24:12.08	Vasodilating Agents – Nitrates and Nitrites	Isosorbide Mononitrate
24:12.08	Vasodilating Agents - Nitrates and Nitrites	Nitroglycerin
24:20	A-Adrenergic Blocking Agents	Doxazosin
24:20	A-Adrenergic Blocking Agents	Prazosin
24:20	A-Adrenergic Blocking Agents	Terazosin
24:24	B-Adrenergic Blocking Agents	Atenolol
24:24	B-Adrenergic Blocking Agents	Carvedilol
24:24	B-Adrenergic Blocking Agents	Labetalol
24:24	B-Adrenergic Blocking Agents	Metoprolol Tartrate
24:24	B-Adrenergic Blocking Agents	Propranolol Hydrochloride
24:24	B-Adrenergic Blocking Agents	Sotalol
24:28	Calcium Channel Blocking Agents	Amlodopine
24:28	Calcium Channel Blocking Agents	Diltiazem
24:28	Calcium Channel Blocking Agents	Nifedipine
24:28	Calcium Channel Blocking Agents	Verapamil
24:32.04	Renin-Angiotensin-Aldosterone System Inhibitors	Captopril
24:32.04	Renin-Angiotensin-Aldosterone System Inhibitors	Enalapril
24:32.04	Renin-Angiotensin-Aldosterone System Inhibitors	Lisinopril
24:32.04	Renin-Angiotensin-Aldosterone System Inhibitors	Lisinopril/ Hydro-chlorothiazide
24:32.08	Angiotensin II Receptor Antagonists	Losartan
24:32.08	Angiotensin II Receptor Antagonists	Losartan/HCTZ
24:32.08	Angiotensin II Receptor Antagonists	Valsartan/Hydro-chlorothiazide
28.12.08	Oral Benzodiazepines	Diazepam

Category Listing

	Therapeutic Class	Generic
28:08.04	Nonsteroidal Anti-inflammatory Agents	Acetaminophen / Aspirin/ Caffeine
28:08.04	Nonsteroidal Anti-inflammatory Agents	Aspirin
28:08.04	Nonsteroidal Anti-inflammatory Agents	Colchicine
28:08.04	Nonsteroidal Anti-inflammatory Agents	Diclofenac ER
28:08.04	Nonsteroidal Anti-inflammatory Agents	Ibuprofen
28:08.04	Nonsteroidal Anti-inflammatory Agents	Indomethacin
28:08.04	Nonsteroidal Anti-inflammatory Agents	Ketorolac
28:08.04	Nonsteroidal Anti-inflammatory Agents	Meloxicam
28:08.04	Nonsteroidal Anti-inflammatory Agents	Naproxen
28:08.08	Opiate Agonist	Acetaminophen and Codeine
28:08.08	Opiate Agonist	Acetaminophen and hydrocodone
28:08.08	Opiate Agonist	Acetaminophen and Oxycodone
28:08.08	Opiate Agonists	Morphine Sulfate
28:08.08	Opiate Agonists	Tramadol
28:08.12	Opiate Partial Agonists	Butorphanol
28:08.92	Miscellaneous Analgesics and Antipyretics	Acetaminophen
28:08.92	Miscellaneous Analgesics and Antipyretics	Acetaminophen and Codeine
28:08.92	Miscellaneous Analgesics and Antipyretics	Acetaminophen and Oxycodone
28:08.92	Miscellaneous Analgesics and Antipyretics	Acetaminophen and hydrocodone
28:10	Opiate Antagonists	Naloxone
28:12.04	Anticonvulsants, Barbiturates	Phenobarbital
28:12.04	Anticonvulsants, Barbiturates	Primidone
28:12.12	Anticonvulsants, Hydantoins	Phenytoin
28:12.90	Anticonvulsants	Valproic Acid
28:12.92	Miscellaneous Anticonvulsants	Carbamazepine
28:12.92	Miscellaneous Anticonvulsants	Divalproex Sodium
28:12.92	Miscellaneous Anticonvulsants	Gabapentin
28:12.92	Anticonvulsants, Miscellaneous	Lamotrigine
28:12.92	Anticonvulsants, Miscellaneous	Levetiracetam
28:12.92	Miscellaneous Anticonvulsants	Magnesium Sulfate
28:12.92	Miscellaneous Anticonvulsants	Oxcarbazepine
28:12.92	Anticonvulsants	Topiramate
28:16.04	Antidepressants	Amitriptyline
28:16.04	Antidepressants	Bupropion
28:16.04	Antidepressants	Citalopram
28:16.04	Antidepressants	Desipramine
28:16.04	Antidepressants	Doxepin
28:16.04	Antidepressants	Duloxetine
28:16.04	Antidepressants	Imipramine
28:16.04	Antidepressants	Mirtazapine
28:16.04	Antidepressants	Paroxetine
28:16.04	Antidepressants	Sertraline Hydrochloride

Category Listing

	Therapeutic Class	Generic
28:16.04	Antidepressants	Trazodone
28:16.04	Antidepressants	Venlafaxine
28:16.04	Antidepressants	Fluoxetine
28:16.08	Atypical Antipsychotics	Lurasidone
28:16.08.04	Atypical Antipsychotics	Aripiprazole
28:16.08.04	Atypical Antipsychotics	Olanzapine
28:16.08.04	Atypical Antipsychotics	Risperidone
28:16.08.04	Atypical Antipsychotics	Ziprasidone
28:16.08.08	Antipsychotic Agents	Haloperidol
28:16.08.08	Antipsychotic Agents	Haloperidol Decanoate
28:16.08.24	Antipsychotic Agents	Chlorpromazine Hydrochloride
28:16.08.24	Antipsychotic Agents	Fluphenazine
28:16.08.24	Antipsychotic Agents	Fluphenazine Decanoate
28:16.08.24	Antipsychotic Agents	Perphenazine
28:16.08.32	Antipsychotic Agents	Thiothixene
28:20	Anorexigenic Agents and Respiratory and Cerebral Stimulants	Ammonia Spirit, Aromatic
28:24.08	Benzodiazepines	Clonazepam
28:24.08	Injectable Benzodiazepines	Diazepam
28:24.08	Benzodiazepines	Lorazepam
28:24.92	Miscellaneous Anxiolytics, Sedatives and Hypnotics	Buspirone
28:24.92	Miscellaneous Anxiolytics, Sedatives, and Hypnotics	Hydroxyzine
28:24.92	Miscellaneous Anxiolytics, Sedatives, and Hypnotics	Promethazine
28:28	Antimanic Agents	Lithium Carbonate
28:32.28	Antimigraine Agents - Selective Serotonin Agonists	Sumatriptan Succinate
28:36	Ergot-Derivative Dopamine Receptor Agonists	Cabergoline
28:36.20	Dopamine Receptor Agonists	Bromocriptine Mesylate
34:00	Dental Agents	Benzocaine
36:68	Diagnostic agent	Barium Sulfate
36:84	Tuberculosis (Diagnostic)	Tuberculin Purified Protein Derivative
40:10	Electrolytic, Caloric, and Water Balance	Lactulose
40:12	Replacement Preparations	Calcium Acetate
40:12	Replacement Preparations	Calcium Carbonate
40:12	Replacement Preparations	Calcium Carbonate with Vitamin D
40:12	Replacement Preparations	Dextrose 5% in normal saline
40:12	Replacement Preparations	Dextrose in sterile water
40:12	Replacement Preparations	Electrolyte Solution
40:12	Replacement Preparations	Lactated Ringers
40:12	Replacement Preparations	Potassium Chloride
40:12	Replacement Preparations	Sodium Chloride
40:18.19	Ion-removing Agent	Sevelamer

Category Listing

	Therapeutic Class	Generic
40:20	Caloric Agents	Dextrose Instant Gel
40:20	Nutritional Supplements	Dietary Supplement, Oral
40:28	Diuretics	Furosemide
40:28	Diuretics	Hydro-cholorothiazide
40:28	Diuretics	Lisinopril/ Hydro-chlorothiazide
40:28	Diuretics	Triamterene and Hydrochlorothiazide
40:28.16	Diuretics-potassium sparing	Spironolactone
40:28.16	Diuretics-potassium sparing	Triamterene and Hydrochlorothiazide
40:28.24	Thiazide-like Diuretics	Chlorthalidone
40:36	Irrigating Solutions	Sodium Chloride, Irrigation Solution
40:40	Uricosuric Agents	Allopurinol
40:40	Uricosuric Agents	Probenecid
48:08	Antitussives	Benzonatate
48:10.24	Leukotriene Modifiers	Montelukast
48:16	Expectorants	Guaifenesin
52:02	Antiallergic Agents	Ketotifen
52:04.04	EENT Anti-infectives	Erythromycin, Ophthalmic
52:04.04	EENT Anti-infectives	Neomycin/ Polymyxin B Sulfate/ Dexamethsone ophthalmic drop
52:04.04	EENT Anti-infectives	Neomycin/ Polymyxin B/ Hydrocortisone
52:04.04	EENT Anti-infectives	Ofloxacin Ophthalmic drop
52:04.04	EENT Anti-infectives	Ofloxacin Otic
52:04.04	EENT Anti-infectives	Polymyxin B/ Neomycin/ Bacitracin
52:04.04	EENT Anti-infectives	Polymyxin B/ Neomycin/ Gramicidin Ophthalmic
52:04.04	EENT Anti-Infectives	Sulfacetamide
52:04.04	EENT Antibacterials	Tobramycin ophtlamic
52:04.92	EENT Anti-Infectives, Miscellanous	Borate/Boric Acid/H2O/NaCl
52:04.92	EENT Anti-Infectives, Miscellanous	Carbamide Peroxide
52:04.92	Anti-Infective; topical cauterizing agent	Silver Nitrate Applicator
52:04.92	EENT Anti-Infectives, Miscellanous	Sulfacetamide and Prednisolone Ophtlamic
52:04.92	EENT Anti-Infectives, Miscellanous	Aluminum Acetate and Acetic Acid Otic
52:08	Anti-inflammatory Agents (EENT)	Dexamethasone, Ophthalmic
52:08	Anti-inflammatory Agents (EENT)	Mometasone Furoate
52:08	Anti-inflammatory Agents (EENT)	Prednisolone Ophthalmic
52:08.20	EENT Nonsteroidal Antiinflammatory Agents	Ketorolac Ophthalmic
52:16	Local Anesthetics (EENT)	Antipyrine and Benzocaine
52:16	Local Anesthetics (EENT)	Benzocaine
52:16	Local Anesthetics (EENT)	Proparacaine Hydrochloride
52:24	Mydriatics	Atropine
52:24	Mydriatics	Cyclopentolate
52:24	Mydriatics	Tropicamide
52:28	Mouthwashes and Gargles	Chlorhexidine Gluconate
52:28	Mouthwashes and Gargles	Hydrogen Peroxide

Category Listing

	Therapeutic Class	Generic
52:32	Vasoconstrictors (EENT)	Oxymetazoline
52:32	Vasoconstrictors (EENT)	Tetrahydrozoline Ophthalmic
52:40.04	A-Adrenergic Agonists (EENT)	Brimonidine Tartrate
52:40.08	EENT Preparations - B-Adrenergic Blocking Agents	Dorzolamide Hydrochloride/ Timolol
52:40.08	EENT Preparations - B-Adrenergic Blocking Agents	Timolol Maleate
52:40.12	Carbonic Anhydrase Inhibitors	Acetazolamide
52:40.12	Carbonic Anhydrase Inhibitors	Dorzolamide Hydrochloride
52:40.12	Carbonic Anhydrase Inhibitors	Dorzolamide Hydrochloride/ Timolol
52:40.28	Prostaglandin Analogs	Latanoprost
52:92	EENT Preparations - Miscellaneous	Normal Saline Nose Drops
52:92	EENT Preparations - Miscellaneous	Tears, Artificial
56:04	Antacids and Adsorbents	Aluminum Hydroxide and Magnesium Trisilicate
56:04	Antacids and Adsorbents	Aluminum Hydroxide/ Magnesium Hydroxide/ Simethicone
56:04	Antacids and Adsorbents	Charcoal, Activated
56:04	Antacids and Adsorbents	Magnesium Oxide
56:08	Antidiarrhea Agents	Bismuth Subsalicylate
56:08	Antidiarrhea Agents	Lactobacillus
56:08	Antidiarrhea Agents	Loperamide Hydrochloride
56:10	Antiflatulents	Simethicone
56:12	Cathartics and Laxatives	Bisacodyl
56:12	Cathartics and Laxatives	Calcium Polycarbophil
56:12	Cathartics and Laxatives	Docusate Sodium
56:12	Cathartics and Laxatives	Glycerin suppository
56:12	Cathartics and Laxatives	Magnesium Hydroxide
56:12	Cathartics and Laxatives	PEG (Polyethylene Glyco) 3350 + Electrolyte Solution
56:12	Cathartics and Laxatives	Polyethylene Glycol
56:12	Cathartics and Laxatives	Psyllium
56:12	Cathartics and Laxatives	Sodium Phosphate, Rectal
56:22	Antiemetics	Meclizine
56:22	Antiemetics	Prochlorperazine
56:22	Antiemetics	Trimethobenzamide Hydrochloride
56:22.20	5-HT3 Receptor Antagonists	Ondansetron
56:28	Gastrointestinal Agents - Antiulcer Agents and Acid Suppressants	Omeprazole
56:28	Gastrointestinal Agents - Antiulcer Agents and Acid Suppressants	Ranitidine Hydrochloride
56:28	Gastrointestinal Agents - Antiulcer Agents and Acid Suppressants	Sucralfate
56:32	Gastrointestinal Agents – Prokinetic Agents	Metoclopramide Hydrochloride
56:36	Anti-inflammatory Agents (GI Drugs)	Mesalamine
68:04	Adrenals	Budesonide/ Formoterol

Category Listing

	Therapeutic Class	Generic
68:04	Adrenals	Fluticasone Propionate
68:04	Adrenals	Methylprednisolone
68:04	Adrenals	Prednisone
68:04	Adrenals	Triamcinolone Hexacetonide
68:08	Androgens	Testosterone
68:12	Contraceptives	Drospirenone - Ethinyl Estradiol
68:12	Progestins	Levonorgestrel
68:12	Contraceptive	Norethindrone
68:12	Contraceptive	Norgestimate-Ethinyl Estradiol
68:12	Contraceptives	Ulipristal
68:16.04	Estrogens	Estradiol Cypionate
68:16.04	Estrogens	Estradiol Valerate
68:20.08	Insulins	Insulin
68:20.20	Antidiabetic Agents	Glipizide
68:20.20	Antidiabetic Agents	Glyburide
68:20.92	Miscellaneous Antidiabetic Agents	Metformin
68:22.12	Glycogenolytic Agents	Glucagon, Human Recombinant
68:22.12	Glycogenolytic Agents	Glucagon, Human Recombinant
68:32	Progestins	Medroxy-progesterone
68:36.04	Thyroid Agents	Levothyroxine
68:36.08	Antithyroid Agents	Methimazole
68:36.08	Antithyroid Agents	Propylthiouracil
72:00	Local Anesthetics	Bupivacaine Hydrochloride with Epinephrine
72:00	Local Anesthetics	Lidocaine and Epinephrine
72:00	Local Anesthetics	Lidocaine Hydrochloride
72:00	Local Anesthetics	Mepivacaine
80:04	Serums	Immune Globulin
80:08	Toxoids	Diphtheria and Tetanus Toxoid, Pediatric
80:08	Toxoids	Diphtheria, Tetanus Toxoid, Acellular Pertussis Vaccine
80:08	Toxoids	Tetanus Toxoid
80:08	Toxoids	Tetanus Toxoid Fluid
80:08	Toxoids	Tetanus and Diphtheria
80:12	Vaccines	Hepatitis A Vaccine
80:12	Vaccines	Hepatitis B Vaccine
80:12	Vaccines	Influenza vaccine
80:12	Vaccines	Measles, Mumps, and Rubella Vaccine
80:12	Vaccines	Measles, Mumps, Rubella, and Varicella Vaccine
80:12	Vaccines	Meningococcal
80:12	Vaccines	Papillomavirus
80:12	Vaccines	Pneumococcal Vaccine
80:12	Vaccines	Poliovirus Vaccine
80:12	Vaccines	Rotavirus

Category Listing

	Therapeutic Class	Generic
80:12	Vaccines	Varicella Vaccine
84:04.04	Antibacterials (Skin and Mucous Membrane)	Bacitracin
84:04.04	Antibacterials (Skin and Mucous Membrane)	Erythromycin Topical
84:04.04	Antibacterials (Skin and Mucous Membrane)	Metronidazole
84:04.04	Antibacterials (Skin and Mucous Membrane)	Mupirocin
84:04.08	Antifungals (Skin and Mucous Membrane)	Clotrimazole
84:04.08	Antifungals (Skin and Mucous Membrane)	Gentian Violet
84:04.08	Antifungals (Skin and Mucous Membrane)	Miconazole
84:04.12	Scabicides and Pediculicides	Permethrin
84:04.12	Scabicides and Pediculicides	Piperonyl Butoxide/Pyrethrins
84:04.12	Scabicides and Pediculicides	Crotamiton
84:04.92	Miscellaneous Local Anti-Infectives	Alcohol, Isopropyl
84:04.92	Miscellaneous Local Anti-Infectives	Selenium Sulfide
84:04.92	Miscellaneous Local Anti-Infectives	Silver Sulfadiazine
84:06	Anti-inflammatory Agents (Skin and Mucous Membrane)	Clobetasol
84:06	Anti-inflammatory Agents (Skin and Mucous Membrane)	Fluocinonide
84:06	Anti-Inflammatory Agents (Skin and Mucous Membranes)	Hydrocortisone Suppository
84:06	Anti-Inflammatory Agents (Skin and Mucous Membranes)	Hydrocortisone, Topical
84:06	Anti-Inflammatory Agents (Skin and Mucous Membranes)	Triamcinolone Acetonide
84:06	Anti-Inflammatory Agents (Skin and Mucous Membranes)	Triamcinolone Dental Paste
84:08	Antipruritics and Local Anesthetics	Benzocaine
84:08	Antipruritics and Local Anesthetics	Dibucaine
84:08	Antipruritics and Anesthetics	Lidocaine Hydrochloride
84:08	Antipruritics and Anesthetics	Phenazopyridine
84:16	Skin and Mucous Membrane Agents	Tretinoin Topical
84:24	Emollients, Demulcents and Protectants	Petrolatum
84:24	Emollient, Demulcents and Protectants	Zinc Oxide
84:24.04	Basic Lotions and Liniments	Ammonium lactate
84:24.04	Basic Lotions and Liniments	Camphor/menthol
84:24.12	Basic Ointments and protectants	Vitamin A&D Ointment
84:28	Keratolytic Agent	Benzoyl Peroxide
84:28	Keratolytic Agent	Podophyllin
84:28	Keratolytic Agents	Salicylic Acid
84:28	Keratolytic Agents	Sulfur and Salicylic Acid
84:32	Keratinoplastic Agents	Tar Shampoo

Category Listing

	Therapeutic Class	Generic
84:80	Sunscreen Agents	Titanium Dioxide
84:92	Skin and Mucous Membrane Agents	Adapalene
84:92	Miscellaneous Skin and Mucous Membrane Agents	Calamine
84:92	Miscellaneous Skin and Mucous Membrane Agents	Calcipotriene
84:92	Miscellaneous Skin and Mucous Membrane Agents	Phenylephrine
84:92	Skin and Mucous Membrane Agents	Podofilox
84:92	Miscellaneous Skin and Mucous Membrand Agents	Aluminum Acetate Topical
86:12	Genitourinary Smooth Muscle Relaxant	Oxybutynin
86:16	Respiratory Smooth Muscle Relaxants	Theophylline
88:00	Vitamins	B vitamins, vitamin C with folic acid
88:04	Vitamin A	Vitamin A
88:08	Vitamin B complex	Cyanocobalamin
88:08	Vitamin B Complex	Folic Acid
88:08	Vitamin B Complex	Niacin
88:08	Vitamin B Complex	Pyridoxine
88:08	Vitamin B Complex	Thiamine
88:12	Vitamin C	Ascorbic Acid
88:16	Vitamin D	Vitamin D
88:24	Vitamin K	Phytonadione
88:28	Multivitamin Preparation	Multivitamin
88:28	Multivitamin Preparation	Multivitamin, Children's
88:28	Multivitamin Preparation	Multivitamin/ Mineral/Folic Acid
92:00	Miscellaneous Therapeutic Agents	Cinacalcet
92:00	Miscellaneous Therapeutic Agents	Leucovorin Calcium
92:00	Miscellaneous Therapeutic Agents	Alendronate
92:08	5 Alpha-Reductase Inhibitor	Finasteride
92:36	Disease-Modifying Antirheumatic Agents	Leflunomide
92:44	Immunosuppressive Agents	Azathioprine
92:44	Immunosuppressive agents	Cyclosporine
92:44	Immunosuppressive Agents	Mycophenolate
92:44	Immunosuppressive Agents	Tacroliums

Torrance County

P.O. Box 48
205 South Ninth Street
Estancia, New Mexico 87016
505-544-4700

April 16, 2019

Broderick Morris
Detention, Compliance and Removals
Section Chief
Department of Homeland Security
Immigration and Customs Enforcement
Office of Acquisition Management
801 I Street NW
Suite 930
Washington, DC 20536

Re: ICE IGSA – Torrance County

Dear Mr. Morris:

Torrance County authorizes CoreCivic to communicate directly with ICE on behalf of the County regarding an IGSA to house detainees at the Torrance County Detention Center. Please let me know if you have any questions or need any further information.

Sincerely,

Wayne Johnson
County Manager

Cover Page Instructions
Complete the light brown cells with the facility's identifying information and population data below. All white cells calculate automatically from other sheets.

A. Identifying Information			
Facility name	Torrance County Detention Facility		
Total facility size (square feet)	235,318		
B. Capacity			
Total capacity	892		
FY2018 ADP	-		
ICE-dedicated beds	892		
C. Time Frame			
Percentage of the facility that is ICE-dedicated	100%		
D. Financial Information			
			% of contract
Staffing Wages	$	12,449,435.56	43%
Staffing Benefits	$	3,205,504.25	11%
Facility	$	1,227,875.82	4%
Other Direct Costs	$	(754,412.13)	-3%
Total Operating Costs	**$**	**16,128,403.50**	**55%**
Depreciation & Interest	$	7,304,071.61	25%
Contracted Services	$	1,862,653.54	6%
G&A	$	3,860,560.35	13%
Total Non-Operating Costs	**$**	**13,027,285.50**	**45%**
TOTAL CONTRACT VALUE FOR THE FACILITY	**$**	**29,155,689.00**	**100%**
TOTAL VALUE FOR ICE-DEDICATED BEDS	**$**	**29,155,689.00**	
Bed-day rate at total capacity	$	89.55	
Bed-day rate for ICE-dedicated beds	$	89.55	
Transportation Costs (if applicable)	**$**	-	

TITLE 29--LABOR

PART 4_LABOR STANDARDS FOR FEDERAL SERVICE CONTRACTS--Table of Contents

Subpart A Service Contract Labor Standards Provisions and Procedures

Sec. 4.6 Labor standards clauses for Federal service contracts exceeding $2,500.

The clauses set forth in the following paragraphs shall be included in full by the contracting agency in every contract/Inter-Governmental Service Agreement (IGSA) entered into by the United States or the District of Columbia, in excess of $2,500, or in an indefinite amount, the principal purpose of which is to furnish services through the use of service employees:

(a) Service Contract Act of 1965, as amended: This contract/IGSA is subject to the Service Contract Act of 1965 as amended (41 U.S.C. 351 et seq.) and is subject to the following provisions and to all other applicable provisions of the Act and regulations of the Secretary of Labor issued there under (29 CFR part 4).

(b)(1) Each service employee employed in the performance of this Contract/IGSA by the contractor or any subcontractor shall be paid not less than the minimum monetary wages and shall be furnished fringe benefits in accordance with the wages and fringe benefits determined by the Secretary of Labor or authorized representative, as specified in any wage determination attached to this contract.

(2)(i) If there is such a wage determination attached to this Contract/IGSA, the contracting officer shall require that any class of service employee which is not listed therein and which is to be employed under the Contract/IGSA (i.e., the work to be performed is not performed by any classification listed in the wage determination), be classified by the contractor so as to provide a reasonable relationship (i.e., appropriate level of skill comparison) between such unlisted classifications and the classifications listed in the wage determination. Such conformed class of employees shall be paid the monetary wages and furnished the fringe benefits as are determined pursuant to the procedures in this section.

(ii)Such conforming procedure shall be initiated by the contractor prior to the performance of contract/IGSA work by such unlisted class of employee. A written report of the proposed conforming action, including information regarding the agreement or disagreement of the authorized representative of the employees involved or, where there is no authorized representative, the employees themselves, shall be submitted by the contractor to the contracting officer no later than 30 days after such unlisted class of employees performs any Contract/IGSA work. The contracting officer shall review the proposed action and promptly submit a report of the action, together with the agency's recommendation and all pertinent information including the position of the contractor and the employees, to the Wage and Hour Division, Employment Standards Administration, U.S. Department of Labor, for review. The Wage and Hour Division will approve, modify, or disapprove the action or render a final determination in the event of disagreement within 30 days of receipt or will notify the contracting officer within 30 days of receipt that additional time is necessary.

(iii) The final determination of the conformance action by the Wage and Hour Division shall be transmitted to the contracting officer who shall promptly notify the contractor of the action taken. Each affected employee shall be furnished by the contractor with a written copy of such determination or it shall be posted as a part of the wage determination.

(iv)(A) The process of establishing wage and fringe benefit rates that bears a reasonable relationship to those listed in a wage determination cannot be [[Page 41]] reduced to any single formula. The approach used may vary from wage determination to wage determination depending on the circumstances. Standard wage and salary administration practices, which rank various job classifications by pay grade pursuant to point schemes or other job factors may, for example, be relied upon. Guidance may also be obtained from the way different jobs are rated under Federal pay systems (Federal Wage Board Pay System and the General Schedule) or from other wage determinations issued in the same locality. Basic to the establishment of any conformable wage rate(s) is the concept that a pay relationship should be maintained between job classifications based on the skill required and the duties performed.

(B) In the case of a Contract/IGSA modification, an exercise of an option or extension of an existing contract, or in any other case where a contractor succeeds a Contract/IGSA under which the classification in question was previously conformed pursuant to this section, a new conformed wage rate and fringe benefits may be assigned to such conformed classification by indexing (i.e., adjusting) the previous conformed rate and fringe benefits by an amount equal to the average (mean) percentage increase (or decrease, where appropriate) between the wages and fringe benefits specified for all classifications to be used on the Contract/IGSA which are listed in the current wage determination, and those specified for the corresponding classifications in the previously applicable wage determination. Where conforming actions are accomplished in accordance with this paragraph prior to the performance of Contract/IGSA work by the unlisted class of employees, the contractor shall advise the contracting officer of the action taken but the other procedures in paragraph (b) (2) (ii) of this section need not be followed.

(C) No employee engaged in performing work on this Contract/IGSA shall in any event be paid less than the currently applicable minimum wage specified under section 6(a) (1) of the Fair Labor Standards Act of 1938, as amended. (v) The wage rate and fringe benefits finally determined pursuant to paragraphs (b)(2)(i) and (ii) of this section shall be paid to all employees performing in the classification from the first day on which Contract/IGSA work is performed by them in the classification. Failure to pay such unlisted employees the compensation agreed upon by the interested parties and/or finally determined by the Wage and Hour Division retroactive to the date such class of employees commenced Contract/IGSA work shall be a violation of the Act and this contract.(vi) Upon discovery of failure to comply with paragraphs (b)(2)(i) through (v) of this section, the Wage and Hour Division shall make a final determination of conformed classification, wage rate, and/or fringe benefits which shall be retroactive to the date such class of employees commenced Contract/IGSA work.

(3) If, as authorized pursuant to section 4(d) of the Service Contract Act of 1965 as amended, the term of this Contract/IGSA is more than 1 year, the minimum monetary wages and fringe benefits required to be paid or furnished there under to service employees shall be subject to adjustment after 1 year and not less often than once every 2 years, pursuant to wage

determinations to be issued by the Wage and Hour Division, Employment Standards Administration of the Department of Labor as provided in such Act.

(c) The contractor or subcontractor may discharge the obligation to furnish fringe benefits specified in the attachment or determined conformably thereto by furnishing any equivalent combinations of bona fide fringe benefits, or by making equivalent or differential payments in cash in accordance with the applicable rules set forth in subpart D of 29 CFR part 4, and not otherwise.

(d)(1) In the absence of a minimum wage attachment for this contract, neither the contractor nor any subcontractor under this Contract/IGSA shall pay any person performing work under the Contract/IGSA (regardless of whether they are service employees) less than the minimum wage specified by section 6(a)(1) of the Fair Labor Standards Act of 1938. Nothing in this provision shall relieve the contractor or any subcontractor of any other obligation under [[Page 42]] law or Contract/IGSA for the payment of a higher wage to any employee.

(2) If this Contract/IGSA succeeds a contract, subject to the Service Contract Act of 1965 as amended, under which substantially the same services were furnished in the same locality and service employees were paid wages and fringe benefits provided for in a collective bargaining agreement, in the absence of the minimum wage attachment for this Contract/IGSA setting forth such collectively bargained wage rates and fringe benefits, neither the contractor nor any subcontractor under this Contract/IGSA shall pay any service employee performing any of the Contract/IGSA work (regardless of whether or not such employee was employed under the predecessor contract), less than the wages and fringe benefits provided for in such collective bargaining agreements, to which such employee would have been entitled if employed under the predecessor contract, including accrued wages and fringe benefits and any prospective increases in wages and fringe benefits provided for under such agreement. No contractor or subcontractor under this Contract/IGSA may be relieved of the foregoing obligation unless the limitations of Sec. 4.1b(b) of 29 CFR part 4 apply or unless the Secretary of Labor or his authorized representative finds, after a hearing as provided in Sec. 4.10 of 29 CFR part 4 that the wages and/or fringe benefits provided for in such agreement are substantially at variance with those which prevail for services of a character similar in the locality, or determines, as provided in Sec. 4.11 of 29 CFR part 4, that the collective bargaining agreement applicable to service employees employed under the predecessor Contract/IGSA was not entered into as a result of arm's-length negotiations. Where it is found in accordance with the review procedures provided in 29 CFR 4.10 and/or 4.11 and parts 6 and 8 that some or all of the wages and/or fringe benefits contained in a predecessor contractor's collective bargaining agreement are substantially at variance with those which prevail for services of a character similar in the locality, and/or that the collective bargaining agreement applicable to service employees employed under the predecessor Contract/IGSA was not entered into as a result of arm's-length negotiations, the Department will issue a new or revised wage determination setting forth the applicable wage rates and fringe benefits. Such determination shall be made part of the Contract/IGSA or subcontract, in accordance with the decision of the Administrator, the Administrative Law Judge, or the Administrative Review Board, as the case may be, irrespective of whether such issuance occurs prior to or after the award of a Contract/IGSA or subcontract. 53 Comp. Gen. 401 (1973). In the case of a wage determination issued solely as a result of a finding of substantial variance, such determination shall be effective as of the date of the final administrative decision.

(e) The contractor and any subcontractor under this Contract/IGSA shall notify each service employee commencing work on this Contract/IGSA of the minimum monetary wage and any fringe benefits required to be paid pursuant to this contract, or shall post the wage determination attached to this contract. The poster provided by the Department of Labor (Publication WH 1313) shall be posted in a prominent and accessible place at the worksite. Failure to comply with this requirement is a violation of section 2(a) (4) of the Act and of this contract.

(f) The contractor or subcontractor shall not permit any part of the services called for by this Contract/IGSA to be performed in buildings or surroundings or under working conditions provided by or under the control or supervision of the contractor or subcontractor which are unsanitary or hazardous or dangerous to the health or safety of service employees engaged to furnish these services, and the contractor or subcontractor shall comply with the safety and health standards applied under 29 CFR part 1925.

(g)(1) The contractor and each subcontractor performing work subject to the Act shall make and maintain for 3 years from the completion of the work records containing the information specified in paragraphs (g)(1) (i) through (vi) of this section for each employee subject to the Act and shall make them available for inspection [[Page 43]] and transcription by authorized representatives of the Wage and Hour Division, Employment Standards Administration of the U.S. Department of Labor:

(i) Name and address and social security number of each employee.

(ii)The correct work classification or classifications, rate or rates of monetary wages paid and fringe benefits provided, rate or rates of fringe benefit payments in lieu thereof, and total daily and weekly compensation of each employee.

(iii) The number of daily and weekly hours so worked by each employee.

(iv) Any deductions, rebates, or refunds from the total daily or weekly compensation of each employee.

(v) A list of monetary wages and fringe benefits for those classes of service employees not included in the wage
determination attached to this Contract/IGSA but for which such wage rates or fringe benefits have been determined by the interested parties or by the Administrator or authorized representative pursuant to the labor standards clause in paragraph (b) of this section. A copy of the report required by the clause in Paragraph (b) (2) (ii) of this section shall be deemed to be such a list.

(vi) Any list of the predecessor contractor's employees which had been furnished to the contractor pursuant to Sec. 4.6(l)(2).

(2) The contractor shall also make available a copy of this Contract/IGSA for inspection or transcription by authorized representatives of the Wage and Hour Division.

(3) Failure to make and maintain or to make available such records for inspection and transcription shall be a violation of the regulations and this contract, and in the case of failure to produce such records, the contracting officer, upon direction of the Department of Labor and notification of the contractor, shall take action to cause suspension of any further payment or advance of funds until such violation ceases.

(4) The contractor shall permit authorized representatives of the Wage and Hour Division to conduct interviews with employees at the worksite during normal working hours.

(h) The contractor shall unconditionally pay to each employee subject to the Act all wages due free and clear and without subsequent deduction (except as otherwise provided by law or Regulations, 29 CFR part 4), rebate, or kickback on any account. Such payments shall be made no later than one pay period following the end of the regular
pay period in which such wages were earned or accrued. A pay period under this Act may not be of any duration longer than semi-monthly.

(i) The contracting officer shall withhold or cause to be withheld from the Government prime contractor under this or any other Government Contract/IGSA with the prime contractor such sums as an appropriate official of the Department of Labor requests or such sums as the contracting officer decides may be necessary to pay underpaid employees employed by the contractor or subcontractor. In the event of failure to pay any employees subject to the Act all or part of the wages or fringe benefits due under the Act, the agency may, after authorization or by direction of the Department of Labor and written notification to the contractor, take action to cause suspension of any further payment or advance of funds until such violations have ceased. Additionally, any failure to comply with the requirements of these clauses relating to the Service Contract Act of 1965, may be grounds for termination of the right to proceed with the Contract/IGSA work. In such event, the Government may enter into other contracts or arrangements for completion of the work, charging the contractor in default with any additional cost.

(j) The contractor agrees to insert these clauses in this section relating to the Service Contract Act of 1965 in all Subcontracts subject to the Act. The term contractor as used in these clauses in any subcontract shall be deemed to refer to the subcontractor, except in the term Government prime contractor.

(k)(1) As used in these clauses, the term service employee means any person engaged in the performance of this Contract/IGSA other than any person employed in a bona fide executive, administrative, or professional capacity, as those terms are defined in part 541 of title 29, Code of Federal Regulations, as of July [[Page44)) 30, 1976, and any subsequent revision of those regulations. The term service employee includes all such persons regardless of any contractual relationship that may be alleged to exist between a contractor or subcontractor and such persons.

(2) The following statement is included in contracts pursuant to section 2(a) (5) of the Act and is for informational purposes only:

The following classes of service employees expected to be employed under the Contract/IGSA with the Government would be subject, if employed by the contracting agency, to the provisions

of 5 U.S.C. 5341 or 5 U.S.C. 5332 and would, if so employed, be paid not less than the following rates of wages and fringe benefits:

Employee class	wage-fringe benefit
GS-05	$
GS-07	$
GS-09	$

Search current rates at http://www.opm.gov/oca/12tables/

(l)(1) If wages to be paid or fringe benefits to be furnished any service employees employed by the Government prime contractor or any subcontractor under the Contract/IGSA are provided for in a collective bargaining agreement which is or will be effective during any period in which the Contract/IGSA is being performed, the Government prime contractor shall report such fact to the contracting officer, together with full information as to the application and accrual of such wages and fringe benefits, including any prospective increases, to service employees engaged in work on the contract, and a copy of the collective bargaining agreement. Such report shall be made upon commencing performance of the contract, in the case of collective bargaining agreements effective at such time, and in the case of such agreements or provisions or amendments thereof effective at a later time during the period of Contract/IGSA performance, such agreements shall be reported promptly after negotiation thereof.

(2) Not less than 10 days prior to completion of any Contract/IGSA being performed at a Federal facility where service employees may be retained in the performance of the succeeding Contract/IGSA and subject to a wage determination which contains vacation or other benefit provisions based upon length of service with a contractor (predecessor) or successor (Sec. 4.173 of Regulations, 29 CFR part 4), the incumbent prime contractor shall furnish to the contracting officer a certified list of the names of all service employees on the contractor's or subcontractor's payroll during the last month of Contract/IGSA performance. Such list shall also contain anniversary dates of employment on the Contract/IGSA either with the current or predecessor contractors of each such service employee. The contracting officer shall turn over such list to the successor contractor at the commencement of the succeeding contract.

(m) Rulings and interpretations of the Service Contract Act of 1965, as amended, are contained in Regulations, 29 CFR part 4.

(n)(1) By entering into this contract, the contractor (and officials thereof) certifies that neither it (nor he or she) nor any person or firm who has a substantial interest in the contractor's firm is a person or firm ineligible to be awarded Government contracts by virtue of the sanctions imposed pursuant to section 5 of the Act.

(2) No part of this Contract/IGSA shall be subcontracted to any person or firm ineligible for award of a Government Contract/IGSA pursuant to section 5 of the Act.

(3) The penalty for making false statements is prescribed in the U.S. Criminal Code, 18 U.S.C. 1001.

(o) Notwithstanding any of the clauses in paragraphs (b) through (m) of this section relating to the Service Contract Act of 1965, the following employees may be employed in accordance with the following variations, tolerances, and exemptions, which the Secretary of Labor, pursuant to section 4(b) of the Act prior to its amendment by Public Law 92-473, found to be necessary and proper in the public interest or to avoid serious impairment of the conduct of Government business:

(1)Apprentices, student-learners, and workers whose earning capacity is impaired by age, physical, or mental deficiency or injury may be employed at wages lower than the minimum wages otherwise required by section 2(a) (1) or([Page 45]]

(2)(b)(1) of the Service Contract Act without diminishing any fringe benefits or cash payments in lieu thereof required under section 2(a) (2) of that Act, in accordance with the conditions and procedures prescribed for the employment of apprentices, student-learners, handicapped persons, and handicapped clients of sheltered workshops under section 14 of the Fair Labor Standards Act of 1938, in the regulations issued by the Administrator (29 CFR parts 520, 521, 524, and 525).

(3) The Administrator will issue certificates under the Service Contract Act for the employment of apprentices, student-learners, handicapped persons, or handicapped clients of sheltered workshops not subject to the Fair Labor Standards Act of 1938, or subject to different minimum rates of pay under the two acts, authorizing appropriate rates of minimum wages (but without changing requirements concerning fringe benefits or supplementary cash payments in lieu thereof), applying procedures prescribed by the applicable regulations issued under the Fair Labor Standards Act of 1938 (29 CFR parts 520, 521, 524, and 525).

(4) The Administrator will also withdraw, annul, or cancel such certificates in accordance with the regulations in parts 525 and 528 of title 29 of the Code of Federal Regulations.

(p) Apprentices will be permitted to work at less than the predetermined rate for the work they perform when they are employed and individually registered in a bona fide apprenticeship program registered with a State Apprenticeship Agency which is recognized by the U.S. Department of Labor, or if no such recognized agency exists in a State, under a program registered with the Bureau of Apprenticeship and Training, Employment and Training Administration, U.S. Department of Labor. Any employee who is not registered as an apprentice in an approved program shall be paid the wage rate and fringe benefits contained in the applicable wage determination for the journeyman classification of work actually performed. The wage rates paid apprentices shall not be less than the wage rate for their level of progress set forth in the registered program, expressed as the appropriate percentage of the journeyman's rate contained in the applicable wage determination. The allowable ratio of apprentices to journeymen employed on the Contract/IGSA work in any craft classification shall not be greater than the ratio permitted to the contractor as to his entire work force under the registered program.

(q) Where an employee engaged in an occupation in which he or she customarily and regularly receives more than $30 a month in tips, the amount of tips received by the employee may be

credited by the employer against the minimum wage required by Section 2(a)(1) or 2(b)(1) of the Act to the extent permitted by section 3(m) of the Fair Labor Standards Act and Regulations, 29 CFR Part 531. To utilize this provison:

(1)The employer must inform tipped employees about this tip credit allowance before the credit is utilized;

(2)The employees must be allowed to retain all tips (individually or through a pooling arrangement and regardless of whether the employer elects to take a credit for tips received);

(3) The employer must be able to show by records that the employee receives at least the applicable Service Contract Act minimum wage through the combination of direct wages and tip credit;

(4) The use of such tip credit must have been permitted under any predecessor collective bargaining agreement applicable by virtue of section 4(c) of the Act.

(r) Disputes concerning labor standards. Disputes arising out of the labor standards provisions of this Contract/IGSA shall not be subject to the general disputes clause of this contract. Such disputes shall be resolved in accordance with the procedures of the Department of Labor set forth in 29 CFR parts 4, 6, and 8. Disputes within the meaning of this clause include disputes between the contractor (or any of its subcontractors) and the contracting agency, the U.S. Department of Labor, or the employees or their representatives.(The information collection, recordkeeping, and reporting requirements contained in this section have been approved by the Office of Management and Budget under the following numbers:
[[Page 46]]

Paragraph	OMB control number
(b)(2) (i)--(iv)	1215-0150
(e)	1215-0150
(g)(1) (i)--(iv)	1215-0017
(g)(1) (v), (vi)	1215-0150
(l) (1), (2)	1215-0150
(q)(3)	1215-0017

[48 FR 49762, Oct. 27, 1983; 48 FR 50529, Nov. 2, 1983, as amended at 61 FR 68663, Dec. 30, 1996]

WD 15-5443 (Rev.-7) was first posted on www.wdol.gov on 01/01/2019

REGISTER OF WAGE DETERMINATIONS UNDER THE SERVICE CONTRACT ACT
By direction of the Secretary of Labor

U.S. DEPARTMENT OF LABOR
EMPLOYMENT STANDARDS ADMINISTRATION
WAGE AND HOUR DIVISION
WASHINGTON D.C. 20210

Daniel W. Simms
Director

Division of
Wage Determinations

Wage Determination No.: 2015-5443
Revision No.: 7
Date Of Revision: 12/26/2018

Note: Under Executive Order (EO) 13658, an hourly minimum wage of $10.60 for calendar year 2019 applies to all contracts subject to the Service Contract Act for which the contract is awarded (and any solicitation was issued) on or after January 1, 2015. If this contract is covered by the EO, the contractor must pay all workers in any classification listed on this wage determination at least $10.60 per hour (or the applicable wage rate listed on this wage determination, if it is higher) for all hours spent performing on the contract in calendar year 2019. The EO minimum wage rate will be adjusted annually. Additional information on contractor requirements and worker protections under the EO is available at www.dol.gov/whd/govcontracts.

State: New Mexico

Area: New Mexico Counties of Bernalillo, Sandoval, Torrance, Valencia

Fringe Benefits Required Follow the Occupational Listing

OCCUPATION CODE - TITLE	FOOTNOTE	RATE
01000 - Administrative Support And Clerical Occupations		
01011 - Accounting Clerk I		13.70
01012 - Accounting Clerk II		15.38
01013 - Accounting Clerk III		17.21
01020 - Administrative Assistant		24.19
01035 - Court Reporter		22.52
01041 - Customer Service Representative I		12.03
01042 - Customer Service Representative II		13.53
01043 - Customer Service Representative III		14.76
01051 - Data Entry Operator I		12.21
01052 - Data Entry Operator II		13.44
01060 - Dispatcher, Motor Vehicle		16.40
01070 - Document Preparation Clerk		14.03
01090 - Duplicating Machine Operator		14.03
01111 - General Clerk I		12.00
01112 - General Clerk II		13.09
01113 - General Clerk III		14.70
01120 - Housing Referral Assistant		18.41
01141 - Messenger Courier		12.97
01191 - Order Clerk I		14.14
01192 - Order Clerk II		15.62
01261 - Personnel Assistant (Employment) I		15.82
01262 - Personnel Assistant (Employment) II		17.71
01263 - Personnel Assistant (Employment) III		19.74
01270 - Production Control Clerk		24.73
01290 - Rental Clerk		12.25
01300 - Scheduler, Maintenance		14.76
01311 - Secretary I		14.76
01312 - Secretary II		16.51
01313 - Secretary III		18.41

01320 - Service Order Dispatcher	14.65
01410 - Supply Technician	24.19
01420 - Survey Worker	16.38
01460 - Switchboard Operator/Receptionist	13.22
01531 - Travel Clerk I	13.00
01532 - Travel Clerk II	14.04
01533 - Travel Clerk III	14.93
01611 - Word Processor I	14.11
01612 - Word Processor II	15.84
01613 - Word Processor III	17.73
05000 - Automotive Service Occupations	
05005 - Automobile Body Repairer, Fiberglass	21.86
05010 - Automotive Electrician	18.12
05040 - Automotive Glass Installer	15.82
05070 - Automotive Worker	15.82
05110 - Mobile Equipment Servicer	13.50
05130 - Motor Equipment Metal Mechanic	18.38
05160 - Motor Equipment Metal Worker	15.82
05190 - Motor Vehicle Mechanic	18.38
05220 - Motor Vehicle Mechanic Helper	13.62
05250 - Motor Vehicle Upholstery Worker	15.82
05280 - Motor Vehicle Wrecker	15.82
05310 - Painter, Automotive	17.19
05340 - Radiator Repair Specialist	15.82
05370 - Tire Repairer	13.06
05400 - Transmission Repair Specialist	18.38
07000 - Food Preparation And Service Occupations	
07010 - Baker	11.60
07041 - Cook I	11.46
07042 - Cook II	13.82
07070 - Dishwasher	10.35
07130 - Food Service Worker	10.22
07210 - Meat Cutter	16.33
07260 - Waiter/Waitress	9.07
09000 - Furniture Maintenance And Repair Occupations	
09010 - Electrostatic Spray Painter	14.83
09040 - Furniture Handler	11.44
09080 - Furniture Refinisher	14.83
09090 - Furniture Refinisher Helper	12.45
09110 - Furniture Repairer, Minor	13.85
09130 - Upholsterer	14.83
11000 - General Services And Support Occupations	
11030 - Cleaner, Vehicles	10.90
11060 - Elevator Operator	10.90
11090 - Gardener	17.46
11122 - Housekeeping Aide	11.00
11150 - Janitor	11.00
11210 - Laborer, Grounds Maintenance	12.10
11240 - Maid or Houseman	9.64
11260 - Pruner	10.33
11270 - Tractor Operator	15.65
11330 - Trail Maintenance Worker	12.10
11360 - Window Cleaner	12.88
12000 - Health Occupations	
12010 - Ambulance Driver	16.34
12011 - Breath Alcohol Technician	20.92
12012 - Certified Occupational Therapist Assistant	30.64
12015 - Certified Physical Therapist Assistant	25.85
12020 - Dental Assistant	16.12
12025 - Dental Hygienist	42.98
12030 - EKG Technician	26.61

12035 - Electroneurodiagnostic Technologist		26.61
12040 - Emergency Medical Technician		16.34
12071 - Licensed Practical Nurse I		18.73
12072 - Licensed Practical Nurse II		20.92
12073 - Licensed Practical Nurse III		23.32
12100 - Medical Assistant		14.28
12130 - Medical Laboratory Technician		19.85
12160 - Medical Record Clerk		15.02
12190 - Medical Record Technician		16.81
12195 - Medical Transcriptionist		16.76
12210 - Nuclear Medicine Technologist		37.11
12221 - Nursing Assistant I		11.25
12222 - Nursing Assistant II		12.65
12223 - Nursing Assistant III		13.80
12224 - Nursing Assistant IV		15.49
12235 - Optical Dispenser		16.79
12236 - Optical Technician		14.78
12250 - Pharmacy Technician		15.17
12280 - Phlebotomist		14.57
12305 - Radiologic Technologist		28.89
12311 - Registered Nurse I		25.39
12312 - Registered Nurse II		31.06
12313 - Registered Nurse II, Specialist		31.06
12314 - Registered Nurse III		37.58
12315 - Registered Nurse III, Anesthetist		37.58
12316 - Registered Nurse IV		45.04
12317 - Scheduler (Drug and Alcohol Testing)		25.91
12320 - Substance Abuse Treatment Counselor		25.84
13000 - Information And Arts Occupations		
13011 - Exhibits Specialist I		19.40
13012 - Exhibits Specialist II		24.02
13013 - Exhibits Specialist III		29.40
13041 - Illustrator I		16.10
13042 - Illustrator II		19.95
13043 - Illustrator III		24.24
13047 - Librarian		22.91
13050 - Library Aide/Clerk		12.12
13054 - Library Information Technology Systems Administrator		20.67
13058 - Library Technician		16.37
13061 - Media Specialist I		15.31
13062 - Media Specialist II		17.18
13063 - Media Specialist III		19.07
13071 - Photographer I		15.88
13072 - Photographer II		17.63
13073 - Photographer III		21.70
13074 - Photographer IV		24.30
13075 - Photographer V		29.39
13090 - Technical Order Library Clerk		15.61
13110 - Video Teleconference Technician		18.57
14000 - Information Technology Occupations		
14041 - Computer Operator I		15.79
14042 - Computer Operator II		17.67
14043 - Computer Operator III		19.70
14044 - Computer Operator IV		21.89
14045 - Computer Operator V		24.34
14071 - Computer Programmer I	(see 1)	24.65
14072 - Computer Programmer II	(see 1)	
14073 - Computer Programmer III	(see 1)	
14074 - Computer Programmer IV	(see 1)	
14101 - Computer Systems Analyst I	(see 1)	

14102 - Computer Systems Analyst II	(see 1)	
14103 - Computer Systems Analyst III	(see 1)	
14150 - Peripheral Equipment Operator		15.79
14160 - Personal Computer Support Technician		21.89
14170 - System Support Specialist		24.31
15000 - Instructional Occupations		
15010 - Aircrew Training Devices Instructor (Non-Rated)		27.62
15020 - Aircrew Training Devices Instructor (Rated)		33.39
15030 - Air Crew Training Devices Instructor (Pilot)		40.05
15050 - Computer Based Training Specialist / Instructor		27.62
15060 - Educational Technologist		28.52
15070 - Flight Instructor (Pilot)		40.05
15080 - Graphic Artist		22.41
15085 - Maintenance Test Pilot, Fixed, Jet/Prop		37.70
15086 - Maintenance Test Pilot, Rotary Wing		37.70
15088 - Non-Maintenance Test/Co-Pilot		37.70
15090 - Technical Instructor		21.76
15095 - Technical Instructor/Course Developer		26.63
15110 - Test Proctor		17.58
15120 - Tutor		17.58
16000 - Laundry, Dry-Cleaning, Pressing And Related Occupations		
16010 - Assembler		10.13
16030 - Counter Attendant		10.13
16040 - Dry Cleaner		11.56
16070 - Finisher, Flatwork, Machine		10.13
16090 - Presser, Hand		10.13
16110 - Presser, Machine, Drycleaning		10.13
16130 - Presser, Machine, Shirts		10.13
16160 - Presser, Machine, Wearing Apparel, Laundry		10.13
16190 - Sewing Machine Operator		12.07
16220 - Tailor		12.68
16250 - Washer, Machine		10.60
19000 - Machine Tool Operation And Repair Occupations		
19010 - Machine-Tool Operator (Tool Room)		21.92
19040 - Tool And Die Maker		28.03
21000 - Materials Handling And Packing Occupations		
21020 - Forklift Operator		18.14
21030 - Material Coordinator		24.73
21040 - Material Expediter		24.73
21050 - Material Handling Laborer		12.27
21071 - Order Filler		12.33
21080 - Production Line Worker (Food Processing)		18.14
21110 - Shipping Packer		14.30
21130 - Shipping/Receiving Clerk		14.30
21140 - Store Worker I		9.22
21150 - Stock Clerk		14.90
21210 - Tools And Parts Attendant		18.14
21410 - Warehouse Specialist		18.14
23000 - Mechanics And Maintenance And Repair Occupations		
23010 - Aerospace Structural Welder		31.07
23019 - Aircraft Logs and Records Technician		22.72
23021 - Aircraft Mechanic I		29.09
23022 - Aircraft Mechanic II		31.07
23023 - Aircraft Mechanic III		32.75
23040 - Aircraft Mechanic Helper		18.46
23050 - Aircraft, Painter		26.96
23060 - Aircraft Servicer		22.72
23070 - Aircraft Survival Flight Equipment Technician		26.96
23080 - Aircraft Worker		24.84
23091 - Aircrew Life Support Equipment (ALSE) Mechanic I		24.84

23092 - Aircrew Life Support Equipment (ALSE) Mechanic II	29.09
23110 - Appliance Mechanic	16.83
23120 - Bicycle Repairer	14.55
23125 - Cable Splicer	28.84
23130 - Carpenter, Maintenance	17.12
23140 - Carpet Layer	20.19
23160 - Electrician, Maintenance	22.63
23181 - Electronics Technician Maintenance I	25.16
23182 - Electronics Technician Maintenance II	27.32
23183 - Electronics Technician Maintenance III	29.47
23260 - Fabric Worker	18.47
23290 - Fire Alarm System Mechanic	18.76
23310 - Fire Extinguisher Repairer	16.74
23311 - Fuel Distribution System Mechanic	28.08
23312 - Fuel Distribution System Operator	21.03
23370 - General Maintenance Worker	15.77
23380 - Ground Support Equipment Mechanic	29.09
23381 - Ground Support Equipment Servicer	22.72
23382 - Ground Support Equipment Worker	24.84
23391 - Gunsmith I	16.74
23392 - Gunsmith II	20.19
23393 - Gunsmith III	23.64
23410 - Heating, Ventilation And Air-Conditioning Mechanic	21.12
23411 - Heating, Ventilation And Air Contidioning Mechanic (Research Facility)	22.56
23430 - Heavy Equipment Mechanic	22.98
23440 - Heavy Equipment Operator	18.38
23460 - Instrument Mechanic	29.49
23465 - Laboratory/Shelter Mechanic	21.92
23470 - Laborer	12.27
23510 - Locksmith	20.07
23530 - Machinery Maintenance Mechanic	22.60
23550 - Machinist, Maintenance	21.73
23580 - Maintenance Trades Helper	12.56
23591 - Metrology Technician I	29.49
23592 - Metrology Technician II	31.50
23593 - Metrology Technician III	33.20
23640 - Millwright	24.33
23710 - Office Appliance Repairer	19.21
23760 - Painter, Maintenance	15.94
23790 - Pipefitter, Maintenance	23.77
23810 - Plumber, Maintenance	22.03
23820 - Pneudraulic Systems Mechanic	23.64
23850 - Rigger	23.64
23870 - Scale Mechanic	20.19
23890 - Sheet-Metal Worker, Maintenance	23.25
23910 - Small Engine Mechanic	17.52
23931 - Telecommunications Mechanic I	26.47
23932 - Telecommunications Mechanic II	28.27
23950 - Telephone Lineman	23.39
23960 - Welder, Combination, Maintenance	20.13
23965 - Well Driller	23.64
23970 - Woodcraft Worker	23.64
23980 - Woodworker	16.74
24000 - Personal Needs Occupations	
24550 - Case Manager	15.96
24570 - Child Care Attendant	10.32
24580 - Child Care Center Clerk	14.77
24610 - Chore Aide	9.75

24620 - Family Readiness And Support Services Coordinator		15.96
24630 - Homemaker		17.49
25000 - Plant And System Operations Occupations		
25010 - Boiler Tender		24.88
25040 - Sewage Plant Operator		19.00
25070 - Stationary Engineer		24.88
25190 - Ventilation Equipment Tender		15.79
25210 - Water Treatment Plant Operator		19.00
27000 - Protective Service Occupations		
27004 - Alarm Monitor		16.78
27007 - Baggage Inspector		11.75
27008 - Corrections Officer		16.73
27010 - Court Security Officer		17.12
27030 - Detection Dog Handler		13.16
27040 - Detention Officer		16.73
27070 - Firefighter		17.51
27101 - Guard I		11.75
27102 - Guard II		13.15
27131 - Police Officer I		24.59
27132 - Police Officer II		27.31
28000 - Recreation Occupations		
28041 - Carnival Equipment Operator		15.76
28042 - Carnival Equipment Repairer		17.59
28043 - Carnival Worker		10.41
28210 - Gate Attendant/Gate Tender		13.59
28310 - Lifeguard		11.34
28350 - Park Attendant (Aide)		15.21
28510 - Recreation Aide/Health Facility Attendant		11.10
28515 - Recreation Specialist		18.06
28630 - Sports Official		12.11
28690 - Swimming Pool Operator		21.21
29000 - Stevedoring/Longshoremen Occupational Services		
29010 - Blocker And Bracer		20.42
29020 - Hatch Tender		20.42
29030 - Line Handler		20.42
29041 - Stevedore I		19.04
29042 - Stevedore II		22.17
30000 - Technical Occupations		
30010 - Air Traffic Control Specialist, Center (HFO)	(see 2)	38.27
30011 - Air Traffic Control Specialist, Station (HFO)	(see 2)	26.40
30012 - Air Traffic Control Specialist, Terminal (HFO)	(see 2)	29.06
30021 - Archeological Technician I		17.39
30022 - Archeological Technician II		19.50
30023 - Archeological Technician III		23.87
30030 - Cartographic Technician		24.17
30040 - Civil Engineering Technician		24.00
30051 - Cryogenic Technician I		23.25
30052 - Cryogenic Technician II		25.69
30061 - Drafter/CAD Operator I		17.39
30062 - Drafter/CAD Operator II		19.50
30063 - Drafter/CAD Operator III		21.75
30064 - Drafter/CAD Operator IV		25.91
30081 - Engineering Technician I		15.18
30082 - Engineering Technician II		17.03
30083 - Engineering Technician III		19.05
30084 - Engineering Technician IV		23.61
30085 - Engineering Technician V		28.88
30086 - Engineering Technician VI		34.94
30090 - Environmental Technician		23.20
30095 - Evidence Control Specialist		21.00

30210 - Laboratory Technician		24.14
30221 - Latent Fingerprint Technician I		22.62
30222 - Latent Fingerprint Technician II		24.98
30240 - Mathematical Technician		24.17
30361 - Paralegal/Legal Assistant I		17.75
30362 - Paralegal/Legal Assistant II		21.98
30363 - Paralegal/Legal Assistant III		26.90
30364 - Paralegal/Legal Assistant IV		32.54
30375 - Petroleum Supply Specialist		25.69
30390 - Photo-Optics Technician		24.17
30395 - Radiation Control Technician		25.69
30461 - Technical Writer I		23.29
30462 - Technical Writer II		28.49
30463 - Technical Writer III		34.46
30491 - Unexploded Ordnance (UXO) Technician I		24.33
30492 - Unexploded Ordnance (UXO) Technician II		29.43
30493 - Unexploded Ordnance (UXO) Technician III		35.28
30494 - Unexploded (UXO) Safety Escort		24.33
30495 - Unexploded (UXO) Sweep Personnel		24.33
30501 - Weather Forecaster I		25.91
30502 - Weather Forecaster II		31.51
30620 - Weather Observer, Combined Upper Air Or Surface Programs	(see 2)	21.75
30621 - Weather Observer, Senior	(see 2)	24.17
31000 - Transportation/Mobile Equipment Operation Occupations		
31010 - Airplane Pilot		29.43
31020 - Bus Aide		10.73
31030 - Bus Driver		17.17
31043 - Driver Courier		13.34
31260 - Parking and Lot Attendant		10.35
31290 - Shuttle Bus Driver		14.77
31310 - Taxi Driver		11.58
31361 - Truckdriver, Light		14.77
31362 - Truckdriver, Medium		16.66
31363 - Truckdriver, Heavy		19.11
31364 - Truckdriver, Tractor-Trailer		19.11
99000 - Miscellaneous Occupations		
99020 - Cabin Safety Specialist		14.35
99030 - Cashier		9.55
99050 - Desk Clerk		10.42
99095 - Embalmer		23.75
99130 - Flight Follower		24.33
99251 - Laboratory Animal Caretaker I		13.30
99252 - Laboratory Animal Caretaker II		14.84
99260 - Marketing Analyst		26.40
99310 - Mortician		23.75
99410 - Pest Controller		17.07
99510 - Photofinishing Worker		13.35
99710 - Recycling Laborer		16.01
99711 - Recycling Specialist		20.72
99730 - Refuse Collector		14.63
99810 - Sales Clerk		11.98
99820 - School Crossing Guard		12.87
99830 - Survey Party Chief		22.92
99831 - Surveying Aide		20.85
99832 - Surveying Technician		21.03
99840 - Vending Machine Attendant		12.16
99841 - Vending Machine Repairer		16.30
99842 - Vending Machine Repairer Helper		12.11

Note: Executive Order (EO) 13706, Establishing Paid Sick Leave for Federal Contractors, applies to all contracts subject to the Service Contract Act for which the contract is awarded (and any solicitation was issued) on or after January 1, 2017. If this contract is covered by the EO, the contractor must provide employees with 1 hour of paid sick leave for every 30 hours they work, up to 56 hours of paid sick leave each year. Employees must be permitted to use paid sick leave for their own illness, injury or other health-related needs, including preventive care; to assist a family member (or person who is like family to the employee) who is ill, injured, or has other health-related needs, including preventive care; or for reasons resulting from, or to assist a family member (or person who is like family to the employee) who is the victim of, domestic violence, sexual assault, or stalking. Additional information on contractor requirements and worker protections under the EO is available at www.dol.gov/whd/govcontracts.

ALL OCCUPATIONS LISTED ABOVE RECEIVE THE FOLLOWING BENEFITS:

HEALTH & WELFARE: $4.48 per hour or $179.20 per week or $776.53 per month

HEALTH & WELFARE EO 13706: $4.18 per hour, or $167.20 per week, or $724.53 per month*

*This rate is to be used only when compensating employees for performance on an SCA-covered contract also covered by EO 13706, Establishing Paid Sick Leave for Federal Contractors. A contractor may not receive credit toward its SCA obligations for any paid sick leave provided pursuant to EO 13706.

VACATION: 2 weeks paid vacation after 1 year of service with a contractor or successor, 3 weeks after 10 years, and 4 weeks after 15 years. Length of service includes the whole span of continuous service with the present contractor or successor, wherever employed, and with the predecessor contractors in the performance of similar work at the same Federal facility. (See 29 CFR 4.173)

HOLIDAYS: A minimum of ten paid holidays per year: New Year's Day, Martin Luther King Jr.'s Birthday, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans' Day, Thanksgiving Day, and Christmas Day. (A contractor may substitute for any of the named holidays another day off with pay in accordance with a plan communicated to the employees involved.) (See 29 CFR 4.174)

THE OCCUPATIONS WHICH HAVE NUMBERED FOOTNOTES IN PARENTHESES RECEIVE THE FOLLOWING:

1) COMPUTER EMPLOYEES: Under the SCA at section 8(b), this wage determination does not apply to any employee who individually qualifies as a bona fide executive, administrative, or professional employee as defined in 29 C.F.R. Part 541. Because most Computer System Analysts and Computer Programmers who are compensated at a rate not less than $27.63 (or on a salary or fee basis at a rate not less than $455 per week) an hour would likely qualify as exempt computer professionals, (29 C.F.R. 541. 400) wage rates may not be listed on this wage determination for all occupations within those job families. In addition, because this wage determination may not list a wage rate for some or all occupations within those job families if the survey data indicates that the prevailing wage rate for the occupation equals or exceeds $27.63 per hour conformances may be necessary for certain nonexempt employees. For example, if an individual employee is nonexempt but nevertheless performs duties within the scope of one of the Computer Systems Analyst or Computer Programmer occupations for which this wage determination does not specify an SCA wage rate, then the wage rate for that employee must be conformed in accordance with the conformance procedures described in the conformance note included on this wage

determination.

Additionally, because job titles vary widely and change quickly in the computer industry, job titles are not determinative of the application of the computer professional exemption. Therefore, the exemption applies only to computer employees who satisfy the compensation requirements and whose primary duty consists of:
(1) The application of systems analysis techniques and procedures, including consulting with users, to determine hardware, software or system functional specifications;
(2) The design, development, documentation, analysis, creation, testing or modification of computer systems or programs, including prototypes, based on and related to user or system design specifications;
(3) The design, documentation, testing, creation or modification of computer programs related to machine operating systems; or
(4) A combination of the aforementioned duties, the performance of which requires the same level of skills. (29 C.F.R. 541.400).

2) AIR TRAFFIC CONTROLLERS AND WEATHER OBSERVERS - NIGHT PAY & SUNDAY PAY: If you work at night as part of a regular tour of duty, you will earn a night differential and receive an additional 10% of basic pay for any hours worked between 6pm and 6am. If you are a full-time employed (40 hours a week) and Sunday is part of your regularly scheduled workweek, you are paid at your rate of basic pay plus a Sunday premium of 25% of your basic rate for each hour of Sunday work which is not overtime (i.e. occasional work on Sunday outside the normal tour of duty is considered overtime work).

** HAZARDOUS PAY DIFFERENTIAL **

An 8 percent differential is applicable to employees employed in a position that represents a high degree of hazard when working with or in close proximity to ordnance, explosives, and incendiary materials. This includes work such as screening, blending, dying, mixing, and pressing of sensitive ordnance, explosives, and pyrotechnic compositions such as lead azide, black powder and photoflash powder. All dry-house activities involving propellants or explosives. Demilitarization, modification, renovation, demolition, and maintenance operations on sensitive ordnance, explosives and incendiary materials. All operations involving re-grading and cleaning of artillery ranges.

A 4 percent differential is applicable to employees employed in a position that represents a low degree of hazard when working with, or in close proximity to ordnance, (or employees possibly adjacent to) explosives and incendiary materials which involves potential injury such as laceration of hands, face, or arms of the employee engaged in the operation, irritation of the skin, minor burns and the like; minimal damage to immediate or adjacent work area or equipment being used. All operations involving, unloading, storage, and hauling of ordnance, explosive, and incendiary ordnance material other than small arms ammunition. These differentials are only applicable to work that has been specifically designated by the agency for ordnance, explosives, and incendiary material differential pay.

** UNIFORM ALLOWANCE **

If employees are required to wear uniforms in the performance of this contract (either by the terms of the Government contract, by the employer, by the state or local law, etc.), the cost of furnishing such uniforms and maintaining (by laundering or dry cleaning) such uniforms is an expense that may not be borne by an employee where such cost reduces the hourly rate below that required by the wage determination. The Department of Labor will accept payment in accordance with the following standards as compliance:

The contractor or subcontractor is required to furnish all employees with an

adequate number of uniforms without cost or to reimburse employees for the actual cost of the uniforms. In addition, where uniform cleaning and maintenance is made the responsibility of the employee, all contractors and subcontractors subject to this wage determination shall (in the absence of a bona fide collective bargaining agreement providing for a different amount, or the furnishing of contrary affirmative proof as to the actual cost), reimburse all employees for such cleaning and maintenance at a rate of $3.35 per week (or $.67 cents per day). However, in those instances where the uniforms furnished are made of "wash and wear" materials, may be routinely washed and dried with other personal garments, and do not require any special treatment such as dry cleaning, daily washing, or commercial laundering in order to meet the cleanliness or appearance standards set by the terms of the Government contract, by the contractor, by law, or by the nature of the work, there is no requirement that employees be reimbursed for uniform maintenance costs.

** SERVICE CONTRACT ACT DIRECTORY OF OCCUPATIONS **

The duties of employees under job titles listed are those described in the "Service Contract Act Directory of Occupations", Fifth Edition (Revision 1), dated September 2015, unless otherwise indicated.

** REQUEST FOR AUTHORIZATION OF ADDITIONAL CLASSIFICATION AND WAGE RATE, Standard Form 1444 (SF-1444) **

Conformance Process:

The contracting officer shall require that any class of service employee which is not listed herein and which is to be employed under the contract (i.e., the work to be performed is not performed by any classification listed in the wage determination), be classified by the contractor so as to provide a reasonable relationship (i.e., appropriate level of skill comparison) between such unlisted classifications and the classifications listed in the wage determination (See 29 CFR 4.6(b)(2)(i)). Such conforming procedures shall be initiated by the contractor prior to the performance of contract work by such unlisted class(es) of employees (See 29 CFR 4.6(b)(2)(ii)). The Wage and Hour Division shall make a final determination of conformed classification, wage rate, and/or fringe benefits which shall be paid to all employees performing in the classification from the first day of work on which contract work is performed by them in the classification. Failure to pay such unlisted employees the compensation agreed upon by the interested parties and/or fully determined by the Wage and Hour Division retroactive to the date such class of employees commenced contract work shall be a violation of the Act and this contract. (See 29 CFR 4.6(b)(2)(v)). When multiple wage determinations are included in a contract, a separate SF-1444 should be prepared for each wage determination to which a class(es) is to be conformed.

The process for preparing a conformance request is as follows:

1) When preparing the bid, the contractor identifies the need for a conformed occupation(s) and computes a proposed rate(s).

2) After contract award, the contractor prepares a written report listing in order the proposed classification title(s), a Federal grade equivalency (FGE) for each proposed classification(s), job description(s), and rationale for proposed wage rate(s), including information regarding the agreement or disagreement of the authorized representative of the employees involved, or where there is no authorized representative, the employees themselves. This report should be submitted to the contracting officer no later than 30 days after such unlisted class(es) of employees performs any contract work.

3) The contracting officer reviews the proposed action and promptly submits a report of the action, together with the agency's recommendations and pertinent information including the position of the contractor and the employees, to the U.S.

Department of Labor, Wage and Hour Division, for review (See 29 CFR 4.6(b)(2)(ii)).

4) Within 30 days of receipt, the Wage and Hour Division approves, modifies, or disapproves the action via transmittal to the agency contracting officer, or notifies the contracting officer that additional time will be required to process the request.

5) The contracting officer transmits the Wage and Hour Division's decision to the contractor.

6) Each affected employee shall be furnished by the contractor with a written copy of such determination or it shall be posted as a part of the wage determination (See 29 CFR 4.6(b)(2)(iii)).

Information required by the Regulations must be submitted on SF-1444 or bond paper.

When preparing a conformance request, the "Service Contract Act Directory of Occupations" should be used to compare job definitions to ensure that duties requested are not performed by a classification already listed in the wage determination. Remember, it is not the job title, but the required tasks that determine whether a class is included in an established wage determination. Conformances may not be used to artificially split, combine, or subdivide classifications listed in the wage determination (See 29 CFR 4.152(c)(1)).

CoreCivic

QUALITY CONTROL PLAN

1. Introduction

CoreCivic's Quality Control Plan (QCP) is designed to work in conjunction with the Government's Quality Assurance Surveillance Plan (QASP) to provide continuous quality assurance and improvement. The objectives of CoreCivic's QCP at Torrance County Detention Facility (TCDF) are (1) to ensure that critical operational performance standards for the services required under the IGSA are provided at a uniform and acceptable level, consistent with the IGSA's Performance Requirements Summary (PRS) and Performance Work Statement (PWS), as well as all applicable standards, policies, and procedures, and (2) to identify operational deficiencies, develop effective corrective action plans, and implement those corrective actions in a timely manner. These objectives will ensure that all programs and services provided by CoreCivic are performed at an acceptable and consistent level, and in a manner that ensures the public safety and the welfare of ICE detainees.

This QCP comprises a comprehensive program of audits, inspections, audit reports, and corrective action plans which provide CoreCivic staff with a structured monitoring and corrective action methodology that is aligned with the Government's QASP.

2. Quality Assurance Policies, Procedures, and Tools

Quality Assurance (QA) is a priority at TCDF and at all facilities operated by CoreCivic. This is reflected in the significant resources allocated to CoreCivic's QA Division and the QA Division's functional autonomy. Organizationally, the QA Division resides within, and reports directly to, CoreCivic's Office of General Counsel, allowing it to operate independently of the Operations Division and effectively eliminating the potential for internal conflicts of interest when reporting operational audit findings. The QA Division is headquartered at the Company's corporate office in Nashville, Tennessee, often referred to internally as the Facility Support Center (FSC). The Managing Director, Quality Assurance, oversees all facility QCPs for CoreCivic, including the scheduling and execution of internal, unannounced Annual Operational Audits, which are described more fully below.

Consistent contract compliance and continuous quality improvement are the primary objectives of CoreCivic's QA Division. The structure and methodology for achieving these objectives is established by this QCP and by CoreCivic Policy 1-22, *Audits, Inspections and Corrective Action*. Moreover, CoreCivic maintains a comprehensive set of policies and procedures which govern all facets of TCDF's operations. Specific emphasis is placed on incorporating the requirements of the applicable, minimal ICE 2011 Performance Based National Detention Standards (PBNDS) and American Correctional Association (ACA) Standards for Adult Local Detention Facilities (ALDF) into TCDF's policies and procedures. As these standards change and evolve over time, CoreCivic periodically reviews and updates the QCP and applicable policies and procedures at least on an annual basis. Should an update to the QCP or related policies and procedures be appropriate, CoreCivic will submit the changes in writing to the COR.

CoreCivic's internal audit tool is another key component of the QCP, and is designed with the objective of providing the following information:

- Identification of deficiencies in contractual obligations, safety, and security;
- Assurance that operations and programs are functioning in compliance with the PRS, PWS, and all applicable standards, laws, and regulations;

- Identification of potential fraud, waste, abuse, mismanagement, or illegal acts, so as to detect, report, and prevent such activity; and
- Assurance that financial and administrative controls are in place and effective.

CoreCivic's internal audit tool is updated at least annually to reflect current policies, procedures, and requirements.

3. Monthly Self-Monitoring Inspections and the Quality Assurance Manager

At TCDF, CoreCivic will employ a Quality Assurance Manager (QAM) who will report directly to the Warden and be responsible for managing the QCP. In accordance with these responsibilities and CoreCivic Policy 1-22, the QAM will perform or oversee revolving monthly self-monitoring inspections of the facility's critical operations associated with ICE and ICE detainees for compliance with the QCP and to validate that TCDF's operations and services meet applicable performance standards. Critical operational areas generally include safety, security, order/control, care (including food service and health services), detainee activities, detainee justice, administration and management, workforce integrity, and prevention of detainee discrimination. TCDF will notify the COR at least 48 hours in advance of these monthly inspections to ensure the COR has the opportunity to participate. Through these self-monitoring inspections, TCDF will identify deficiencies and develop and timely implement appropriate corrective actions.

4. Annual Operational Audits

In addition to the monthly self-monitoring inspections, CoreCivic will conduct an internal, unannounced annual operational audit of TCDF (commencing after its first full year of continuous operations). This "Annual Operational Audit" is performed by CoreCivic's internal, full-time audit team, consisting of non-TCDF personnel. The audit team will arrive at TCDF on an unannounced basis, which ensures that auditors are able to view and assess the facility's normal day-to-day staffing, conditions, and operations. The audit team typically spends three to four days at the facility auditing all critical operational areas. Moreover, the audit team looks well beyond documentary evidence as part of the audit process, observing facility operational practices across numerous functions to determine compliance. In addition, audit team members routinely share operational best practices with facility staff to encourage a commitment to continuous improvement.

The audit team will conduct daily audit closeout meetings with the facility's staff, communicating their detailed observations and audit findings, focusing on areas that need improvement, and offering guidance and best practices for resolving deficiencies. A final audit report is compiled and distributed to key personnel at TCDF and at the FSC following the audit. Final audit reports and other results generated by TCDF's QCP activities will be provided to the COR or COTR as requested.

5. External Audits and Inspections

For all external audits and inspections, including Government audits, local health department inspections, annual fire marshal inspections, and other external audits and inspections, the QAM will distribute copies of the audit report to TCDF's Warden, appropriate facility department head(s), and appropriate FSC stakeholders. In addition, the QAM will upload the report and any identified findings to CoreCivic's electronic database and send a copy of the report to the COR or COTR as requested.

6. Corrective Action Program

TCDF will develop a written corrective action plan (CAP) for each deficiency identified during a monthly self-monitoring inspection, Annual Operational Audit, or external audit or inspection. TCDF's QAM will work directly with the Warden, Assistant Wardens, and department heads to identify root causes and develop CAPs that effectively correct the deficiencies to include: (a) a clear statement of each corrective action step; (b) the title of the person who will perform each corrective action step; (c) how the corrective action step will be documented; and (d) the target completion date for each corrective action step. As needed, CoreCivic subject matter experts may be consulted to assist in identifying root causes and in developing effective CAPs. Once developed, CAPs must be implemented by facility staff as soon as possible.

Under current CoreCivic Policy 1-22, upon written notification of a deficiency by the Government, the associated CAP must be sent to the FSC QA Division for review. The FSC QA Division then reviews the CAP to help ensure the CAP addresses the root cause, includes all key elements, and is likely to be effective. Once reviewed by the FSC QA Division, the CAP is transmitted to the Government for final approval and to the facility for implementation.

In certain instances, additional measures may be instituted to ensure that deficiencies are fully resolved. Such additional measures include the use of targeted follow-up audits or inspections, targeted technical assistance visits (to assist facility personnel with identifying root causes, correcting deficiencies, and improving processes and procedures), and requiring monthly monitoring of CAPs. These additional QA measures are implemented on a case-by-case basis, consistent with what is necessary to ensure compliance with the performance standards.

7. Reporting and Communication

CoreCivic's FSC QA Division provides comprehensive reporting to executive, operational, and facility leadership regarding both external and internal audit results, corrective action plans, and facility certifications. These communications are provided through a variety of means, including weekly audit reports, CAP status reports, and quarterly executive reports and briefings

Similarly, staff at TCDF will cooperate collaboratively with Government staff, providing access to detainees and staff in all areas of the facility at all times. Government staff will have access during normal administrative business hours to all books, records, reports and self-monitoring documents maintained by CoreCivic concerning the operation of TCDF.

In addition, the Warden and QAM will communicate directly with TCDF's on-site Government monitor on a regular basis, through a combination of formal and informal meetings, phone calls, and email. TCDF staff are expected to be diligent in ensuring both courteous and timely cooperation with all Government staff, as CoreCivic is committed to maintaining a cooperative and supportive relationship with the Government.

8. QCP Past Performance

Through the use of this QCP methodology, CoreCivic has been successful in developing a relationship of trust and integrity with ICE at numerous facilities. CoreCivic's inspection and auditing processes, along with its corrective action and reporting programs, allow staff to identify areas of operational risk and quickly provide additional resources, staff training, policy revisions, or other needed changes to ensure compliance with performance standards.

QUALITY ASSURANCE SURVEILLANCE PLAN

1. INTRODUCTION

ICE's Quality Assurance Surveillance Plan (QASP) is based on the premise that the Service Provider, and not the Government, is responsible for the day-to-day operation of the Facility and all the management and quality control actions required to meet the terms of the Agreement. The role of the Government in quality assurance is to ensure performance standards are achieved and maintained. The Service Provider shall develop a comprehensive program of inspections and monitoring actions and document its approach in a Quality Control Plan (QCP). The Service Provider's QCP, upon approval by the Government, will be made a part of the resultant Agreement.

This QASP is designed to provide an effective surveillance method to monitor the Service Provider's performance relative to the requirements listed in the Agreement. The QASP illustrates the systematic method the Government (or its designated representative) will use to evaluate the services the Service Provider is required to furnish.

This QASP is based on the premise the Government will validate that the Service Provider is complying with ERO-mandated quality standards in operating and maintaining detention facilities. Performance standards address all facets of detainee handling, including safety, health, legal rights, facility and records management, etc. Good management by the Service Provider and use of an approved QCP will ensure that the Facility is operating within acceptable quality levels.

2. DEFINITIONS

Performance Requirements Summary (Attachment A): The Performance Requirements Summary (PRS) communicates what the Government intends to qualitatively inspect. The PRS is based on the American Correctional Association (ACA) Standards for Adult Local Detention Facilities (ALDF) and ICE 2011 Performance Based National Detention Standards (PBNDS). The PRS identifies performance standards grouped into nine functional areas, and quality levels essential for successful performance of each requirement. The PRS is used by ICE when conducting quality assurance surveillance to guide them through the inspection and review processes.

Functional Area: A logical grouping of performance standards.

Contracting Officer's Technical Representative (COTR): The COTR interacts with the Service Provider to inspect and accept services/work performed in accordance with the technical standards prescribed in the Agreement. The Contracting Officer issues a written memorandum that appoints the COTR. Other individuals may be designated to assist in the inspection and quality assurance surveillance activities.

Performance Standards: The performance standards are established in the ERO ICE 2011 PBNDS at http://www.ice.gov/detention-standards/2011 as well as the ACA standards for ALDF. Other standards may also be defined in the Agreement.

Measures: The method for evaluating compliance with the standards.

Acceptable Quality Level: The minimum level of quality that will be accepted by ICE to meet the performance standard.

Withholding: Amount of monthly invoice payment withheld pending correction of a deficiency. See Attachment A for information on the percentages of an invoice amount that may be withheld for each functional area. Funds withheld from payment are recoverable (See Sections 7 and 8) if the COTR and Contracting Officer confirm resolution or correction, and should be included in the next month's invoice.

Deduction: Funds may be deducted from a monthly invoice for an egregious act or event, or if the same deficiency continues to occur. The Service Provider will be notified immediately if such a situation arises. The Contracting Officer in consultation with the ERO will determine the amount of the deduction. Amounts deducted are not recoverable.

4. QUALITY CONTROL PLAN

The Service Provider shall develop, implement, and maintain a Quality Control Plan (QCP) that illustrates the methods it will use to review its performance to ensure it conforms to the performance requirements. (See Attachment A for a summary list of performance requirements.) Such reviews shall be performed by the Service Provider to validate its operations, and assure ICE that the services meet the performance standards.

The Service Provider's QCP shall include monitoring methods that ensure and demonstrate its compliance with the performance standards. This includes inspection methods and schedules that are consistent with the regular reviews conducted by ERO. The reports and other results generated by the Service Provider's QCP activities should be provided to the COTR as requested.

The frequency and type of the Service Provider's reviews should be consistent with what is necessary in order to ensure compliance with the performance standards.

The Service Provider is encouraged not to limit its inspection to only the processes outlined in the 2011 PBNDS; however, certain key documents shall be produced by the Service Provider to ensure that the services meet the performance standards. Some of the documentation that shall be generated and made available to the COTR for inspection is listed below. The list is intended as illustrative and is not all-inclusive. The Service Provider shall develop and implement a program that addresses the specific requirement of each standard and the means it will use to document compliance.

- Written policies and procedures to implement and assess operational requirements of the standard
- Documentation and record keeping to ensure ongoing operational compliance with the standards (e.g.; inventories, logbooks, register of receipts, reports, etc.)
- Staff training records
- Contract discrepancy reports (CDRs)
- Investigative reports

- Medical records
- Records of investigative actions taken
- Equipment inspections
- System tests and evaluation

5. METHODS OF SURVEILLANCE

ICE will monitor the Service Provider's compliance with the Performance Standards using a variety of methods. All facilities will be subject to a full annual inspection, which will include a review of the Service Provider's QCP activities. In addition, ICE may conduct additional routine, follow-up, or unscheduled ad hoc inspections as necessary (for instance, as a result of unusual incidents or data reflected in routine monitoring). ICE may also maintain an on-site presence in some facilities in order to conduct more regular or frequent monitoring. Inspections and monitoring may involve direct observation of facility conditions and operations, review of documentation (including QCP reports), and/or interviews of facility personnel and detainees.

5.1 Documentation Requirements: The Service Provider shall develop and maintain all documentation as prescribed in the PBNDS (e.g., post logs, policies, and records of corrective actions). In addition to the documentation prescribed by the standards, the Service Provider shall also develop and maintain documentation that demonstrates the results of its own inspections as prescribed in its QCP. The Government may review 100% of the documents, or a representative sample, at any point during the period of performance.

6. FUNCTIONAL PERFORMANCE AREAS AND STANDARDS

To facilitate the performance review process, the required performance standards are organized into nine functional areas. Each functional area represents a proportionate share (i.e., weight) of the monthly invoice amount payable to the Service Provider based on meeting the performance standards. Payment withholdings and deductions will be based on these percentages and weights applied to the overall monthly invoice.

ICE may, consistent with the scope the Agreement, unilaterally change the functional areas and associated standards affiliated with a specific functional area. The Contracting Officer will notify the Service Provider at least 30 calendar days in advance of implementation of the new standard(s). If the Service Provider is not provided with the notification, adjustment to the new standard shall be made within 30 calendar days after notification. If any change affects pricing, the Service Provider may submit a request for equitable price adjustment in accordance with the "Changes" clause. ICE reserves the right to develop and implement new inspection techniques and instructions at any time during performance without notice to the Service Provider, so long as the standards are not more stringent than those being replaced.

7. FAILURE TO MEET PERFORMANCE STANDARDS

Performance of services in conformance with the PRS standards is essential for the Service Provider to receive full payment as identified in the Agreement. The Contracting Officer may take withholdings or deductions against the monthly invoices for unsatisfactory performance documented through surveillance of the Service Provider's activities gained through site inspections, reviews of documentation (including monthly QCP reports), interviews and other

feedback. As a result of its surveillance, the Service Provider will be assigned the following rating relative to each performance standard:

Rating	Description
Acceptable	Based on the measures, the performance standard is demonstrated.
Deficient	Based on the measures, compliance with most of the attributes of the performance standard is demonstrated or observed with some area(s) needing improvement. There are no critical areas of unacceptable performance
At-Risk	Based on the performance measures, the majority of a performance standard's attributes are not met.

Using the above standards as a guide, the Contracting Officer will implement adjustments to the Service Provider's monthly invoice as prescribed in Attachment A.

Rather than withholding funds until a deficiency is corrected, there may be times when an event or a deficiency is so egregious that the Government ***deducts*** (vs. "withholds") amounts from the Service Provider's monthly invoice. This may happen when a significant event occurs, when a particular deficiency is noted multiple times without correction, or when the Service Provider has failed to take timely action on a deficiency about which he was properly and timely notified. The amount deducted will be consistent with the relative weight of the functional performance area where the deficiency was noted. The deduction may be a one-time event, or may continue until the Service Provider has either corrected the deficiency, or made substantial progress in the correction.

Further, a deficiency found in one functional area may tie into another. If a detainee escaped, for example, a deficiency would be noted in "Security," but may also relate to a deficiency in the area of "Administration and Management." In no event will the withhold or deduction exceed 100% of the invoice amount.

8. NOTIFICATIONS

(a) Based on the inspection of the Service Provider's performance, the COTR will document instances of deficient or at-risk performance (e.g., noncompliance with the standard) using the CDR located at Attachment B. To the extent practicable, issues should be resolved informally, with the COTR and Service Provider working together. When documentation of an issue or deficiency is required, the procedures set forth in this section will be followed.

(b) When a CDR is required to document performance issues, it will be submitted to the Service Provider with a date when a response is due. Upon receipt of a CDR, the Service Provider shall immediately assess the situation and either correct the deficiency as quickly as possible or prepare a corrective action plan. In either event, the Service Provider shall return the CDR with the action planned or taken noted. After the COTR reviews the Service Provider's response to the CDR including its planned remedy or corrective action taken, the COTR will either accept the plan or correction or reject the correction or plan for revision and provide an

explanation. This process should take no more than one week. The CDR shall not be used as a substitute for quality control by the Service Provider.

(c) The COTR, in addition to any other designated ICE official, shall be notified immediately in the event of all emergencies. Emergencies include, but are not limited to the following: activation of disturbance control team(s); disturbances (including gang activities, group demonstrations, food boycotts, work strikes, work-place violence, civil disturbances, or protests); staff use of force including use of lethal and less-lethal force (includes detainees in restraints more than eight hours); assaults on staff or detainees resulting in injuries requiring medical attention (does not include routine medical evaluation after the incident); fights resulting in injuries requiring medical attention; fires; full or partial lock down of the Facility; escape; weapons discharge; suicide attempts; deaths; declared or non-declared hunger strikes; adverse incidents that attract unusual interest or significant publicity; adverse weather (e.g., hurricanes, floods, ice or snow storms, heat waves, tornadoes); fence damage; power outages; bomb threats; significant environmental problems that impact the Facility operations; transportation accidents resulting in injuries, death or property damage; and sexual assaults. Note that in an emergency situation, a CDR may not be issued until an investigation has been completed.

(d) If the COTR concludes that the deficient or at-risk performance warrants a withholding or deduction, the COTR will include the CDR in its monthly report, with a copy to the Contracting Officer. The CDR will be accompanied by the COTR's investigation report and written recommendation for any withholding. The Contracting Officer will consider the COTR's recommendation and forward the CDR along with any relevant supporting information to the Service Provider in order to confirm or further discuss the prospective cure, including the Government's proposed course of action. As described in section 7 above, portions of the monthly invoice amount may be withheld until such time as the corrective action is completed, ***or*** a deduction may be taken.

(e) Following receipt of the Service Provider's notification that the correction has been made, the COTR may re-inspect the Facility. Based upon the COTR's findings, he or she will recommend that the Contracting Officer continue to withhold a proportionate share of the payment until the correction is made, or accept the correction as final and release the full amount withheld for that issue.

(f) If funds have been withheld and either the Government or the Service Provider terminates the Agreement, those funds will not be released. The Service Provider may only receive withheld payments upon successful correction of an instance of non-compliance. Further, the Service Provider is not relieved of full performance of the required services hereunder; the Agreement may be terminated upon adequate notice from the Government based upon any one instance, or failure to remedy deficient performance, even if a deduction was previously taken for any inadequate performance.

(g) The COTR will maintain a record of all open and resolved CDRs.

9. DETAINEE OR MEMBER OF THE PUBLIC COMPLAINTS

The detainee and the public are the ultimate recipients of the services identified in this Agreement. Any complaints made known to the COTR will be logged and forwarded to the Service Provider for remedy. Upon notification, the Service Provider shall be given a pre-specified number of hours after verbal notification from the COTR to address the issue. The Service Provider shall submit documentation to the COTR regarding the actions taken to remedy the situation. If the complaint is found to be invalid, the Service Provider shall document its findings and notify the COTR.

10. ATTACHMENTS

A. Performance Requirements Summary

B. Contract Discrepancy Report

Attachment A – Performance Requirements Summary

FUNCTIONAL AREA/ WEIGHT	PERFORMANCE STANDARD (PBNDS 2011)	WITHHOLDING CRITERIA
Safety (20%) Addresses a safe work environment for staff, volunteers, contractors and detainees	**PBNDS References: Part 1 - SAFETY** 1.1 Emergency Plans; 1.2 Environmental Health and Safety; 1.3 Transportation (by Land).	A Contract Discrepancy Report that cites violations of cited PBNDS and PWS (contract) sections that provide a safe work environment for staff, volunteers, contractors and detainees, permits the Contract Officer to withhold or deduct up to **20%** of a month invoice until the Contract Officer determines there is full compliance with the standard or section.
Security (20%) Addresses protection of the community, staff, contractors, volunteers and detainees from harm	**PBNDS References: Part 2 - SECURITY** 2.1 Admission and Release; 2.2 Classification System; 2.3 Contraband; 2.4 Facility Security and Control; 2.5 Funds and Personal Property; 2.6 Hold Rooms in Detention Facilities; 2.7 Key and Lock Control; 2.8 Population Counts; 2.9 Post Orders; 2.10 Searches of Detainees; 2.11 Sexual Abuse and Assault Prevention and Intervention; 2.12 Special Management Units; 2.13 Staff-Detainee Communication; 2.14 Tool Control; 2.15 Use of Force and Restraints.	A Contract Discrepancy Report that cites violations of PBNDS and PWS (contract) sections that protect the community, staff, contractors, volunteers, and detainees from harm, permits the Contract Officer to withhold or deduct up to **20%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard or section.
Order (10%) Addresses contractor responsibility to maintain an orderly environment with clear expectations of behavior and systems of accountability	**PBNDS Reference: Part 3 - ORDER** 3.1 Disciplinary System.	A Contract Discrepancy Report that cites violations of PBNDS and PWS (contract) sections that maintain an orderly environment with clear expectations of behavior and systems of accountability permits the Contract Officer to withhold or deduct up to **10%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard of section.
Care (20%) Addresses contractor responsibility to provide for the basic needs and personal care of detainees	**PBNDS References: Part 4 - CARE** 4.1 Food Service; 4.2 Hunger Strikes; 4.3 Medical Care; 4.4 Personal Hygiene; 4.5 Suicide Prevention and Intervention; 4.6 Terminal Illness, Advanced Directives, and Death.	A Contract Discrepancy Report that cites violations of PBNDS and PWS (contract) sections that provide for the basic needs and personal care of detainees, permits the Contract Officer to withhold or deduct up to **20%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard or section.
Activities (10%) Addresses contractor responsibilities to reduce the negative effects of confinement	**PBNDS References: Part 5 - ACTIVITIES** 5.1 Correspondence and Other Mail; 5.2 Escorted Trips for Non-Medical Emergencies; 5.3 Marriage Requests; 5.4 Recreation; 5.5 Religious Practices; 5.6 Telephone Access; 5.7 Visitation; 5.8 Voluntary Work Program.	A Contract Discrepancy Report that cites violations of PBNDS and PWS (contract) sections that reduce the negative effects of confinement permits the Contract Officer to withhold or deduct up to **10%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard or section.
Justice (10%) Addresses contractor responsibilities to treat detainees fairly and respect their legal rights	**PBNDS References: Part 6 - JUSTICE** 6.1 Detainee Handbook; 6.2 Grievance System; 6.3 Law Libraries and Legal Materials; 6.4 Legal Rights Group Presentations.	A Contract Discrepancy Report that cites violations of PBNDS and PWS (contract) sections that treat detainees fairly and respect their legal rights, permits the Contract Officer to withhold or deduct up to **10%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard or section.

Attachment A – Performance Requirements Summary

FUNCTIONAL AREA/ WEIGHT	PERFORMANCE STANDARD (PBNDS 2011)	WITHHOLDING CRITERIA
Administration and Management (10%) Addresses contractor responsibilities to administer and manage the facility in a professional and responsible manner consistent with legal requirements	**PBNDS References: Part 7 - -ADMIN & MANAGEMENT** 7.1 Detention Files; 7.2 News Media Interviews and Tours; 7.3 Staff Training; 7.4 Transfer of Detainees; **Accommodations for the Disabled, 4-ALDF-6B-04, 4-ALDF-6B-07**	A Contract Discrepancy Report that cites violations of PBNDS and PWS (contract) sections that require the Contractor's administration and management of the facility in a professional and responsible manner consistent with legal requirements, permits the Contract Officer to withhold or deduct up to **10%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard or section.
Workforce Integrity (10%) Addresses the adequacy of the detention/correctional officer hiring process, staff training and licensing/certification and adequacy of systems	**Staff Background and Reference Checks (Contract) 4-ALDF-7B-03** **Staff Misconduct 4-ALDF-7B-01** **Staffing Pattern Compliance within 10% of required (Contract) 4-ALDF-2A-14** **Staff Training, Licensing, and Credentialing (Contract) 4-ALDF-4D-05, 4-ALDF-7B-05, 4-ALDF-7B-08**	A Contract Discrepancy Report that cites violations of the ALDF Standards associated with Workforce Integrity and PWS (contract) sections permits the Contract Officer to withhold or deduct up to **10%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard or section.
Detainee Discrimination (10%) Addresses the adequacy of policies and procedures to prevent discrimination against detainees based on their gender, race, religion, national origin, or disability	**Discrimination Prevention 4-ALDF-6B-02-03**	A Contract Discrepancy Report that cites violations of the ALDF Standards associated with Detainee Discrimination and PWS (contract) sections permits the Contract Officer to withhold or deduct up to **10%** of a monthly invoice until the Contract Officer determines there is full compliance with the standard or section.

Attachment B – Contract Discrepancy Report

CONTRACT DISCREPANCY REPORT			1. CONTRACT NUMBER
Report Number:			**Date:**
2. TO: (Contractor and Manager Name)		3. FROM: (Name of COTR)	
DATES			
CONTRACTOR NOTIFICATION	CONTRACTOR RESPONSE DUE BY	RETURNED BY CONTRACTOR	ACTION COMPLETE
4. DISCREPANCY OR PROBLEM *(Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)*			
5. SIGNATURE OF CONTRACTING OFFICER'S TECHNICAL REPRESENTATIVE (COTR)			
6. TO: (*COTR*)		7. FROM: (*Contractor*)	
8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. (*Cite applicable Q.A. program procedures or new A.W. procedures.*)			
9. SIGNATURE OF CONTRACTOR REPRESENTATIVE			10. DATE
11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: (*Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary*)			
12. GOVERNMENT ACTIONS (*Payment withholding, cure notice, show cause, other.*)			

CLOSE OUT			
	NAME AND TITLE	SIGNATURE	DATE
CONTRACTOR NOTIFIED			
COTR			
CONTRACTING OFFICER			

Attachment 8

TABLE OF CONTENTS

Performance Work Statement

I. INTRODUCTION

A. Background

Enforcement and Removal Operations (ERO), a component of U.S. Immigration and Customs Enforcement (ICE), maintains custody of one of the most highly transient and diverse populations of any detention system in the nation. These detainees are housed in authorized facilities nationwide including local facilities operating under Inter-Governmental Service Agreements (IGSAs), private Contract Detention Facilities (CDFs), and ICE-owned Service Processing Centers (SPC).

B. Scope of Work Performance

This Performance Work Statement (PWS) sets forth the Agreement's performance requirements for IGSA-provided detention facilities and services for ICE detainees.

The Facility's operation shall conform to the 2011 Performance-Based National Detention Standards (PBNDS) Expected Outcomes and Practices. The Minimal Level PBNDS are required under this Agreement. The Contractor is not required to provide service at the Optimal Level.

C. Explanation of Terms/Acronyms

1. ADMINISTRATIVE CONTRACTING OFFICER (ACO): ICE employee responsible for contract compliance, contract administration, cost control, and reviewing Contracting Officer's Representative's (COR) assessment of Service Provider's performance.

2. ADULT LOCAL DETENTION FACILITY (ALDF): A facility which detains persons over the age of 18.

3. ALIEN: Any person who is not a citizen or national of the United States.

4. BED DAY: Per diem "detainee day" or "man-day" means day in or day out and all days in between. The Service Provider may charge for day of arrival or day of departure, but not both.

5. BOOKING: Admission procedure for an ICE detainee, which includes searching, fingerprinting, photographing, medical screening, and collecting personal history data. Booking also includes the inventory and storage of the individual's accompanying personal property.

6. BUREAU OF PRISONS (BOP): The U.S. Federal Bureau of Prisons protects society by confining offenders in the controlled environments of prisons and community-based facilities that are safe, humane, cost-efficient, and appropriately secure, and that provide work and other self-improvement opportunities to assist offenders in becoming law-abiding citizens.

7. COMPLAINT: A written or verbal expression of grief, pain, or dissatisfaction by a detainee with the facility administrator concerning personal health/welfare or the operations and services of the facility.

8. CONTRACTOR: The entity, which provides the services, described in this Performance Work Statement.

9. CONTRACTING OFFICER (CO): An employee of the Government responsible for the complete conduct and integrity of the contracting process, including administration after award. The only individual authorized to issue changes to this contract.

10. CONTRACTING OFFICER'S REPRESENTATIVE (COR): An employee of the Government, appointed by the Contracting Officer, to assist in the technical monitoring or administration of the contract.

11. CONTROL ROOM: Integrates all internal and external security communications networks within a secure room. Activities conducted within the control room have a critical impact on the institution's orderly and secure operation.

12. DEPARTMENT OF HOMELAND SECURITY (DHS): The United States federal executive department responsible for ensuring the homeland is safe, secure, and resilient against terrorism and other hazards.

13. DEPARTMENT OF JUSTICE (DOJ): The United States federal executive department responsible for enforcement of the law and administration of justice. It includes the Executive Office of Immigration Review (EOIR), the Federal Bureau of Investigation (FBI), and the Federal Bureau of Prisons (BOP), and the U.S. Marshals Service (USMS).

14. DESIGNATED SERVICE OFFICIAL: An employee of U.S. Immigration and Customs Enforcement designated in writing by ICE Officer-In-Charge (OIC) to represent ICE on matters pertaining to the operation of the facility.

15. DETAINEE: Any person confined under the auspices and the authority of any Federal agency.

16. DETAINEE RECORDS: Information concerning the individual's personal, criminal and medical history, behavior, and activities while in custody, including, but not limited to:

Detainee, Personal Property, Receipts, Visitors List, Photographs, Fingerprints, Disciplinary Infractions, Actions Taken, Grievance Reports, Medical Records, Work Assignments, Program Participation, Miscellaneous Correspondence, etc.

17. DETENTION OFFICERS: Service Provider's staff members responsible for the security, care, transportation, and supervision of detainees during all phases of activity in a detention facility. The officer is also responsible for the safety and security of the facility.

18. DETENTION STANDARDS COMPLIANCE UNIT (DSCU): A unit within Enforcement and Removal Operations whose purpose is to develop and prescribe policies, standards, and procedures for ICE detention operations and to ensure detention facilities are operated in a safe, secure, and humane condition for both detainees and staff.

19. DIRECT SUPERVISION: A method of detainee management that ensures continuous direct contact between detainees and staff by posting sufficient officers to provide frequent, nonscheduled observation of, and personal interaction with detainees.

20. EMERGENCY: Any significant disruption of normal facility procedure, policy, or activity caused by riot, strike, escape, fire, medical exigency, natural disaster, or other serious incident.

21. ENFORCEMENT AND REMOVAL OPERATIONS (ERO): A component of U.S. Immigration and Customs Enforcement, responsible for the identification, apprehension, and removal of illegal aliens from the United States.

22. ENTRY ON DUTY (EOD): The first day the employee begins performance at a designated duty station on this contract.

23. ENVIRONMENTAL ANALYSIS AND EVALUATION (EAE): This document initiates the analysis and evaluation of environmental effects of proposed actions and considers alternative proposals. It determines the need for an Environmental Assessment.

24. ENVIRONMENTAL ASSESSMENT (EA): Specific document summarizing the results of thorough analyses of environmental impacts caused by proposed actions. It determines the need for an Environmental Impact Statement.

25. ENVIRONMENTAL IMPACT STATEMENT (EIS): Comprehensive document providing full and fair discussion of significant environmental impacts caused by the proposed action(s). It also states the reasonable alternatives, which would avoid or minimize the adverse impact(s) or enhance the quality of the human environment.

26. FACILITY: The physical plant and grounds in which the Service Provider's services are operated.

27. FINDING OF NO SIGNIFICANT IMPACT (FONSI): Formal statement indicating that no significant effect upon the quality of the human environment will occur because of the proposed action(s).

28. IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE): An agency within the U.S. Department of Homeland Security that promotes homeland security and public safety through the criminal and civil enforcement of federal laws governing border control, customs, trade, and immigration.

29. ICE HEALTH SERVICE CORPS (IHSC): The medical authority for ICE, provides on-site, direct patient care to ICE detainees at 23 detention locations and manages off-site medical referrals for aliens housed in approximately 270 other facilities nationwide. IHSC medical facilities follow applicable health care standards that guide current national policy regarding the delivery of health care.

30. IMMEDIATE RELATIVES: Spouses, children (including stepchildren and adopted children) and their spouses, parents (including stepparents), siblings (including stepsiblings and half-siblings) and their spouses.

31. INCIDENT REPORT: Written documentation of an event, such as a minor disturbance, officer misconduct, any detainee rule infraction, etc.

32. JUSTICE PRISONER AND ALIEN TRANSPORTATION SYSTEM (JPATS): DOJ's prisoner transportation system operated by the U.S. Marshals Service (USMS), sometimes referred to as the "airlift."

33. LIFE SAFETY CODE: A manual published by The National Fire Protection Association specifying minimum standards for fire safety necessary in the public interest.

34. LOG BOOK: The official record of post operations and inspections.

35. MAN-DAY: See Bed Day.

36. MAN-HOUR: Man-hour means productive hours when the required services are performed. Only productive hours can be billed.

37. MARSHALS SERVICE (USMS): An agency within the U.S. Department of Justice responsible for enforcing federal laws and providing support to virtually all elements of the federal justice system.

38. MEDICAL RECORDS: Separate records of medical examinations and diagnosis maintained by the responsible physician or nurse. Limited information from these

records is transferred to the detainee record: date and time of all medical examinations; and, copies of standing or direct medical orders from the physician to the facility staff.

39. MEDICAL SCREENING: A system of structured observation and/or initial health assessment to identify newly-arrived detainees who could pose a health or safety threat to themselves or others.

40. OFFICE OF PROFESSIONAL RESPONSIBILITY, PERSONNEL SECURITY UNIT (OPR-PSU): The ICE office, which implements a component-wide personnel security program.

41. ON CALL/REMOTE CUSTODY OFFICER POST: These posts shall be operated on demand by the COR and shall include, but not be limited to, escorting and providing custody of detainees for hearings, ICE interviews, or at any other location requested by the COR.

42. QUALIFIED HEALTH PROFESSIONAL: Physicians, dentists, and other professional and technical workers who by state law engage in activities that support, complement or supplement the functions of physicians and/or dentists who are licensed, registered, or certified, as appropriate to their qualifications, to practice.

43. QUALITY ASSURANCE: The actions taken by the Government to assure requirements of the Performance Work Statement (PWS) are met.

44. QUALITY ASSURANCE SURVEILLANCE PLAN (QASP): A Government document used to ensure that systematic quality assurance methods are used in the administration of performance based standards and other requirements included in this agreement.

45. QUALITY CQNTRQL (QC): The Service Provider's inspection system, which covers all the services to be performed under the Agreement. The actions that a Service Provider takes to control the production of services so that they meet the requirements stated in the Agreement.

46. QUALITY CQNTRQL PLAN (QCP): A Service Provider-produced document that addresses critical operational performance standards for services provided.

47. RESPONSIBLE PHYSICIAN: A person licensed to practice medicine with whom the facility enters into a contractual agreement to plan for and provide health care services to the detainee population of the facility.

48. RESTRAINT EQUIPMENT: This includes but is not limited to: handcuffs, belly chains, leg irons, straight jackets, flexi cuffs, soft (leather) cuffs, and leg weights.

49. SAFETY EQUIPMENT: This includes, but is not limited to, firefighting equipment (i.e., chemical extinguisher, hoses, nozzles, water supplies, alarm systems, portable breathing devices, gas masks, fans, first aid kits, stretchers, and emergency alarms).

50. SECURITY DEVICES: Locks, gates, doors, bars, fences, screens, hardened ceilings, floors, walls and barriers used to confine and control detainees. In addition, electronic monitoring equipment, security alarm systems, security light units, auxiliary power supply, and other equipment used to maintain facility security.

51. SECURITY PERIMETER: The outer portions of a facility, which actually provide for secure confinement of detainees.

52. SERVICE PROVIDER: See Contractor.

53. STANDING MEDICAL ORDERS: Written orders, by a physician, to medical personnel for the definitive treatment of identified minor, self-limiting conditions and for on-site treatment of emergency conditions.

54. TOUR OF DUTY: No more than 12 hours in any 24-hour period with a minimum of eight hours off between shifts, except as directed by state or local law.

55. TRANSPORTATION COSTS: All materials, equipment and labor necessary to respond to requests by designated officials for secure movement of detainees from place to place necessary for processing, hearings, interviews, etc.

56. UNIFORM: A clearly identifiable outfit which can include traditional or non-traditional articles such as khaki pants and polo shirts.

57. WEAPONS: This includes but is not limited to firearms, ammunition, knives, slappers, billy clubs, electronic defense modules, chemical weapons (mace), and authorized batons.

II. GENERAL INFORMATION

A. Introduction

Unless otherwise specified, *all* plans, policies, and procedures shall be developed by the Service Provider and submitted in writing to the CO for review **and concurrence** prior to receiving detainees for housing. Once concurrence has been granted, these plans, policies, and procedures shall not be modified without the prior written acknowledgment of the CO. The Service Provider is prohibited from constructing or making modifications to or adding any additional bed space or facilities at the facility location without the prior written approval of the CO.

B. General

The Service Provider shall abide by all rules and regulations in the following sources:

1. Post Orders

2. American Correctional Association (ACA) Standards for Adult Local Detention Facilities (most current edition) and the most recent copies of the supplements as they are issued. Copies are obtainable for purchase through the Internet website. HTTP://www.aca.org/storeibookstore/.

3. Officers' Handbook (M-68) excluding Grooming Standards

4. The 2011 Performance Based National Detention Standards (PBNDS). (Note: The provisions of the PBNDS 2011 should be interpreted as minimum requirements. Facilities are encouraged to design and operate the facility to provide the least restrictive conditions appropriate to maintain the security and safety of the staff and detainees.) The Minimal Level PBNDS are required under this Agreement. The Contractor is not required to provide service at the Optimal Level.

5. Subpart A of the U.S. Department of Homeland Security (DHS) Regulation titled "Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities," 79 Fed. Reg. 13100 (Mar. 7, 2014).

6. Federal, state, and local laws governing use of firearms, fire safety and environmental health.

7. All other regulations provided to the Service Provider by the authority of the CO. In accordance with Article 5 of the IGSA, the Contractor may negotiate a change to the per diem for changes to existing standards or regulations or additional standards or regulations that result in a documentable financial impact.

All services must comply with this agreement and all applicable federal, state, and local laws and ICE detention standards. Should a conflict exist between any of these laws or standards or regulations, the most stringent shall apply. If the Service Provider is unable to determine which law or standard is more stringent, the CO shall determine the appropriate standard.

This PWS contains numerous references, which direct the Service Provider to notify, contact, or provide the CO with information or data. Post-award, the CO may formally designate other Government individuals to assume those responsibilities. The Service Provider is responsible for a Quality Control Program (QCP), which ensures all requirements of this PWS are achieved. The specific requirements for the QCP are further detailed within this PWS.

C. Records Management

The Service Provider shall comply with all statutes, regulations, and guidelines from the National Archives and Records Administration. Records and information management functions are required and mandated by the following laws and regulations: Chapters 21, 29, 31, and 33 of Title 44, United States Code; 36 CFR 12; 41 CFR 201 subchapters A and B; OMB Circular A-l30; and DO] Order 271 O.8A, *Removal and Maintenance of Documents*. Criminal penalties for unlawfully destroying, damaging, removing, or improperly handling or releasing federal records are addressed in Chapters 37 and 101 of Title 18, United States Code.

D. Inspection by Regulatory Agencies

Work described in the contract is subject to inspection by other Government agencies. The Service Provider shall participate in responding to all requests for information and inspection or review findings by regulatory agencies.

E. Performance Evaluation Meetings

The Service Provider's representatives shall meet with the COR(s) on a regular basis as determined necessary by the Government. These meetings will provide a management level review and assessment of Service Provider performance and allow for discussion and resolution of problems.

F. Service Provider's Employee Manual

The Service Provider shall provide an Employee Manual, which, at a minimum, addresses the following:

1. Organization
2. Recruiting procedures
3. Opportunities for Equal Employment

4. Qualifying for jobs, job descriptions, responsibilities, salaries, and fringe benefits
5. Screening employees for illegal drug use
6. Holidays, leave, and work hours
7. Personnel records, employee evaluations, promotion, and retirement
8. Training
9. Standards of conduct, disciplinary procedures, and grievance procedures
10. Resignation and termination
11. Employee-management relations
12. Security, safety, health, welfare, and injury incidents

The Service Provider must provide a copy of the Employee Manual to the Service Provider's employees at the facility. Upon request by the COR, the Service Provider shall document to the Government that all employees have reviewed a copy of the manual.

G. Housing, Health, and Medical Care

The Service Provider shall provide detention services, to include detainee welfare and record keeping services for ICE.

1. Detention Site Standards

   The Service Provider shall ensure the detention site conforms to ACA and the 2011 PBNDS. A fire and emergency plan shall exist and shall be aggressively managed. The Service Provider shall ensure facilities conformance to the following:

   For safety, security, and sanitation purposes, an inspection of the detainee housing areas shall be conducted by a supervisor at a minimum of two (2) times per shift. All locks, windows, walls, floors, ventilators, covers, access panels, and doors shall be checked daily for operational wear and detainee tampering. The Service Provider shall take immediate action to repair all defective findings and/or equipment. All inspection results and any instructions to staff shall be logged into the housing area security logbook and be available for review by the COR.

   The Facility shall be subject to periodic and random inspections by the COR, or other officials as may be determined by ICE, to ensure compliance with the 2011 PBNDS and the terms of this agreement. Deficiencies shall be immediately rectified or a plan for correction submitted by the Service Provider to the COR for approval.

2. Health and Medical Care

   The Service Provider shall comply with written policies and procedures for appropriately addressing the health needs of ICE detainees. The Service Provider will pursue and receive National Commission on Correctional Health Care

(NCCHC) accreditation within 24months of the initiation of services and ensure compliance with NCCHC guidelines for the duration of services. Policies and procedures shall be written to ensure that medical, dental, and mental health care are delivered in compliance with PBNDS 2011 and NCCHC standards and shall include, but not be limited to, the following:

a. Policies and procedures for accessing 24-hour emergency medical care for ICE detainees.
b. Policies and procedures for prompt summoning of emergency medical personnel.
c. Policies and procedures for emergency medical evacuation of detainees, if deemed necessary by qualified medical personnel.
d. Policies, procedures, and post orders for duty officers to ensure that medical emergencies are recognized and promptly attended to.
e. Policies and procedures addressing detention standards on medical care to include access to care, suicide prevention, hunger strikes, etc.
f. Policies and procedures that support a system allowing for detainees to request medical/mental health services through submission of written requests. Medical/mental health requests for treatment deemed urgent by the medical provider will be forwarded by the Service Provider to the COR and/or alternate COR as soon as possible. Detainee requests shall be addressed with urgency.
g. Policies and procedures that support a continuum of health care services including screening, prevention, health education, diagnosis, and treatment consistent with NCCHC standards and applicable clinical guidelines.
h. Policies and procedures that ensure that detainees released or removed will receive a discharge plan, a summary of medical records, medication and referrals to community-based providers as medically appropriate.
i. Policies and Procedures that include all of the following screening inquiries required by PBNDS 2011 including, but not limited to, past hospitalizations, relevant family medical history, dietary needs and past or recent abuse or violence; and that include – where there is a clinically significant finding as a result of the initial screening – an immediate medical/mental referral with the detainee receiving a health assessment no later than two working days from the initial screening unless the clinical situation would dictate earlier evaluation.
j. Policies and procedures that ensure that detainees experiencing severe, life-threatening intoxication or withdrawal are transferred immediately to a licensed acute care facility.
k. Any detainee complaint for medical care not received shall be promptly addressed and the COR shall be immediately notified.

III. PERSONNEL

The Service Provider shall employ personnel whose qualifications are commensurate with job responsibilities and authority levels. The Service Provider shall assure that employees meet the standards of competency, training, appearance, behavior and integrity. The Service Provider will effect disciplinary or adverse action against employees who disregard those standards.

A. Minimum Standards of Employee Conduct

The Service Provider shall develop standards of employee conduct and corresponding disciplinary actions that are consistent with the following standards of conduct. All employees shall certify in writing that they have read and understand the standards.

A record of this certificate must be provided to the COR prior to the employees beginning work under this contract. The Service Provider shall hold employees accountable for their conduct based on these standards, which are not restricted to, but must include:

1. Employees shall not display favoritism or preferential treatment to one detainee, or group of detainees, over another.
2. Employees shall not discuss or disclose information from detainee files or immigration cases, except when necessary in the performance of duties under this contract.
3. The employee may not interact with any detainee except in a relationship that supports the approved goals of the facility. Specifically, employees shall not receive nor accept any personal (tangible or intangible) gift, favor, or service, from any detainee, any detainee's family, or associate no matter how trivial the gift, favor, or service may seem, for themselves or any members of their family. In addition, the employee shall not give any gift, favor, or service to detainees, detainee's family, or associates.
4. The employee shall not enter into any business relationship with detainees or their families (e.g., selling, buying, or trading personal property).
5. The employee shall not have any outside or social contact with any detainee, his or her family, or associates, except for those activities, which are part of the facility program and a part of the employee's job description.
6. All employees are required to immediately report to the Warden/Facility Director or ICE Supervisor any criminal or non-criminal violation or attempted violation of these standards.
7. The Service Provider shall report all violations or attempted violations of the standards of conduct or any criminal activity immediately to the COR. Violations may result in employee removal from the facility. Failure on the part of the Service Provider either to report a known violation or to take appropriate disciplinary action against offending employee or employees shall subject the Service Provider to appropriate action including possible termination for default.

8. The Service Provider shall not employ any person who is currently an employee of any federal agency - including active duty military personnel - or whose employment would present an actual or apparent conflict of interest.

B. Random Drug Testing

The Service Provider shall have a random drug-screening program that randomly tests a minimum of 10% of all Service Provider staff every quarter. ICE may require drug screening for cause at any time. The Service Provider shall order and accomplish drug screening at the Service Provider's expense. A laboratory approved by the National Institute of Drug Abuse (NIDA) must perform the screening. The Service Provider shall provide the results of all such drug screening to the COR within 24 hours after receipt.

C. Contraband Program and Inspection

A contraband control program shall be established in accordance with the 2011 PBNDS and the ACA standards on the control of contraband. The Service Provider's employees are subject to random contraband inspection in accordance with facility standards and policies. ICE may require contraband screening and inspection for cause at any time. Upon notification of a violation by the COR, the Service Provider shall immediately remove the employee from performing duties under this Agreement. The Service Provider shall revoke employees' credentials, complete required disposition, and immediately notify the COR when the employee is removed from duty.

D. Removal from Duty

If the COR or the Service Provider receives and confirms disqualifying information concerning a Service Provider employee, the Service Provider shall, upon notification by the COR, immediately remove the employee from performing duties under this Agreement. The Service Provider shall revoke the employee's identification credentials and complete any required dispositions. The Service Provider shall immediately notify the COR when the employee is removed from duty. Disqualifying information includes but is not limited to the following:

1. Conviction of a felony, a crime of violence, domestic violence, or a serious misdemeanor.
2. Possessing a record of arrests for continuing offenses.
3. Falsification of information entered on suitability forms.
4. Non-payment of court ordered payments (child support, liens, etc.), or excessive delinquent debt as determined by credit check.
5. Misconduct or negligence in prior employment, which would have a bearing on efficient service in the position in question, or would interfere with or prevent effective accomplishment by the employing agency of its duties and responsibilities.

6. Alcohol abuse of a nature and duration, which suggests that the applicant or appointee would be prevented from performing the duties of the position in question, or would constitute a direct threat to the property or safety of others.
7. Illegal use of narcotics, drugs, or other controlled substances, without evidence of substantial rehabilitation.

ICE may direct the Service Provider to remove any employee who has been disqualified either for security reasons or for being unfit to perform his/her duties as determined by the COR or the Contracting Officer. The Service Provider shall take action immediately and notify the COR when the employee is removed from duty. A determination of being unfit for duty may be made from, but is not limited to, incidents of delinquency set forth below:

1. Violation of the Rules and Regulations Governing Detention facilities set forth in ICE Publications entitled "Detention Officer Handbook",
2. Violation of the Rules and Regulations Governing Public Buildings and Grounds, CFR 101-20.3;
3. Neglect of duty, including sleeping while on duty, loafing, unreasonable delays or failures to carry out assigned tasks, conducting personal affairs during official time, leaving post without relief, and refusing to render assistance or cooperation in upholding the integrity of the security program at the work sites;
4. Falsification or unlawful concealment, removal, mutilation, or destruction of any official documents or records, or concealment of material facts by willful omissions from official documents or records;
5. Theft, vandalism, immoral conduct, or any other criminal actions;
6. Possessing, selling, consuming, or being under the influence of intoxicants, drugs, or substances which produce similar effects;
7. Unethical or improper use of official authority or credentials;
8. Unauthorized use of communication equipment or government property;
9. Misuse of equipment or weapons;
10. Violations of security procedures or regulations;
11. Recurring tardiness;
12. Possession of alcohol, illegal substances, or contraband while on duty;
13. Undue fraternization with detainees as determined by the COR;
14. Repeated failure to comply with visitor procedures as determined by the COR;
15. Performance, as determined by investigation by the Contracting Officer involving acquiescence, negligence, misconduct, lack of diligence, good judgment, and/or good common sense resulting in, or contributing to, a detainee escape;
16. Failure to maintain acceptable levels of proficiency or to fulfill training requirements;
17. Changes in an employee's ability to meet the physical and/or mental health requirements of this Agreement;

18. Service Provider employee who is under investigation by any law enforcement agency will be removed from duties pending outcome of the disposition. At the direction of the COR, the Service Provider shall reassign contract employees who have been arrested or who have alleged misconduct to duties that do not permit direct contact with detainees pending the disposition of the charges. Any alleged misconduct shall be reported immediately to the COR. If such reassignments are not available, the Service Provider shall remove the employee from work under this contract and other ICE contracts.

E. Tour of Duty Restrictions

The Service Provider shall not utilize any uniformed contract employee to perform duties under this Agreement for more than 12 hours in any 24-hour period, and shall ensure that such employees have a minimum of eight hours off between shifts. Authorization is required from the COR prior to an employee performing services that exceed 12 hours; provided, however, Service Provider may utilize uniformed contract employees to perform duties under this Agreement for up to 16 hours in any 24 hour period in the event of an emergency or other non-routine circumstances.. If an employee is performing other duties for either the Service Provider or another employer, those hours shall count against the 16-hour limitation. Employees performing transportation duties can work up to 15 hrs in a 24 hr. period as needed under Department of Transportation regulations.

F. Dual Positions

In the event that a supervisory detention officer is not available for duty the Service Provider should provide a full-time supervisor as a replacement. A contract employee shall not hold the position of Detention Officer and Supervisory Detention Officer simultaneously. The COR will document and refer to the Contracting Officer the failure of the Service Provider to provide necessary personnel to cover positions.

G. Post Relief

As indicated in the post orders, the Detention Officer shall not leave his or her post until relieved by another Detention Officer. When the Service Provider or Service Provider's Supervisors authorize rest or relief periods, the Service Provider shall assign undesignated officers to perform the duties of the Detention Officers on break.

H. Personnel Files

The Service Provider shall maintain a system of personnel files, and make all personnel files available to the CO and the COR upon request. These files shall be maintained and current for the duration of the employee's tenure under the Agreement. The files shall contain verification of training and experience and credentials for all the staff.

I. Uniform Requirements

These requirements apply to Resident Monitoring Staff (Supervisory Detention Officers and Detention Officers) who perform work under the contract.

1. Uniforms

The Service Provider shall provide uniforms to its employees, such as khaki pants and polo shirts. The design and color of the Service Provider's uniforms shall not be similar to those worn by ICE officers. All officers performing under this contract shall wear uniforms of the same style and color while on duty. Supervisory personnel should wear different color shirts to distinguish them from line staff. Uniforms and equipment do not have to be new, but shall be in good condition and meet the standards at start of duty. Officers not in proper uniform shall be considered "not ready for duty/not on duty" until properly uniformed. All uniforms shall be clean, neat, and in good order.

The complete uniform consists of seasonal attire that includes appropriate shirt, pants, belt (mandatory), jacket, shoes or boots (mandatory), duty belt, mini-mag flashlight and holder, handheld radio, and key-holder. The Service Provider shall ensure that each officer has a complete uniform while performing assignments under this Agreement.

Prior to the Agreement performance date, the Service Provider shall document to the COR the uniform and equipment items that have been issued to each employee. The COR shall have the right to approve or disapprove any uniform apparel.

2. Identification Credentials

The Service Provider shall ensure that all employees both uniformed and non-uniformed (if applicable) have the required identification credentials in their possession while on the premises. The Service Provider identification credential document shall contain the following:

a. A photograph that is at least one inch square that shows the full face and shoulders of the employee and is no more than 30 days old when the Service Provider issues the credential.
b. A printed document that contains personal data and description consisting of the employee's name, sex, birth date, height, weight, hair color and eye color, as well as the date of issuance, the signature of the employee, and the signature of project manager designated Service Provider personnel.
c. To avoid the appearance of having Government issued badges, the Service Provider shall not possess wallet type badges or credentials. All credentials shall be approved by the COR.

J. Permits and Licenses

1. Business Permits and Licenses

   The Service Provider must obtain all required permits and licenses by the date of the Agreement award. The Service Provider must (depending on the state's requirements) be licensed as a qualified security service company in accordance with the requirements of the district, municipality, county, and state in which ICE work site(s) is/are located. Throughout the term of this Agreement, the Service Provider shall maintain current permits/business licenses and make copies available for Government Inspection. The Service Provider shall comply with all applicable federal, state, and local laws and all applicable Occupational Safety and Health Administration (OSHA) standards.

2. Licensing of Employees

   Before reporting to duty on this contract, the Service Provider shall ensure each employee has registration, commissions, permits, and licenses as required by the district, municipality, county, and state in which ICE work site is located. The Service Provider shall verify all licenses and certifications. If applicable, all Service Provider staff shall possess a current license/registration, in the state in which they are practicing.

3. Jurisdiction

   The Service Provider's authority under this Agreement is limited to space or posts that are under the charge and control of ICE. The Service Provider will not extend his services into any other areas.

K. Encroachment

Service Provider employees shall not have access to Government equipment, documents, materials, and telephones for any purpose other than as authorized by ICE. Service Provider employees shall not enter any restricted areas of the processing centers unless necessary for the performance of their duties.

L. Work Schedules

The Service Provider shall follow the criteria described below when establishing work schedules, contact relief, rest periods, and starting and stopping work.

1. Post Work Schedules

One week in advance, the Service Provider shall prepare supervisory and Detention Officer work schedules, for a two-week period, and shall post them in work areas or locker rooms. A manpower report shall be submitted to the COR on a monthly basis. Schedules shall be prepared on a form designated by ICE. The Service Provider can use their own format if they already have an established procedure for doing so. Changes in duty hours shall also be posted on this form in sufficient time to ensure 24-hour advance notice. By noon each day, the Service Provider shall provide, to ICE the duty roster showing all assignments for the following day. At the completion of each shift, the Service Provider shall also provide an employment report listing (copies of the sign-in sheets [GSA Form 139, or approved equivalent Record of Arrival and Departure from Buildings during Security Hours] for each shift) for each employee who actually worked, work classification, post assignments, and hours worked, as well as total hours worked by supervisory and non-supervisory employees to the COR. The on-duty Service Provider Supervisor shall conduct regular post checks to ensure personnel are prepared to be on duty. When an employee is not being utilized at a given post, the Service Provider at the direction of the COR or ICE Supervisor on Duty may reassign him/her to another post.

2. Starting and Stopping Work

The Service Provider is responsible for all employees to be dressed in full uniform and ready to begin work promptly at the beginning of each shift. Each employee shall remain at the duty locations until the shift is completed. The Service Provider shall provide, to ICE COR, documentation certifying that each contract employee has been issued approved uniforms and equipment prior to Entry on Duty (EOD) date.

3. Recording Presence

The Service Provider shall direct its employees to sign in when reporting for work, and to sign out when leaving at the end of their period of duty. The Service Provider's supervisory and regular personnel are required to register at the applicable work site(s) and shall use GSA Form 139, Record of Arrival and Departure from Buildings during normal duty hours or other forms designated by ICE. The Government shall specify the registration points, which will be at the protected premises, and the Service Provider must utilize those points for this purpose. Officers, working as supervisors, shall make the designation "Supervisor" in the rank column on GSA Form 139, Record of Arrival and Departure from Buildings during normal duty hours, or other forms designated by ICE; all others will enter "On Duty." The applicable post or position numbers may be entered in the "relief' column after mutual concurrence between ICE and the Service Provider.

Each line on GSA Form 139, Record of Arrival and Departure from Buildings during normal duty hours, or other forms designated by ICE must be completed in

chronological order, without exception. Lines may not be left blank between signatures. If an entire line is used to enter a calendar date to separate individual workdays, a one-line limit for each date entered will be followed. Erasures, obliterations, superimposed, or double entries of any type on anyone line are unacceptable and will not be processed for payment. If errors are made in signatures, times, post numbers, or duty status on this form, the next line immediately following the line containing such errors, will be used to record all corrected information. A single line will be drawn through the entire line on which such mistakes appear. The Service Provider must attach a detailed memorandum explaining the reasons for the mistakes to each form containing erroneous entries.

4. Rest Periods

   When the Service Provider authorizes rest and relief periods for a Service Provider employee, a substitute officer shall be assigned to the duty location.

5. Work Relief

   When the work assignments require that the Service Provider's employees do not leave the assigned duty locations until a substitute officer has provided relief, this condition shall be explicitly stated on GSA Form 2580, Guard Post Assignment Record, or other forms designated by ICE COR. The Service Provider shall enforce the procedure without exceptions.

6. Hospitalization of Detainees

   The contract employees shall not fraternize with clinic/hospital staff or with casual visitors to the clinic/hospital. The Service Provider is obligated to relay messages as requested by the detainee to ICE COR.

IV. BACKGROUND AND CLEARANCE PROCEDURES

A. Initial Drug Testing

The Service Provider must obtain screening for the use of illicit drugs of every employee and prospective employee working under this Agreement. Drug screening is urinalysis to detect the use of amphetamines, cocaine metabolites, opiates (morphine/codeine), phencyclidine (PCP), and marijuana metabolites by an individual. ICE may expand the above list to include additional drugs. A lab approved by the National Institute of Drug Abuse (NIDA) must perform the screening. Prior to the granting of a favorable EOD decision, the Service Provider must submit the results of the drug screening on the applicant to the COR. Drug testing of an applicant will commence as soon as scheduled upon receipt of an applicant's personnel suitability packet by the COR. The results of an applicant's drug test must be submitted to the COR no later than 21 calendar days after receipt of an applicant's personnel suitability packet. Such tests shall be obtained from a National Institute of Drug Abuse (NIDA) approved laboratory and screened for the presence of the following drugs or drug classes: amphetamines, cocaine metabolites, opiates (morphine/codeine), phencyclidine (PCP) and marijuana metabolites. (The ICEIDRO reserves the right to expand the list above to include additional drug/drug classes.) Service Provider shall ensure that all federal, state, and local legal procedures are followed whether or not included in these procedures, with regard to the specimen, Service Provider must ensure that the confirmations are correct and that an adequate chain of custody procedure exists and is followed. The Service Provider must post the ICE "Drug Free Workplace Policy" in all facility work areas.

B. Training

Employees shall not perform duties under this Agreement until they have successfully completed all initial training and the COR receives written certification from the Service Provider.

Facility staff will be trained in accordance with the 2011 PBNDS and ACA standards. To enhance the staff's ability to carry out the mission of civil detention, additional training related to communication skills, sensitivity, multi-cultural awareness, PREA and basic medical care shall be provided and required.

Employees shall not perform duties under this Agreement until they have successfully completed all initial training and the COR receives written certification from the Service Provider.

1. General Training Requirements

    a. All employees will have the training described in the ACA Standards and in this section. The Service Provider shall provide the required refresher courses or have an institution acceptable to the COR to provide the training. Failure of any employee to complete training successfully is sufficient reason to disqualify him or her from duty.

    b. All new Officers and Custody staff will receive 120 hours of training as delineated in the ACA Standards during the first year of employment.

    All staff assigned to the facilities addressed in this IGSA will also receive any other additional training ICE may require.

    ***Firearm Training for Required Armed Detention Services in accordance with State licensing requirements. Service Provider shall certify proficiencyannually.*

    Additional classes shall be at the discretion of the Service Provider with the approval of the COR.

2. Refresher Training

    a. Every year the Service Provider shall conduct 40 hours of Refresher Training for all Officers and Custody staff including Supervisory Officers. Refresher training shall consist of these critical subjects listed above and a review of basic training subjects and others as approved by ICE.

    b. The Service Provider shall coordinate recertification in CPR and First Aid with the ICE training staff. This training shall be provided at no cost to the Government. Annually, upon completion, the Service Provider shall provide documentation of refresher training to the COR.

    c. In addition to the refresher training requirements for all Officers and Custody staff, supervisors must receive refresher training relating to supervisory duties.

3. Basic First Aid and CPR Training

    a. All members of the Service Provider's security staff shall be trained annually in basic first aid and CPR. They must be able to:

        1. Respond to emergency situations within four minutes.
        2. Recognize warning signs of impending medical emergencies.
        3. Know how to obtain medical assistance.
        4. Recognize signs and symptoms of mental illness.
        5. Know the universal precautions for protection against blood-borne diseases.

4. Supervisory Training

All new Supervisory Officers assigned to perform work under this agreement must successfully complete a minimum of 40 hours of formal supervisory training provided by the Service Provider prior to assuming duties. This training is in addition to mandatory training requirements for Officers. Supervisory training shall include the following management areas:

a. Techniques for issuing written and verbal orders
b. Uniform clothing and grooming standards
c. Security Post Inspection procedures
d. Employee motivation
e. Scheduling and overtime controls
f. Managerial public relations
g. Supervision of detainees
h. Other company policies
i. Responding to sexual assault/abuse
j. Responding to assaults on staff, detainee on detainee violence, and supervising and/or responding to uses of force.

All supervisory staff assigned to the facilities addressed in this IGSA will also receive training in the Civil Liberties- Criminal Justice and Legal Issures and Mental Health Concerns in ICE Detention.

Additional classes shall be at the discretion of the Service Provider with the approval of the COR.

The Service Provider shall submit documentation to the COR, to confirm that each supervisor has received basic training as specified in the basic training curriculum.

5. Proficiency Testing

The Service Provider shall give each Detention Officer a written examination following each training class to display proficiency.

6. Training Documentation

a. The Service Provider shall submit a training forecast and lesson plans to the COR or ICE designee, on a monthly basis, for the following 60-day

period. The training forecast shall provide date, time, and location of scheduled training and afford the COR observation/evaluation opportunity.

b. The Service Provider shall certify and submit the training hours, type of training, date and location of training, and name of the instructor monthly for each employee to the COR or ICE designee.

V. REQUIRED SERVICES - ADMINISTRATION AND MANAGEMENT

A. Manage Information System for Collecting, Retrieving, Storing, and Reporting Detainee Detention

All detainee files are to be prepared, maintained, retired, and disposed of in accordance with the 2011 PBNDS. Policy and procedures shall be developed to ensure the confidentiality and security of all detainee files. Information from a detention file will be released to an outside third party only with the detainee's signed release-of-information consent form. Any release of information will be in accordance with applicable Federal and state regulations.

B. Manage the Receiving and Discharge of Detainees

In accordance with the 2011 PBNDS, the Service Provider will provide for the admitting and releasing of detainees to protect the health, safety, and welfare of each individual. During the admissions process, detainees undergo screening for medical purposes, have their files reviewed to ensure they can be housed at the facility, submit to a standard body search, and are personally observed and certified regarding the examination, categorization, inventorying, and safeguarding of all personal belongings. This shall include fingerprinting of detainees.

The Service Provider shall comply with the ICE policy on Admission and Release when entering detainee admission and release data. ICE detainees shall be fingerprinted in accordance with the ICE policy on Admissions Documentation. The intake process shall include, at a minimum, a medical and social screening prior to detainee release into the general population.

This facility is designed for Level I, II, and III detainees that include non-criminals as well as those with criminal records.

Detainees will have access to a minimum of one free telephone call during the admission process and the release process.

C. Manage and Account for Detainee Assets (funds, property)

The Service Provider will provide for the control and safeguarding of detainees' personal property. This will include: the secure storage and return of funds, valuables, baggage, and other personal property; a procedure for documentation and receipting of surrendered property; and the initial and regularly scheduled inventories of all funds, valuables, and other property.

The Service Provider shall have written standard procedures for inventory and receipt of detainee funds and valuables that adheres to the requirements of ICE policy on Funds and Personal Property; and Detention and Removal Operations Policy and Procedure Manual (DROPPM) Update: Chapter 30: Detainee Property Management.

Written procedures shall be established for returning funds, valuables, and personal property to a detainee being transferred or released that adheres to the requirements of ICE policy. The Service Provider shall ensure that all detainees who are scheduled for release are given all funds (in cash) immediately prior to leaving the facility. Funds for detainees being transferred to another facility shall be issued to the transfer facility in a check at he directionof an ICE official. Confiscated foreign currency funds are to be returned to the detainee.

D. Securely Operate the Facility

Policy and procedures for the maintenance and security of keys and locking mechanisms shall be developed. The procedures shall include, but are not limited to: method of inspection to expose compromised locks or locking mechanisms; method of replacement for all damaged keys and/or locks; a preventive maintenance schedule for servicing locks and locking mechanisms and method of logging all work performed on locks and locking mechanisms; policy for restricting security keys from 24 hour issue or removal from the institution; and method of issuing emergency keys. Staff responsible for lock maintenance shall receive training and be certified from a Government approved training program (or equivalent) specializing in the operation of locks and locking mechanisms. The Service Provider shall provide constant unarmed perimeter surveillance of the facility. Surveillance may be provided via a minimum of one motorized security patrol.

The Service Provider shall develop policies and procedures regarding detainee use of those classified controlled tools and equipment most likely to be used in an escape or as a weapon. Further, the Service Provider shall ensure that detainee usage of those classified controlled tools and equipment is only under direct Service Provider staff supervision.

E. Enforce the Detainee Disciplinary Policy

The facility shall have a written disciplinary policy and procedures that clearly define detainee rights and responsibilities. The Service Provider shall comply with the 2011 PBNDS disciplinary policy, and may take disciplinary action against any detainee who is not in compliance with the rules and procedures of the facility consistent with PBNDS 2011.

F. Maintain Detainee Accountability

Population counts will be conducted in accordance with the 2011 PBNDS. All counts shall be documented in separate logs maintained in the applicable locations where detainees are housed, the control center and shift supervisor's office and shall be maintained for a minimum of 30 days. Count records must be available for review and secured away from the detainee population.

G. Collect and Disseminate Intelligence Information

Policy and procedures for collecting, analyzing, and disseminating intelligence information regarding issues affecting safety, security, and the orderly running of the facility shall be developed. This information should include, but not be limited to: gang affiliations; domestic terrorist groups; tracking of detainees having advanced skills in areas of concern (locksmiths, gunsmiths, explosives, and computers, etc.); narcotics trafficking; mail and correspondences; detainee financial information; detainee telephone calls; visiting room activity; and actions of high profile detainees. The Service Provider shall share all intelligence information with the ICE Intelligence Office.

H. Provide Security Inspection System

The Service Provider will develop and maintain a security inspection system with the aim of controlling the introduction of contraband into the facility, ensure facility safety, security and good order, prevent escapes, maintain sanitary standards, and eliminate fire and safety hazards. The Service Provider's inspections program will meet the requirements of the 2011 PBNDS for Security Inspections.

The Service Provider shall report all criminal activity related to the performance of this contract to the appropriate law enforcement investigative agency. The Government may investigate any incident pertaining to performance of this contract. The Service Provider shall cooperate with the Government on all such investigations. The Service Provider shall immediately report all serious incidents or criminal activity to the COR Serious incidents include, but are not limited to the following: activation of disturbance control team(s); disturbances (including gang activities, group demonstrations, food boycotts, work strikes, work place violence, civil disturbances/protests); staff uses of force including use of lethal and less lethal force (includes detainees in restraints more than eight hours); assaults on staff/detainees resulting in injuries that require medical attention (does not include routine medical evaluation after the incident); fires; fights resulting in injuries requiring medical attention; full or partial lock-down of the facility; escape; weapons discharge; suicide attempts; deaths; declared or non-declared hunger strikes; adverse incidents that attract unusual interest or significant publicity; adverse weather; fence damage; power outages; bomb threats; high profile detainee cases admitted to a hospital; significant environmental problems that impact the facility operations; transportation accidents resulting in injuries, death or property damage; and sexual assaults. Pursuant to ICE instructions, the Service Provider shall counteract civil disturbances, attempts to commit espionage or sabotage, and other acts that adversely affect the normal site conditions, the security and safety of personnel, property, detainees, and the general public.

I. Maintain Institutional Emergency Readiness

The Service Provider shall submit an institutional emergency plan that will be operational prior to issuance of the NTP. The plan shall receive the concurrence of the COR prior to implementation and shall not be modified without the further written concurrence of the CO. The Service Provider shall have written agreements with appropriate state and local authorities that will allow the Service Provider to make requests for assistance in the event of any emergency incident that would adversely affect the community. Likewise, the Service Provider shall have in place, an internal corporate nation-wide staff contingency plan consisting of employees who possess the same expertise and skills required of staff working directly on this contract. At the discretion of ICE, these employees would be required to respond to an institutional emergency at the contracted facility if deemed necessary. The emergency plans shall include provisions for one disturbance control team. Protective clothing and equipment for each team member shall be provided by the Service Provider, and maintained in a secure location outside the secure perimeter of the facility.

Any decision by ICE or other federal agencies to provide and/or direct emergency assistance will be at the discretion of the Government. The Service Provider shall reimburse the Government for any and all expenses incurred in providing such assistance.

Attempts to apprehend any escapee(s) shall be in accordance with the Emergency Plan, which shall comply with the 2011 PBNDS regarding Emergency Plans.

The Service Provider shall submit to the COR a proposed inventory of intervention equipment (e.g., weapons, munitions, chemical agents) intended for use during performance of this contract. The COR, prior to issuance of the NTP, shall provide concurrence of the intervention equipment. The approved intervention equipment inventory shall not be modified without prior written concurrence of the CO.

The Service Provider shall obtain the appropriate authority from state or local law enforcement agencies to use force as necessary to maintain the security of the facility. The use of force by the Service Provider shall at all times be consistent with all applicable policies of the 2011 PBNDS on Use of Force.

J. Manage Computer Equipment and Services in Accordance with all Operational Security Requirements

The Service Provider must comply with all federal security and privacy laws and regulations established to protect federal systems and data. The Service Provider will inform all personnel of the confidential nature of ICE detainee information.

The Service Provider will restrict access of data information pertaining to ICE detainees to authorized employees with the appropriate clearance who require this information in the course of their official duties. In accordance with the Freedom of Information/Privacy Act (FOIAIP A), the Service Provider may not disclose information obtained pertaining to ICE detainees to a third party without written permission from the COR. The Service Provider is required to develop a procedural system to identify and record unauthorized access, or attempts to access ICE detainee information. The Service Provider will notify the COR and alternate COR within four hours of a security incident.

VI. FACILITY SECURITY AND CONTROL

A. Security and Control (General)

The Service Provider shall maintain a copy of facility post orders for employee review within the areas of assignment, and shall initiate responses to any incidents as outlined in the post orders. The Service Provider employees shall write reports of incidents as outlined in the post orders. The Service Provider shall operate and control all designated points of access and egress on the site; such as, detainee housing units, courtrooms, medical facilities, and hold rooms. The Service Provider shall inspect all packages carried in or out of site in accordance with ICE procedures. The Service Provider shall comply with ICE security plans.

The Service Provider shall comply with all the 2011 PBNDS pertaining to the security and control of the detention facilities. The Service Provider will adhere to local operating procedures within each facility.

B. Unauthorized Access

The Service Provider shall detect and detain persons attempting to gain unauthorized access to the site(s) identified in this contract.

C. Supervision of Detainees

The Service Provider shall provide supervision of all detainees in all areas, including supervision in detainee housing and activity areas, to permit Detention Officers to hear and respond promptly to emergencies.

D. Logbooks

The Service Provider shall be responsible to complete and document in writing, for each shift, the following information in the logbooks:

1. Activities that have an impact on the detainee population (e.g., detainee counts, shakedowns, detainee movement in and out of the site, and escorts to and from court).
2. Shift activities (e.g., security checks, meals, recreation, religious services, property lockers, medical visits).
3. Entry and exit of persons other than detainees, ICE staff, or Service Provider Staff (e.g., attorneys and other visitors).
4. Fire drills and unusual occurrences.

E. Records and Reports

The Service Provider shall furnish, on a daily basis, a manifest of all detainees currently detained in the facility. The manifest shall contain the following information for each detainee: "A" File Number (system of numbering supplied by ICE); office received from; name; date of birth; gender; nationality; date of arrival; number of days the detainee has been in the facility; and type of release, if applicable. The Service Provider shall provide monthly status reports to the COR or alternate COR. Such reports will include a monthly key indicator report, which indicates the key personnel positions of the facility (e.g., position title, name of the employee, vacancies and length of vacancies, dates of service, additional comments). These monthly reports must be submitted to the COR or alternate COR by the fifth of each month for the previous month's activities and staffing.

The Service Provider shall prepare required orders, instructions, and reports of accidents, security violations, fires, and bomb threats. The reports shall be maintained, on file, concerning all activities in connection with duties and responsibilities for the services performed under this Agreement. All such records must be kept using a system with a written policy, which allows the reports to be made available to the Government for inspection. The Service Provider shall, at the request of ICE, prepare any special or other reports, or issue further orders and instruction as may be required in support of work within the scope of this Agreement. The distribution, format, and time elements for these reports shall be directed by Government requirements. All records and logs, required for operation and performance of work under this Agreement, shall be made available to ICE at Agreement completion. The Service Provider shall provide a detailed and comprehensive inventory of records to be turned over to the Contracting Officer at contract completion or contract termination. The written inventory shall be recorded on Standard Form (SF) 135 or approved equivalent, Records Transmittal and Receipt, and shall be consistent with the National Archives and Records Administration (NARA) guidelines for inventoried records (see: http://www.nara.gov/records/index.html). Inventory shall describe the contents of a particular box of records and shall include record type and date of records, and shall be consistent with NARA inventory requirements.

The SF - 135, Records Transmittal and Receipt, shall be itemized in sufficient detail to provide program officials with the information required for researching or retrieving retired records. Instructions for the level of detail required can be found on the back of the SF- 135a, Records Transmittal and Receipt (continuation), and the Service Provider shall inventory the records to that level of detail.

F. Detainee Counts

The Service Provider shall monitor detainee movement and physically count detainees as directed in the ICE Detentions Operations Manual and post orders. (For the ICE Detention Operations Manual, please seehttp://www.ice.gov/detention-

standards/2011/).. All counts shall be documented in separate logs maintained in the applicable locations where detainees are housed, control center, and shift supervisor's office and shall be maintained for a minimum of 30 days.

G. Daily Inspections

The Detention Officers shall conduct daily inspections of all security aspects of the site. They shall check all bars, locks, windows, walls, floors, ventilation covers, glass panels, access plates, protective screens, doors, lights, and equipment for operational wear and detainee tampering. The Detention Officers shall also report slippery floor surfaces. This documentation shall be made daily in a logbook. Problems discovered during these inspections shall be clearly identified in the documentation.

The Service Provider shall also notify the COR of any abnormalities or problems. The Service Provider shall immediately notify the COR or alternate COR on duty of any physical facility damage. Written documentation of any problem areas shall be submitted to the COR by the end of the shift.

H. Control of Contraband

The Service Provider shall conduct searches for contraband at least once daily, in all areas in which detainees have access. Searches shall be random and unannounced. During the searches, detainee possessions shall be disturbed as little as possible. Contraband items shall be immediately confiscated, logged into the Contraband logbook in accordance with the 2011 PBNDS, and turned over to the COR or alternate COR on duty. The Service Provider shall document records of the searches in a logbook and forward a report to the COR within 24 hours after discovery of the contraband items.

I. Keys and Access Control Devices

The Service Provider shall adhere to key control policies, in accordance with the 2011 PBNDS

Entrance Access Controls: The Service Provider shall operate and enforce the personnel admitting and identification systems, and package inspection procedures in accordance with security guidelines at the protected premises prescribed by the 2011 PBNDS.

The Service Provider may accept registered mail and parcels, in accordance with ICE approved procedures. The Service Provider shall be responsible for the distribution of all received mail and parcels.

J. Control of Chemicals

The Service Provider shall adhere to, the 2011 PBNDS, ACA, and OSHA established procedures, applicable laws, and regulations governing the storage and inventory of all flammable, toxic, and caustic materials used for janitorial cleaning, laundry maintenance, vehicle maintenance, and other applications.

K. Post Orders

The Service Provider shall develop post orders, policies and procedures, and instructions necessary for proper performance at each duty post. Each post will have a separate post order. The Service Provider is responsible for compliance with all such orders, policies and procedures, and instructions. ICE shall approve all post orders prior to implementation of them.

The Service Provider shall make post orders available to all Service Provider employees. Each Service Provider Detention Officer shall certify, in writing, that he or she understands and agrees to comply with all post orders, policies and procedures, and instructions prior to being initially assigned to that post. The Service Provider shall retain its employees' certifications and make them available to the COR upon request.

L. Deviation from Prescribed Schedule Assignments

The Service Provider is authorized to deviate from the scheduled assignment when unusual conditions or circumstances so demand, and if prior approval is received from the COR. All deviations shall be recorded in the daily logbook. When the COR is not available, the Service Provider shall notify the alternate COR immediately or as soon as is practically possible.

M. Use of Force Policy

ICE restricts the use of physical force by Detention Officers to instances of justifiable self-protection, protection of others, and protection of property and prevention of escapes. Physical force may only be used to the degree necessary to safeguard the well-being of the detainee(s) and others in the immediate area. The following policies pertain to use of force:

1. The Service Provider shall adhere to the 2011 PBNDS on the use of deadly and non-deadly force to include the use of intermediate and deadly weapons.
2. The physical force report shall include:
    a. An accounting of the events leading to the use of force.
    b. A precise description of the incident to include date, time, place, type of force used, and reasons for employing force.
    c. A description of the person (Detention Officers or detainees) who suffered described injuries, if any, and the treatment given.

d. A list of all participants and witnesses (Service Providers, detainees, and ICE personnel) to incident.

3. The calculated use of force must be in accordance with the 2011 PBNDS and requires, at a minimum, the following:
    e. The formulation of an After Action Review Team.
    f. An After Action Report submitted to the Field Office Director and COR within 30 days of the incident, with corrective actions noted, if applicable.
    g. Video footage of the incident must be made available for potential ICE review.

N. Use of Restraints Policy

The Service Provider shall comply with the 2011 PBNDS governing the use of restraint equipment. Restraints shall never be applied as punishment nor shall they be used for more time than is necessary. Restraints shall be used only as a precaution against escape during transfer to prevent detainee self-injury, injury to others, property damage, or for medical reasons under direction of the Health Authority. Restraints consist of handcuffs, waist restraints, and leg restraints. When directed by the COR, the Detention Officer may use Government-provided disposable nylon straps in lieu of handcuffs or leg restraints in emergencies, mass arrest situations, or if a detainee's wrists or ankles are too large for conventional restraints. ICE prohibits the Service Provider from using all other restraint devices.

O. Intelligence Information

The Service Provider shall notify the COR or Alternate COR immediately on issues, which could impact the safety, security, and the orderly operation of the facility.

P. Lost and Found

The Service Provider shall log and maintain all lost and found articles and shall report all items to the COR or Alternate COR.

Q. Escapes

The Service Provider shall take all appropriate measures to prevent escapes. The Service Provider shall notify the COR and Alternate COR immediately if an escape or an attempted escape has occurred. The Service Provider shall provide the COR and alternate COR with a written report prior to the end of the shift. The Service Provider shall be held to the following standards concerning escapes:

1. The Service Provider assumes absolute liability for the escape of any detainee in its control, subject to limitations delineated in item 5 below.
2. The Service Provider shall provide written policies and procedures regarding the actions to be taken in the event of an escape. This document

must include reporting requirements for all contract employees, escorts, supervisors, and management personnel. These procedures must meet the approval of the COR, be reviewed at least annually, and updated as necessary.

3. Escapes shall be grounds for removing the responsible Service Provider Employee(s) from duty if the Service Provider Employee(s) is/are determined by the Service Provider or the COR to be negligent. Notice of removal shall be provided to the Contracting Officer.
4. Corrective actions to prevent future escapes or attempted escapes shall be taken immediately and verbally communicated to the COR for approval. A written report of the remedial action shall be due to the COR within 24 hours of an escape or attempted escape.
5. ICE may make deductions due to nonperformance. It is specifically understood and agreed that the Government may not reduce the Service Provider's invoice or otherwise withhold payment from or impose any financial penalty upon the Service Provider based upon walk-aways or escapes from the facility, unless such walk-aways or escapes are the result of the Service Provider's gross negligence, it being understood and agreed that this is not a secure facility.

R. Injury, Illness, and Reports

The Service Provider shall immediately assist employees, detainees, or others on the premises in need of immediate help or who are injured or ill. Service Provider employees shall provide first aid when necessary.

The Service Provider shall immediately notify the COR and alternate COR about all incidents that result in physical harm to or threaten the safety, health, or welfare of any person at the site including job-related injuries. If a detainee requires immediate medical attention, the Detention Officer shall notify the medical provider as well as the COR and alternate COR. The Service Provider shall submit a follow-up written report to the COR within 24 hours of the occurrence. The Service Provider shall cooperate with ICE in reviewing serious incidents. A serious incident means any incident resulting in injury to a detainee, Service Provider staff, ICE staff, or property damage.

The Service Provider shall submit a monthly injury report summary containing, but not limited to, name, time/date, location, circumstances, care rendered, current status, Worker's Compensation status, and reference to identification of initial report.

S. Protection of Employees

The Service Provider shall develop plans that comply with ICE comprehensive plans and procedures to safeguard employees against exposure of blood borne pathogens. The ICE plan is based upon OSHA standards found in the Employee Occupational Safety and Health (EOSH) Manual. (For additional information, please see Occupational Exposure to Blood Bourne Pathogens, 29 CFR 1910.1030.)

T. Medical Requests

The Service Provider shall adhere to ICE policies and procedures regarding detainee medical requests. Please see http://www.ice.gov/doclibIPBNDS/pdf/medical_care.pdf to view the 2011 PBNDS on Medical Care. If a detainee requires emergency medical attention, the Detention Officer shall immediately notify his or her Supervisor via radio or telephone. The Service Provider's Supervisor will, in turn, notify the medical provider as well as the COR and alternate COR.

U. Emergency Medical Evacuation

The Service Provider shall develop and implement written policies and procedures that define emergency health care evacuation of detainees from within the facility.

V. Sanitation and Hygienic Living Conditions

The Service Provider shall comply with the requirements of the Occupational Safety and Health Act of 1970 and all codes and regulations associated with 29 CFR 1910 and 1926. The Service Provider shall comply with all applicable ICE, federal, state and local laws, statutes, regulations, detention standards, and codes. In the event there is more than one reference to a safety, health, or environment requirement in an applicable law, standard, code, regulation, or ICE policy, the most stringent requirement shall apply.

VII. MANAGE A DETAINEE WORK PROGRAM

A. General

The Service Provider will establish a Voluntary Work Program with provisions to pay eligible detainees who volunteer to perform paid work assignments. The program must comply with the requirements of the PBNDS 2011. Detainees shall not be used to perform the responsibilities or duties of an employee of the Service Provider. Detainees shall not be used to perform work in areas where sensitive documents are maintained (designated ICE workspace). Custodial/janitorial services to be performed in designated ICE work space will be the responsibility of the Service Provider. Appropriate safety/protective clothing and equipment shall be provided to detainee workers as appropriate. Detainees shall not be assigned work that is considered hazardous or dangerous. This includes, but is not limited to, areas or assignments requiring great heights, extreme temperatures, use of toxic substances, unusual physical demands, and cleaning of medical areas.

VIII. HEALTH SERVICES

The Service Provider will provide all health and medical-related services for the facility, as previously described in this PWS and PBNDS 2011.

A. Manage a Detainee Death in Accordance with the 2011 PBNDS on Terminal Illness, Advance Directives, and Death

The Service Provider shall fingerprint the deceased. Staff members performing the fingerprinting shall date and sign the fingerprint card to ensure that a positive identification has been made and file the card in the detainee's file..

If death is due to violence, accident surrounded by unusual or questionable circumstances, or is sudden and the deceased has not been under immediate medical supervision, the Service Provider shall notify the coroner of the local jurisdiction to request a review of the case, and if necessary, examination of the body.

The Service Provider shall establish coroner notification procedures outlining such issues as performance of an autopsy, which will perform the autopsy, obtaining state approved death certificates, and local transportation of the body. The Service Provider shall in cooperation with the Field Office representative, ensure the body is turned over to the designated family member, the nearest of kin or the Consular Officer of the detainee's country of legal residence.

IX. FOOD SERVICE

A. Manage Food Service Program in a Safe and Sanitary Environment

The Service Provider shall provide detainees with nutritious, adequately varied meals, prepared in a sanitary manner while identifying, developing, and managing resources to meet the operational needs of the food service program. The Service Provider shall identify, develop, and manage food service program policy, procedures, and practices in accordance with the provisions of the 2011 PBNDS on Food Service.

X. DETAINEE SERVICES AND PROGRAMS

A. Manage Multi-Denominational Religious Services Program

The Service Provider shall ensure detainees of different religious beliefs will be provided reasonable and equitable opportunity to practice their respective faiths. The religious services program will comply with all elements of the 2011 PBNDS on Religious Practices and relevant federal statutes.

B. Provide for a Detainee Recreation Program

The Service Provider shall develop and ensure adequate and meaningful recreation programs for detainees at the facility, consistent with the requirements of PBNDS 2011.

C. Manage and Maintain a Commissary

A commissary shall be operated by the Service Provider as a privilege to detainees who will have the opportunity to purchase from the commissary once per week. These items will not include those items prohibited by the Warden/Facility Director. All items available at the commissary must be approved by the COR or alternate COR. The commissary inventory shall be provided to the COR upon request. The Service Provider may assess sales tax to the price of items, if state sales tax is applicable.

Revenues are to be maintained in a separate account and not commingled with any other funds. If funds are placed in an interest bearing account, the interest earned must be credited to the detainees. Any expenditure of funds from the account shall only be made with the approval of the Contracting Officer. Any revenues earned in excess of those needed for commissary operations shall be used solely to benefit detainees at the facility. Profits may also be used to offset commissary staff salaries. The Service Provider shall provide independent auditor certification of the funds to the COR every 90 days. At the end of the contract period, or as directed by the Contracting Officer, a check for any balance remaining in this account shall be made payable to the *Treasury General Trust Fund* and given/transmitted to the Contracting Officer.

Detainees are permitted to receive funds from outside sources (i.e., from family, friends, bank accounts). Outside funds or those generated from work may be used to pay for products and services from the commissary.

D. Visitation

The Service Provider shall provide detainees options for contact visitation with family members, the community, legal representatives and consular officials consistent with the applicable provisions in PBNDS 2011. Visitation will include appropriate space for children to visit detainees and allow for extended visitation time for family and friends who have travelled longer distances to reach the facility. Visitation shall be provided with hours of operation throughout the week consistent with the PBNDS 2011.

E. Legal Rights Group Presentations

The Service Provider shall make available multi-purpose rooms for volunteers and subcontractors of EOIR LOP to provide group presentations on immigration law and procedures for detainees. These rooms shall also be available for use by consular officials.

F. Law Library

The Service Provider shall provide a dedicated room as a "Law Library" containing computers, printers, books, and materials in accordance with the 2011 PBNDS. .

G. Library

The Service Provider shall provide secure space within the secure perimeter, either a dedicated room or a multipurpose room for books and materials to provide a reading area and detainees will be permitted to take books back to their housing area consistent with safety and security requirements.

H. Barber Shop

A barber shop, designed and equipped in accordance with ICE standards, shall be made available to ICE detainees.

I. Language Access

The Service Provider is responsible for providing meaningful access to all programs and services (e.g. medical, intake, classification, sexual assault reporting) for individuals with limited English proficiency. This should be accomplished through professional interpretation and translation or qualified bilingual personnel for necessary communication with detainees who do not speak or understand English. Oral interpretation should be provided for detainees who are illiterate. Other than in emergencies, and even then only for that period of time before appropriate language services can be procured, detainees shall not be used for interpretation or translation services. The Service Provider should utilize commercial phone

language interpretive services to ensure fulfillment of this requirement. All written materials provided to detainees shall generally be translated into Spanish. Where practicable, provisions for written translation shall be made for other significant segments of the ICE population with limited English proficiency.

J. Disability Accommodation

It is the obligation of the Service Provider that detainees with disabilities (e.g. physical, mental, intellectual, developmental) are housed/served in the least restrictive environment and that reasonable modifications be provided to allow individuals with disabilities to have equal opportunity to participate in programs and services. The Service Provider will use auxiliary aids and necessary assistive devices for detainees who because of a disability need additional communication support.

K. Physical Plant

The facility operation and maintenance shall ensure that detainees are housed in a safe, secure, and humane manner. All equipment, supplies, and services shall be Service Provider-furnished except as otherwise noted. The facility, whether new construction expansion or an existing physical plant, shall be designed, constructed, operated, and maintained in accordance with all applicable federal, state, and local laws, regulations, codes, guidelines, and policies. In the event of a conflict between federal, state, or local codes, regulations or requirements, the most stringent shall apply. In the event there is more than one reference to a safety, health, or environmental requirement in an applicable law, standard, code, regulation or Government policy, the most stringent requirement shall apply.

The facility shall provide housing configurations commensurate with the security needs of the population. A one year construction schedule is acceptable for new physical plant requirements. The facility, whether new construction expansion or existing physical plant, shall comply with the building codes under which it was permitted at the time of original construction.

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. Whether new construction expansion or existing physical plant, fire protection and life safety issues shall be governed by the building and life safety codes under which the facility was permitted at the time of original construction.
The facility, whether new construction expansion or existing physical plant, shall comply with the requirements in effect at the time of the original facility construction of the Architectural Barriers Act of 1968 as amended and the Rehabilitation Act of 1973 as amended. The standards for facility accessibility by physically handicapped persons as set forth in "Uniform Federal Accessibility Standards/Fed Std. - 795 *4/01188* Edition" (UFAS) shall apply. All areas of the buildings and site shall meet these requirements. Activities, which are implemented, in whole or in part, with

federal funds, must comply with applicable legislation and regulations established to protect the human or physical environment and to ensure public opportunity for review. The Service Provider shall remain in compliance with federal statutes during performance of the contract including, but not limited to the following Acts: Clean Air, Clean Water, Endangered Species, Resources Conservation and Recovery; and other applicable laws, regulations and requirements. The Service Provider shall also comply with all applicable limitations and mitigation identified in any Environmental Assessment or Environmental Impact Statement prepared in conjunction with the contract pursuant to the National Environmental Policy Act, 42U.S.C. 4321. The Service Provider shall be responsible for and shall indemnify and hold the Government harmless for any and all spills, releases, emission, disposal and discharges of any toxic or hazardous substance, any pollutant, or any waste, whether sudden or gradual, caused by or arising under the performance of the contract or any substance, material, equipment, or facility utilized. For the purposes of any environmental statute or regulation, the Service Provider shall be considered the "owner and operator" for any facility utilized in the performance of the contract, and shall indemnify and hold the Government harmless for the failure to adhere to any applicable law or regulation established to protect the human or physical environment. The Service Provider shall be responsible in the same manner as above regardless of whether activities leading to or causing a spill, release, emission or discharge are performed by the Service Provider, its agent or designee, a detainee, visitors, or any third party.

If a spill(s) or release(s) of any substance into the environment occur, the Service Provider shall immediately report the incident to the COR or ICE designated official. The liability for the spill or release of such substances rests solely with the Service Provider and its agent.

A safety program shall be maintained in compliance with all applicable Federal, state and local laws, statutes, regulations and codes. The Service Provider shall comply with the requirements of the *Occupational Safety and Health Act of 1970* and all codes and regulations associated with 29 CFR 1910 and 1926.

Fire Alarm Systems and Equipment - All fire detection, communication, alarm, annunciation, suppression and related equipment shall be operated, inspected, maintained and tested in accordance with the edition of the applicable NEC and Life Safety Codes under which the facility was permitted at the time of original construction. The Service Provider shall provide outside lighting sufficient to illuminate the entire facility and secure perimeter with at least 1.5foot candles..

For new construction expansion or existing physical plant, final and completed, the Service Provider prior to issuance of the NTP shall submit design/construction documents to the COR. For all new construction expansion, the construction schedule shall be updated to reflect current progress and submitted to the COR on a monthly basis. Government staff will make periodic visits during construction to verify Service Provider progress and compliance with contract requirements. As-built drawings and

current drawings of the buildings and site utilities shall be maintained in a secure location during construction and contract performance. These updates shall be provided to the COR within 30 days of any changes made. Site utilities include, but are not limited to: water and sewer lines; gas lines; tunnels; steam lines; chilled water lines; recording layouts; elevations; modifications; additions; etc. Two copies of the as-built drawings shall be provided to the COR in AUTOCAD release 14.0 on a CD-ROM no later than 90 days after issuance of the NTP. Promptly after the occurrence of any physical damage to the facility (including disturbances), the Service Provider shall report such damage to the COR or ICE designated official. It shall be the responsibility of the Service Provider to repair such damage, to rebuild or restore the institution. A number of Government staff will be on-site to monitor contract performance and manage other Government interests associated with operation of the facility. Government staff will have full access to all areas of the facility. Service Provider access to Government required space must be pre-approved by the COR. In cases of emergency the Service Provider shall notify the COR promptly.

The Service Provider, in accordance with its facility operation and maintenance, shall ensure that detainees are housed in a safe, secure, and humane manner. All equipment, supplies, and services shall be Service Provider-furnished except as otherwise noted.

The facility shall be designed, constructed, operated, and maintained in accordance with all applicable federal, state, and local laws, regulations, codes, guidelines, and policies.

The Service Provider shall provide and maintain a perimeter patrol and an electronic surveillance system, which will identify any unauthorized access to the institution's perimeter.

4. ICE IT Equipment: ICE shall provide and install IT equipment in office spaces for ICE personnel only, to include computer workstations and screens, printers and fax machines. All infrastructure and cabling shall be provided by the Service Provider.

> **NOTE:** ICE IT system must be a complete, independent and physically separate system from the Service Provider's IT system. The system shall serve all operational components to include ICE, EOIR and OPLA.

Government space shall be climate controlled and located consistent with the administrative office space for the Service Provider's staff. Government-occupied space shall be separate from, but accessible to, detainee housing units and the centralized visiting area. Government-occupied space shall also be secure and inaccessible to Service Provider staff, except when specific permission is granted by on-site ICE, or OPLA staff. The Service Provider shall be responsible for all maintenance, security, and janitorial costs associated with space designated for Government staff. The Service Provider shall provide no less than 10 on-site parking spaces for Government use. The Service Provider shall ensure that video cameras

monitor hallways, exits, and common areas. A qualified individual shall be responsible for monitoring this system inside and outside the building. Considering that the videos will be recordings of residents who may be seeking asylum or other considerations under U.S. immigration law, the Service Provider is required to maintain the tapes and may not release them to anyone, unless approved by DRS. The Service Provider shall develop a plan for keeping the videos for the duration of the project period and destruction of them upon completion of the program.

XI. PROPERTY ACCOUNTABILITY

A. General

The Service Provider shall enact practices to safeguard and protect Government property against abuse, loss, or any other such incidents. Government property shall be used only for official business.

ICE shall maintain a written inventory of all Government property issued to the Service Provider for performance hereunder. Upon expiration of this contract, the Service Provider shall render a written accounting to the COR of all such property. The Service Provider shall assume all risk, and shall be responsible for any damage to or loss of Government furnished property used by Service Provider employees.

Normal wear and tear will be allowed. The Service Provider, upon expiration of services, shall immediately transfer to the COR, any and all Government property in its possession or in the possession of any individuals or organizations under its control, except as otherwise provided for in this contract. The Service Provider shall cooperate fully in transferring property to the successor Service Provider.

The Government shall withhold final payment until adjustments are made for any lost property.

B. Facility, Equipment, Materials, Supplies, and Instructions Furnished by the Government

The Government will furnish the following property at no cost to the Service Provider:

I. Copies of the detention standards cited in the PWS and one copy of all pertinent operational manuals prior to starting work under the contract. The Service Provider shall be responsible to duplicate these standards for Service Provider employees.

II. Administrative forms, Equal Employment Opportunity, Occupational Safety and Health Administration, Service Contract Act, Drug Free Posters, and DHS OIG hotline poster, as required in this contract. As applicable DHS work orders will be issued to the Service Provider via DHS Form 1-203, Order to Detain or Release Alien.

III. ICE office space equipment, such as, but not limited to: office telephones, copying machines, fax machines, computer equipment, and typewriters for Government use. The Government shall be responsible for installation of conduit and data lines within the dedicated Government office space, to include the ICE and EOIR administrative phone system.

XII. FIREARMS / BODY ARMOR

A. Firearms Requirements

1. The Service Provider shall provide serviceable firearms and maintain sufficient licensed firearms and ammunition to equip each armed Detention Officer and armed supervisor(s) with a licensed weapon while on duty. Firearms may be reissued to new replacement employees throughout the life of the contract as long as the firearm is in serviceable condition.
2. Personal firearms shall not be used. A licensed gunsmith shall certify, in writing, all firearms safe and accurate.
3. Firearms shall be standard police service-type, semi-automatic or revolvers capable of firing hollow-point ammunition that meets the recommendations of the firearms manufacturer. Ammunition will be factory load only - no reloads. The Service Provider shall adhere to the manufacturer's specifications regarding ammunition retention, e.g., ammunition shall be properly rotated and older ammunition utilized prior to utilization of newer ammunition.
4. The Service Provider shall provide sufficient ammunition for each armed Detention Officer, including uniformed contract supervisor(s); they shall be issued three full magazines.
5. The Service Provider shall account for all firearms and ammunition daily.
6. If any weapons or ammunition are missing from the inventory, the COR shall be notified immediately.
7. All firearms shall be licensed by the State.
8. Firearms will be inspected. This shall be documented by the Warden/Facility Director.
9. Loading, unloading, and cleaning of the firearms shall only take place in designated areas.
10. The firearms shall be cleaned and oiled as appropriate to ensure optimum operating conditions.
11. Firearms shall be carried with the safety on, if applicable, with a round in the chamber.
12. The Service Provider shall maintain appropriate and ample supplies of firearms upkeep and maintenance equipment (cleaning solvents, lubricating oil, rods, brushes, patches, and other normal maintenance tools).
13. The Service Provider shall provide a complete listing of licensed firearms by serial numbers and by each safe location to the COR prior to beginning performance under this contract.
14. These lists shall be kept current through the terms of the contract and posted within each firearm's safe.
15. The Service Provider shall obtain and maintain on file appropriate State and municipality permits and weapons permits for each officer.
16. A copy of this permit shall be provided to the COR at least three working days prior to the anticipated assignment date of any individual.

17. The Service Provider shall ensure that his/her employees have all permits and licenses in their possession at all times while in performance of this contract.
18. The Service Provider shall provide safes/vaults for storage of firearms and ammunition, for each location where firearms are issued or exchanged, which meet agency requirements and are approved for the storage of firearms and ammunition.
19. The COR is responsible for approving the proposed safes/vaults prior to usage. Contract supervisors and guards shall make accurate receipt and return entries on a Firearms and Equipment Control Register.
20. Except when issuing or returning ammunition or firearms, each safe/vault shall remain locked at all times.
21. The Service Provider shall be responsible for having the combination of each safe/vault changed at least once every six months, or more often if circumstances warrant.
22. The Service Provider certifies firearms training to the COR.
23. The Service Provider shall certify proficiency annually.
24. The Service Provider shall provide an ICE approved intermediate weapon(s).

B. Body Armor Requirements

1. The Service Provider shall provide body armor to all armed Detention Officers and armed supervisor(s).
2. Body armor shall be worn while on armed duty.
3. The body armor shall meet all requirements as set forth in the ICE Firearms Policy.
4. The Service Provider shall procure replacement body armor if the body armor becomes unserviceable, ill-fitting, worn/damaged, or at the expiration of service life.
5. All armed Detention Officers and armed supervisors need to be made aware of the health risks associated with the wearing of body armor in high heat/high humidity conditions and/or during strenuous exertion. When Detention Officers and supervisors are required to wear body armor, they shall be provided opportunities to rehydrate and remove the body armor as necessary.
6. The use of personally owned body armor is not authorized.

TORRANCE COUNTY DETENTION FACILITY
Estancia, New Mexico
752 BEDS (714 ICE / 38 TCSO MALES)

ICE CONTRACT STAFFING PATTERN

STAFF DEPLOYMENT BY SHIFT & POSITION	
MANAGEMENT/SUPPORT	17.50
SECURITY OPERATIONS	100.00
UNIT MANAGEMENT	75.00
MAINTENANCE	6.00
SERVICES	5.00
PROGRAMS	3.00
HEALTH SERVICES	33.77
TOTAL	240.27

MANAGEMENT / SUPPORT	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
WARDEN		1016	1	0	0	5	80	1.00	1.00
ASSISTANT WARDEN		1003	1	0	0	5	80	1.00	1.00
MANAGER, LEARNING AND DEVELOPMENT		2156	1	0	0	5	80	1.00	1.00
MANAGER, OPERATIONS FINANCE		1031	1	0	0	5	80	1.00	1.00
BOOKKEEPER		5004	1	0	0	5	80	1.00	1.00
ACCOUNTING CLERK		5016	1	0	0	5	80	1.00	1.00
MANAGER, HUMAN RESOURCES		5019	1	0	0	5	80	1.00	1.00
HUMAN RESOURCES ASSISTANT		5076	1	0	0	5	80	1.00	1.00
MANAGER, QUALITY ASSURANCE		2009	1	0	0	5	80	1.00	1.00
INVESTIGATOR		2051	1	0	0	5	80	1.00	1.00
SAFETY MANAGER		9087	1	0	0	5	80	1.00	1.00
GRIEVANCE COORDINATOR		5094	1	0	0	5	80	1.00	1.00
MASTER SCHEDULER		5082	1	0	0	5	80	1.00	1.00
SECRETARY		5014	1	0	0	5	80	1.00	1.00
MAILROOM CLERK		5009	2	0	0	5	80	1.00	2.00
ADMINISTRATIVE CLERK, P/T	Business	5025	1	0	0	5	80	0.50	0.50
ADMINISTRATIVE CLERK		5002	1	0	0	5	80	1.00	1.00
TOTAL			18	0	0				17.50

SECURITY OPERATIONS - 8HR SHIFTS	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
CHIEF OF SECURITY		1005	1	0	0	5	80	1.00	1.00
ASST SHIFT SUPERVISOR		9104	1	1	1	7	80	1.70	5.00
ASST SHIFT SUPERVISOR	Intake/Release/Transport	9104	1	0	0	5	80	1.00	1.00
SR DETENTION OFFICER	Disciplinary Hearing	9013	1	0	0	5	80	1.00	1.00
SR DETENTION OFFICER	Housing Zone	9013	0	0	2	7	80	1.70	3.40
SR DETENTION OFFICER	Armory/Key Control	9013	1	0	0	5	80	1.00	1.00
DETENTION OFFICER	Visitation	9005	1	0	0	7	80	1.70	1.70
SR DETENTION OFFICER	Transportation	9013	4	0	0	5	80	1.21	4.84
DETENTION OFFICER	Transportation	9005	4	0	0	5	80	1.21	4.84
DETENTION OFFICER	Laundry	9005	0	1	0	7	80	1.70	1.70
DETENTION OFFICER	Work Detail	9005	1	0	0	5	80	1.00	1.00
DETENTION OFFICER	Back Gate	9005	1	0	0	5	80	1.00	1.00
DETENTION OFFICER	Front Entry	9005	1	1	0	7	80	1.70	3.40
DETENTION OFFICER	Kitchen	9005	1	1	0	7	80	1.70	3.40
DETENTION OFFICER	Asylum Escort	9005	2	2	0	5	80	1.21	4.84
DETENTION OFFICER	Asylum Phones	9005	1	1	0	5	80	1.21	2.42
ADMINISTRATIVE CLERK	Booking	5002	1	1	0	5	80	1.00	2.00
ADMINISTRATIVE CLERK		5002	1	0	0	5	80	1.00	1.00

TORRANCE COUNTY DETENTION FACILITY
Estancia, New Mexico
752 BEDS (714 ICE / 38 TCSO MALES)

ICE CONTRACT STAFFING PATTERI

SECURITY OPERATIONS - 12HR SHIFTS	Post / Assignment	Job Code	1st Shift	2nd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
SHIFT SUPERVISOR		1014	1	1	7	84	2.20	5.00
DETENTION OFFICER	Booking/Intake	9005	4	3	7	84	2.20	15.40
DETENTION OFFICER	Perimeter Patrol (Mobile)	9005	1	1	7	84	2.20	4.40
DETENTION OFFICER	Recreation	9005	3	0	7	84	2.20	6.60
DETENTION OFFICER	Central Control	9005	2	2	7	84	2.20	8.80
DETENTION OFFICER	Medical	9005	1	1	7	84	2.20	4.40
DETENTION OFFICER	Utility/Search & Escort	9005	3	2	7	84	2.20	11.00
TOTAL			34	15				100.00

UNIT MANAGEMENT - 8HR SHIFTS	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
CHIEF OF UNIT MANAGEMENT		1032	1	0	0	5	80	1.00	1.00
UNIT MANAGER		1015	2	0	0	5	80	1.00	2.00
DETENTION COUNSELOR		2090	4	0	0	5	80	1.00	4.00
CLASSIFICATION SUPERVISOR		2145	1	0	0	5	80	1.00	1.00
RECORDS CLERK		5013	2	0	0	5	80	1.00	2.00
DETENTION OFFICER	Recreation-RHU	9005	1	0	0	5	80	1.00	1.00
ADMINISTRATIVE CLERK		5002	2	0	0	5	80	1.00	2.00

UNIT MANAGEMENT - 12HR SHIFTS	Post / Assignment	Job Code	1st Shift	2nd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
UNITS 100 - 300 (38 TCSO Males, 246 ICE)								
DETENTION OFFICER	Pod Control	9005	1	1	7	84	2.20	4.40
DETENTION OFFICER	Housing	9005	2	2	7	84	2.20	8.80
UNIT 400 (SMU)								
SR DETENTION OFFICER	RHU	9013	1	1	7	84	2.20	4.40
DETENTION OFFICER	Housing	9005	1	1	7	84	2.20	4.40
UNIT 600 (156 ICE)								
DETENTION OFFICER	Pod Control	9005	1	1	7	84	2.20	4.40
DETENTION OFFICER	Housing	9005	2	2	7	84	2.20	8.80
UNIT 700 (156 ICE)								
DETENTION OFFICER	Pod Control	9005	1	1	7	84	2.20	4.40
DETENTION OFFICER	Housing	9005	2	2	7	84	2.20	8.80
UNIT 800 (156 ICE)								
DETENTION OFFICER	Pod Control	9005	1	1	7	84	2.20	4.40
DETENTION OFFICER	Housing	9005	2	2	7	84	2.20	8.80
TOTAL			27	14				75.00

MAINTENANCE	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
MAINTENANCE SUPERVISOR		1009	1	0	0	5	80	1.00	1.00
MAINTENANCE WORKER		6003	4	0	0	5	80	1.00	4.00
ADMINISTRATIVE CLERK		5002	1	0	0	5	80	1.00	1.00
TOTAL			6	0	0				6.00

TORRANCE COUNTY DETENTION FACILITY
Estancia, New Mexico
752 BEDS (714 ICE / 38 TCSO MALES)

ICE CONTRACT STAFFING PATTERN

	SERVICES	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
**	WAREHOUSE MANAGER		1070	1	0	0	5	80	1.00	1.00
	WAREHOUSE/COMMISSARY WORKER		9046	3	0	0	5	80	1.00	3.00
*	LAUNDRY SUPERVISOR		9009	1	0	0	5	80	1.00	1.00
*	FOOD SERVICE MANAGER		1069	1	0	0	5	80	1.00	Contract
	FOOD SERVICE WORKER	Supervisor	9006	1	2	0	5	80	1.40	Contract
	TOTAL			7	2	0				5.00

PROGRAMS	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
RECREATION COORDINATOR		2017	1	0	0	5	80	1.00	1.00
CHAPLAIN		2142	1	0	0	5	80	1.00	1.00
LIBRARY AIDE		5017	1	0	0	5	80	1.00	1.00
TOTAL			3	0	0				3.00

HEALTH SERVICES - 8HR SHIFTS	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
HEALTH SERVICES ADMINISTRATOR		1010	1	0	0	5	80	1.00	1.00
PHYSICIAN		2031	1	0	0	5	80	1.00	1.00
ARNP		2014	3	0	0	7	80	1.00	3.00
PSYCHIATRIST, P/T		2091	1	0	0	5	80	0.75	0.75
MENTAL HEALTH COORDINATOR		2034	1	0	0	5	80	1.00	1.00
DENTIST, P/T		2067	1	0	0	5	80	0.60	0.60
DENTAL ASSISTANT		3014	1	0	0	5	80	1.00	1.00
CLINICAL SUPERVISOR		2046	1	0	0	5	80	1.00	1.00
RN	Infectious Disease / CQI	2068	1	0	0	5	80	1.00	1.00
RN	Chronic Care	2068	1	0	0	5	80	1.00	1.00
RN	Pharmacy	2068	1	0	0	5	80	1.00	1.00
MEDICAL TRANSLATOR		5071	1	1	0	5	80	1.00	2.00
MEDICAL RECORDS CLERK		5018	2	1	0	5	80	1.00	3.00
ADMINISTRATIVE CLERK		5002	1	0	0	5	80	1.00	1.00
* MENTAL HEALTH COUNSELOR		CONTRACT/ PRN (2)							

HEALTH SERVICES - 12HR SHIFTS	Post / Assignment	Job Code	1st Shift	2nd Shift	3rd Shift	Days Covered	Hrs/ PP	Relief Factor	Total Staff
RN		2068	2	2		7	80	2.57	10.28
LPN		3003	1	1		7	80	2.57	5.14
TOTAL			20	5					33.77

*Positions hired under a contractual or fee basis for services rendered.

** Three Commissary / Warehouse workers salary and wages funded through Commissary proceeds.

Shift schedules may be adjusted as necessary to accommodate inmate activity.

TORRANCE (714 ICE) - 05/07/2019

POSITION SUMMARY	
SHIFT SUPERVISOR	5
ASST SHIFT SUPERVISOR	6
SCO DETENTION OFFICER	15
DETENTION OFFICER	133
UNIT MANAGER	2
CASE MANAGER	0
DETENTION COUNSELOR	4
FOOD SERVICE CONTRACT STAFF	5
ALL OTHER STAFF	75.27

STAFF RATIOS	
DETENTION OFFICER TO INMATE	1:5.6
UNIFORMED STAFF TO INMATE	1:8.7
ALL STAFF TO INMATE	1:3.1

UNIT MANAGEMENT RATIOS	
UNIT MANAGER TO INMATE	1:376
CASE MANAGER TO INMATE	0
DETENTION COUNSELOR TO INMATE	1:125

Intake Screening (795-A)

Patient was identified by (check 2 sources):
[Wrist Band, Picture, Verbally, ID Badge, Other]
Chaperone Present [yes, no] If yes, give chaperone name_____

Time of arrival at facility: _____ Time of initial screening: _____
If detainee was transferred from another facility, did a medical transfer summary accompany the detainee?
[No, Yes, N/A]
Was the Pre-Screening Note reviewed? *[Yes, No]*
1. What language do you speak?
[English, Spanish, Other: ___]
Interpretation provided? *[Yes, No] If yes, name or INT#*_____
[Yes, No, Detainee speaks English fluently; Provider fluent in patient's native language; no interpreter available during visit,]

Subjective:
Medical Screening
2. How do you feel today? (Explain in his/her own words) _____
3. Are you currently having any pain?
[Yes, No]
If yes, complete pain assessment below:
3a. Character of pain: 3b. Location: 3c. Duration: 3d. Intensity (0-10 pain scale): 3e. What relieves pain or makes it worse?
4. Do you have any current or past medical problems?
[Yes, No]
If yes, explain: __
5. Are you currently or have you ever taken any medication on a regular basis, including over the counter and herbal?
[Yes, No]
If yes, list medications: __
Do you have your medications with you? *[Yes, No]*. If yes, list medications:
6. Do you have any allergies including allergies to medication or food?
[Yes, No]
If yes, list all: __
7. Are you now being or have you ever been treated by a doctor for a medical condition to include hospitalizations, surgeries, infectious or communicable diseases?
[Yes, No]
If yes, explain:
8. Do you now or have you ever had Tuberculosis (TB)? *[Yes, No]*
In the past 2 months, have you experienced any of the following signs or symptoms continuously for more than 2 weeks?
Cough *[Yes, No] Coughing up blood? [Yes, No]*
Chest pain? *[Yes, No]*
Loss of appetite? *[Yes, No]*
Fever, chills, or night sweats for no known reason? *[Yes, No]*
Unexplained weight loss? *[Yes, No]*
Symptom screening with positive response(s) is concerning for active TB:
If yes, explain
Referred to provider for further evaluation
[Yes, No]
9. Are you pregnant?
[Yes, No, N/A (male)]
If yes, date of last menstrual period: __
Are you currently breastfeeding? *[Yes,No]*
Have you had unprotected sexual intercourse in the past 5 days? *[Yes,No]*
If yes, explain_____
Would you like to speak to a medical provider about emergency contraception to prevent a possible pregnancy? *[Yes,No]*
If yes, make referral to medical provider.
10. Have you had any recent acute changes with your vision or hearing?
[Yes, No]
If yes, explain: __

11. Do you have any specific dietary needs? *[Yes, No]*
    If yes, explain:___
12. Have you traveled outside the US within the past 30 days? *[Yes, No]*
    If so, where?
13. Have you ever had or have you ever been vaccinated against Chicken Pox?
    [Admits prior infection, Admits being vaccinated, History denied at time of intake]
14. Do you identify as transgender?
    [Yes, No] If yes, what is your gender self-identification?_____

Oral Screening

15. Are you having any significant dental problems?
    [Yes, No]
    If yes, explain: __

Mental Health Screening

16. Have you ever received counseling, medication or hospitalization for mental health problems*[Yes, No]*
    If yes, explain: ___
    If yes, implement Health and Safety Plan.
17. Currently or in the past, have you ever been diagnoses with mental illnesses, mental health conditions, or have you been hospitalized for mental health reasons (to include outpatient treatment)?
    [Yes, No]
    If yes, what illness? ___
18. Do you have a history of self-injurious behavior?
    [Yes, No] If yes, *[cutting, self-mutilation]* Most recent_____
    If yes, implement Health and Safety Plan
19. Have you ever tried to kill or harm yourself?
    [Yes, No]
    If yes, when did the attempt occur? _____
    Method:
    [Gun, Hanging, Cutting Skin, Pills, Other]
    If attempt was within the last 90 days, make referral immediately and ensure safety.
20. Are you currently thinking about killing or harming yourself?
    [Yes, No]
    If yes, make referral immediately and ensure safety.
21. Do you have a history of assaulting or attacking others?
    [Yes, No]
    Do you know of someone in this facility whom you wish to attack or harm?
    [Yes, No]
    If yes, who is this person?
    If yes, make referral immediately and ensure safety.
22. Do you now or have you ever heard voices that other people don't hear; seen things or people that others don't see; or felt others were trying to harm you for no logical or apparent reason?
    [Yes, No]
    If yes, explain: ___
23. Have you been a victim of physical or sexual abuse?
    [Yes, No]
    If yes, explain: ___
24. Have you had a physical or emotional trauma due to abuse or victimization?
    [Yes, No]
25. Do you feel that you are currently in danger of being physically or sexually assaulted?
    [Yes, No]
    If yes, explain: ___
    If yes, implement Health and Safety Plan
26. Have you ever sexually assaulted anyone?
    [Yes, No]
    If yes, explain: ___

INTAKE SCREENING (Continued)

Trauma Assessment

26. Have you ever experienced, witnessed, or been confronted with an event or events that involved actual or threatened death or serious injury? ☐ Yes ☐ No

If yes, have any of the events included:

a. Violent personal assault (domestic violence, sexual assault, robbery, mugging, kidnapping, trafficking)? ☐ Yes ☐ No

If yes, answer the following:

- Was your response to this event intense fear, helplessness or horror? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Has this experience caused significant distress or impairment in your life? Has it affected your interpersonal relationships, occupational or other areas of functioning? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Is this experience currently causing significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme

b. Manmade or natural disaster? ☐ Yes ☐ No

If yes, answer the following:

- Was your response to this event intense fear, helplessness or horror? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Has this experience caused significant distress or impairment in your life? Has it affected your interpersonal relationships, occupational or other areas of functioning? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Is this experience currently causing significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme

c. Diagnosed with a serious illness, mental illness, medical trauma? ☐ Yes ☐ No

If yes, answer the following:

- Was your response to this event intense fear, helplessness or horror? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Has this experience caused significant distress or impairment in your life? Has it affected your interpersonal relationships, occupational or other areas of functioning? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Is this experience currently causing significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme

d. Witness to a violent assault or observed the serious injury or unnatural death of a person due to violent assault? ☐ Yes ☐ No

If yes, answer the following:

- Was your response to this event intense fear, helplessness or horror? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Has this experience caused significant distress or impairment in your life? Has it affected your interpersonal relationships, occupational or other areas of functioning? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Is this experience currently causing significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme

e. Learning about the unexpected death, serious harm, or threat of death experienced by a family member or close associate? ☐ Yes ☐ No

If yes, answer the following:

- Was your response to this event intense fear, helplessness or horror? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Has this experience caused significant distress or impairment in your life? Has it affected your interpersonal relationships, occupational or other areas of functioning? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Is this experience currently causing significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme

f. War, terrorism, political violence (inside or outside the United States? ☐ Yes ☐ No

If yes, answer the following:

- Was your response to this event intense fear, helplessness or horror? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Has this experience caused significant distress or impairment in your life? Has it affected your interpersonal relationships, occupational or other areas of functioning? ☐ No ☐ Some ☐ Moderate ☐ Extreme
- Is this experience currently causing significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme

Learning/Cultural/Religious Assessment

28. Can you read? *[Yes, No]* Can you write? *[Yes, No]* What was the highest grade completed in school?

29. Is there anything important to know about your religious or cultural beliefs that are of concern to you while in detention?
[Yes, No]
If yes, explain: ___

Substance Use/Abuse Screening

30. Have you ever been treated for drug or alcohol problems or suffered withdrawal symptoms from drug use?
[Yes, No]
If yes, explain: ___
If yes, implement Health and Safety Plan

31. Do you now or have you ever used tobacco products, drank alcohol or used drugs?
[Yes, No]
If yes, explain: ___
If yes, implement Health and Safety Plan.

Substance Use/Route of Use	Date of Last Use	Amount/Quantity Last Used

Objective:

Patient appears to have normal physical and emotional characteristics.

[Yes, No]

Patient appears to have no barriers to communication.

[Yes, No]

Patient is oriented to person *[Yes, No]* , place *[Yes, No],* and time*[Yes, No]*

Patient is NOT to be oriented to:

[Person, Place, Time]

Explain any abnormalities the patient appears to have: ___

If you observe any of the following, check the appropriate box:

[Skin broken out in bumps/rash, Malnourished appearance, Shaking/tremors, Agitation, Inability to focus or concentrate, Developmental disabilities, Excessive sweating, Cuts, bruises, jaundice, lesions, scars, or tattoos, Patient wears glasses or contacts, Bizarre behavior, Physical disabilities, Needle tracks, Nits or active lice, Abnormal breathing (persistent cough, hyperventilation, etc), None observed]

Comments: ___

Vital Signs:

T__ P__ Resp. __ BP __ Height __ Weight __

HCG Results:

[Pos, Neg, N/A (Male)]

Assessment:

Initial medical screening:

[No abnormal findings, Abnormal findings identified]

List all abnormal findings:

Plan:

Disposition:

[General population,
General population with referral for medical/mental health care,
Isolation until medically evaluated,
Referral for immediate medical/mental health or dental care]

Education:

[Tuberculosis and CXR explained to patient and process completed with appropriate shielding,
Physical exam scheduled for patient, Access to medical/dental/mental health care, grievance process explained to patient,
Patient given the Dealing with Stress and. Medical Orientation and Health Information Brochure in the patient's language,
Patient verbalized understanding of any teaching or instruction,
Patient was asked if he or she had any additional questions, and any questions were addressed]

[Female: Educated and provided brochure describing female medical and mental health services related to pregnancy, terminated/miscarried pregnancies, contraction, family planning and age-appropriate gynecological health care.]

Care/Intervention/Follow-up:

[See SF 600 for detailed assessment and plan,
Physical exam schedule for patient,
The following care/treatment was given during this intake screening: ___]

Provider's Signature	Stamp/Printed Name	Date	Time
Reviewer's Signature	Stamp/Printed Name	Date	Time

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ICE HEALTH SERVICE CORPS

Approach to Trauma Informed Care

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PURPOSE

To support the provision of trauma informed care by providing staff with information on psychological trauma and ensure a safe residential environment for residents that may have experienced psychological trauma

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OBJECTIVES

After completing this training staff will be able to:

- Utilize available resources to incorporate trauma informed care into all interactions with the detained/resident population in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA) National Center for Trauma Informed Care (NCTIC) principles.

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OBJECTIVES, CONT'D

- Define Psychological Trauma including acute and chronic types
- List variables that affect response to trauma across the spectrum of custody
- List the potential effects of trauma exposure
- Describe the interpersonal as well as physical, psychological, and social safety considerations that are essential to providing trauma informed care

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PSYCHOLOGICAL TRAUMA

What is psychological trauma and how can you employ trauma informed care?

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WHAT IS PSYCHOLOGICAL TRAUMA?

- Psychological Trauma refers to the *physical and emotional responses* of a person to events that threaten the life or physical integrity of that person or of someone critically important to that person (such as a parent or spouse).
- Traumatic events can overwhelm a person's capacity to cope and elicit feelings of terror, powerlessness, and out-of-control physiological arousal.

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WHAT IS PSYCHOLOGICAL TRAUMA?

Traumatic events core elements:

- Often unexpected
- Unpredictable: person was unprepared
- Person could do nothing to prevent it from happening

Traumatic events may affect :

- Ability to trust others
- Sense of personal safety
- Effectiveness in navigating life changes

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TYPES OF ACUTE TRAUMA

- Experiencing or witnessing horrific injury, carnage, or fatalities
- Serious accidents
- Community violence
- Natural disasters (earthquakes, wildfires, floods)
- Sudden or violent loss of a loved one
- Physical or sexual assault (e.g., being shot, raped, molested)
- Breakup of a significant relationship
- Surgery or invasive medical procedure
- A humiliating or deeply disappointing experience
- Discovery of a life-threatening illness or disabling condition

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TYPES OF CHRONIC TRAUMA

Chronic Trauma refers to the experience of multiple traumatic events.

- Domestic violence/sexual violence
- Longstanding physical abuse or neglect
- Living through long-lasting war & torture
- Extreme poverty

The effects of chronic trauma are often cumulative, as each event serves to remind the person of prior trauma and reinforce its negative impact.

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TRAUMA INFORMED APPROACH KEY ASSUMPTIONS & PRINCIPLES

SAMSHA's concept of a trauma approach is grounded in a set of three assumptions and four key principles. The context in which trauma is addressed contributes to the outcome of trauma survivors.

Discussion in the upcoming slides will address:

- The Three E's of Trauma Informed Care
- The Four R's of Trauma Informed Care, and
- The Six Key Principles of a Trauma Informed Approach

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THE THREE E'S OF TRAUMA INFORMED CARE

- Event
- Experience
- Effect

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THE THREE E'S OF TRAUMA INFORMED CARE

Event(s): May include the actual threat of physical or psychological harm. These events may be a single occurrence or repeated over time.

Examples of **Events include but are not limited to:**

- Serious Accident
- Sudden or violent loss of a loved one
- Physical or sexual assault (shot, raped or molested)
- Witnessing horrific injury, carnage or fatalities
- Natural disasters
- Severe or life threatening neglect of a child

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THE THREE E'S OF TRAUMA INFORMED CARE

Experience: A particular event may be experienced as traumatic for one individual and not another.

How the individual labels, and assigns meaning to an event will contribute to whether or not the experience is traumatic. Cultural beliefs, developmental stages and availability of social supports also play a key role to the individual's perception of experience and trauma.

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THE THREE E'S OF TRAUMA INFORMED CARE

Examples of Experience include but are not limited to:

- Extreme Poverty
- Separations from parent/siblings
- Traumatic grief and loss
- Domestic violence
- Living through extended periods of war
- Refugee or immigrant experiences

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THE THREE E'S OF TRAUMA INFORMED CARE

Effect - High-risk or destructive coping behaviors, may lead to serious mental and physical health problems.(SAMSHA)

Examples of effects include but are not limited to:

- Alcoholism
- Drug abuse
- Depression
- Suicide attempts
- Sexually transmitted diseases (due to high risk activity with multiple partners)

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THE FOUR R'S: KEY ASSUMPTIONS IN TRAUMA APPROACH

- Realization
- Recognize
- Respond
- Re-traumatization

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THE FOUR R'S: KEY ASSUMPTIONS IN TRAUMA APPROACH

Realization- To become aware of the possible impact of trauma in an organization or system at all levels.

To be able to understand that trauma can affect families, groups, and individuals.

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THE FOUR R'S: KEY ASSUMPTIONS IN TRAUMA APPROACH

Recognize-People within the organization are able to identify sign & symptoms of trauma. As a result people may exhibit but may not be limited to:

- Sleep Disturbances
- Difficulty with Learning
- Behavior that shifts from being overly fearful and overly aggressive

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THE FOUR R'S: KEY ASSUMPTIONS IN TRAUMA APPROACH

Respond - Integrate knowledge about trauma into policies, procedures & practices into all areas of functioning. This involves all staff of the organization whether directly or indirectly involved with care.

Best practices may include but are not limited to:

- Active Listening
- Creating Initiatives
- Fostering an environment of safety

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THE FOUR R'S: KEY ASSUMPTIONS IN TRAUMA APPROACH

Re-traumatization- Re-experiencing thoughts and feelings related to the trauma.

Organizations often inadvertently create stressful or toxic environments that interfere with recovery of clients.

For example: Using restraints on a person that has been sexually abused or placing a child who has a history of neglect and abuse in a seclusion room.

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CONSIDERATIONS FOR IMPLEMENTATION OF A TRAUMA INFORMED APPROACH

- First and foremost, provide supportive listening
- Go by what detainee/resident tells you, not by what may or may not be true
- Goal is to help person recover and rehabilitate
- Role of staff is to facilitate healing
- Keep in mind that persons with most severe behavior problems may be the most traumatized
- Work to avoid re-traumatizing
- Remember that traumatized persons may be functioning well. Do not assume that trauma=impairment in functioning

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CONSIDERATIONS FOR IMPLEMENTATION OF A TRAUMA INFORMED APPROACH

Foster an environment of safety

1. Physical

- Absence of Violence
- Feeling that basic needs are met

2. Psychological

- Feeling safe with oneself & the environment
- Able to exercise self-control & self discipline
- Able to express sense of humor, creativity and spirituality

3. Social Safety

- Feeling respected by others
- Feeling free to express private thoughts and feelings without being misjudged

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Scenarios

CASE STUDY # I

Hi, my name is Juan and I'm 8 years old. I just came to the United States with my sister. My sister's boyfriend has been hitting her and he got mad at me one day and hit me in the face and I could not open my eye. My Mom died when I was 5 and my sister is all I have. I never knew my father.

Juan's sister reports that he has nightmares and at times is not eating. He gets scared when he hears others voices getting loud. He has at times been real withdrawn or gets very angry.

Juan has experienced multiple traumatic events(**chronic trauma**),such as death of his mother, witnessing family violence-sister being beaten by her boyfriend, these events are having an impact on Juan's functioning and sense of safety-(**complex trauma**)

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Scenarios

Case Study # 2

Nina is a 28 year old female from New Guinea. There was a genocide in her village and she was left alone and captured by rebels. She was tortured and forced to have sex. She was trafficked to Mexico where she escaped and came to the United States in the back of a van with 5 other women. She reports to the security staff at the detention facility that she is having difficulty sleeping and she has lost a significant amount of weight. She feels that the male guards are looking at her inappropriately. The female Guard took her to medical and discussed weight loss with the RN. After a brief check of her vitals she was referred by the RN for both a medical appointment and a mental health intake.

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Everyone who interacts with detainees/residents plays a role in trauma informed care throughout the duration of custody.

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RESOURCES

- National Center for Trauma-Informed Care
  - 866-254-4819
  - NCTIC@NASMHPD.org
  - http://www.samhsa.gov/nctic

IHSC Evaluation of Adverse Drug Events (ADEs)/Reactions (ADRs)

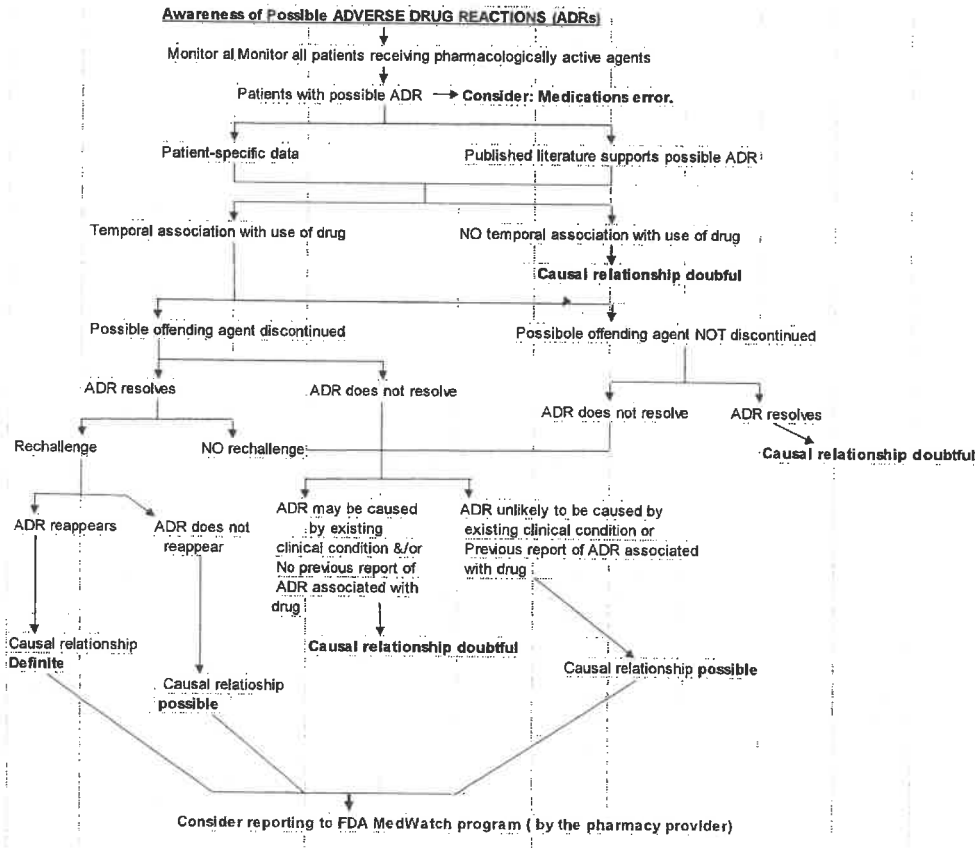
Introduction:

ADEs/ADRs are defined as any injuries resulting from medication use, including physical harm, mental harm, or loss of function. ADEs/ADRs, compared to medication errors, are a more direct measure of patient harm. Medications errors refer to any mistakes occurring in the medication use process, regardless of whether an injury occurred or whether the potential for injury was present. Although relatively few medication errors in IHSC pill-line administrations result in ADEs, they provide important information for identifying opportunities to improve detainee patient care.
At least a quarter of all medications-related injuries are preventable. Preventable ADEs/ADRs include errors made by the clinician and systemic errors.

ADRs/ADEs are far more common single category of adverse events experienced by hospitalized patients than many clinicians/ clinical providers believe. It is estimated that 11% of hospitalized patients experience an ADR, with 2.1% of those considered serious. The IHSC pharmacy unit is collecting the statistics.

An ADR is unexpected, unintended, undesired, or excessive response to a drug or medication that (1) requires modifying the dosages; (2) requires discontinuing the medication; (3) requires changing the medication; (4) necessitates supportive treatment; (5) necessitates hospital admission; (6) prolongs stay in a health care facility; (7) significantly complicates diagnosis; (8) negatively affects prognosis; or (9) results in temporary or permanent harm, disability, or death. The concept of medication misadventures included medication errors and ADRs

This management guideline focuses on interventions to prevent ADEs caused by medication errors in the IHSC setting.


Awareness of Possible ADVERSE DRUG REACTIONS (ADRs)
Monitor al Monitor all patients receiving pharmacologically active agents
Patients with possible ADR
Consider: Medications error.
Patient-specific data
Published literature supports possible ADR
Temporal association with use of drug
NO temporal association with use of drug
Causal relationship doubful
Possible offending agent discontinued
Possibole offending agent NOT discontinued
ADR resolves
ADR does not resolve
ADR does not resolve
ADR resolves
Causal relationship doubtful
Rechallenge
NO rechallenge
ADR reappears
ADR does not reappear
ADR may be caused by existing clinical condition &/or No previous report of ADR associated with drug
ADR unlikely to be caused by existing clinical condition or Previous report of ADR associated with drug
Causal relationship Definite
Causal relatioship possible
Causal relationship doubtful
Causal relationship possible
Consider reporting to FDA MedWatch program (by the pharmacy provider)

Clinical Guidelines for the Diagnosis, Evaluation and Management of Adults with Asthma (≥ 12 years of Age)

Introduction:

As all Guidelines are intended to be flexible, they serve as recommendations, *not rigid criteria.* The guideline for asthma (reactive airway disease) should be followed in most cases, but depending on the patient, and the circumstances, the clinical practice guidelines for asthma may need to be tailored to fit individual needs. These guidelines are tied to the concept of severity, control and responsiveness and domains of impairment and risk.

1. ***Criteria that suggest the diagnosis of asthma:***

Consider a diagnosis of asthma and perform spirometry if any of these indicators are present *:

- The symptoms of dyspnea, cough and/or wheezing, especially nocturnal-difficulty breathing or chest tightness-
- With acute episodes: hyperventilation of thorax, decreased breath sounds, high pitched wheezing, and use of accessory muscles
- Symptoms worse in presence of exercise, viral infection, inhaled allergens, irritants, changes in weather, strong emotional expression, stress, menstrual cycles
- Reversible airflow obstruction: FEV_1> 12% from baseline or increase in FEV_1 > 10 % of predicted after inhalation of bronchodilator, if able to perform spirometry
- Alternative diagnoses are excluded.

*** Eczema, hay fever, and/or a family history of asthma or atopic diseases are often associated with asthma, but they are not key indicators.**

2. ***Goal of Therapy : Control of Asthma***

A). Reduce Impairment

- Prevent chronic and troublesome symptoms (e.g., coughing or breathlessness in the daytime, in night, or after exertion).
- Require infrequent use (< 2 days a week) of inhaled Short-Acting Beta $_2$-Agonist (SABA) for quick relief of symptoms (not including prevention of exercise-induced bronchospasm [EIB])
- Maintain (near) normal pulmonary function; Peak Expiratory Flow circadian variation < 20%
- Maintain normal activity levels (including exercise and other physical activity and attendance at work)
- Meet patients' expectations under his/her detention environment regarding satisfaction with asthma care.

B). Reduce Risk

- Prevent recurrent exacerbations of asthma and minimize the need for emergency department visits or hospitalizations.
- Provide optimal pharmacotherapy with minimal or no adverse effects of therapy.

3). Refer to Asthma Specialist such as an allergist or pulmonologist when the following occurs:

- A life-threatening asthma exacerbation
- Failure to meet the goals of asthma therapy after 3-6 months of treatment. An earlier referral or consultation is appropriate if the physician concludes that the patient is unresponsive to therapy.
- Signs and symptoms are atypical, or there are problems in differential diagnosis.
- Other conditions complicate asthma or its diagnosis, e.g., sinusitis; nasal polyps; Bronchopulmonary aspergillosis (BPA) which is uncommon and results from an allergic pulmonary reaction to inhaled spores of *Aspergillus fumigatus and occasionally from other Aspergillus* species; severe rhinitis; vocal cord dysfunction; GERD; chronic obstructive pulmonary disease.
- Additional diagnostic testing is indicated (e.g., allergy skin testing, rhinoscopy, complete pulmonary function studies, provocative challenge, bronchoscopy)
- Additional education and guidance is required on complications of therapy, problems with adherence, or allergen avoidance.
- The detainee patient is being considered for immunotherapy.
- The detainee patient requires step 4 care or higher.
- The detainee patient has had more than two bursts of oral corticosteroids in one year or has an exacerbation requiring hospitalization.
- Requiring confirmation of a history that suggests that an occupational or environmental inhalant or ingested substance is provoking or contributing to asthma. Depending on the complexities of diagnosis, treatment, or the intervention required in the detention environment, it may be appropriate in some cases for the specialist to manage the patients over a period of time or to co-manage with the IHSC provider.

Table 1 **Classification of Asthma Severity ≥ 12 years of Age & Adults**

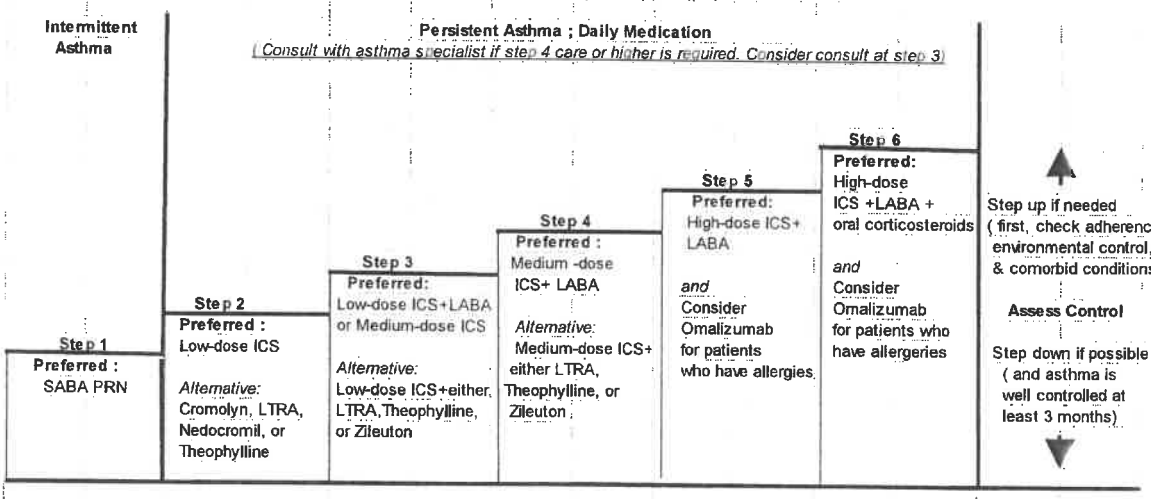
Component of Severity		Intermittent	PERSISTENT		
			Mild	Moderate	Severe
Impairment	Symptoms	≤ 2 days/week	≥ 2 days/week but not daily	Daily	Throughout day
	Nighttime awakenings	≤ 2x/month	3-4x/ month	≥ 1x/week but not nightly	Often 7x/week
Normal FEV_1/FVC: 8-19 yr 85 %; 20-39 yr 80 %; 40-59 yr 75 %; 60-80 yr 70 %;	Short-acting $beta_2$-agonist use for symptom control (not prevention of Exercise Induced Bronchospasm)	≤ 2 days/week	> 2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day.
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung Function	Norm. FEV_1 between exacerbations. FEV_1> 80% predicted FEV_1/FVC normal	FEV_1≥ 80% predicted FEV_1/FVC normal	FEV_1> 60% but<80% predicted FEV_1/FVC reduced 5%	FEV_1 < 60% predicted FEV_1/FVC reduced 5%
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year (see note)	≥ 2 in 1 year (see note)		
		Consider severity & interval since last exacerbation. Frequency & severity may fluctuate over time for patients in any severity category.			
		Relative annual risk of exacerbations may be related to FEV_1			
Recommended step for initial Rx. (see table 2)	Step 1	Step 2	Step 3	Step 4 or Step 5	
	in 2-6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly		and consider short course of oral systemic corticosteroids		

Notes:

* Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient's/ caregiver's recall of previous 2-4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.

* At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general ,more frequent and intense exacerbations (e.g.,requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purpose, patients who had ≥ 2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Table 2 **Stepwise Approach for Managing Asthma in ≥ 12 years of Age and Adults** [Table 3-1 & 3-2]



Each Step : Patient education, environmental control, and management of comorbidities.
Step 2-4 : Consider subcutaneous allergen immunotherapy for patients who have allergic asthma.
* SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. Short course of oral syste,ic corticosteroids may be needed.
* Caution : Increasing use of SABA or use > 2 days a week for symptom relief (not prevention of Exercise Induced broncho-spasm) generally indicates inadequate control and the need to step up treatment.
* ICS, Inhaled Cortocisteroids; LTRA, Leukotriene Receptor Antagonist; SABA, Short-Acting Beta$_2$-Agonist; LABA, Long-Acting Beta$_2$-Agonist

Table 3-1 **LONG -Term Control Medications & QUICK-Relief Medications**
(For ≥ 12 years of Age & Adults)

Usual Doses for Quick -Relief Medictions

	Inhaled Short-Acting Beta$_2$-Agonists (SABA)	Dosage
M E D I C A T I O N S	Albuterol HFA MDI (90 mcg/puff; 200puffs/canister)	2 puffs every 4-6 hours, as needed for symptoms; 2 puffs 5 minutes before *exercise*
	Albuterol Nebulizeer Solution	1.25- 5 mg in 3 cc of saline q 4-8 hours, as needed
	Levalbuterol HFA (45 mcg/puff; 200 puffs/ canister)	2 puffs every 4-6 hours, as needed for symptoms; 2 puffs 5minutes before *exercise*
	Levalbuterol (R-albuterol) Nebulizer Solution	0.63-1.25 mg, q 8hours, as needed
	For Asthma Exacerbations	
	Albuterol MDI (90mcg/puff)	4-8 puffs every 20 minutes up to 4 hours, then every 1-4 hours as needed.
	Albuterol Nebulizer solution	2.5-5 mg every 20 minutes for 3 doses, then 2.5-10 mg every 1-4 hours as needed, or 10-15 mg/hour continuously.
	Anticholinergics	
	Ipratropium HFA MDI (17mcgpuffs,200 puffs/canister)	2-3 puffs every 6 hours
	Ipratropium HFA (Nebulizer soultion)	0.25 mg every 6 hours
	Ipratropium with albuterol MDI (18mcg/puff of Ipratropium bromide and 90mcg/puff of albuterol; 200puffs.canister)	2-3 puffs every 6 hours
	Ipratropium with albuterol (Nebulizer solution)	3 ml every 4-6 hours
	Systemic Corticosteroids	
	Methylprednisolone (2,4,6,8,16,32 mg tablets)	Short course "burst": 40-60 mg/day as single or 2 divided doses for 3-10 days
	Prednisolone (5mg tablets,5mg/5cc,15mg/5cc)	
	Prednisone (1,2,5,5,10,20,50mg tablets; 5mg/5cc,5mg/cc)	
	Repository injection (Methylprednisolone acetate)	240mg IM once

Notes: HFA, hydrofluoroalkane; IM , intramuscular; MDI, metered-dose inhaler

Table 3-2 **Usual Doses for LONG-Term Control Medications**

	Inhaled Corticosteroids	Dosage
MEDICATIONS	Beclomethasone HFA (40 or 80mcg/puff) Budesonide DPI (90,180, or 200mcg/inhalation) Flunisolide (250 mcg/puff) Flunisolide HFA (80mcg/puff) Fluticasone HFA/MDI (44,110,or 220 mcg/puff) Fluticasone DPI (50,100, or 250 mcg/inhalation) Mometasone DPI (200mcg/inhalation) Triamcinolone acetonide (75 mcg/puff)	80 mcg - > 480mcg 180mcg- 1,200mcg 500mcg- > 2,000mcg 320mcg- > 640mcg 88mcg- 440mcg 100mcg- >500mcg 200mcg-> 400mcg 300mcg- >1,500 mcg
	Oral Systemic Corticosteroids	
	Methylprednisolone Prednisolone Prednisone	7.5 -60 mg daily in a single dose in A.M. or qod as needed for control. Short course "burst": to achieve control, 40-60mg/day as single or two divided doses for 3-10 days.
	Inhaled Long-Acting Beta$_2$-Agonists (LABAs)	
	Salmeterol (DPI: 50 mcg/blister) Formoterol (DPI: 12 mcg/single-use capsule)	1 blister every 12 hours 1 capsule every 12 hours.
	Combined Medication	
	Fluticasone/ Salmeterol Budesonide/Formoterol	1 inhalation bid, dose depends on level of severity or control 2 puffs bid, dose depends on level of severity or control
	Cromolyn/Nedocromil	
	Cromolyn (MDI: 0.8 mg/puff) Nebulizer (20mg/ampule) Nedocromil (MDI: 1.75 mg/puff)	2 puffs qid 1 ampule qid 2 puffs qid
	Immunomodulators	
	Omalizumab (Anti IgE)	150-375 mg SC q 2-4 weeks, depending on body weight & pretreatment serum IgE level
	Leukotriene Modifiers (Leukotriene Receptor Antagonists)	
	Montelukast Zafirlukast Zileuton (5-Lipoxygenase Inhibitor)	10mg qhs 40mg daily (20 mg tablets bid) 2,400 mg daily
	Methylxantines	
	Theophylline (Liquid,sustained-release tablets, & capsules)	Starting dose 10mg/kg/day up to 300 mg maximum; usual maximu 800mg/day

Note: DPI, Dry Powder Inhaler; IgE, immunoglobulin E; MDI, meter-dose inhaler.

* Dosages are provided for those products that have been approved by the U.S. Food and Drug Administration or have sufficient clinical trial safety & efficacy data in the ≥12 years of age and adults to support their use.

Figure 1. **Diagnosis, Evaluation, and mangement of Adults-detainees with Asthma**

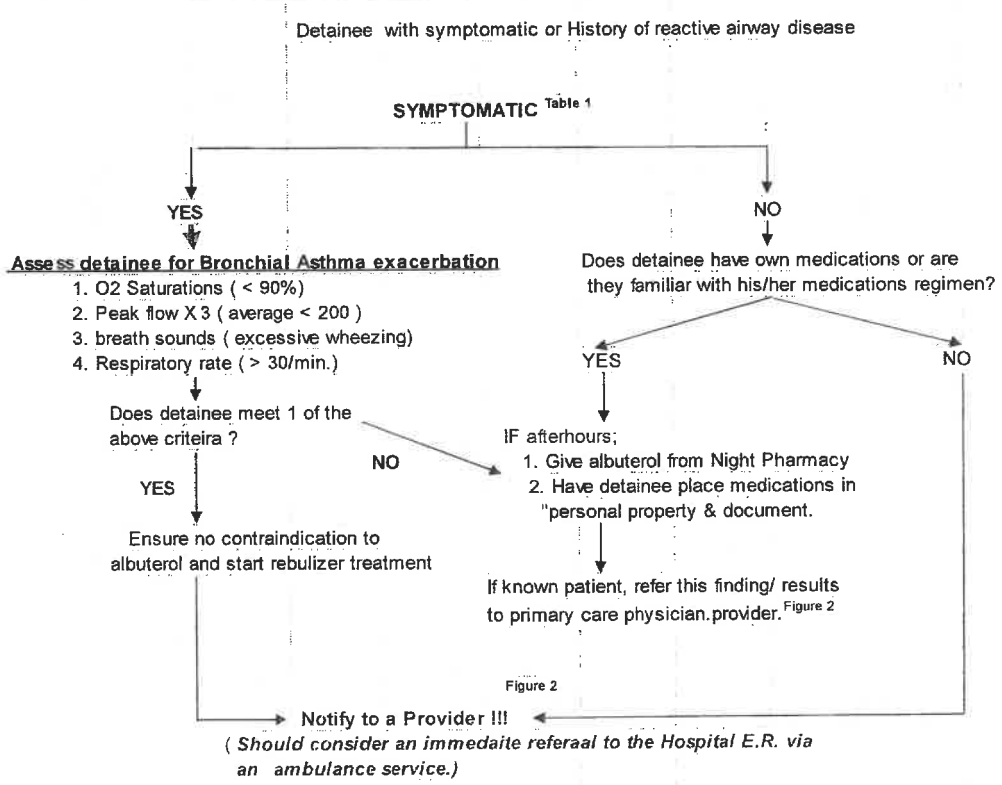
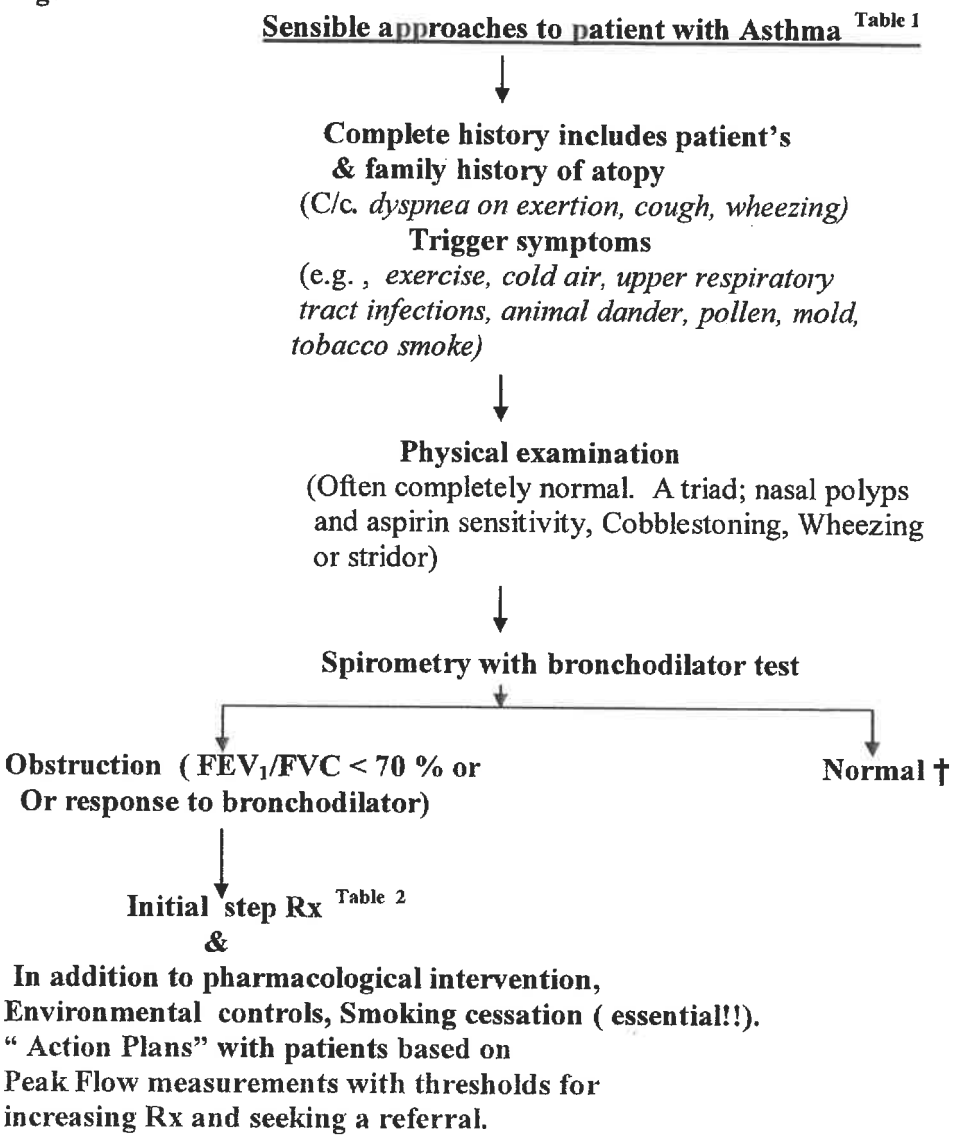


Figure 2



Note : † ; **The American Thoracic Society criteria for " responsiveness " require an increase 200ml and 12 % in either FEV_1 or FVC.** A key aspect of asthma is variability in airflow obstruction. Spirometry testing can often be effort dependent. After being instructed in appropriate technique, patients should obtain peak flows at different times of day, when asymptomatic and when dyspneic or wheezy. Variability in peak flows > 20 % is consistent with asthma. Although useful diagnostically, the peak flow meter is generally more useful as a way to monitor for control of established disease.

IHSC

DIAGNOSTIC APPROACH: CHEST PAIN

INTRODUCTION

Chest pain can be broadly defined as any discomfort in the anterior thorax occurring above the epigastrium and below the mandible. However, pain of cardiac origin may be felt primarily in the arms or jaws. The patient who describes ***chest pain*** to the primary care providers represents an immediate challenge with a portentous catastrophe, although the symptom is usually of benign etiology.

A thorough description of the ***chest pain*** is an essential first step in the diagnosis of the ***chest pain.*** An estimated 6.2 million to 16.5 million Americans experience significant chest pain every year. In IHSC, a significant number of detainees presents to the health service and emergency rooms complaining of ***chest pain.***

The evaluation of ***chest pain in females*** is also an important step in the diagnosis of coronary artery disease (CAD) among IHSC detainees. The diagnosis of CAD in females is problematic because of diagnostic pathways and outcomes based on research in males. Improved diagnosis of CAD in early stages is critical to prevent complications in females, since CAD in females is a significant cause of morbidity and mortality and a worse prognostic than males with myocardial infarction.

ETIOLOGIES

The principal causes of ***chest pain*** may be grouped into life-threatening versus non-life-threatening.[Table 1]

The principal life-threatening causes are: acute coronary syndrome (ACS), aortic dissection, tension pneumothorax, and pulmonary embolism (PE) - all of which should be transferred immediately to the nearest emergency facility.[Figure 1 & Figure 3]

The principal non-life-threatening causes are: stable angina, pericarditits, gastrointestinal reflux diseases (GERD), esophageal spasm, musculoskeletal disorders, valvular heart disease, hypertrophic cardiomyopathy, and panic disorder. These conditions may be followed by IHSC medical providers in the ambulatory care settings.[Table 1]

A majority of patients with chest pain have non-life threatening cause. Therefore, it is important to identify these patients early, to provide effective treatment, relieve patients' concerns, and appropriately utilize IHSC health care resources. To appropriately utilize health care resources, referring to the algorithm for approach to the ***chest pain*** patient.[Figure 1 & Figure 3]

INITIAL MANAGEMENT FOR PERSISTENT PAIN:

STEP 1: (5-10 minutes)
Expeditious history, focused physical examination, ECG

History taking: location, onset, duration character, intensity, and radiation of chest discomfort. Be cautious to use *"chest discomfort"* rather than *"chest pain"* as many may denying having "pain" per se.

Physical examination: assess possible musculoskeletal, gastrointestinal, and pulmonary abnormalities. Careful consideration should be given to any other focal or systemic diseases for which abnormalities in the neck, chest, or upper abdomen may coexist.

Lab tests: ECG mandatory; other tests are electively initiated for non-life-threatening causes.

STEP II (A): EXCLUDE LIFE-THREATENING CAUSES
If *life-threatening* causes [Table 1] suspected, place on cardiac monitor, send cardiac enzymes laboratory tests, and transfer to ER.

STEP II (B): (5-10 minutes for recurrent, episodic pain) [Figure 2, Figure 3, Table 4]
ESTABLISH READILY APPARENT DIAGNOSIS
Non-life-threatening causes may include: gastrointestinal diseases, musculoskeletal abnormalities, and less commonly, pulmonary diseases or pericarditis. Also, pain that persists for hours or even days is highly unlikely to be caused by a *life-threatening* condition, i.e. myocardial ischemia in the absence of acute myocardial infarction. Non-cardiac ***chest pain*** may be monitored conservatively, depending on the cause.

STEP III:
DETERMINE PROGNOSIS [Figure 3]
DETERMINE WHICH PATIENTS NEED FURTHER ISCHEMIA EVALUATION
There remains a large group of patients who has equivocal or unclear diagnosis (life-threatening causes excluded) after full initial evaluation. In these cases, the medical providers must weigh the risks and benefits: the risks of missing a critical life-threatening diagnosis (acute myocardial infarction, PE, *pneumothorax*, or aortic dissection) *versus* the benefits of effective health care appropriation in a generally young and healthy population with low prevalence for these critical conditions. In general, patients with no cardiac risk factors and no clear cardiac source of ***chest pain*** are at low risk for adverse cardiovascular outcomes and may be *conservatively managed.*

SUMMARY

Although numerous clinical guidelines are available, the assessment of ***chest pain*** must integrate multiple pieces of data. No single clinical feature is <u>*decisive*</u>. As a single cause of ***chest pain*** can present in different ways, provide often rely on Bayes' theorem to make a final diagnosis. Consequently, this sometimes results in *false-positive or false-negative* diagnosis.

Clinical reasoning with a problem-oriented approach should be applied in all patient evaluations. **Table 5** Cost-conscious utilization of IHSC resources does not necessarily exclude making accurate clinical assessments and providing life-saving treatments. The algorithm provided here is a method essential to avoid missing *life-threatening* causes of ***chest pain.*** **Figure 3 & Figure 1**

REFERENCES

1. *American Heart Association's 1999 Heart and Stroke Statistics.*
2. ***ACC/AHA/ACP-ASIM 1999*** *guidelines For Management of Patients With Chronic Stable Angina*
3. *Cardiology, 4th Edition.* London: Blackwell Science Ltd., 2002
4. *Practical Cardiology: Treatment of Common Cardiovascular Disorders.* Philadelphia: Lippincott Williams & Wilkins, 2003
5. *Harrison's Principles of Internal Medicine, 17th Edition.* New York: McGraw Hill, 2008
6. *Hurst's The Heart, 12th Edition.* New York: McGraw Hill, 2008

Table 1: ***Principle causes of chest pain***

Life-threatening	**Non-life-threatening**
Acute coronary syndrome	Stable angina
Aortic dissection	GERD/esophageal spasm
Pulmonary embolism	Musculoskeletal
Pneumothorax	Valvular heart diseases
	Hypertrophic cardiomyopathy
	Panic Disorder

Table 2: ***Grading of angina pectoris by the Canadian Cardiovascular Society Classification system***

Class I:
Ordinary physical activity does not cause angina, such as walking or climbing stairs. Angina occurs with strenuous, rapid, or prolonged exertion at work or recreation.

Class II:
Slight limitation of ordinary activity: Angina occurs on walking or climbing stairs rapidly; walking uphill; walking or stair climbing after meals, in the cold, in the wind, or under emotional stress; or only during the few hours after awakening.

Class III:
Marked limitations of ordinary physical activity: Angina occurs on walking one or two blocks on the level, and climbing one flight of stairs in normal conditions and at a normal pace.

Class IV:
Inability to carry on any physical activity without discomfort; anginal syndromes may be present at rest.

Table 3: ***Principle presentations of unstable angina***

Rest angina:
Angina occurring at rest and usually prolonged (>20 minutes), occurring within a week of presentation.

New-onset angina:
Angina of at least CCSC III severity with onset within two months of initial presentation.

Increasing angina:
Previously diagnosed angina that is distinctly more frequent, longer in duration or lower in threshold (i.e., increased by at least one CCSC class within two months of initial presentation to at least CCSC III severity).

Table 4: ***Approach to the Patient with Persistent Pain (lasting perhaps for days)***

1. Complete History and physical examination
2. Testing guided by data may include:
   -Electrocardiogram (ECG)
   -Chest radiographic study
   -Computed tomography of chest
   -Gastrointestinal evaluation
   -Spine, shoulder, or rib radiographs
   -Echocardiogram

Table 5: ***Clinical Reasoning Approach***

1. History and physical examination
2. Diagnostic tests (order only accurate and useful tests)
3. Make a diagnosis (integrate 1 & 2)
4. Risks, benefits, and alternative of therapeutic options.
5. Discuss with patient and form a plan.

Table 6: ***Risk Factor Determinants of Coronary Artery Disease in Females with Chest Pain***

Major
Typical angina
Postmenopausal status
Diabetes (twice the risk of CAD of male diabetic patients)
Peripheral vascular disease

Intermediate
Hypertension
Smoking, especially in premenopausal females
Lipid abnormalities, including HDL< 35mg/dl & triglyceride> 400mg/dl.

Minor
Age> 65years
Central obesity (waist/hip ratio> 0.85 or waist> 38 cm)
Sedentary lifestyle
Family history of CAD (2.8 times increase in relative risk of nonfatal myocardial infarction and five times increase in CAD
Other risk factors (hemostatic, psychosocial)

Figure 1 **Proposed Algorithm for Managing Chest Pain**

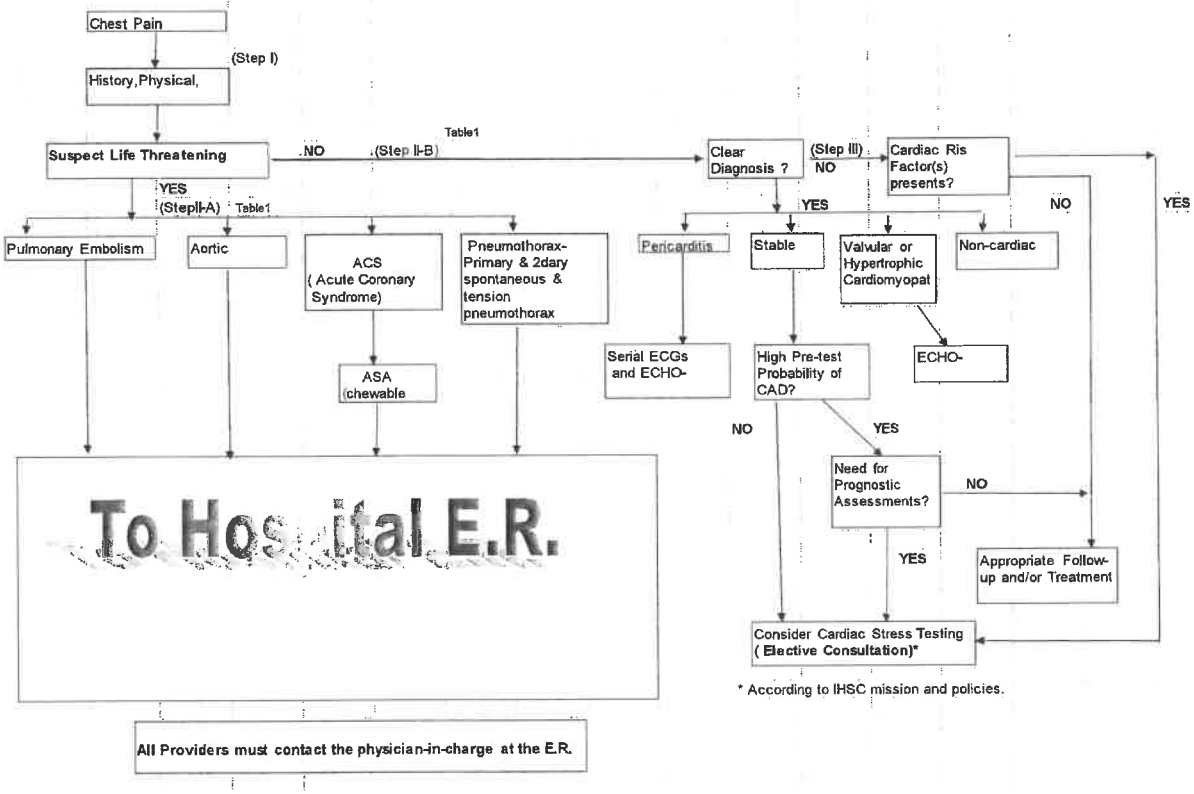
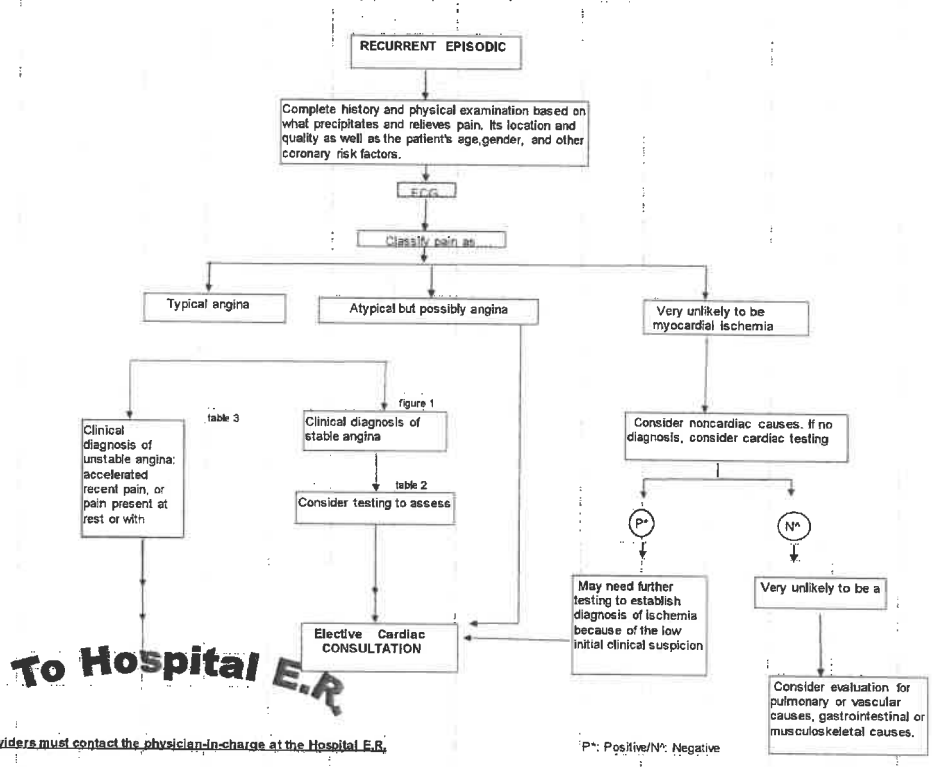


Figure 2

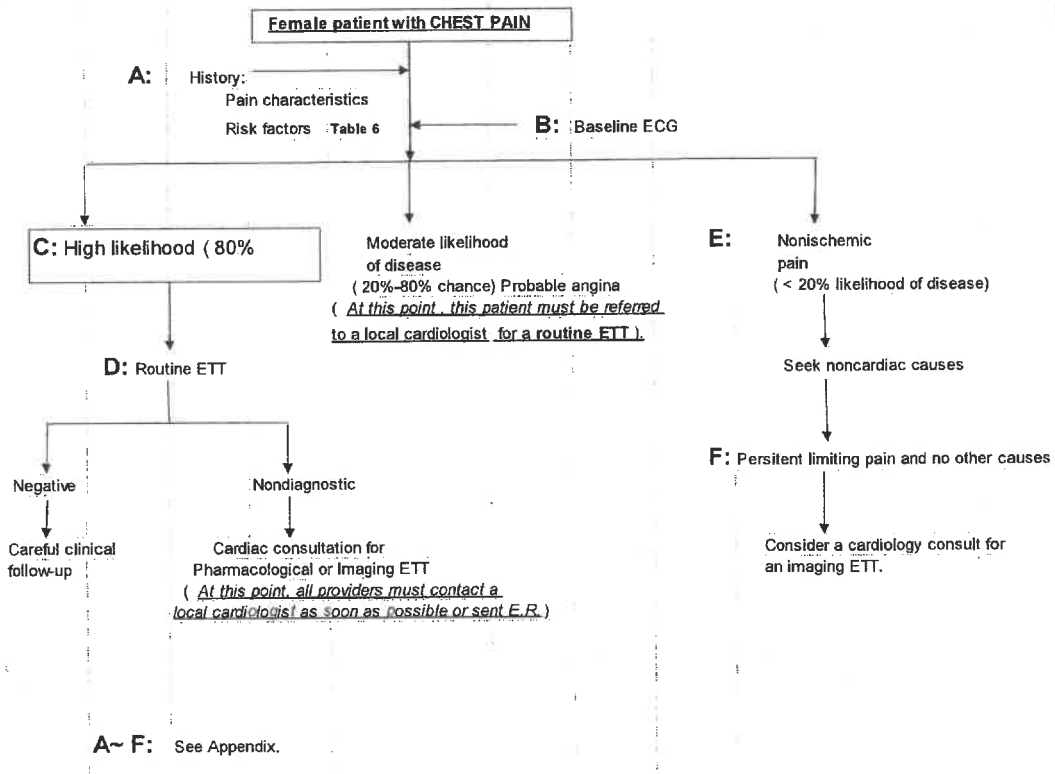
Approach to the Patient with recurrent Episodic CHEST PAIN



All providers must contact the physician-in-charge at the Hospital E.R.

P*: Positive/N^: Negative

Figure 3


Female patient with CHEST PAIN
A: History:
Pain characteristics
Risk factors Table 6
B: Baseline ECG
C: High likelihood (80%
Moderate likelihood of disease
(20%-80% chance) Probable angina
(At this point , this patient must be referred to a local cardiologist for a routine ETT).
E: Nonischemic pain
(< 20% likelihood of disease)
Seek noncardiac causes
F: Persitent limiting pain and no other causes
Consider a cardiology consult for an imaging ETT.
D: Routine ETT
Negative
Careful clinical follow-up
Nondiagnostic
Cardiac consultation for Pharmacological or Imaging ETT
(At this point, all providers must contact a local cardiologist as soon as possible or sent E.R.)
A~ F: See Appendix.

APPENDIX
(FEMALE patient with **CHEST PAIN**) Figure 3

A: There are clear gender differences in presenting symptoms of chest pain and in risk stratification. Females may have more ***atypical sites of pain***, such as neck, shoulder, and interscapular pain, and may have more associated symptoms of exertional dyspnea or decreased exercise tolerance. It is, therefore, important to ask not only the usual historical questions to determine whether the patient has angina but also to ask about ***atypical characteristics***. Risk factor assessment can be divided into major, intermediate, and minor.[Table 6]
These risk factors with the character of the pain can be used to place females in categories of likelihood of CAD. ***This stratification makes testing for CAD more cost effective and informative.*** Risk factor assessment is more likely to predict CAD in females than in males. Stronger predictive value exists, particularly in younger females with risk factors.

B: Evaluate a baseline electrocardiogram (ECG) before conducting other tests in females. Because exercise tolerance testing (ETT) in females may be flawed by false-positive results, having ***a normal resting ECG improves the diagnostic yield of testing***. If the resting ECG is abnormal, with left ventricular hypertrophy, bundle branch block, or an early J point elevation, it may increase the likelihood of a false-positive result, and therefore an imaging ETT may the most cost effective test in this group.

C: High likelihood of disease or definite angina is predicted by two or more major determinants or by one major plus more than one intermediate or minor determinant. [Table 6] This group of females has a pretest likelihood of CAD of 80%. In this group, ETT without imaging is the initial test of choice ***(unless the patient has clinical characteristics other than being female that necessitate imaging).*** The providers at IHSC may request/arrange an ETT with a consultant cardiologist instead of a comprehensive consultation.

D: ***The most cost-effective approach in females with typical angina and a normal baseline ECG is ETT.*** Females in this group are unlikely to have false-positive results, and the likelihood of false-negative results is much less than in their male counterparts if they achieve maximal heart rate. ***Imaging ETT increases the cost of this test and adds little clinically useful information.***

E: Females with nonischemic chest pain are in the lowest risk group, with > 20 % likelihood of CAD. This group is defined as those with no major determinants, no or one intermediate determinant, and two or fewer minor determinants. [Table 6]
On further analysis, the nonischemic chest pain group will have a 2-7% incidence of CAD and virtually no multivessel disease. Because of the low prevalence of significant disease in this group, any test that might show an abnormality is of little value, or more likely a false positive. The medical providers must look for noncardiac causes of chest pain such as acute or chronic cholecystitis, gastrointestinal reflux, chest wall pain, pulmonary etiology, or ***anxiety*** in this group before proceeding with evaluation.

F: If the female patient continues to have symptoms ***(chest pain)*** that limit her lifestyle, further evaluation by a consultant cardiologist may be needed to refute or confirm the existence of CAD. At this point of evaluation, a consultant cardiologist may order an imaging ETT or even coronary angiography, particularly in postmenopausal females.

ICE Health Service Corps

Clinical Guidelines for the Treatment of Gender Dysphoria (formerly Gender Identity Disorder, GID) February 2015

Introduction

Gender, that is the essence of male and female, is not a clear cut distinction, but rather a spectrum on which an individual perceives themselves and is perceived by others. Discordance between self-perception and gender assignment at birth is the origin of issues regarding gender identity, the most extreme of which is Gender Dysphoria (GD). Gender dysphoric individuals do not identify with their birth-assigned gender which in turn generates distress from internal discord as well as external (family and social) misunderstanding and rejection which may culminate in neglect and/or abuse. Many patients with GD have a strong desire to modify their appearance to match their desired gender, and this may achieved through hormonal supplementation as well as a vast array of surgical procedures. Both hormone treatment, as well as gender affirmation (reassignment) surgery (generally limited to genital reconstruction), are covered as necessary medical treatment by major health plans as long as appropriate medical evaluation has occurred and documentation of such is documented.

Basic Tenets of Managing Patients with Gender Dysphoria

1) Evaluation and treatment of detainees with GD should involve a multidisciplinary team including medical, mental health, pharmacy, nursing and administrative staff.

2) Treatment of GD is not cosmetic; denial of treatment may lead to worsening mental health and even self-mutilation by distressed detainees.

3) Use of the pronoun corresponding to the desired gender should be utilized; slang terms ("tranny", "he-she", etc.) are derogatory and are not permitted to be used by IHSC staff.

4) Instituting treatment for ICE detainees with GD does **not** require them to have been treated with hormones in the past. Newly diagnosed and/or previously untreated GD will be managed with the same liberality as newly diagnosed and/or previously untreated hypertension or diabetes – if treatment is clinically indicated, is desired by the patient and no medical/mental health contraindications exist, it will be initiated. Initiation of treatment does, however, require 1) evaluation by a mental health provider to officially establish the diagnosis of GD and 2) counseling by a trained medical provider regarding the risks and benefits of treatment as well as reasonable

expectations of hormone treatment. Gender reassignment surgery will not be considered for our detainees as their length of stay in ICE custody is generally brief.

5) Laboratory values are utilized to guide your treatment plan; corresponding physiologic changes are slow and variable amongst individuals and "failure to see changes" should not prompt an increase in dosage without supportive laboratory data. In addition, safety laboratories, pertinent review of systems, extensive counseling and physical examinations are all necessary for harm reduction. See **Appendix A** for the current treatment protocols and **Appendix D** for the informed consent document which should be utilized as a counseling tool as well as documentation of the patient's understanding of the risks and benefits of hormone treatment.

6) Screening for concomitant medical conditions

   Mental Health (MH) diagnoses (mood disorders, anxiety disorders, PTSD etc.) are more common in transgendered individuals than the general population. All transgendered individuals will be referred to a MH professional for the initial evaluation of GD as well as other concomitant MH diagnoses; the care plan including frequency of MH appointments will follow as deemed clinically appropriate by the MH provider.

   Blood borne pathogens and sexually transmitted infections (STIs) – HIV, syphilis, hepatitis B and C, chlamydia and gonorrhea - are common infections among transgendered individuals and should be actively screened for at the initial provider evaluation as many are treatable. Failure to diagnose may lead to untoward clinical outcomes and/or spread of infection both within and outside of the correctional environment.

7) For additional staff training and resources see **Appendix B**.

Special Issues for Transgendered Individuals in Custody

1) *Housing determination*

   Segregation is not required nor encouraged unless the detainee self-identifies as feeling vulnerable or at risk of harm because of their gender identity. Such concerns should be queried at the time of intake, as well as during periodic evaluations. Automatic assignment to administrative segregation for simple disclosure of gender dysphoria without perceived risk of harm/vulnerability may lead to the well-

recognized risks of prolonged isolation, including significant self-harm and suicide. Assignment to housing in the general population should be based on the current genitalia of the detainee; if the detainee has a penis, she would be assigned to male housing and vice versa. Medical staff may assist custody staff in establishing housing assignment. A few facilities may have dedicated housing units to accommodate those who self-identify in the LGBT community; such units are preferable to long term segregation/isolation and but it isn't clear they are preferable to general population.

A correctional setting poses many challenges for the transgendered person given the lack of privacy, targeted discrimination and abuse which may be amplified in close quarters and the risk of sexual assault. Resources are available to help these detainees share common experiences for support and encouragement. See **Appendix B**.

2) *Special Equipment*

For male to female (MTF) transgendered individuals housed in male units, sports bras should be issued for humility and comfort. Special needs forms should suffice as medical orders which custody staff shall honor.

Continuity of Care Referrals

If a detainee is released to the U.S., there are many regional centers of excellence as well as independent practitioners where the detainee may continue their care. See **Appendix C**. In the case of deportation, in country resources for transgender care may be limited and IHSC-directed referrals won't usually be possible. However, TG detainees will be provided with two weeks of medication (in line with standard IHSC guidelines) to provide them with a chance to establish care once they have repatriated.

References

1) http://transhealth.ucsf.edu/trans?page=protocol-00-00

2) Tom Waddell Health Center. (2006, revised May 2013). *Protocols for Hormonal Reassignment of Gender*. Accessed online January 28, 2014 from: http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf

3) Hembree et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2009; 94(9):3132-54

4) VA Pharmacy Benefits Management Services, Medical Advisory Panel and VISN Pharmacist Executives. Transgender Cross-Sex Hormone Therapy Use. February 2012

Appendix A – Male to Female Transgender Treatment Protocol

***Starting MTF transgender treatment*:**

Visit 1 – assessment, referral to MH if not already done, order blood work (HIV serology, RPR, GC/chlamydia nucleic acid test, hepatitis B surface antigen, hepatitis C serology, testosterone, estradiol, lipids, chem. 14, prolactin*), general counseling

Visit 2 (1 week later)– if baseline lab work and confirmed GD by MHP then start estradiol 2 mg / spironolactone 50 mg/ aspirin 81 mg daily. Order chem. 8 for next visit

Visit 3 (1 month later) – if chem. 8 (potassium and creatinine) is normal, increase spironolactone to 100 mg daily. Order lab work (testosterone, estradiol, prolactin, chem. 14, lipids) for next visit

Visit 4 (2 months later) – review lab work, PE assessment; if testosterone is not fully suppressed (<50) would increase spironolactone to 150 mg daily**; if estradiol is not at female pre-menopausal (100-200) level, increase estradiol by 2 mg daily

Visit 5 (2-3 months later) and so on… every 2-3 months for the first year until at goal; if 1 year of steady follow up, can reduce full blood work panel and visits to every 6 months if hormone levels are at steady, physiologic level and no signs of end organ effects (LFTs, renal function, electrolytes)

***Continuing MTF transgender treatment*:**

Visit 1 – assessment, referral to MH if not already done, order blood work (HIV serology, RPR, GC/chlamydia nucleic acid test, hepatitis B surface antigen, hepatitis C serology, testosterone, estradiol, lipids, chem. 14, prolactin), general counseling, continue outpatient oral dose (maximum of estradiol 8 mg daily, maximum spironolactone 150 mg daily) add aspirin 81 mg PO daily (if not already receiving), add spironolactone if not yet receiving, start at 50 mg daily

Visit 2 (2 weeks later)– confirm GD diagnosis as per by MHP, review laboratories with patient. If was not previously on spironolactone, can increase from 50 mg to 100 mg daily if potassium and creatinine are normal. Otherwise, no need to modify treatment at this point assuming safety labs are within normal limits. Order lab work (testosterone, estradiol, prolactin, chem. 14, lipids) for next visit.

Visit 3 (2 months later) – review lab work, PE assessment; if testosterone is not fully suppressed (<50) would increase spironolactone to 150 mg daily; if estradiol is not at female pre-

menopausal (100-200) level, increase the estradiol by 2 mg daily. Order lab work (testosterone, estradiol, prolactin, chem. 14, lipids) for next visit.

Visit 4 (2-3 months later) and so on.... for the first year following labs above and making adjustments based on estradiol and testosterone levels (assuming safety labs are normal); after 1 year of steady follow up, can reduce full blood work panel and visits to every 6 months if hormone levels are physiologic and no signs of end organ effects (LFTs, renal function, electrolytes).

*prolactin levels are often mildly elevated and this is normal; prolactin levels should ideally be obtained in the early AM and fasting. If levels are above 50, consider decreasing the estrogen supplementation to see if they decline as well as inquire about the symptoms of prolactinoma which may include galactorrhea, headaches and diplopia. If the level does not decline or rises regardless of the medication adjustment OR review of systems is positive, consider an MRI of the sella to exclude a prolactinoma.

**spironolactone can be increased to 200 mg daily if indicated, but please split dose as 100 mg 2x/day

Estrogen conversion¥

Estradiol (P.O.) daily	Premarin (P.O.) daily
2 mg	1.8 mg
4 mg	2.7 mg
6 mg	3.75 mg
8 mg	5 mg

¥ Estimated values, please use serum estradiol to adjust accordingly

Appendix B - Additional Provider and Patient Resources

1) Trans in Prison Journal, produced by the Gender Identity Center of Colorado; you can download a copy and give to your detainees; they can mail in the request form on the issue and they will receive the future publications gratis as long as they are in a correctional setting. http://www.gicofcolo.org/tip/tip-journals.aspx

2) "Cruel and Unusual", documentary by Janet Baus and Dan Hunt, about transgendered persons and the challenges they face in and out of the correctional system. ~1 hour long www.fandor.com/films/cruel_and_unusual

3) Resources on children diagnosed with GD, Most of our detainees will receive their hormone treatment during adolescence or adulthood but to benefit the most from this treatment, diagnosis of GD and treatment should occur during childhood. www.youtube.com/watch?v=oYOY1Clyd_0, www.youtube.com/watch?v=YfqmEYC_rMI http://www.huffingtonpost.com/2014/05/30/whittington-family-ryland-transgender-son_n_5414718.html

Appendix C - Regional Centers of Excellence for Continuity of Care or Referring Challenging Cases

AOR	Facility name	Phone number	Website
Washington DC	Transgender Health Empowerment	202-636-1646	http://theincdc.org/
Boston	Fenway Health	617-267-0900	http://www.fenwayhealth.org
New York	Transgender Resources		http://transgendercny.org/
Newark	Callen Lorde	212-271-7200	http://callen-lorde.org/our-services/sexual-health-clinic/transgender-health-services/
	City of Newark Dept of Child and Family Well Being	973-733-7635	
Philadelphia	Mazzoni Center	215-563-0658	http://mazzonicenter.org/content/transgender-services
Buffalo	Endocrinology center of Western New York	716-887-4069	
Detroit	UMHS-CGCP	734-736-0465	http://www.med.umich.edu/transgender/index.htm
Chicago	Howard Brown Health Center	773-388-1600	www.howardbrown.org
Atlanta	In town Primary Care	404-541-0944	http://www.intownprimarycare.com/glbt-health/transgender-health.html
Miami	Care Resource	305-576-1234	http://www.careresource.org/programs/transgender-services/
New Orleans	Louisiana Trans Advocates	337-580-4615	http://www.latransadvocates.org/resources.html

Appendix C - Regional Centers of Excellence for Continuity of Care or Referring Challenging Cases

AOR	Facility name	Phone number	Website
Houston	Dr. Hammill Transgender Health Clinic	713-799-8994	http://drhammill.transhouston.com/
	Transgender Center	713-520-8586	http://www.tgctr.org/
San Antonio	SAGA		http://www.sagender.com/local-resources/
Dallas	Transgender Health Clinic	214-528-2336	
	Resource Center of Dalllas	214-528-0144	http://www.rcdallas.org/family/transgender
El Paso	Trans Health Referral Line	915-532-7000	2301 N Oregon St, El Paso, TX 79902
Saint Paul	Transgender Health Services University of MN	612-625-1500	http://www.med.umn.edu/fm/phs/clinic/transgender.html
Denver	Gender Identity Center of Colorado	303-202-6466	http://www.gicofcolo.org
Salt Lake City	Susan Chasson	801-357-7930	
	D. S. Burton	385-282-2750	
	LeAnne Swenson	385-282-2000	
Phoenix	Prime Medical Clinic	602-840-3584	http://www.myprimeclinic.com/
Seattle	Gay City Health Project	206-323-5428	https://www.gaycity.org/resources/
San Francisco	The San Francisco Center		http://www.sfcenter.org/

Appendix C - Regional Centers of Excellence for Continuity of Care or Referring Challenging Cases

AOR	Facility name	Phone number	Website
San Francisco	UCSF Center of Excellence	415-597-8198	http://www.transhealth.ucsf.edu/
Los Angeles	Western Medical Center Anaheim	714-533-6220	
	UCLA LGBT Resource Center	310-206-3628	http://www.lgbt.ucla.edu
San Diego	The Center	619-692-2077	http://www.thecentersd.org
General Resources			http://www.tglynnsplace.com/tg-medical-resources.htm

ICE Health Service Corps

INFORMED CONSENT FOR ESTROGEN/ANTIANDROGEN THERAPY

For Male to Female Transition

This form refers to the use of estrogen and antiandrogens by detainees who wish to become more feminized as part of a gender transitioning process.

Your agreement or disagreement of the various statements on this form indicates that the risks as well as the changes which may occur as a result of the use of estrogen and antiandrogens have been explained in the language that you understand. If you have any questions or concerns about this information, you are encouraged to take the time you need to ask for clarification, read, research, talk with staff and think about the potential effects of this treatment before signing.

IF YOU DO NOT UNDERSTAND THIS INFORMATION STOP AND ASK FOR CLARIFICATION

Please initial each section below to indicate that you understand and agree with the statements.

1) ○ Agree ○ Disagree

I have been informed that the feminizing effects of estrogen can take several months to become noticeable and several years to be complete.

Some of these changes will be permanent including:

- Breast development: Breast development may take years to reach full size. There are natural variations in the size of breasts, and one person's breast development will not correlate with that of another person's. If estrogen therapy is discontinued, there may be some breast shrinkage, but breast development will not completely disappear.
- Brain structures are affected by testosterone and estrogen. The long term effects of changing the levels of one's hormones through the use of estrogen therapy and testosterone suppressants have not been scientifically studied and are impossible to predict. These effects may be beneficial, damaging, or both.
- Changes in fertility and sperm production (see information below in # 5).

These additional changes will not be permanent if I stop taking estrogen:

- Decreased acne
- Male pattern balding stops or slows (no hair loss will be reversed once it occurs)
- Skin may become softer

- Facial and body hair growth may *decrease* (not stop) in thickness or quantity to a greater or lesser extent
- Redistribution of body fat to a more female pattern (i.e., abdominal fat may decrease while fat on the buttocks and thighs may increase

2) ○ Agree ○ Disagree
I understand that estrogen may cause or contribute to depression. If I have a history of depression I will discuss this with my provider to explore treatment/therapy options that are available to me.

3) ○ Agree ○ Disagree
I understand the effects of estrogen will <u>not</u> protect me from sexually transmitted diseases or HIV and that condoms or barrier methods should be used.

4) ○ Agree ○ Disagree
Due to breast development with estrogen therapy, I understand that I will need to do monthly breast self-examinations, have an annual medical exam, and, once I am 40 or older, I will need to have an annual mammogram.

5) ○ Agree ○ Disagree
I understand that estrogen therapy will decrease hormones that support the size and function of my testicles, which may then effect overall sexual functioning and fertility. The changes that may occur include:

a. Up to 40% shrinkage in size of the testicles.
b. Decrease in testosterone production from the testicles
c. The amount and quality of erections and ejaculation may decrease or stop entirely.
d. Sperm will still be present in the testicles, but may stop maturing which may cause infertility.
e. I may become sterile; sterility may not be reversible.
f. Erections may no longer be firm enough for penetrative intercourse.
g. There may be a decrease or loss of morning and spontaneous erections.
h. Sex drive or libido may decrease.

6) ○ Agree ○ Disagree
I understand that taking estrogen can significantly increase the risk of blood clots (thrombosis), which can result in:

a. **Death**
b. Deep vein thrombosis (clots in large veins)
c. Chronic leg vein problems
d. Pulmonary embolism (blood clot in the lung, which can cause permanent lung damage or death)
e. Cerebral vascular accident (stroke) which may result in permanent brain damage, blindness, paralysis, difficulty talking or death.

7) ○ Agree ○ Disagree
I understand that ***the risk of blood clots, heart attack, and stroke on estrogen therapy is significantly increased if I smoke tobacco and*** especially if I am over the age of 35.

8) ○ Agree ○ Disagree
I understand that estrogen can cause increased blood pressure. If I have existing high blood pressure and it is controlled with medication and/or diet and exercise, I understand that I may be able to take estrogen safely with close medical monitoring.

9) ○ Agree ○ Disagree
I understand that estrogen use may lead to liver inflammation or liver disease. I agree that while I am on estrogen therapy I will be monitored for liver problems before and periodically during therapy. I understand with long term estrogen use, there is a slight risk for liver cancer.

10) ○ Agree ○ Disagree
I understand that estrogen may increase migraine headaches and this may be a reason for me to choose to stop taking estrogen or may be a reason for estrogen to be discontinued by my provider. I also understand there is a very small risk of developing a tumor at the base of the brain (pituitary gland), but my blood tests will be monitored regularly to detect this problem early. If I develop new headaches, double vision and/or breast milk production, **I should inform my health care provider immediately.**

11) ○ Agree ○ Disagree
I understand that estrogen may cause nausea and vomiting, similar to morning sickness in a pregnant woman. If I experience nausea and vomiting that are severe and/or prolonged, I understand that I will require medical attention and a change or discontinuation of hormone therapy to prevent serious physical damage to myself.

12) ○ Agree ○ Disagree
I understand that the most dangerous side effects from estrogen therapy occur in connection with smoking cigarettes, being overweight, being over 40 years old, and having a history of blood clots, high blood pressure, or prior estrogen dependent cancer. I understand that estrogen therapy may be discontinued or adjusted at *any time* if concerns or complications arise which are threatening to my continued physical and/or psychological well-being.

13) ○ Agree ○ Disagree
I understand that estrogen may cause changes in my cholesterol. My HDL (good cholesterol) may go up and my LDL (bad cholesterol) may go down.

14) ○ Agree ○ Disagree
I understand that estrogen may prevent prostate problems. I have been informed that there is a slight chance that taking estrogen will cause overgrowth of the prostrate. Prostate cancer screening is recommended for people 50 years of age and older as well as in younger people if otherwise medically indicated.

15) ○ Agree ○ Disagree
I understand that anti-androgen side effects include dehydration, high potassium levels, breast enlargement, low blood pressure and kidney problems. My labs and blood pressure will be routinely monitored to detect significant changes.

16) ○ Agree ○ Disagree
I understand that everyone's body will respond differently to estrogen and that there is no way to predict what will be my body's response to hormones. I understand that the correct dosage for me may not be the same as for another person. I understand I must follow *my* prescribed regimen of estrogen treatment to continue to receive hormone therapy at this clinic.

17) ○ Agree ○ Disagree
I agree to take estrogen and all other transition related medications *as prescribed* and to inform my provider of any problems or dissatisfactions I may have with my treatment. I understand that if I take too much estrogen my body may convert it to testosterone which is counterproductive.

18) ○ Agree ○ Disagree
I will complete a physical examination annually and lab tests periodically as required to make sure I am not having an adverse reaction to hormone treatment and to continue maintaining a healthy lifestyle. I understand that this is required to continue hormone therapy through this clinic.

19) ○ Agree ○ Disagree
I understand that there are medical conditions that could make taking estrogen either dangerous or physically damaging. I agree that if my provider suspects I may have any condition that could be dangerous to me, I will be evaluated before the decision to start or continue my hormones is made. I understand that if I do not agree to be evaluated, my prescription for estrogen may be cancelled or refused.

20) ○ Agree ○ Disagree
I understand that I can choose to stop taking estrogen at any time. I also understand that my provider can discontinue treatment for clinical reasons. I agree to follow a prescribed reduction plan if either of these situations occurs in order to reduce potentially harmful side effects that may occur if I suddenly stop my hormone therapy.

All of the above information has been explained to my satisfaction
(Check only one)

_____**Yes. I choose to begin Estrogen/Antiandrogen Therapy.**

_____**No. I decline Estrogen/Antiandrogen Therapy at this time.**

_____	_____	_____
Patient Signature	Patient Name Printed	Date
_____	_____	_____
Provider signature	Provider Name Printed	Date

5/16/2013

IHSC
HYPERTENSION THERAPEUTIC GUIDELINES

INTRODUCTION

Physiologically, blood pressure (BP) rises with age. The distribution of **BP** readings within populations is on a continuum, making it *arbitrary* where the normal BP ends and elevated BP (Hypertension) begins. Nonetheless, hypertension is traditionally defined as the level of blood pressure above which intervention reduces risk, or the level of blood pressure where treatment with antihypertensive medication may be of more benefit than detriment.

Therefore, it is important to accurately define hypertension, as significant morbidity and mortality result from uncontrolled blood pressure. Moreover, such a diagnosis carries the possibility of lifetime drug therapy.

All providers must understand that blood pressure varies to a great degree, according to different circumstances and environments. It rises with exercise, emotion, and stress. It falls during sleep (the so- called "night dip"). Therefore, a patient should only be labeled as hypertensive, if they have had consistently elevated readings from at least three separate visits within 4-6 weeks. The hypertension should also be approached and managed by deferent cause (*primary or secondary*) [Table 4], age (*young or old*) [Table 7], and race *(white, black, and other ethnic groups).*

Sometimes, the hypertension specialists utilize the 24-hours ambulatory BP monitoring for confirming certain hypertensive conditions [Table 8]. Especially, when there is doubt regarding the diagnosis of hypertension or its response to treatment, the 24-hours ambulatory BP monitoring is utilized. This technique has been shown to correlate better with subsequent end-organ damage and cardiovascular outcome than random measurements taken by medical providers. However, in the detention setting, this approach is neither feasible nor necessary. At the same time, all medical providers in the IHSC must understand that hypertension is both preventable and treatable in the majority of patients. But, both in the detention environment and outside community, appropriate hypertension managements continue to be neglected.

Correct measurement of blood pressure is essential to the diagnosis and management of hypertension.

MEASURING BLOOD PRESSURE

STEP ONE:

- Patients rest in a quiet and cool room (12 degree C° or 54 degree F°) for 5-10 minutes.
- Discontinue all stimulants, e.g. tea, caffeine, in the hour prior to BP measurement.
- Multiple readings should be taken at various times throughout the waking hours of patients (except 24-hour ambulatory monitoring.)
- **REMEMBER** that patients can raise their BP by as much as 8-15 mmHg when talking and when seeing medical professionals ("white *coat hypertension*"). Initially, check for postural changes by taking readings after five minutes supine, then, immediately and two minutes after standing- this is particularly important in patients over age 65 (*it has been estimated that 2.5% of subjects older than age 65 may have pseudohypertension*), diabetes mellitus, or those taking antihypertensive drugs.

STEP TWO:

- Length of sphygmomanometer cuff bladder should be 80% of the circumference of upper arm.
- Width at least 40% (46 % is average cuff size = 12-14 cm).
- Use a wide THIGH cuff as needed in obese patients with big arms.
- **REMEMBER-** A loose cuff or a bladder that balloons outside the cuff leads to falsely high readings, i.e. cuffs too narrow with less coverage gives falsely elevated BP readings.

STEP THREE:

- The patient should sit quietly with the back supported for five minutes and the arm supported at the level of heart (especially for a routine follow-up).
- **REMEMBER-** If brachial artery is much below heart level, BP appears falsely high. The patient's own effort to support the arm may raise the BP.

STEP FOUR:

- Palpate the arterial pulse on the ipsilateral side and inflate the sphygmomanometer cuff gradually to systolic pressure 20 mmHg above the point where the radial pulse is felt to disappear.
- Auscultate, *using the **BELL of stethoscope,*** pressed lightly over the brachial artery.
- Record the point at which the first pulsation is heard, i.e. 1st. Korotokoff, which is the *systolic* BP.
- Continue to lower the pressure slowly until the sounds become muffled and disappear. To confirm the disappearance of sounds, listen as the pressure falls another 10-20 mmHg, then deflate the cuff rapidly to zero. The disappearance point, which is usually only a few mmHg below the muffling point, provides the best estimate of true diastolic pressure in adults. Record the point which the

pulsatile sound disappears, i.e. 5th. Korotokoff sound, which is now defined as the *diastolic BP.*

- **REMEMBER-** The 4th. Korotokoff sound is where the sound becomes muffled and is an outdated definition of diastolic BP. Using excessive pressure over the brachial artery increases turbulence and delays the disappearance of sounds, falsely reducing diastolic BP by 10-15 mmHg. For some people, the muffling point and the disappearance point are farther apart. Occasionally, as in aortic regurgitation, the sounds never disappear. If there is more than 10 mmHg difference, record both figures (e.g., 160/80/65).

REMINDER:

- Ensure no BP difference between arms. If a difference exists, use the arm with higher pressure for future readings.
- On each visit, take BP twice (in both arms); readings should be separated by 5-10 minutes.
- All healthy adults: BP checks every 2 years until age 80. Table 2
- Prehypertensive adults: BP checks every 12 months. Table 2

CURRENT BLOOD PRESSURE CLASSIFICATION Table 1

- Use higher value for classification.
- In general, the more risk factors a person has, a lower blood pressure is desirable.
- ***Ideal goal for all***: lowest tolerated blood pressure (may be well below arbitrary threshold of 140/90 mmHg).
- ***Treatment goals for patients with diabetes and chronic kidney failure***: <130/80 mmHg.
- *Prehypertension* is **not** a disease category. Rather, it is red flag for patients at risk for hypertension and for providers to practice preventive management/medicine.

BASELINE EVALUATION Table 3 & 4

1. Natural History
   - Usually asymptomatic
   - Hypertension usually diagnosed incidentally on the screening examinations
   - Typical symptoms of headache, dizziness, tinnitus, and fainting are as prevalent in Hypertension as normotensive patients. In particular, headaches correlate poorly with the *level of BP.*
   - Organ damage, principally cardiac, cerebral and renal, is related to the severity of the Hypertension.

Cardiac: Prominent "a "wave (arterial systole)

Systolic and diastolic left ventricular failure
Coronary artery disease
Cardiac ischemia, especially nocturnal (when BP is lowest)

Renal: Renal impairment more often in a long-time, with poor control
More common in blacks
Nocturia (loss of urinary concentrating ability)
Microalbuminuria ≥ severe proteinuria ≥ CrCl decline

Cerebral: Strokes and Transient Ischemic Attacks (TIA) are common.
Fundoscopic changes of **Hypertension**

- Grade 1 and 2 correlate with other target organ damage Table 3
- Grade 3 and 4 in accelerated and severe Hypertension

2. Assessment

- Thorough history and examinations on all
- Often only a few focused questions are necessary Table 4; even these will be normal in the majority of cases.
- ***Indications for Treatment*** Figure 1 & 2
  - The ultimate public health goal of antihypertensive therapy is to reduce cardiovascular and renal morbidity and mortality.
  - The primary focus should be to attain Systolic BP goal because in most cases, especially in those older than 50-years, the diastolic BP goal will be achieved respectively.
  - ALL- target BP < 140/90 mmHg decreases cardiovascular complications
  - Target BP for Diabetes mellitus and renal disease should be < 130/ 80 mmHg. Though ideal goal (target BPs) is often not *achievable.* Figure 1

3. Treatment:

* Lifestyle modifications (trial of 4-6 months for prehypertensive stage prior to drugs)
  - Weight loss (obesity control)
  - Low intake of salt and saturated fats
  - No alcohol
  - Increase fruits and vegetables.
  - Regular exercise.

* Drug therapy Figure 1 & 2
* Recommended follow-up frame Table 2/ Figure 3
* Refer accelerated Hypertension and Hypertensive crisis to a consultant, if IHSC setting is not equipped for monitoring. Figure 3

* Additional drugs to consider:
  - **ASPIRIN** is now used for secondary prevention of cardiovascular disease.
  - **Statins.** ATP III GUIDELINES
* Reasons for poor therapeutic response in Hypertension Table 5

  - **Critical caveats** common to both the **JNC-7 and ESH/ESC** Table 6

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Table 1

**JNC-7 CLASSIFICATION of HYPERTENSION BLOOD PRESSURE CLASSIFICATION

	SBP(mmHg)*	DBP (mmHg)*
Normal	< 120	and < 80
Prehypertension	120-139	or 80-90
Stage 1 Hypertension	140-159	or 90-99
Stage 2 Hypertension	≥ 160	or ≥ 100

SBP; Systolic blood pressure. *DBP; diastolic blood pressure*

* Treatment determined by highest BP category.

** The 7th. Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. The JNC 7 Report.

Table 2

Recommendations for follow-up based on initial blood pressure measurements for adults *without* acute end organ damage

INITIAL BLOOD PRESSURE (mmHg)*	FOLLOW-UP RECOMMENDED †
Normal	Recheck in 2 years
Prehypertension	Recheck in 1 year ‡
Stage 1 Hypertension	Confirm within 2 months ‡
Stage 2 Hypertension	Evaluate or refer to source of care within 1 month. For those with higher pressure (e.g. > 180/110mmHg), evaluate and treat immediately or within 1 week depending on clinical situation and complications.

* If systolic and diastolic categories are different, follow recommendations for shorter time followup (e.g., 160/86 should be evaluated or referred to source of care within 1 month.)

+ Modify the scheduling of followup according to reliable information about past BP measurements, other cardiovascular risk factors, or target organ disease.

‡ Provide advice about lifestyle modifications (see Lifestyle modification).

Table 3

Natural History

Retinopathy Associated with Hypertension (HTN)

Grade 1; Mild narrowing or sclerosis of the retinal arteriolar lumen producing a "silver wiring" effect

Grade 2; Moderate to marked sclerosis of the artreroles, visible as a arteriovenous " nipping"

Grade 3; Progressive retinal changes resulting in edema, "cotton wool" spots and hemorrhages

Grade 4; All of the above with papilledema

Table 4

ASSESSMENT OF HYPERTENSION (HTN)

Tests	Reason
Always included	
Urinalysis for protein, blood, glucose & microscopic findings	May indicate renal disease either causing or caused by the HTN or rarely may suggest adrenal HTN.
Hematocrit	
Serum electrolytes (K^+, BUN, Cr)	
Fasting glucose	To exclude Diabetes mellitus or glucose intolerance.
Lipid profile (Total Cholesterol, HDL, LDL)	To assess risk of future CV events
ECG	May suggest LVH.
Usually Included (consider cost & other factors)	
Thyroid screen (TSH)	
Serum Ca^{++} & Phosphorus	
Chest X-ray	
Limited ECHOcardiogram	May confirm LVH with associated disease, e.g., heart murmur

Special studies to screen for Secondary Hypertension

Tests	Reason
ACE inhibitor radionuclide renal scan, renal duplex, Doppler flow studies and MRA/CTA	Renovascular disease
Urinary free catechoamines; Metanephrines & VMA, Plasma catecholamines	Pheochromocytoma
Overnight dexamethasone suppression test or 24-hour urine free cortisol.	Cushing's syndrome
Plasma aldosterone, renin activity ratio	Primary aldosteronism
Polysomnographic study	Sleep apnea

Table 5

Reasons for poor therapeutic response in patient with hypertension

1. **Inadequate patient compliance.**
2. **Volume expansion**: (a). caused by excessive sodium intake (b). Caused by non-diuretic antihypertensive agent (c). Caused by renal damage.
3. **Excessive weight gain**.
4. **Inadequate dose of antihypertensive drugs.**
5. **Drug antagonism.**
6. **Cold remedies.**
7. **Sympathomimetics.**
8. **Oral contraceptives (estrogen)**
9. **Adrenal steroids.**
10. **Secondary Forms of Hypertension: e.g.,** renal artery disease, Coarctation of aorta, Obstructive uropathy, sleep apnea, Thyroid/parathyroid disease.

Table 6

Several critical caveats common to both the JNC-7 & ESH/ESC approaches:

1. **Start with an agent that may treat &/or not harm coexisting condition.**
2. **Start with an agent that the patient is likely to tolerate best; long term compliance is related to tolerability and efficacy of the first agent used.**
3. **For low or medium-risk patients, start with a low dose of an agent & if the BP is not controlled, increase only moderately.**
4. **Add an additional agent from a different, complimentary class if BP is not controlled with a moderate dose of the agent.**
5. **Use a diuretic when two agents are used, in nearly all cases.**
6. **Use thiazide diuretics only at low dose or its equivalent, unless some pressing reason exists.**
7. **For medium to high-risk patients, strongly consider low-dose combination therapy as initial therapy:**
   (a). A diuretic with a Beta-Blocker, ACE inhibitor, or angiotensin II antagonist (ARB).
   (b). A Calcium channel blocker with an ACE inhibitor or a Beat-blocker.

Table 7:

Differences between Hypertension in Younger and Older Patients

Factors	Young (< 60 Years)	OLD (>60 Years)
Blood Pressure Increase	Systolic & Diastolic	Systolic
Major cause	Hormonal	Mechanical
Hemodynamic Change	Increased peripheral resistance	Increased arterial stiffness
Sleep apnea	Yes	No
Treatment threshold	140/90 mmHg	160 mmHg systolic

Table 8

Use of Ambulatory Blood Pressure Monitoring (ABPM)

- Useful way to assess Blood Pressure (BP) over 24 hours, in early morning and extent of fall in BP during sleep.
- May be helpful in the following groups:
  - Suspect white-coat hypertension in patients with hypertension and no target organ damage
  - Apparent drug resistance/ office resistance
  - Hypertensive symptoms with antihypertensive medication
  - Episodic hypertension
  - Autonomic dysfunction.

- Those with 24-hour ABPM measures exceeding 135/85 mmHg are nearly twice as likely to have a cardiovascular disease (CVD) event.
- Clinical decisions can be based on mean 24-hour measures. Thresholds are more difficult to establish as they are markedly influenced by behavior during day or night.
- Use only validated devices by international standardized protocols, appropriate cuff size, and record readings at no more than 30-minute intervals.
- *Medicare* reimbursement for ABPM is available to assess suspected *white-coat hypertension.*

Figure 1

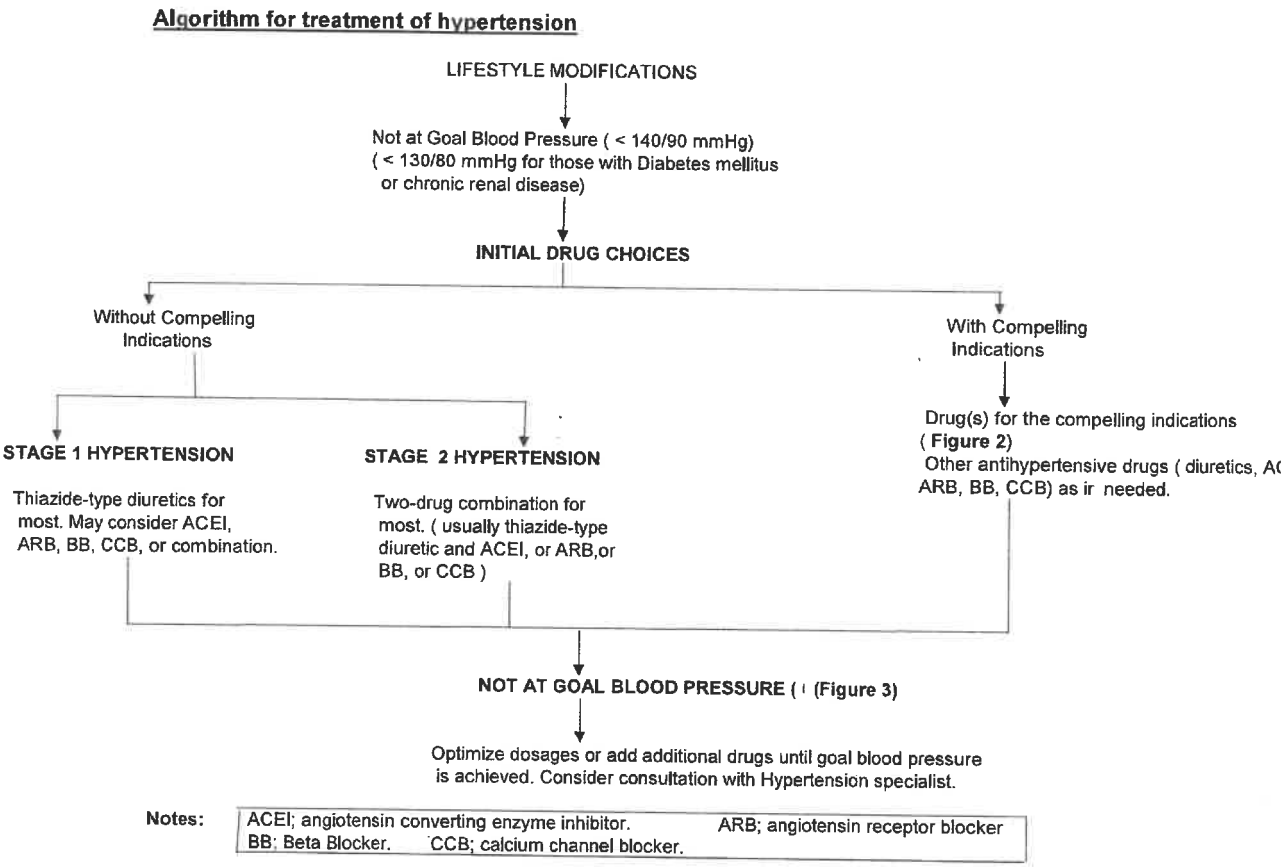

Algorithm for treatment of hypertension
LIFESTYLE MODIFICATIONS
Not at Goal Blood Pressure (< 140/90 mmHg)
(< 130/80 mmHg for those with Diabetes mellitus
or chronic renal disease)
INITIAL DRUG CHOICES
Without Compelling Indications
With Compelling Indications
STAGE 1 HYPERTENSION
Thiazide-type diuretics for most. May consider ACEI, ARB, BB, CCB, or combination.
STAGE 2 HYPERTENSION
Two-drug combination for most. (usually thiazide-type diuretic and ACEI, or ARB,or BB, or CCB)
Drug(s) for the compelling indications
(Figure 2)
Other antihypertensive drugs (diuretics, AC
ARB, BB, CCB) as ir needed.
NOT AT GOAL BLOOD PRESSURE (' (Figure 3)
Optimize dosages or add additional drugs until goal blood pressure is achieved. Consider consultation with Hypertension specialist.
Notes:
ACEI; angiotensin converting enzyme inhibitor. ARB; angiotensin receptor blocker
BB; Beta Blocker. CCB; calcium channel blocker.

Figure 2

JNC-7 : Compelling Indications for Specific Antihypertensive Agents

	Diuretics	BB	ACEI	ARB	CCB	AA
CHF	X	X	X	X		X
Post-MI		X	X			X
CAD risk	X	X	X		X	
Diabetes	X	X	X	X	X	
Renal Disease			X	X		
Recurrent stroke prevention	X		X			

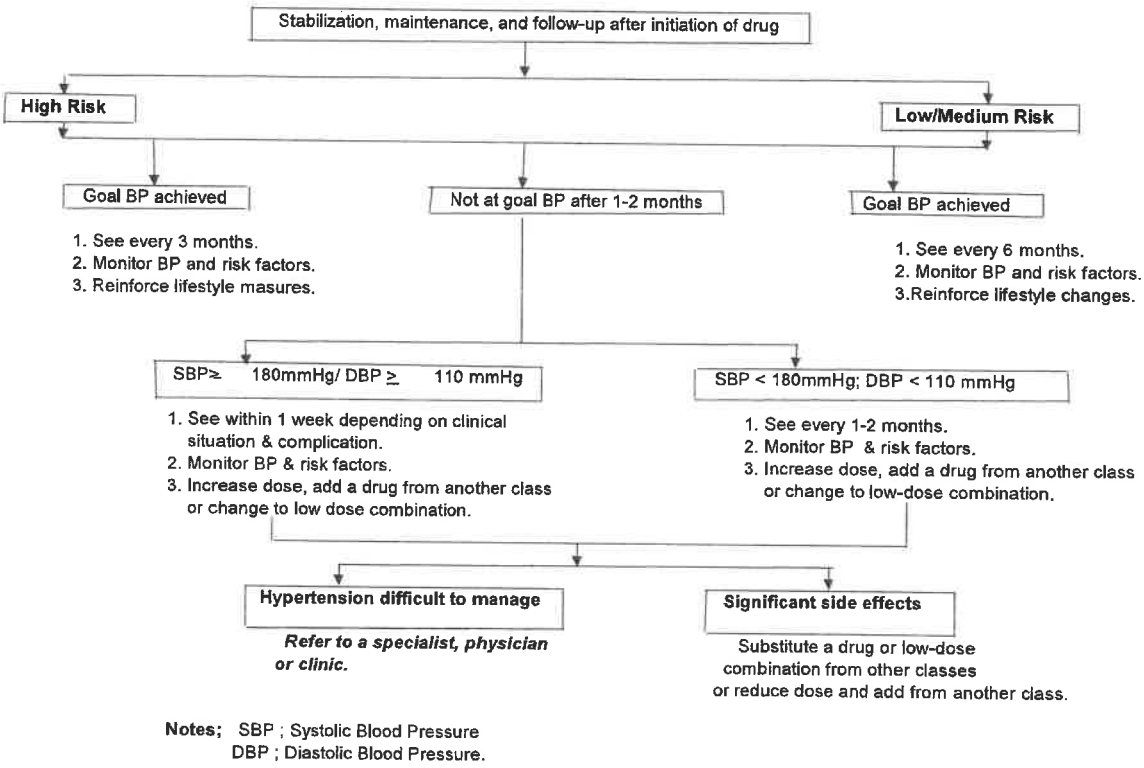
(Based on Favorable Outcome Data from Clinical Trials)

Notes ;

AA : aldosterone antagonist
CHF: congestive heart failure
MI : myocardial infarction
BB: beta blocker
CAD: coronary artery disease
ACEI: angiotensin converting enzyme inhibitor
ARB : angiotensin receptor blocker
CCB : calcium channel blocker

Figure 3

APPROACH TO THE HYPERTENSIVE PATIENT AFTER INITIATING *ANTIHYPERTENSIVE DRUG TREATMENT*



Notes; SBP ; Systolic Blood Pressure
DBP ; Diastolic Blood Pressure.

SELF Assessment Questions for HYPERTENSION

Q1.

A 46-year-old male detainee from India has multiple blood pressures on his sick-calls between 140-150/90-95 mmHg. When he is referred to you for further evaluation of his blood pressures from a mid-level provider or a nurse, he states his primary care physician's readings before being detained used to be between 135-140/85-89 mmHg. His primary care physician's office confirms his statement has been found to be reliable.

Based on these readings, you would consider this detainee to be:

1. Normotensive.
2. Stage 1 Hypertensive.
3. Stage 2 Hypertensive.
4. Pre-hypertensive.
5. Borderline hypertensive.

Q2.

This question relates to the same detainee patient as the previous question: a 46-year-old male with blood pressures between 135-140/85-89 mmHg using reliable his primary care physician's office readings. This detainee patient, with no other risk factors, should be *initially* treated with:

1. Lifestyle modification.
2. Diuretics.
3. Beta blockers.
4. Calcium channel blockers.
5. ACE inhibitors.

Q3.

A 45-year-old, obese female detainee with type II diabetes mellitus is found to have blood pressure readings of 140-160 mmHg/90-99mm Hg during her frequent chronic care visits. She has no complaints. Our IHSC clinic monitors her blood sugars which ranges from 80-130 on an oral hypoglycemic agent, her only besides aspirin 81 mg per day. She is a nonsmoker on a low fat, low cholesterol diet but has not been able to lose weight (5'3", 160 lbs). Her total cholesterol= 212 mg/dL, HDL-C=39mg/dL, Triglyceride=265mg/dL, All other laboratory values are within normal limits except for a trace proteinuria.

What is the *most* appropriate antihypertensive drug class for this detainee patient?

1. Diuretics.
2. Beta blockers.
3. Calcium channel blockers.
4. ACE inhibitors.
5. Angiotensin II receptor blockers (ARB).

Q4.

This question relates to the same detainee patient in **the Q3.**

What would be *the* treatment goal for her blood pressure according to the JNC 7?

1. 120 mmHg/85 mmHg.
2. 135 mmHg/85 mmHg.
3. 140 mmHg/89 mmHg.
4. 130 mmHg/85 mmHg.
5. 130 mmHg/80 mmHg.

Q5.

What is the drug of *first* choice for uncontrolled hypertensive patients undergoing surgery?

1. Diuretics.
2. Beta blockers.
3. Calcium antagonists.
4. ACE inhibitors
5. ARB

Q6.

What is *the drug of choice* for women who become hypertensive during pregnancy?

1. Diuretics.
2. Beta blockers.
3. Calcium antagonists.
4. ACE inhibitors.
5. Methyldopa.

Q7.

The Joint National Committee 7 Report published in 2003 sets the standard for the evaluation and management of hypertension.

The following are important aspects of the report, with one exception. Select *the incorrect* statement.

1. Diuretics or beta blockers are recommended as initial therapy for all patients with hypertension.
2. ACE inhibitors and angiotensin receptor blockers (ARB) should not be used in pregnancy.
3. Control of hypertension is more effective in reducing stroke than myocardial infarction.
4. ACE inhibitors are recommended for patients with type-1 diabetes mellitus and proteinuria.
5. Fast-acting nifedipine is not recommended for hypertensive emergencies.

Q8.

Which of the following is *not* a contributor to the development of essential hypertension?

1. Cigarette smoking.
2. Alcohol intake in excess of three ounces per day.
3. Salt intake.
4. Obesity.
5. Lack of exercise.

Q9.

Which of the following antihypertensive agents *is contraindicated* in women who are pregnant?

1. Triamterene-containing diuretics.
2. Beta blockers.
3. Central alpha agonists.
4. ACE inhibitors.
5. Methyldopa.

Q 10.

For the initial pharmacological treatment of essential hypertension, each of the following statements is correct *except:*

1. Diuretics, because of their effectiveness, cost, and low side-effect profile should be the first consideration.
2. ACE inhibitors offer renal protection independent of blood pressure control in hypertensive patient with diabetes mellitus.
3. Alpha blockers are of particular benefit in the treatment of hypertension complicated by congestive heart failure.
4. ACE inhibitors are appropriate for treatment in the face of all the compelling indications.

Q11.

Which of the following statements is *incorrect* with regard to hypertension in a 50-year-old female detainee with type II Diabetes mellitus?

1. The combination of Diabetes mellitus and hypertension is additive in her risk of cardiovascular disease.
2. ACE inhibitors and ARB are contraindicated in the presence of advancing renal dysfunction in patient with Diabetes mellitus.
3. Thiazide diuretics in small doses are unlikely to significantly worsen glycemic control.
4. A sudden worsening in blood pressure control in a Diabetes mellitus may be secondary to renovascular disease.

Q12. (Bonus Q)

The presence of *a dilated cardiomyopathy* in a person requiring three medications to maintain a normal blood pressure suggests the presence of

1. Renal artery stenosis.
2. Pheochromocytoma.
3. Amyloid heart disease.
4. Viral myocarditis.

Q13. (Bonus Q)

The diagnosis of Primary Aldosteronism requires each of the followings *except:*

1. Hypertension.
2. Hypokalemia (salt replete).
3. Increased 24-hours Urinary Aldosterone Rate.
4. Normal Renal Arteries.
5. Suppressed Plasma Renin Activity.

Q14. (Bonus Q) for next 1-4 Qs.

You are asked to see a 53-year-old female detainee from Greece, a dietician when she was in her country, in consultation for hypertension. She was found to have an elevated blood pressure on the last evening intake screening. According to her history, she followed her physician's recommendations and strictly avoids salt (uses Morton's No Salt), limits alcohol consumption, and exercises.

She adopted a vegetarian lifestyle until this detention. You are informed about her medications until this detention include:

→ PremPro (0.625/2.5mg)per day.

→ Triamterene/Hydrochlorothiazide (37.5/25mg) per day.

→Lisinopril (20mg) twice daily.

→ Atenolol (50mg) daily.

Your examination detects the following:

→BP: 188/100 (seated) →190/100 (standing); HR: 80/min.

→ Normal fundoscopic examination.

→ Normal peripheral pulses and no abdominal bruits.

→ Normal cardiovascular examination.

Despite these measures her blood pressure remained above normal and her health care provider prescribed several medications as above. However, her blood pressure could not be maintained at less than 160/95.

Her Initial laboratory results show normal blood counts, normal limits of electrolytes (Na; 145mEq/L, K; 3.7 mEq/L, Uric Acid 3.0mEq/L.) and elevated creatinine at 1.9mg/dL.

Normal chest X-ray. EKG LVH by voltage criteria.

1. **Of the follow statements regarding the clinical presentation, which is *correct?***

a. The hypertension is not "resistant" because the patient is not taking the medications at their maximum doses.
b. The absence of an abdominal bruit excludes renovascular hypertension as the underlying diagnosis.
c. The blood pressure response to postural change and serum concentration suggestive a state of low volume-high resistance hypertension.
d. The serum potassium concentration of 3.7 mEq/L in the setting of ACE inhibitor, triamterene therapy, and a diet likely to be high in potassium (NoSalt=KCl) is inappropriately low.
e. "I am confused by her story, I am concerned about OPLA and CR/CL inquiries. Why don't we send this detainee out to avoid her attorney's call or contact the regional CD or IHSC medical director for further guidance?"

2. **The most *likely secondary* form of hypertension in this setting is:**
a. Primary Aldosteronism.
b. Renal Artery Stenosis.
c. Pheochromocytoma.
d. Chronic renal failure.

3. **Which of the following would be *the most* reasonable "screening" test for primary Aldosteronism in this setting?**
   a. Referral to specialists (cardiology/nephrology/endocrinology)
   b. Adrenal CT scan.
   c. Duplex ultrasonogram of renal arteries.
   d. Renal angiography.
   e. Determination of the ratio of serum aldosterone to plasma renin activity.

4. **If the serum aldosterone concentration was 2 ng/dL (norm: 1-21), which of the following substance might be *playing a role* in this patient's hypertension?**
   a. Alcohol.
   b. Licorice.
   c. Diuretic.
   d. Premarin.

Answers:

Q1: 2.

_The definition of hypertension is based on office readings (ambulatory) which have consistently been elevated. Epidemiologic and randomized clinical trial data were collected in this manner. Furthermore, this patient's clinic (sick-calls) readings are higher than the recommended upper for such readings (SBP < 135 mmHg; DBP < 85 mmHg).

Q2: 1.

In accordance with the JNC-7 recommendations, lifestyle modification, including weight loss (attain and maintain BMI <25 kg/m^2), exercise (e.g., brisk walking for 30 min/day), and sodium reduction (< 6 N_aCl/day) DASH dietary plan, should be tried for 4-6 months prior to initiation of pharmacotherapy. (Do not be confused with the JNC-6 recommendation which was for up to 12 months.).

Q3: 4.

The proteinuria is most likely a manifestation of diabetic nephropathy, and an ACE inhibitor is the drug of choice based on randomized clinical trial data. In addition, the treatment goal would be < 130 mmHg systolic and < 80 mmHg diastolic *(Until the JNC-5, it was < 130/85 mmHg*). If necessary, a low dose diuretic should be the second drug to achieve the necessary control. Other drug classes also may be effective and added as required. (The *most appropriate*)

Q4: 5.

Reference Q3.

Q5: 2.

Because the perioperative risk in part is due to the associated catecholamine surge, hypertensive patients undergoing surgery are best treated with cardioselective beta blocker therapy. If possible, surgery should be delayed to bring the blood pressure down to < 180/100 mmHg. Patients who were treated and controlled adequately prior to surgery should be maintained on their usual regimen if possible or it should be re-started as soon as possible after surgery.

Q6: 5.

Methyldopa (Aldomet®) has been evaluated most extensibly and is recommended for women who become hypertensive during pregnancy. Beta blockers are also efficacious and are considered safe in late but should not be used in early pregnancy. ACE inhibitors and angiotensin II receptors are *contraindicated* during pregnancy. **As a general rule, all drugs should be used with greater caution during pregnancy. Consult to the pharmacist(s) on site.**

Q7: 1.

In the previous JNC-5, diuretics or Beta Blockers are recommended as initial therapy for all patients with hypertension. Since then, however, it is clear that there are numerous circumstances where other anti-hypertensive agents would be more effective, such as the use of ACE inhibitors/ ARB **and** diuretics in patients with hypertension and heart failure. Accordingly, diuretics or beta blockers are only recommended as initial therapy for patients with uncomplicated hypertension. A review of all of the controlled hypertension trials shows that reduction of blood pressures is more effective in reducing stroke than in reducing myocardial infarction rate. ACE inhibitors and ARB are contraindicated in pregnancy because of pre-clinical data. ACE inhibitors are especially recommended for patients with type I DM and proteinuria because they appear to slow the rate of renal diseases. Although fast-acting nifedipine has been commonly used for hypertensive emergencies, because of serious adverse side effects, it is no longer recommended as treatment for hypertensive emergencies.

Q8: 1.

Although cigarette smoking dose contribute to the development of astherosclerotic cardiovascular disease and nicotine acutely increase blood pressure, smoking does not *lead* to essential hypertension.

Q9: 4.

ACE inhibitors have been associated with birth defects when used in treating pregnant women.

Q10: 3

Alpha blockers were dropped as an arm of ALLHAT because of their increased risk of CHF when compared to thiazide-like diuretics.

Q11: 2

ACE inhibitors and ARBs slow the progression of Chronic Renal Disease(CRD) to dialysis or transplant in patients with Diabetes mellitus.

Q12. (Bonus Q): 2.

Long-standing catecholamine excess leads to a dilated cardiomyopathy as opposed to uncontrolled hypertension of other causes which leads to left ventricular hypertrophy.

Q13. (Bonus Q): 4.

The presence or absence of normal renal arteries is *irrelevant* if the other four criteria are met.

Q14.(Bonus Q): *1 (d), 2(a), 3(e),4(b).*

1(d),

The serum potassium concentration of 3.7 in the setting of ACE inhibition, triamterene therapy, and a diet likely to be high in potassium (NoSalt = KCl) is appropriately low in my opinion.

The JNC -7 classifies hypertension as resistant when it is inadequately controlled despite usual doses of three different medications, including a diuretic. The absence of a bruit is not exclusionary of renal artery stenosis. A fall in blood pressure with the assumption of upright posture with a compensatory rise is heart rate suggesting intravascular volume depletion. Beta blockers may blunt the rise in heart rate.

Some my fellow providers may choose **"e"** because of their concerns. Please remember that we should be the medical providers/ authorities. Ask it for yourself, why I am referring this patient to a specialist (consultant)? What do you want to learn from a supervisor/ specialist?

2(a),

The electrolyte pattern and failure of ACE inhibition to lower the blood pressure favors a primary mineralocorticoid state (i.e., Primary Aldosteronism).

3(e),

In the face of ACE inhibition a suppressed Plasma Renin Activity of would be inappropriate and suggest a mineralocorticoid excess state.

4(b),

Glycyrrhizic acid present in licorice inhibits the 11- beta- hydroxydehydrogenase enzyme that converts cortisol to its inactive metabolite, cortisone, creating a local "Cushing's" Syndrome at the level of the renal tubule.

Management of Methicillin-Resistant *Staphylococcus aureus* (MRSA) Infections

Prevention, Recognition, and Treatment

INTRODUCTION:

Methicillin-resistant *Staphylococcus aureus,* more commonly known MRSA, has been a concern of health care professionals since its initial discovery in the United Kingdom in 1961. In 1968, the first case of MRSA was reported in the U.S. This medical history tracks MRSA from the discovery of penicillin through today. MRSA naturally colonizes the mucosal surfaces and skin; 30% of people in the U.S. are colonized with *Staphylococcus aureus,* and perhaps 3% are colonized with MRSA. MRSA also can survive on the surfaces of inanimate objects like linen and soap. Transmission occurs primarily through direct contact (person-to-person) and via contact with these inanimate objects.

Many MRSA infections occur traditionally in hospital settings and health care facilities, with a higher incidence rate in nursing homes or long-term care facilities. Health care provider-to-patient transfer is not unheard of, especially when health care providers move from patient to patient without performing necessary sanitation techniques, such as hand hygiene. MRSA has newly evolved to include bacterial strains affecting persons without previous exposure to health care environments. The community–associated MRSA (CA-MRSA) infections have also been identified among athletes participating in close contact sports, military recruits in barracks setting, intravenous drug users, men who have sex with men, tattoo recipients, religious community members, and inmate/detainee populations. Within the correction/detention prison system, CA-MRSA infections have been associated with illicit, unsanitary tattoo practices and poor detainee hygiene. MRSA transmission has been linked to detainees sharing soap or towels with one another, infrequent showering, and detainees lacing boils with fingernails or tweezers.

In most communities in the U.S., MRSA is the leading cause of skin and soft tissue infections among persons seeking emergency care. The infection may not remain confined to the skin and serious complications, including spread to virtually any organ, may arise when MRSA enters the bloodstream. The CDC has reported that the rates of bacteremia had more than doubled, and by 2005 mortality from MRSA in the U.S. was greater than HIV/AIDS, tuberculosis, Salmonella, and influenza combined. Statistical data suggest that as many as 19,000 people with MRSA die annually in the U.S., although MRSA is not the sole cause of death. Some data suggest this

number has declined by about 25%-35% in recent years, in part because of prevention practices and techniques instituted in hospitals.

While some antibiotics remain effective, MRSA is constantly adapting, making it challenging to treat, and thereby driving the development of newer treatments. As treatment options are somewhat limited by virtue of its antibiotic resistance, preventing transmission is preferable to treatment and is paramount to control of these infections in our detainee population. Europe has had a great deal of success because they generally use isolation or contact precautions for high-risk patients. Hospitals in the U.S. have also adapted contact isolation procedures and the use of personal protective equipment; screening for MRSA among high-risk groups in emergency departments helps to identify colonized individuals before admission allowing for appropriate isolation procedures.

Table 1. Risk Factors that should increase suspicion of MRSA infection

- High prevalence of MRSA in the institute or community origin
- History of MRSA infection or colonization
- Close contact with someone known to be infected with MRSA
- Recent or frequent antibiotic use
- Chronic skin disease (e.g., atopic dermatitis, psoriasis)
- Crowded living conditions
- Clusters of infections among persons in groups with skin-to-skin contact or sharing items, e.g. towels, exercise equipment
- Complaint of "spider or insect bite"
- Skin and soft tissue infections with failure to respond to beta-lactam antibiotics
- Infection with HIV
- History in the past year of:
    - Hospitalization
    - Long-term care
    - Dialysis and end-stage renal failure
    - Diabetes mellitus
    - Surgery
    - Indwelling catheter

- Injection drug use

Identification and diagnosis:

One issue for clinicians/other medical providers who are not infectious disease specialists is identifying patients at high risk of being carriers [Table 1] by a careful patient history and skin examination. The decision about obtaining a wound culture is based on empiric and clinical presentations.

Clinical presentation:

The spectrum of disease caused by CA-MRSA is similar to that caused by CA-methicillin sensitive *Staphylococcus aureus* (MSSA). The most common lesions are abscesses and cellulitis. Frequently, abscesses are accompanied with an area of central necrosis. Furuncles are also common, particularly in the context of a MRSA outbreak. Frequently MRSA infections are reported by patients to be **"spider bites."** This is not because a spider bite has actually occurred, but because CA-MRSA lesions often have a similar appearance to a spider bite- a raised red tender lesion that may progress to develop a necrotic center. Fever, leukocytosis, and systemic signs of inflammation are often absent. Less commonly, but not infrequently, CA-MRSA presents: impetigo, folliculitis, deep- seated abscesses, pyomyositis, osteomyelitis, necrotizing fasciitis, staphylococcal toxic-shock syndrome, pneumonia, and sepsis. Serious systemic infections are more common among persons with a history of injection drug use, diabetes, or other immunocompromising conditions.

Transmission:

A primary mode of transmission of MRSA is "skin-to- skin" (person-to-person) via contaminated hands. MRSA may also be transmitted by sharing towels, personal hygiene items, and athletic equipment, as well as through close-contact sports, and by sharing tattoo or injection drug use equipment. Persons with MRSA pneumonia who are in close contact with others can potentially transmit MRSA by coughing up large droplets of infectious particles that can contaminate the environment. Persons with asymptomatic MRSA nasal carriage can also cause a toxin-mediated, food borne gastroenteritis.

The infection control plan:

Once MRSA infection is confirmed, the next step is how to control it and to prevent MRSA from spreading to others. IHSC recommends following CDC guidelines [References 5& 6] for hand hygiene, isolation precautions, and preventing transmission of infectious agent in health-care setting.

Screening and surveillance for SSTIs in the IHSC:

The following screening measures should be implemented routinely to assure prompt detection of SSTIs within the IHSC.

Intake and Physical Examination: All detainees undergoing intake medical screening and physical examinations should be carefully evaluated for skin infections.

Recently hospitalized detainees: All detainees who are discharged from the hospital should be screened for skin infections immediately upon return to the prison and be specifically instructed to self-report any new onset of skin infections or fever. Old peripheral intravenous sites and post-operative wounds should be carefully examined. (MRSA or other hospital-acquired infections may develop weeks after hospital discharge.)

Detainees at great risk of serious MRSA infections: Detainees with risk factors, such as diabetes, immunocompromising conditions, open wounds, recent surgery, indwelling catheters, implantable devices, chronic skin conditions, or paraplegia with decubiti, should be periodically evaluated for skin infections during routine evaluations.

Monitoring bacterial culture results: All bacterial culture results should be reviewed in a timely manner to detect new MRSA infections.

Observations by custody workers: Detainees with minor skin infections may be reluctant to seek health care. Detainees with visible or reported sores or wounds, or who self-report "boils" or "insect or spider bites" should be referred to health services.

Food handlers: All detainee food handlers should be advised on the necessity of self-reporting all skin infections, no matter how minor. Food handlers should be routinely examined for visible skin infections. Food handlers with skin infections should be removed from their duties until their infection has clinically resolved.

Transfers: Detainees with SSTIs should ordinarily not be transferred to other institutions until fully evaluated and appropriately treated. More information is provided under detainee transfers and releases in section 6.

Staff (including correctional workers): Staff (including correctional workers) should report all skin infections and any confirmed MRSA infections to their supervisor. Supervisors should refer correctional workers with possible skin infections to their health care provider. Staff with MRSA infections should be removed from direct detainee contact until the infection resolves. ***Periodic bacteriologic surveillance:*** Bacterial wound cultures should be obtained as part of periodic surveillance of SSTI pathogens within a given correctional setting to determine the predominant strains and incidence of drug susceptible and resistant organisms. Determination of common patterns will help guide empiric treatment recommendations.

Principles of SSTI Diagnosis and Treatment [Appendix 1]:

- ***Empiric diagnosis:*** The diagnosis of a probable Staphylococcal SSTI can be made empirically, without culture confirmation, for detainees who present with a SSTI within the context of a known MRSA outbreak, or when periodic surveillance of SSTIs confirms that CA-MRSA is the predominant circulating pathogen within a given detention setting.
- ***Culture diagnosis:***

MRSA infections are diagnosed by routine aerobic bacterial cultures. Positive MRSA cultures from blood and sterile body fluids are considered diagnostic as well. Wound cultures obtained from expressed pus (avoiding skin contamination) or aspirated abscesses are diagnostically meaningful; however, positive cultures obtained directly from the surface of a wound are of limited value in detecting true infection. When providers note a possible MRSA SSTI from detainees, including serious MRSA infections e.g. deep-seated abscesses requiring drainage; recurrent skin infections; an SSTI that is not resolving with current treatment; and as part of periodic surveillance to determine the predominant circulating pathogens in a given facility, bacterial cultures should be obtained. Blood culture should be obtained in febrile detainees with suspected MRSA infections. Whenever a systemic infection with Staphylococcus aureus; e.g., active injection drug use or endocarditis, is clinically suspected, the detainee patient should be referred to the community hospital for an expeditious evaluation.

Treatment Measures:

Once MRSA is diagnosed in a patient, treatment must begin as soon as a possible. Therapies are important for MRSA and also underscore the good diagnostic and clinical data needed to determine which therapies work best for particular patients. The guidelines are practical and they are step-by-step. Fortunately, there are a number of options available. But once a provider

gets into the details of therapy, they have to understand what type of infection they are treating, because for conditions such as skin and soft tissue infection, there are an "abundance" of antimicrobials. But for other conditions such as MRSA pneumonia or infective endocarditis, there are fewer options. Pharmacology, availability, efficacy and cost are all factors. Some have made the argument that newer, costlier drugs can save money if used up front in place of older and cheaper alternatives. Remember that this is a recent review of therapy issues related to MRSA, and provides answers to the most basic questions related to this condition. So if a provider has a question, there is a document that looks at all the recent literature and that is where the provider should probably start.

Conservative Treatment approach:

A conservative, mechanical approach should be a component of treatment of most SSTIs and is the primary treatment of choice for minor SSTIs (< 5 cm) that have no signs of systemic illness. Most skin abscesses in the early stages of development can be treated **with warm soaks or compresses** to promote spontaneous drainage. **(Note:** Decisions about how to safely implement warm soaks and/or compresses in the correctional/ detention setting must be made on a case-by-case basis, in consultation with the infection control officer and physician. Consideration should be given to how and where to safely perform the soaks, as well the safe disposal of bandages for the primary and secondary aspects of infection control.

Incision and drainage (I and D) [Appendix 2]**:** Surgical drainage may be required if spontaneous drainage does not occur. I and D should not be performed on lesions involving the face, hands, and genitalia. If an infection requires drainage, frequently reassess to determine whether repeated drainage is warranted. This approach must be determined on a case-by-case basis by the IHSC facility, because with some deep-seated abscesses, it may not be possible to successfully perform I & D without conducting imaging studies or performing an invasive procedure. (**Note:** Catheters and other foreign devices should be removed whenever possible; infections cannot be adequately treated in the presence of a foreign body.)

Optimizing pharmacologic therapy: [Appendix 3&4]

One key with pharmacology is monitoring and optimization. When optimization comes, there is more recent data that helps explain how antimicrobials work. Some agents are more than 50 years old and we are only realizing what types of dosages would be required to actually overcome some of these more serious infections, deeper infections, more difficult to eradicate infections, to bring those dosage regimens up to higher levels and then balance between giving

bigger dosage of drugs and determining whether or not that is also going to bring us more toxicity.

In the IHSC detention setting, antibiotic therapy for MRSA should be considered for the following treatment: large SSTI (>5cm); cellulitis; and with signs or symptoms of systemic infection and other serious manifestation. The optimal drug regimen for CA-MRSA is unknown. When antibiotics are clearly warranted for the treatment of a SSTI, it is recommended that antibiotics be prescribed that are effective *in vitro* to the culture isolated. Lacking culture results, prescribe antibiotics that are effective against the circulating strain of MRSA, if known. **Empiric antibiotic treatment** of SSTIs can be considered for large (≥ 5cm) lesions when bacterial cultures are not easily obtainable or local IHSC surveillance of wound cultures has identified a circulating strain of MRSA which has stable antibiotic sensitivities. CA-MRSA is now the predominant cause of SSTIs in many communities throughout the United States; however, MSSA remains an extremely common bacterial pathogen causing SSTIs. The appearance or severity of most abscesses is not useful clinically in identifying the offending pathogen. The choice of empirical antibiotic therapy should be based on surveillance data and on whether or not the patient has associated risk factors for MRSA, such as recent hospitalization. Beta-lactam antibiotics, such as *cephalexin*, can be prescribed empirically if periodic surveillance cultures reveal that MSSA is the predominant circulating pathogen. When an IHSC provider suspects serious SSTIs such as systemic infections, significant cellulitis, endocarditis and other endovascular infections, osteomyelitis, necrotizing fasciitis, pneumonia, and other deep-seated MRSA infections, evaluation at a community (local) emergency department is recommended to expedite diagnosis and allow for urgent consultations with specialists.

Staphylococcus aureus bacteremia is a serious condition and should be treated minimally for two weeks (some experts recommend three weeks) with intravenous (or IV equivalent) antibiotics. Metastatic infections due to bacteremia are common and are associated with significant morbidity and mortality. These patients should be monitored with weekly laboratories and physician visits and in some cases require drug level monitoring and pharmacist consultation.

The use of broad-spectrum antibiotics should be strictly monitored and unnecessary use curtailed, to reduce the development of antibiotic resistance among the detainee population.

(NOTE: The most recent guidelines recommend much higher dosing and monitoring of blood levels to reach targets that are higher than those in the past. The issue of appropriate dosing has arisen with other drugs as well; daptomycin is an excellent example. Many physicians are using doses that are significantly higher than have been approved by the FDA based on registration trials. This means there is at least a recognition that the provider not only has to pick the right drug, the provider has to pick at the right dose and administer it properly.)

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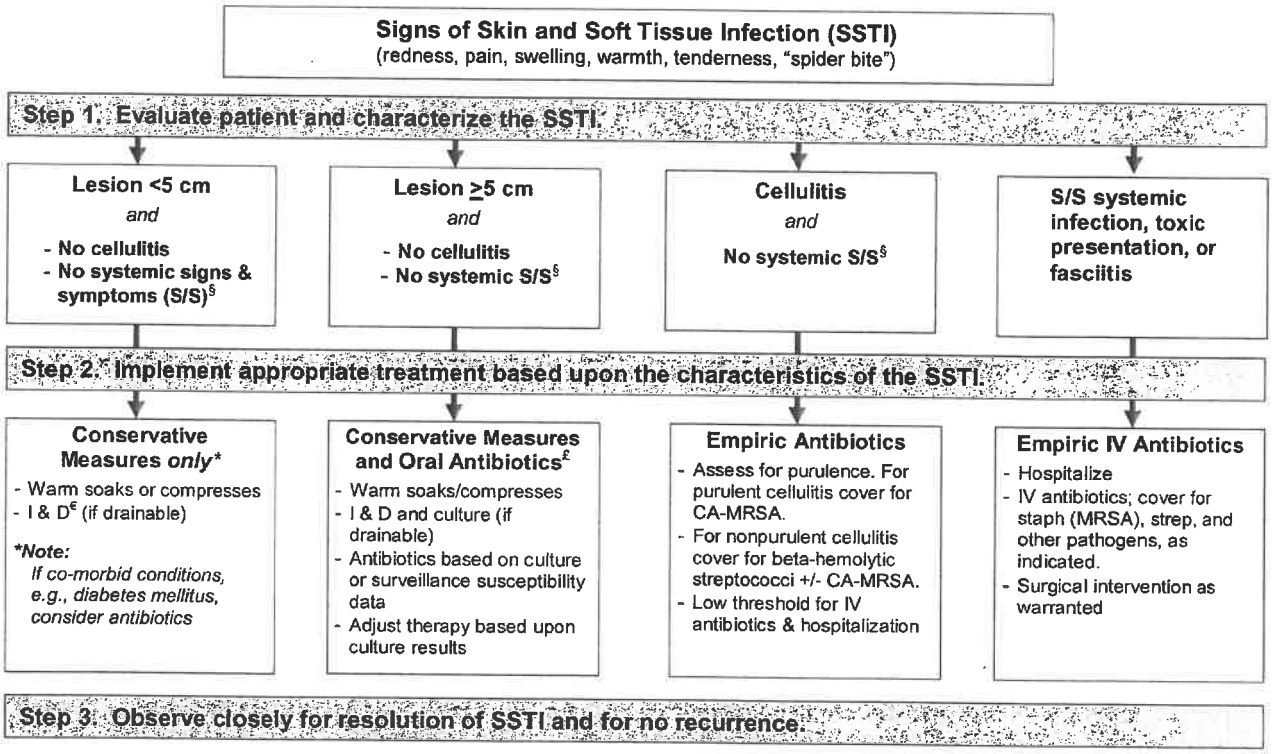
Appendix 1. Steps for Evaluation and Treatment of Skin and Soft Tissue Infections[¶]



[¶] Every SSTI presentation warrants management on a case-by-case basis.
[€] I & D = incision and drain (see *Appendix 2*). Abscesses of face, hand, and genitalia should not be drained.
[£] Antibiotic treatment for presumed or confirmed MRSA infection should be directly observed via pill line.
[§] Signs and symptoms (S/S) of systemic infection include: fever, unstable vital signs, "toxic" presentation, streaking from the infection site, crepitus, necrosis, and rapid spread of inflammation over a period of hours.

Appendix 2. Incision and Drainage (I&D) Procedure

Abscesses are localized infections of tissue marked by a collection of pus surrounded by inflamed tissue. Abscesses may be found in any area of the body, but most abscesses presenting for urgent attention are found on the extremities, buttocks, breast, perianal area, axilla, groin, or from a hair follicle. Abscesses begin when the normal skin barrier is breached, and microorganisms colonize the underlying tissues. Causative organisms commonly include *Streptococcus sp.*, *Staphylococcus sp.*, enteric bacteria (perianal abscesses), or a combination of anaerobic and gram-negative organisms.

Abscesses resolve by drainage. Smaller abscesses may resolve with conservative measures (warm soaks) to promote spontaneous drainage. Larger abscesses will require incision to drain them (I & D), as the increased inflammation, pus collection, and walling-off of the abscess cavity diminish the effectiveness of antibiotic treatment. Healing following an I & D should progress from the inside of the abscess outward to the incision site. This will require a gauze packing to promote healing from the inside outward.

Indication: Abscess within the skin that is palpable.

Contraindications

1. Extremely large abscesses that require extensive incision, debridement, or irrigation (best done in operating room).
2. Deep abscesses in very sensitive areas (labial, supralevator, ischiorectal, perirectal) that require a general anesthetic to obtain proper exposure.
3. Abscess in the hands or feet.
4. Abscesses in the triangle formed by the bridge of the nose and the corners of the mouth (should generally be treated with warm compresses and aggressive antibiotic therapy).
5. Abscesses located near major vessels must be differentiated from aneurysms before I & D are performed to avoid fatal hemorrhage. The distinction is made through aspiration with a large bore needle.

Materials

1. Sterile gloves
2. Mask/eye protection (if abscess appears to be under pressure enough to cause expulsion of contents with the incision)
3. 1% or 2% lidocaine with epinephrine for local anesthesia; 10 cc syringe and 23 gauge needle for infiltration. Alternatively, diphenydramine (Benadryl) 10 to 25 mg can be used for anesthesia. Dilute a 50 mg (1 cc) vial in a syringe with 4 cc of normal saline. (*Note:* Epinephrine is contraindicated in areas such as the fingers, nose, toes, and penis.)
4. Alcohol or povidone-iodine wipes
5. #11 scalpel blade with handle
6. Draping
7. Hemostat or sterile cotton-tipped applicator
8. Packing (plain or iodoform, ½" or ¼" packing)
9. Scissors
10. Gauze and tape
11. Culture swab (aerobic and anaerobic)

(continued on next page)

Appendix 2. Incision and Drainage Procedure (I&D) *(Page 2 of 3)*

Pre-Procedure Education

1. Obtain informed consent. Inform the patient of potential severe complications and their treatment.
2. Explain the steps of the procedure, including the not insignificant pain associated with anesthetic infiltration.

Procedure

1. Use Standard Precautions.
2. Cleanse site over abscess with skin preparation of choice.
3. Drape to create a sterile field.
4. Infiltrate local anesthetic, allowing 2–3 minutes for anesthetic to take effect.
5. Incise over abscess with the #11 blade, cutting through the skin into the abscess cavity. Follow skin fold lines whenever possible while making the incision. The incision should be sufficiently wide to allow the abscess to drain and to prevent premature closure of the incision.

   For smaller abscesses requiring incisions, a "stab" or "cruciate" incision should be adequate. Some refer to this as a puncture or stab technique since the operator inserts the tip of the scalpel directly into the center of the abscessed tissue without making a linear incision.
6. Allow the pus to drain, using the gauzes to soak up drainage and blood. If a culture is being obtained, use the culture swab to take culture of abscess contents, swabbing inside the abscess cavity—not from the superficial skin over the abscess.
7. Use the hemostat or sterile cotton-tipped applicator to gently explore the abscess cavity to break up any loculations within the abscess.
8. Loosely pack the abscess cavity with the packing.
9. Place gauze dressing over the wound, and tape in place (without placing tape over the incision site).
10. Remove gloves and wash hands. Properly dispose of contaminated articles and assure appropriate cleaning of the area.
11. Schedule a call-out within 24–48 hours post-op. Depending upon the location and size of the abscess, arrange for the packing material to be changed daily or several times per day.
12. Pain from the site may require acetaminophen or nonsteroidal anti-inflammatory drugs; narcotics are rarely needed. With a tense abscess, the pain relief associated with the I & D itself may be sufficient enough that no pain medication is required.

Post-Procedure Patient Education.

Patients should be instructed to watch for the following symptoms:

- Recollection of pus in the abscess
- Fever and chills
- Increased pain and redness
- Red streaks near the abscess
- Increased swelling

While some inmates will have to return to the clinic to have their dressings changed, others can be taught to do this for themselves. In addition to showing these patients how to change the packing and replace the dressings, they should be educated on:

- Disposal of dressing material
- Hand-washing technique
- Cleansing the area after the dressing is complete

(continued on next page)

Appendix 2. Incision and Drainage Procedure (I&D) *(Page 3 of 3)*

Complications

Prevention and management of complications associated with the I & D procedure are outlined below.

Complication	Prevention	Management
Insufficient anesthesia	Remember that the tissue around an abscess is acidotic, and local anesthetic loses effectiveness in acidotic tissues.	Do a field block; use sufficient quantity of anesthetic; allow time for anesthetic effect.
No drainage	Localize site of incision by palpation.	Extend incision deeper or wider as needed.
Drainage is sebaceous material	Abscess was an inflamed sebaceous cyst.	Express all material; break up sac with hemostat; pack open as with an abscess.

Following I & D of any abscess, the site should be observed for signs of recollection of pus or cellulitis. Complications of an inadequately treated abscess include bacteremia and septicemia. In persons who are immunocompromised, particularly diabetics, an abscess on an extremity can be complicated by severe cellulitis or gangrene, with potential loss of the affected extremity. An I & D of a periannal abscess frequently results in a chronic anal fistula that requires fistulaectomy by a surgeon. Deep palmar abscesses are a surgical emergency.

Documentation on the Medical Record

1. Informed Consent (signed)
2. Procedure used, prep, anesthetic (and quantity), success of drainage, culture if collected
3. Any complications (or "none")
4. Who was notified of any complication (MLP, attending MD)
5. Follow-up arrangements for scheduled call-out and dressing changes

Sources:

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Appendix 3. Treatment Options for Mild-to-Moderate Skin and Soft Tissue MRSA Infections

Drug	Oral Dose	Monitoring	Adverse Reactions/ Drug Interactions/Comments
Note: Antibiotic therapy for presumed or confirmed MRSA infection should be administered via pill line.			
TMP-SMX	1 DS tablet twice daily (Consider higher dosing with more serious infections.)	Routine lab tests are not indicated. In cases of prolonged treatment or in complicated patients: Monitor CBC/platelets, and renal & hepatitis parameters.	**Adverse effects:** Rash, erythema multiforme, Stevens-Johnson syndrome, hemolysis w/ G-6-PD deficiency, hepatitis, pancreatitis, bone marrow suppression. **Drug interactions:** Dapsone, anticoagulants, phenytoin, cyclosporine, diuretics, MTX.. **Comments:** With renal insufficiency, maintain hydration to prevent crystalluria. Check for sulfa allergy.
Clindamycin	300–450 mg three times daily	Routine lab tests are not indicated.	**Adverse effects:** GI upset and relatively high incidence of *C. difficile*-induced colitis as compared to other antibiotics. **Comments:** If isolate is erythromycin-resistant *in vitro*, clindamycin resistance may develop during therapy; consult with microbiology laboratory prior to treatment regarding "D test" (*Section 4*). Advise inmate to report diarrhea immediately.

Clinical Notes:

- For less serious infections, antibiotic treatment may be avoided by using conservative measures (warm soaks or compresses and/or I & D). When antibiotics are administered, do so in conjunction with conservative measures.
- Select antibiotics based upon susceptibility results or the prevalent strain circulating in the facility.
- Minocycline or doxycycline, 100 mg twice daily, may be an alternative treatment option; however, laboratory susceptibility results must be carefully reviewed.
- Do not use fluoroquinolones to treat MRSA. MRSA isolates may be sensitive to quinolones *in vitro*; however, the potential for resistance limits the use of this class of antibiotics.
- Within the BOP, rifampin is *not* recommended for treatment of uncomplicated SSTIs. For treatment of recurrent or complicated SSTIs, rifampin can be considered on a case-by-case basis only after Central Office approval. Note that rifampin *must always* be used in conjunction with another antibiotic.
- Recurrent/persistent skin lesions may indicate nonadherence to treatment, antibiotic resistance, or re-exposure to an infected source.
- Resistant or serious infections usually require IV vancomycin or an alternative agent.

Appendix 4. Treatment Options for Serious MRSA Infections

Drug	Dose[1]	Monitoring	Adverse Effects/ Drug Interactions/Comments
Vancomycin (Vancocin®)	15–20 mg/kg/dose (actual body weight) every 8–12 hours, not to exceed 2 g per dose. For most non-obese patients with SSTIs and normal renal function, a dose of 1 gm every 12 hours is adequate. Infuse over 1 hour. ***Ineffective if given orally.***	Refer to the BOP *Antimicrobial Stewardship Guidance*, when available, for more detailed information on monitoring. Collect trough level 1 hour prior to the fourth dose. *Target:* 10–15 mcg/mL for uncomplicated SSTIs or cellulitis *Target:* 15–20 mcg/mL for bacteremia, endocarditis, pneumonia, and other serious infections Auditory function Renal function/CBC	**Adverse effects:** ▸ Ototoxicity, nephrotoxicity, drug fever, hypotension, rash, pruritus, reversible neutropenia. ▸ If used with aminoglycosides, increases nephrotoxicity. ▸ Histamine reaction; flushing. **Drug interactions:** Anesthetics **Comments:** ▸ Infuse over 1 hour to reduce "red man syndrome" → flushing, hypotension. Monitor BP. May need to extend infusion time. ▸ Adjust dosage is based on trough levels. Refer to the BOP *Antimicrobial Stewardship Guidance*, when available, for more detailed dosing information. ▸ May require second or third antibiotic for serious infections.
Linezolid[2] (Zyvox®)	600 mg twice daily, orally or IV Can take with or without meals.	CBC with differential/platelet count weekly Monitor BP if hypertensive or taking a sympathomimetic.	**Adverse effects:** Diarrhea (including pseudomembranous colitis), bone marrow suppression, nausea, headache. Peripheral and optic neuropathy have been reported in patients treated with linezolid, primarily for those patients treated for longer than the maximum recommended duration of 28 days. **Drug interactions:** Avoid adrenergic and serotonergic agents, including decongestants and SSRI antidepressants. **Comments:** ▸ Avoid consuming foods containing large amounts of tyramine[3]. ▸ Use cautiously if patient is hypertensive.

[1] Sepsis requires at least 2 weeks of IV antibiotics. Endovascular infections such as endocarditis, osteomyelitis, and other deep-seated infections require 4–6 weeks of therapy and may require combination antibiotic therapy; consult with expert on treatment regimen and length of treatment.

[2] Linezolid is costly and has potential for serious toxicities. Linezolid should only be used after consultation with a physician expert to determine if alternative antimicrobials would be more appropriate.

[3] Avoid foods with very high tyramine content such as packaged soups, pickled/smoked fish, orange pulp, fava beans, and aged cheeses.

IHSC Hepatitis C Clinical Guidelines – 10/13/2015

Treatment of ICE detainees with hepatitis C

Given the transitional nature of ICE detention, medical care is provided to ICE detainees taking into consideration: the potential risks/harms of initiating treatment when the period of detention is uncertain, the benefits to the detainee, and whether treatment is considered necessary to prevent immediate harm to a detainee.

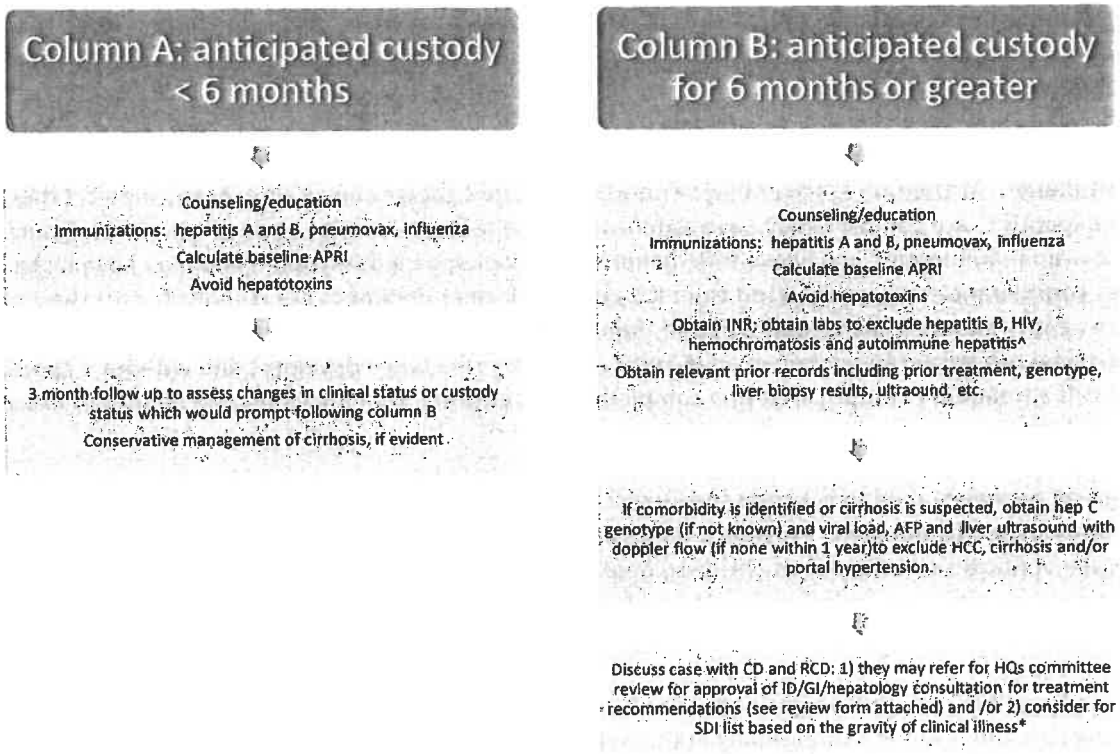
Prior to initiation of treatment for hepatitis C detainees must undergo specialty testing and specialty consultation; furthermore, a liver biopsy may be required to stage the disease. Many medical therapies for hepatitis C are complex, may have significant side effects, may require specific monitoring and follow-up requirements, may have little benefit to the detainee if interrupted and may have logistics or cost considerations. Once released from ICE custody, former detainees are responsible for their health care needs. Initiating such treatment and then releasing the detainee in the US or deporting the individual can impact the detainee adversely (e.g. if drug resistance develops) and without a specific gain. If a treatment course cannot be completed in its entirety, there may be little benefit to initiate such therapies.

Medical providers need to consider the impact to the patient when determining whether a given therapy should be pursued. Providers need to weigh the significance of other co-morbid conditions, degree of fibrosis or evidence of cirrhosis, medication interactions, detainee mental health, and treatment compliance, including cessation of known risk behavior (i.e. intravenous drug use) when considering whether hepatitis C treatment may be appropriate or not.

While hepatitis C can cause significant health complications, it is a chronic infection for most affected individuals and is not life-threatening in the near future; not providing treatment immediately will generally have little effect on the patient. Most individuals diagnosed with hepatitis C have had the infection for extended periods of time and are not at risk of immediate decompensation. Over decades, hepatitis C can cause progressive liver damage that may lead to cirrhosis and other complications such as hepatocellular carcinoma so consideration for treatment should be made for those with anticipated longer custody stays.

In the case of definitive treatment of hepatitis C infection, IHSC generally follows care prioritization as advocated by the Federal Bureau of Prisons which is based on guidance from the American Association for the Study of Liver Diseases and the Infectious Disease Society of America (www.hcvguidelines.org). Prioritization groups include advanced liver fibrosis/cirrhosis, liver transplant recipients, HIV co-infection, comorbid medical conditions associated with hepatitis C (e.g., cryoglobulinemia, lymphoma), and continuity of care for newly detained ICE detainees who enter custody on a hepatitis C treatment regimen. IHSC does offer general education and counseling, and if indicated, immunization for hepatitis A and B, as well as screening for cirrhosis. If detainees remain in ICE custody for extended periods, hepatitis C treatment will be considered and clinical factors will be identified that would support treatment.

The following algorithm should guide providers in determining what interventions should be considered for detainees with laboratory confirmed hepatitis C:



^see following page for suggested screening diagnostics

*if treatment is recommended by ID/GI/hepatology consultant, the patient is to be added to the SDI list

Additional useful information:

APRI calculator: http://hepatitisc.uw.edu/go/evaluation-staging-monitoring/evaluation-staging/calculating-apri

Signs/symptoms of cirrhosis:

- albumin <3.4
- INR greater than the upper limit of normal
- platelets less than the lower limit of normal
- elevated bilirubin
- history of GI variceal bleed, ascites, or hepatic encephalopathy
- taking medication to treat manifestations of cirrhosis (e.g., lactulose or rifamixin for hepatic encephalopathy; nadalol or propranolol for portal hypertension; spironolactone for ascites)
- evidence of hepatic encephalopathy (day/night reversal, asterixis/"flap", slowed mentation)

Suggested laboratory tests for autoimmune hepatitis: ANA screen; if positive anti-smooth muscle antibodies, anti-LMK1, anti-LC1, quantitative immunoglobulins

Suggested laboratory tests for hemochromatosis: iron studies, ferritin

Patient information for counseling: http://www.cdc.gov/hepatitis/C/PatientEduC.htm

Common drugs to use with caution in patients with chronic liver disease: acetaminophen (max 2 grams/day), NSAIDs, aminoglycosides (risk of hepato-renal syndrome), ACE inhibitors, furosemide, drugs with a narrow therapeutic index*.

Narrow therapeutic index drugs*

Carbamazepine	Phenytoin	Cyclosporine
Procainamide	Digoxin	Tacrolimus
Ethosuximide	Theophylline	Levothyroxine
Warfarin	lithium	

Adapted from: North Carolina Pharmacy Practice Act. Article 4A. 90-85.28(b1).

ICE HEALTH SERVICE CORPS Request for Hepatitis C Treatment

Name: **A#:** **Date of request:**
Current facility: **Attending physician:**
Date entered custody: **Anticipated length of stay in custody:**

1. Proposed hepatitis C treatment regimen (medications, doses, and duration of treatment):

2. Is this a request for continuation of treatment? If yes, treatment initiation date?
3. Do any of the following apply: HIV positive, liver transplant recipient, cryoglobulinemia, chronic hepatitis B, autoimmune hepatitis?
4. Does the detainee have an unstable medical or mental health condition?
5. Have there been instances of non-compliance or refusal of treatment while detained?
6. Has the detainee engaged in substance use and/or diversion while detained?
7. Date of hepatitis C diagnosis:

REQUIRED DIAGNOSTICS:

Hep C genotype: Hep C viral load, date:
Date/results of last liver ultrasound or other imaging:
Date/results of most recent:
Platelet count: Albumin:
INR: Bilirubin:

Please list Hepatitis C-related complications:

Please calculate AST to Platelet Ratio Index (APRI):
http://www.hepatitisc.uw.edu/page/clinical-calculators/apri
Please calculate Child-Turcotte-Pugh Classification for Cirrhosis score:
http://www.hepatitisc.uw.edu/page/clinical-calculators/ctp

Not required for hepatitis C treatment consideration, but if these results are available please include:
Date/results of liver biopsy (attach pathology report):
Date/results of last Fibrosure (attach lab result):

A GI consultation is not recommended prior to submission of this request. If one has been obtained either during this custody stay or prior, please attach a copy of the consultant's report. Please also include endoscopy report(s), if performed.

Hepatitis C Treatment Request Board Review
Date of review:
Review Board Decision:

- ☐ Detainee meets criteria for treatment priority level 1, 2, or 3. Treatment request approved.
- ☐ Detainee does not meet criteria for treatment priority level 1, 2 or 3. Treatment request not approved.
- ☐ Additional information is needed. Treatment request not approved.

Priority level 1-4 criteria listed on following page.

Recommendations:

Name/signature:

10/8/15

ICE HEALTH SERVICE CORPS Request for Hepatitis C Treatment

Hepatitis C Treatment Prioritization

Priority Level 1 – Highest Priority for Treatment*
- **Cirrhosis:** *Cases of decompensated cirrhosis with a CTP score of 7 to 9 should receive the highest priority for treatment.*
- **Liver transplant candidates or recipients**
- **Hepatocellular carcinoma (HCC)**
- **Comorbid medical conditions associated with HCV, including:** cryoglobulinemia with renal disease or vasculitis, certain types of lymphomas or hematologic malignancies
- **Immunosuppressant medication for a comorbid medical condition**
- **Continuity of care for those already started on treatment**

Priority Level 2 – High Priority for Treatment*
- APRI score ≥ 2
- Advanced fibrosis on liver biopsy (e.g., Metavir Stage 3 bridging fibrosis)
- HBV coinfection
- HIV coinfection
- Comorbid liver diseases (e.g., autoimmune hepatitis, hemochromatosis, steatohepatitis, etc.)

Priority Level 3 – Intermediate Priority for Treatment*
- Stage 2 fibrosis on liver biopsy
- APRI score 1.5 to < 2
- Diabetes mellitus
- Porphyria cutanea tarda

Priority Level 4 – Routine Priority for Treatment*
- Stage 0 to stage 1 fibrosis on liver biopsy
- All other cases of HCV infection meeting the eligibility criteria for treatment, as noted below under *Other Criteria for Treatment*

**** Exceptions to the above criteria for Priority Levels 1 -4 will be made on an individual basis and will be determined primarily by a compelling or urgent need for treatment, such as evidence for rapid progression of fibrosis, or deteriorating health status from other comorbidities.***

Other Criteria for Treatment
In addition to meeting the above criteria for Priority Levels 1–4, inmates being considered for treatment of HCV infection should:
- Have no contraindications to, or significant drug interactions with, any component of the treatment regimen.
- Have a GFR ≥ 30.
- Not be pregnant, especially for any regimen that would require ribavirin or interferon.
- Have sufficient time remaining on their sentence in the BOP to complete a course of treatment.
- Have a life expectancy > 18 months.
- Demonstrate a willingness and an ability to adhere to a rigorous treatment regimen and to abstain from high-risk activities while incarcerated.

Prioritization for treatment based on the Federal Bureau of Prisons Clinical Practice Guideline for the Evaluation and Treatment of Hepatitis C, July 2015.

10/8/15

The Guidelines for the management of sickle cell disease

October 9, 2014

Introduction;

Sickle cell disease (SCD) is the life-threatening genetic disorder affecting nearly 100,000 individuals in the United States and is associated with many acute and chronic complications requiring immediate medical attention. Two disease-modifying therapies, hydroxyurea and long-term blood transfusions, are available but underused. In addition, hematopoietic stem cell transplantation; the only curative approach, has been used in only a small proportion of affected individuals. This IHSC guideline to support and expand the number of health providers able and willing to provide care for detainees with SCD while in detention. Recognizing the need to provide practical guidance for common problems that may lie outside of the evidence, this IHSC guideline is supplemented by the expertise of the specialists who have many years of experience in managing and studying individuals with SCD. This guideline is divided into sections related to health maintenance as well as clinical manifestations of sickle cell anemia, diagnosis and management of acute and chronic complications. The final 2 sections address hydroxyurea and blood transfusion therapies.

Clinical manifestations of Sickle Cell Anemia;

Most patients with sickling syndromes suffer from *hemolytic anemia*, with hematocrits from 15-30 %, and significant reticulocytosis.

Granulocytosis is common. The white count can fluctuate substantially and unpredictably during and between painful crises, infectious episode, and other intercurrent illness.

Vasoocclusion of which component usually dominates the clinical course and causes protean manifestations. Intermittent episodes of vasoocclusion in connective and musculoskeletal structures produce painful ischemia manifested by acute pain and tenderness, fever, tachycardia, and anxiety. These recurrent episodes, called *painful crises,* are the most common clinical manifestation. Their frequency and severity vary greatly. Pain can develop almost anywhere in the body and may last from a few hours to 2 weeks. Repeated crises requiring hospitalization (> 3 per year) correlate with reduced survival in adult life, suggesting that these episodes are associated with accumulation of chronic end-organ damage. Provocative factors include infection, fever, excessive exercise, anxiety, abrupt changes in temperature, hypoxia, or hypertonic dyes.

Repeated micro-infarction can destroy tissues having microvascular beds that promote sickling. Thus the spleen is frequently lost within the first 18-36 months of life, causing susceptibility to infection, particularly by pneumococci. Acute venous obstruction of the spleen; *splenic sequestration crisis* , a rare

occurrence in early childhood, may require emergency transfusion and/or splenectomy to prevent trapping of the entire arterial output in the obstructed spleen.

Occlusion of retinal vessels can produce hemorrhage, neovascularization, and eventual detachments.

Renal papillary necrosis invariably produces isosthenuria. More widespread renal necrosis leads to renal failure in adults, a common late cause of death.

Bone and joint ischemia can lead to aseptic necrosis, especially of the femoral or humeral heads; chronic

arthropathy; and unusual susceptibility to osteomyelitis, which may be caused by organisms, such as *Salmonella,* rarely encountered in other settings.

The *hand-foot syndrome* is caused by painful infarcts of the digits and dactylitis.

Stroke is especially common in children; a small subset tends to suffer repeated episodes. Stroke is less common in adults and is often hemorrhagic.

Priapism is a particularly painful complication in males. It is due to infarction of the penile venous outflow tracts; permanent impotence is a frequent consequence.

Chronic lower leg ulcers probably arise from ischemia and superinfection in the distal circulation.

Acute chest syndrome (ACS) is a distinctive manifestation characterized by chest pain, tachycardia, fever, cough, and arterial oxygen desaturation. It can mimic pneumonia, pulmonary emboli, bone marrow infarction and embolism, myocardial ischemia, or *in situ* lung infarction.

Repeated episodes of acute chest pain correlate with reduced survival. Acutely, reduction in arterial oxygen saturation is especially ominous because it promotes sickling on massive scale. Chronic acute or subacute pulmonary crises lead to pulmonary hypertension and cor pulmonale, an increasingly common cause of death as patients survive longer.

Diagnosis;

Sickle cell diseases (syndromes) are suspected on the basis of hemolytic anemia, RBC morphology, and intermittent episodes of ischemic pain. Diagnosis is confirmed by hemoglobin electrophoresis and the sickling tests. Sickle hemoglobin (HbS; most prevalent genotype, HbSS), the predominant hemoglobin that is present in the red blood cells of persons with SCD, results from substitution of the amino acid valine for glutamic acid at the six position of the β-chain. When deoxygenated, red blood cells from persons with SCD can develop a sickle or crescent shape, become inflexible, and increase blood viscosity through intrinsic properties of the sickle cells as well as abnormal interactions of these cells with

leukocytes, platelets, vascular endothelium, and clotting factors. The most prevalent genotype, HbSS, and the much less common HbSβ°-thalssemia, both commonly referred to as sickle cell anemia because they are phenotypically very similar and are associated with the most severe clinical manifestations. Most of those affected are of African ancestry or self-identify as black, with a minority being of Hispanic, Middle Eastern, or Asian Indian descent. Thorough characterization of the exact hemoglobin profile of the patient is important, because sickle thalassemia and hemoglobin SC (a variant that causes manifestations of sickle cell disease when paired with HbS) disease have distinct prognoses or clinical features. Diagnosis is usually established in childhood, but occasional patients, often with compound heterozygous states, do not develop symptoms until the onset of puberty, pregnancy, or early adult life. Details of the childhood history establish prognosis and need for aggressive or experimental therapies. Factors associated with increased morbidity and reduced survival are more than three crises requiring hospitalization per year, chronic neutrophilia, a history of splenic sequestration or hand-foot syndrome, and second episodes of acute chest syndrome. Patients with a history of cerebrovascular accidents are at high risk for repeated episodes and require especially close monitoring using Doppler carotid flow. Patients with severe or repeated episodes of acute chest syndrome may need lifelong transfusion support, utilizing partial exchange transfusion, if possible.

Management (*Evidence-Based Recommendations by Expert Panel Members*)

1. ***Health maintenance:***

✍ Prevention of invasive pneumococcal infection:

- *Administer oral penicillin prophylaxis(125mg for those < 3y and 250mg for those ≥ 3y) twice daily until age 5 y in all children with HbSS*
- *Ensure that persons of all ages with SCD have been vaccinated against Streptococcus pneumonia*

✍Immunizations:

- *Children aged 6-18 y with functional or anatomic asplenia receive 1 dose of PVC 13(conjugate 13-valent vaccine)*
- *Adults aged ≥ 19 y who have not received pneumococcal vaccine but have functional or anatomic asplenia and whohave not previously received PCV 13 or PPSV 23 (23-valent polysaccharide vaccine) should receive 1 dose of PCV 13 first, followed by a dose of PPSV 23 at least 8 wk later, with subsequent doses of PPSV23 to follow current PPSV23 recommendations for adults at high risk; a second PPSV 23 dose is recommended 5 y after the first PPSV23 dose for persons aged 19-64 y with functional or anatomic asplenia, in addition, those who received PPSV 23 before age 65 y for any indication should receive another dose of the vaccine at age 65 y or later if at least 5 y have elapsed since their previous PPSV 23 dose*

- *Adults aged ≥ 19 y with previous PPSV23 vaccination and functional or anatomic asplenia who received ≥1 dose of PPSV23 should be given a PCV 13 dose ≥1 y after the last PPSV23 dose- For those who require additional doses of PPSV23, the first such dose should be given no sooner than 8 wk after PCV13 dose and at least 5 y after the most recent dose of PPVC23*

✍ Screening for hepatitis C:

Screen for hepatitis C virus (HVC) infection in persons at high risk for infection (e.g., those with multiple transfusions) and offer 1-time screening for HVC infection to all adults born between 1945 and 1965

✍ Electrocariogram (ECG) screening:

Do not screen asymptomatic children or adults with SCD with ECG

✍ Screening for retinopathy:

Refer to an ophthalmologist for a dilated eye examination to evaluate for retinopathy beginning at age 10 y, then, a normal dilated retinal examination -rescreen 1- to 2-y intervals

✍ Screening for risk of stroke using neuroimaging;

- *In chidren with sickle cell anemia, screen annually(beginning at age 2 y and continuing until at least 1ge 16y)with transcranial Doppler. According to the methods used STOP(Stroke Prevention Trial in Sickle Cell Anemia) studies*
- *In children with conditional (170-199cm/s) or elevated (≥200cm/s) transcranial Doppler results, refer to a specialist with expertise in long-term transfusion therapy aimed at preventing stroke*
- *In children with genotypes other than SCA(e.g,HbSbeta^{+} -thalassemia or HbSC), do not perform screening with transcranial Doppler*
- *In asymptomatic children with SCD, do not perform screening with MRI(magnetic resonance imaging) or CT(computed tomography)*
- *In asymptomatic adults with SCD, do not perform screening with neuroimaging (transcranial Doppler, MRI, or CT*

✍ Screening pulmonary disease:

Do not screen asymptomatic children and adults with pulmonary function tests

✍ Contraception, reproductive counseling, and opioid use during pregnancy:

Consensus-adapted recommendation from the World Health Organization (WHO) and the US Center for Disease Control and Prevention (CDC).

2. ***Managing Acute Complications*** *;*

✍ Vasoocclusive crisis:

- *Continue treatment with nonsteroidal anti-inflammatory drugs (NSAIDs) in adults and children with a vasoocclusive crisis associated with mild to moderate pain in those who report relief with NSAIDs in the absence of contraindications*
- *Rapidly initiate treatment with parenteral opioids in adults and children with a vasoocclusive crisis with severe pain*
- *Initiate around-the-clock opioid administration by patient-controlled analgesia or frequently scheduled doses vs as requested administration in adults and children with a vasoocclusive crisis associated with severe pain*
- *Use incentive spirometry during hospitalization for vasoocclusive crisis to reduce the risk of acute chest syndrome*
- *Do not administer a blood transfusion unless there are other indications for transfusion in children and adults with a vasoocclusive crisis*
- *Use an individualized prescribing and monitoring protocol (written by the patient's SCD clinician) or an SCD-specific protocol whenever possible to promote rapid, effective, and safe analgesic management and resolution of the vasoocclusive crisis in children and adults*

✍ Acute chest syndrome (ACS):

- *Treat persons with SCD who have ACS with an intravenous cephalosporin, an oral macrolide antibiotic, supplemental oxygen (to maintain oxygen saturation of > 95%), and close monitoring for bronchospasm, acute anemia, and hypoxemia*
- *In persons with sickle cell anemia, give simple blood transfusion (10mL/kg of red blood cells) to improve oxygenation-carrying capacity to persons with symptomatic ACS whose hemoglobin concentration is >1.0 g/dL below baseline; if baseline hemoglobin is ≥ 9g/dL, simple blood transfusion may not be required*
- *In persons with HbSC disease or $HbS\beta^{+}$ -thalassemia, consult an SCD expert regarding decisions about transfusion*
- *Perform urgent exchange transfusion in consultation with hematology, critical care, or apheresis specialists, when there is rapid progression of ACS as manifested by oxygen saturation of < 90% despite supplemental oxygen, increasing respiratory distress, progressive pulmonary infiltrates, decline in hemoglobin concentration despite simple transfusion, or all of these*
- *Encourage use of incentive spirometry while awake*

✍ Acute stroke:

- *Consult an SCD expert and perform exchange transfusion in persons with SCD who develop acute stroke confirmed by neuroimaging*
- *Initiate a program of monthly simple or exchange transfusions in children and adults who have had s stroke*
- *Initiate hydroxyurea therapy when it is not possible to initiate a transfusion program in children and adults who have had a stroke*

✍ Priapism:

- *Initiate interventions to include vigorous oral or intravenous hydration and oral or intravenous analgesia when an episode of priapism lasts ≥ 4h*
- *Consult with a urologist when an episode of priapism lasts ≥ 4h*
- *Do not use transfusion therapy for immediate treatment of priapism associated with SCD*
- *Consult with a hematologist for possible preoperative transfusion if surgical intervention is required*

✍ Hepatobiliary complications:

- *Treat asymptomatic gallstones with watchful waiting in children and adults with SCD; in those who develop symptoms specific to gallstones, treat with cholecystectomy (the laparoscopic approach is preferred if surgically feasible and available)*

✍ Splenic sequestration:

- *Provide immediate intravenous fluid resuscitation in persons with hypovolemia due to severe splenic sequestration*
- *Consult an SCD expert and begin transfusion in persons who have acute splenic sequestration and severe anemia to increase hemoglobin to stable level, while avoiding overtransfusion*
- *Consult an SCD expert to address the performance and timing of splenectomy in persons with recurrent acute splenic sequestration or symptomatic hypersplenism*

✍ Acute renal failure:

- *In a patient with an acute increase in serum creatinine level of ≥ 0.3mg/dL, (1) monitor renal function daily, including serum creatinine level, fluid intake, and fluid output; (2) avoid potential nephrotoxic drugs and imaging agents; and (3) evaluate the patient thoroughly for all potential etiologies in consultation with a nephrologist as needed*

- *Do not give blood transfusions to treat acute renal failure unless there are other indications for transfusion*
- *Use renal replacement therapy (e.g., hemodialysis) when needed for acute renal failure*

3. ***Managing chronic complications:***

✍ Avascular necrosis:

- *Evaluate all children and adults with SCD and intermittent or chronic hip pain for avascular necrosis by history, physical examination, radiography, and magnetic resonance imaging, as needed*
- *Treat avascular necrosis with analgesics and consult physical therapy and orthopedic for assessment and follow-up*

✍ Pulmonary hypertension:

- *Refer persons who have symptoms or signs suggestive of pulmonary hypertension for echocardiography*

✍ Renal complication:

- *Refer persons with proteinuria (>300mg/24h) to a nephrologist for further evaluation*
- *For adults with micoralbuminuria without other apparent cause, initiate angiotensin-converting enzyme (ACE) inhibitor therapy*
- *For adults with proteinuria without apparent cause, initiate ACE inhibitor therapy*
- *Initiate ACE inhibitor therapy for renal complications when indicated even in the presence of normal blood pressure*
- *Renal replacement therapy (e.g., hemodialysis, peritoneal dialysis, renal transplantation) should be used in persons with SCD if needed*

✍ Ophthalmologic complications:

- *Refer children and adults with vitreoretinal complications of proliferative sickle retinopathy(PSR) refractory to medical treatment for evaluation and possible vitrectomy*
- *A Refer persons of all ages with PSR to an ophthalmologist for evaluation and possible laser photocoagulation therapy*

✍ Leg ulcers:

- *Treat leg ulcers in persons with SCD with initial standard therapy (e.g., debridement, wet to dry dressings, topical agents)*
- *Evaluate persons with chronic recalcitrant deep leg ulcers for osteomyelitis*
- *Evaluate possible etiologies of leg ulcers to include venous insufficiency and perform wound culture if infection is suspected or if the ulcers deteriorate*

- *Treat with systemic or local antibiotics if leg ulcer site is suspicious for infection and wound culture is positive and organisms are susceptible*

4. ***Hydroxyurea therapy;***

- *In adults with sickle cell anemia (SCA) who have ≥ 3 moderate to severe pain crises associated with sickle cell disease(SCD) during a 12-mo period, initiate treatment with hydroxyurea*
- *In adults with SCA who have sickle cell-associated pain that interferes with daily activities and quality of life, initiate treatment with hydroxyurea*
- *In adults with SCA who have a history of severe or recurrent acute chest syndrome(ACS), initiate treatment with hydroxyurea*
- *In adults with SCA who have severe symptomatic chronic anemia that interferes with daily activities or quality of life, initiate treatment with hydroxyurea*
- *In infants 9 mo of age or older, in children, and in adolescents with SCA, offer treatment with hydroxyurea regardless of clinical severity to reduce complications (e.g., pain, dactylitis, ACS, anemia)related to SCD*
- *Discontinue hydroxyurea therapy in women who are pregnant or breastfeeding*
- *Use an established prescribing and monitoring protocol to ensure proper use of hydroxyurea and maximize benefits and safety*
- *In persons with HBSβ^+ -thalassemia or HbSC who have recurrent SCD-associated pain that interferes with daily activities or quality of life, consult an SCD expert for consideration of hydroxyurea therapy*
- *In persons not demonstrating a clinical response to appropriate doses and duration of hydroxyurea therapy, consult an SCD expert*

5. ***Blood transfusion in the management of SCD :***

✍ Indications for prophylactic perioperative transfusion:

- *In adults and children with sickle cell anemia(SCA), transfuse red blood cells to bring the hemoglobin level to 10 g/dL prior to undergoing a surgical procedure involving general anesthesia*
- *In persons with HbSS disease who require surgery and who already have a hemoglobin level higher than 8.5 g/dL without transfusion, are receiving long-term hydroxyurea therapy, or who require high-risk surgery(e.g., neurosurgery, prolonged anesthesia, cardiac bypass), consult a sickle cell disease(SCD) expert for guidance as to the appropriate transfusion method*
- *In adults and children with HbSC or HbSβ^+-thalassemia, consult an SCD expert to determine if full or partial exchange transfusion is indicated before a surgical procedure involving general anesthesia*

✍ Appropriate management and monitoring:

- *Red blood cell units that are to be transfused to individuals with SCD should include matching for C, E, and K antigens*
- *In persons with SCA who do not receive transfusions long-term and who are therefore at risk for hyperviscosity due to high percentage of circulating HbS-contining erythrocytes, avoid transfusing to a target hemoglobin level > 10 g/dL*
- *In children with SCA who receive transfusions long-term, the goal of transfusion should be to maintain a HbS level of < 30% immediately prior to the next transfusion*
- *The expert panel recommends that clinicians prescribing long-term transfusion therapy follow an established monitoring protocol*

✍ Management and prevention of transfusion complications:

- *Consult the blood bank for a workup of a possible delayed hemolytic transfusion reaction in a patient with any of the following signs or symptoms : acute anemia, pain, or jaundice within 3 weeks after a blood transfusion*
- *In persons who receive long-term transfusion therapy, perform serial assessment of iron overload to include validated liver iron quantification methods such as liver biopsy, MRI R2,T2, and R2; the optimal frequency of assessment has not been established and will be based in part on the individual patient's characteristics*
- *Administer iron chelation therapy (with consultation with a hematologist)to persons with SCD and documented transfusion-acquired iron overload*

References;

1. The evidence-Based Management of Sickle Cell Diseases: Expert panel Report 2014 (available at http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines/)
2. US Center for Disease Control and Prevention. Sickle cell disease: data and statistics. http://www.cdc.gov/ncbddd/sicklecell/data.html.
3. Benjamin LJ, Dampier CD, Jacox A, et al. *Guideline for the management of Acute and Chronic Pain in Sickle-Cell Disease.* Chicago, IL: American Pain Society 1999
4. Chou ST. Transfusion therapy for sickle cell disease: a balancing act. *Hematology Am Soc Hematol Edu Program.* 2013; 2013:439-446.
5. Up-to-date; September, 2014

ICE - HEALTHCARE CONTINUOUS QUALITY IMPROVEMENT
AUDIT TOOL - FY 2016

You will report EVERY quarter on ALL MEASURES that follow. There are 28 measures in total.

- Medication Errors
  - Medication Administration Errors
  - Prescribing/Ordering Errors
  - Pharmacy Order Errors
- Grievances
- Suicide Watch
- Hunger Strikes

For each of these components, you will review 10 charts (unless findings fall below the threshold established [thresholds are listed after each item] – then you must review 10 additional records). NOTE: If there are less than 10 charts, then review 100% of those charts that are applicable.

- Pregnancy Audit
- Medical Housing Unit
- Screening and Health Assessment
- Hypertension
- Diabetes
- Asthma
- HIV
- Tuberculosis
- Seizure Disorder
- Sick Call/Urgent Care
- Mental Illness with Psychotropic Medication
- Dental Care
- Continuity of Care
- Reasonable Accommodations
- Treatment of Disability
- Medication Administration Records
- Medication Refusal
- Diagnostic Services and Specialty Care Access
- Laboratory and Diagnostics
- Credentialing
- Mortality Review
- Medical Recordkeeping Practices

THRESHOLDS FOR COMPLIANCE: Each indicator has a percentage of compliance required (written next to it). If you fall below this threshold for compliance, you must submit a corrective action plan for it. The corrective action plan should be written in the section following the data.

MEDICATIONS (ESSENTIAL)

Instructions: Place the number if medication errors (from incident reports) in the column marked "numbers". If none, put "0". If not applicable, put "N/A". Do not leave any blank. *Number of errors and number of incident reports should match.*

Medication Administration Errors

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong medications given		
2. Number of wrong patients receiving medication		
3. Number of medications given at wrong time		
4. Number of medications missed		
5. Number of medications administered via wrong route		
6. Number of wrong doses given		
7. Number of transcription errors		
8. Number of expired prescriptions given		
9. Number of blank spaces on medication administration record (i.e. no documentation of missed medication)		
10. Other		
TOTAL NUMBER FROM 1-10:		

Prescribing/Ordering Errors

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients receiving medication		
2. Number of wrong drug - indication		
3. Number of wrong drug - allergy		
4. Number of wrong drug – drug interaction		
5. Number of wrong doses		
6. Number of wrong dosing schedules		
7. Number of orders written incorrectly		
8. Number of medication orders not forwarded to pharmacy		
9. Other		
TOTAL NUMBER FROM 1-9:		

Pharmacy Order Errors

	Number of Errors	Number of Incident Reports Submitted
1. Number of wrong patients		
2. Number of wrong medications		
3. Number of wrong doses		
4. Number of incorrect labels		
5. Number of wrong routes		
6. Number of MAR errors (misprinted, medication missing,)		
TOTAL NUMBER FROM QUESTIONS 1-6:		

GRIEVANCES (IMPORTANT)

Instructions: Obtain the numbers from grievance logs.

	Number
1. Number of grievances received	
2. Number of grievances addressed* within 5 business days * Designated medical staff shall act on the grievances within 5 working days of receipt and provide the detainee with a written response of the decision and the rationale.	
3. Number of grievances related to access to care	
4. Number of grievances related to quality of care	

Comments:

Corrective Action Plan(s) (if appropriate):

SUICIDE WATCH (ESSENTIAL)

Instructions: Obtain the numbers from intake screenings, suicide watch logs and medical records.

	Number
1. Total number of detainees on suicide watch during specified timeframe (for suicidal ideation, actions)	
2. Number of detainees (from number above) on suicide watch during specified time frame who made an actual suicide attempt	
3. Number of incident reports submitted (required for detainees with suicidal attempt)	
4. Number of detainees on suicide watch who were evaluated by behavioral health professionals within 24 hours, unless emergent (in which case the evaluation should be immediate)	
5. Number of detainees on suicide watch (from number above) who were seen previously by IHSC for mental health issues.	
6. Number of detainees on suicide watch with daily evaluations done by qualified medical staff	
7. Number of detainees on suicide watch with appropriate documentation (i.e. 15 minute and 8 hour documentation)	
8. Number of detainee on suicide watch that received follow up post/after discharge from suicide watch at interval consistent with the level of acuity (PBNDS)	

Comments:

Corrective Action Plan(s) (if appropriate):

HUNGER STRIKES (ESSENTIAL)

Instructions: Obtain the numbers from hunger strike logs and medical records.

	Number
1. Number of detainees on hunger strikes	
2. Number of detainees requiring medical intervention (intravenous therapy) ON SITE (not those off-site)	
3. Number of detainees requiring medical intervention (intravenous therapy) ON SITE(not those off-site) for whom an incident report was submitted	
4. Number of detainees on hunger strike with complete documentation (daily vital signs, daily weights, intake and output)	
5. Number of detainees on hunger strikes with provider evaluation documented	
6. Number of detainees on hunger strike requiring court-ordered force-feeding on site	
7. Number of detainees on hunger strike requiring court-ordered force-feeding in hospital	

Comments:

Corrective Action Plan(s) (if appropriate):

PREGNANCY AUDIT (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: A health care provider will review 100% of the charts of the pregnant patients during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.
Sample size: 100%

Item #	Measure
1	Was an OB-GYN consult ordered and the scheduled appointment time documented within 7 days of identification of condition? (Not necessarily seen within 7 days) **(100%)**
2	Prenatal vitamins prescribed? **(100%)**
3	Proper diet ordered? **(100%)**
4	Patient education documented at each encounter? **(100%)**
5	Records reviewed by provider after OB appointment? **(100%)**
6	Appropriate labs (consideration for HIV, STI, and viral hepatitis) ordered if not obtained from OB-GYN? **(100%)**

Record	Alien #	1	2	3	4	5	6
1							
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10							
PERCENTAGE							

Comments:

Corrective Action Plan(s) (if appropriate):

MEDICAL HOUSING UNIT REVIEW (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of patients who were admitted to the MHU during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of MHU patients for the designated time period according to A#, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Admitting history/current diagnosis or issues documented on the MHU progress note (to be completed by a physician/MLP or appropriate clinician according to scope of practice)? **(100%)**
2	Appropriate exam documented relevant to the reason for the MHU stay (e.g. dental, medical, or behavioral health exam)? **(100%)**
3	Provider rounds documented as noted in the treatment plan, if applicable? **(90%)**
4	Treatment plan includes specific instructions for nursing and appropriate precautions or interventions for infectious disease, if applicable? **(90%)**
5	Nursing care plan present (pre-developed electronic care plans may be applicable)? **(90%)**
6	Nursing care follow-up documented? **(100%)**
7	Nursing progress notes present for each shift? **(100%)**
8	24 hour chart review indicated with signature, date and time of review? **(90%)**
9	Discharge from MHU documented, if applicable? **(100%)**
10	Language Access: Use of translator, provider fluency in language, or English-speaking detainee is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9	10
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9											
10											
PERCENTAGE											

Comments:

Corrective Action Plan(s) (if appropriate):

SCREENING ASSESSMENT (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review the appropriate number (see page 1) of randomly selected records for patients that have been at the facility for more than two weeks during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

Sample size: See Page 1 of this document

Item #	Measure
1	Initial screening completed within 12 hours of admission to facility? **(100%)**
2	All required areas of the intake screening in electronic health record/manual health record are completed? **(100%)**
3	TB screening completed during medical intake if applicable (PPD or CXR)? **(100%)**
4	PPD read within 48-72 hours? (N/A if CXR performed) **(100%)**
5	TB clearance properly documented? **(100%)**
6	Was there timely (NLT 2 working days after identification) follow-up for significant findings of acute and chronic conditions? (A significant finding is a condition that, without timely intervention, could lead to deterioration in function, pain, death, or risk to the public health) **(100%)**

Record	Alien #	1	2	3	4	5	6
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10							
PERCENTAGE							

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

HEALTH ASSESSMENT (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review the appropriate number (see page 1) of randomly selected records for patients that have been at the facility for more than two weeks during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

Sample size: See Page 1 of this document

Item #	Measure
1	Was health assessment completed within 14 days? **(100%)**
2	Was health assessment completed for patients with chronic illnesses within two working days? **(100%)**
3	Health assessment (health history and hands-on physical examination) completed by licensed physician/PA/NP/RN? **(100%)**
4	If Health Assessment completed by RN, is RN annual training documented in the training files? (If no RN training documented, this item is "no")? **(100%)**
5	If applicable, documentation of transfer summary reviewed within 12 hours? **(100%)**
6	Patient education documented at each encounter? **(100%)**
7	Language access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7
1								
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5								
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10								
PERCENTAGE								

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

HYPERTENSION (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with hypertension during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with hypertension for the designated time period according to A#, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Blood pressure reading documented at intake? **(100%)**
2	Was PE-C completed within two business days of intake or after illness identification? **(100%)**
3	Patient was referred to MLP or higher, if exam was completed by RN? **(95%)**
4	Patient has treatment plan documented? **(95%)**
5	Diagnosis listed in provider SOAP note? **(100%)**
6.	Diagnosis listed on problem list? **(100%)**
7	Baseline labs obtained (CBC, CHEM, lipid profile, UA & EKG) and reviewed within 30 days of illness identification? **(100%)**
8	Patient education documented at each encounter? **(100%)**
9	Language access: Use of translator, provider fluency in language or English speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9
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PERCENTAGE										

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

DIABETES (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with diabetes during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with diabetes for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? **(100%)**
2	Documented blood sugar on intake (if diabetes identified at intake) or documented reason for not testing e.g. detainee just ate food one hour ago? **(90%)**
3	Diagnosis listed in provider SOAP note? **(100%)**
4	Diagnosis listed on problem list? **(100%)**
5	Baseline A1C obtained within 30 days of arrival or within past 3 months? **(100%)**
6	Baseline measurement of lipids within 30 days? **(100%)**
7	Documented prescription of aspirin, as clinically indicated? **(80%)**
8	Degree of control (goal of HgbA1C < 8.0) documented in treatment plan? **(90%)**
9	Was a strategy to attain diabetes control documented if HgbA1C was above goal? **(100%)**
10	Patient education documented at each encounter? **(100%)**
11	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9	10	11
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10												
PERCENTAGE												

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

ASTHMA (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with asthma during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with asthma for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? **(100%)**
2	Peak flow documented during health assessment? **(100%)**
3	Peak flow documented during all chronic care visits? **(100%)**
4	Diagnosis listed in provider SOAP note? **(100%)**
5	Diagnosis listed on problem list? **(100%)**
6	Treatment plan initiated in accordance with chronic care disease guidelines? **(90%)**
7	Patient education documented at each encounter? **(100%)**
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8
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PERCENTAGE									

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

HIV (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**
Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with HIV during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.
To RANDOMLY select, list out the total number of patients diagnosed with HIV for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? **(100%)**
2	Documented HIV+ by laboratory or prior medical record? **(95%)**
3	CD4 and viral load obtained within 30 days of disease identification or recent CD4/viral load results obtained from prior record (recent is within the past 90 days)? **(95%)**
4	Antiretroviral treatment considered and documented? **(100%)**
5	Treatment plan initiated in accordance with chronic care disease guideline within two business days of illness identification? **(95%)**
6	Diagnosis listed in provider SOAP note? **(100%)**
7	Diagnosis listed on problem list? **(100%)**
8	Was patient's care plan evaluated and documented by a physician with experience in managing HIV patients within 30 days of HIV identification or admission to IHSC facility (if diagnosis already known)? (This include referrals to off-site providers) **(95%)**
9	Was the patient seen by a medical provider at least every 90 days? **(95%)**
10	Was a PPD or IGRA performed within the last year? Note: if the patient has been positive in the past, an annual CXR is acceptable **(95%)**
11	If applicable, was the CXR completed or verified within 72 hours of health assessment as part of treatment plan? **(95%)**
12	Patient education documented at each encounter? **(95%)**
13	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9	10	11	12	13
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PERCENTAGE														

Add additional 10 records if you fall below the threshold.
Comments:
Corrective Action Plan(s) (if appropriate):

TUBERCULOSIS (Detainees being treated for active tuberculosis disease) (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records of patients with tuberculosis (TB) disease during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with TB disease for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? **(100%)**
2	All patients evaluated for TB disease are tested for HIV? **(100%)**
3	Pyrazinamide (PZA) and ethambutol (EMB) prescribed for no more than 60 days unless ordered by the advising physician? **(100%)**
4	TB patients are seen at least monthly by a medical provider for follow-up visits? **(100%)**
5	CXR is obtained 6-8 weeks after initiation of RIPE with comparison to previous CXR(s)? **(100%)**
6	Initial cultures are performed with automatic sensitivity testing and culture and sensitivity results (if at least one culture is positive for M. *tb*) are reviewed? **(100%)**
7	TB-CM visit note is completed at the time of diagnosis and updated with culture results, drug sensitivity test results (if culture positive), and final case classification within 90 days of diagnosis? **(100%)**

Record	Alien #	1	2	3	4	5	6	7
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PERCENTAGE								

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

SEIZURE DISORDER (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with seizure disorder during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with seizure disorder for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was PE-C completed within two business days of intake or after illness identification? **(100%)**
2	Documented complete neurological history/assessment at physical examination? **(100%)**
3	Diagnosis listed in provider SOAP note? **(100%)**
4	Diagnosis listed on problem list? **(100%)**
5	If applicable, documented serum drug levels obtained and acknowledged every 3 months until stable, then every 6 months, where indicated? **(100%)**
6	Special Needs issued for lower bunk? **(90%)**
7	Treatment plan initiated in accordance with chronic care disease guidelines? **(90%)**
8	Patient education documented at each encounter? **(100%)**
9	Language Access: Use of translator, provider fluency in language or English speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8	9
1										
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PERCENTAGE										

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

SICK CALL (URGENT CARE) REVIEW (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review appropriate number (see page 1) of randomly selected records from patients that have been seen for sick call during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of sick call encounters for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was patient seen or complaint addressed in timely manner (within 24 hours of submitting request)? **(100%)**
2	Vital signs obtained and documented during assessment? **(100%)**
3	Weight was documented during assessment? **(90%)**
4	A thorough pain assessment (intensity, duration, quality, better/worse, etc.) was documented during assessment, if applicable? **(100%)**
5	Treatment in accordance with nursing guidelines? **(100%)**
6	If appropriate, patient was referred to a higher level of care? (If not appropriate, mark as N/A) **(95%)**
7	Patient education documented at each encounter?**(100%)**
8	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7	8
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10									
PERCENTAGE									

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate)

MENTAL ILLNESS WITH PSYCHOTROPIC MEDICATIONS (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: A mid-level provider or physician will review appropriate number (see page 1) of randomly selected records of patients with mental illness who take psychotropic medications during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of patients diagnosed with mental illness and prescribed psychotropics during the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was a BH referral made in a timely manner (within 72 hours of intake or identification)? **(100%)**
2	Diagnosis listed by behavioral health provider in encounter note? **(100%)**
3	Diagnosis listed on problem list? **(100%)**
4	If patient takes psychotropic medication, psychotropic medication consent (special consent form) signed for the drug ordered? **(100%)**
5	Clinical assessment, treatment, and follow up plan documented? **(100%)**
6	For patients on antipsychotic medication, was there an AIMS (Abnormal Involuntary Movement Scale) test performed? **(100%)** (physician, MLP, RN can conduct an AIMS test)
7	Was appropriate lab monitoring ordered depending on the psychotropic drug? **(100%)**

Record	Alien #	1	2	3	4	5	6	7
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10								
PERCENTAGE								

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

DENTAL CARE (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: A dentist, dental hygienist, RN, mid-level provider or physician will review appropriate number (see page 1) of records from patients seen by a dentist for treatment within the designated time frame. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of health assessments for the designated time period according to A #, and select every other chart for completing audit.

If there are not enough medical records to select the required number of records to review, 100% review will be required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was dental (oral) screening completed and documented within 14 days of arrival to facility (adults)? ***oral screening includes visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist? **(100%)**
2	If applicable, was patient evaluated within 48 hours of referral? **(100%)**
3	Does clinical note describe findings, diagnosis/assessment, treatment plans? **(100%)**
4	If applicable, patient scheduled for follow-up treatment as recommended? **(100%)**
5	Was the oral examination completed by a dentist or scheduled within 12 months of arrival to facility for adults? **(100%)** oral examination by a dentist includes taking or reviewing the patient's oral history, an oral health and neck examination, charting of teeth, and examination of the hard and soft tissue of the oral cavity.

Record	Alien #	1	2	3	4	5
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PERCENTAGE						

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

CONTINUITY OF CARE REVIEW AFTER ED VISIT (ESSENTIAL)

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: Health staff (any IHSC staff) will review appropriate number (see page 1) of randomly selected records of patients who went to the Emergency Department during the current quarter. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

To RANDOMLY select, list out the total number of applicable medical records for the designated time period according to A #, and select every other chart for completing audit. If there are not enough medical records to select the required number of records for auditing, 100% review is required.

Sample size: See page 1 of this document.

Item #	Measure
1	Was a discharge summary/instructions requested or present? (Was a discharge summary/instructions received when the patient returned from the hospital?) **(100%)**
2	Was there a note from the IHSC provider detailing the reason the detainee was sent to the ED? **(100%)**
3	Was a note entered in the medical record upon the detainee's return to the facility listing the ED/hospital's recommended plan of care? **(100%)**
4	Did the provider follow the ED/hospital's recommended plan of care? **(100%)**
5	Upon return from ED, was the patient educated about diagnosis, medications (if applicable) and treatment plan? **(100%)**
6	Is there documentation acknowledging patient/parent understands treatment plan? **(100%)**
7	Language Access: Use of translator, provider fluency in language, or English-speaking patient is documented? **(100%)**

Record	Alien #	1	2	3	4	5	6	7
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PERCENTAGE								

Add additional 10 records if you fall below the threshold.

Comments:

Corrective Action Plan(s) (if appropriate):

REASONABLE ACCOMMODATIONS SELF-ASSESSMENT

Instructions: Obtain the information from the HSA's Reasonable Accommodation Self-Assessment Tool

	YES or NO
POLICY, PROCEDURES AND TRAINING	
1. Procedures are in place to ensure detainees with disabilities are informed of and have an equal opportunity to request and obtain health services.	
2. Medical/Clinical staff has received initial training on interacting with individuals with disabilities and individuals requiring reasonable accommodations, and annually thereafter.	
3. Written evacuation procedures and emergency communications are in place in the clinic for individuals with disabilities.	
4. Facility has a designated Reasonable Accommodations officer (Mark N/A if non-applicable)	
PHYSICAL ACCESSIBILITY	
5. The facility provides reasonable accommodation access for individuals within the Health Unit.	
COMMUNICATION	
6. The medical unit has access to sign language interpreters and telecommunication (TDD/TTY) for individuals with hearing disabilities.	

TREATMENT OF DISABILITY

Facility: **Quarter/Fiscal Year:**

Reviewer:

Purpose: To assess care of detainees who need accommodation for their disabilities.

An individual is considered to have a "disability" if s/he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment (see http://www.ada.gov/q%26aeng02.htm, accessed January 20, 2012). An RN, MLP or physician can review.

Source: Facility logs or tour of facility and interviews with detainees who need accommodation).

Sample: 10 detainees within the population who have a disability that requires special medical treatment. Determine through medical record examination if appropriate treatment and accommodation was given.
Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

Item #	Measure
1	Is the disability prominently noted in the file, along with any needed accommodations? **(100%)**
2	Was the detainee assessed for assistance with activities of daily living (ADL) upon identification of disability? **(100%)**
3	Were appropriate special orders entered (e.g., lower bunk, assistive device, meal, etc.)? **(100%)**
4	Was ADL assistance provided, if applicable? **(100%)**

	A #	1	2	3	4
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10					
	PERCENTAGE				

Comments:

Corrective Action Plan(s) (if appropriate):

MEDICATION ADMINISTRATION RECORDS

Facility: **Quarter/Fiscal Year:**

Reviewer:

Instructions: An RN, MLP, physician or clinical pharmacist will review 10 MARS. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable. Do not leave any area blank.

Sample size: 10

Item #	Measure
1	Is the appropriate up-to-date medication administration record included in the medical record? **(100%)**
2	Are there undocumented (blank) spaces in the medication administration records? **(0%)**
3	Does medication administration record include self-administered medication (KOP)? **(100%)**
4	Is there documentation of patient education for prescribed medications? **(100%)**

Sample size: 10

Record	1	2	3	4
1				
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PERCENTAGES				

Comments:

Corrective Action Plan(s) (if appropriate):

MEDICATION REFUSAL

Facility: **Quarter/Fiscal Year:**

Reviewer:

Purpose: To assess notification of prescribing clinician of poor adherence to medication orders

Source: Medication administration records, medical record.
RN, MLP or physician can review.

Sample: Identify 10 patients from MARs who have missed medication on three consecutive days or four or more doses in a week.
Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

Item #	Measure
1	Documented refusal in the medical record (with signature of detainee, witness)? **(100%)**
2.	Explanation of risks and benefits documented in the medical record? **(100%)**
3.	Was the ordering provider informed of refusals or missed doses (3 consecutive days or 3 consecutive doses and/or 50% of doses missed within 7 days) **(100%)**
4.	If refusals or missed doses, follow-up counseling documented and clinician response? **(100%)**
5.	If detainee refused to sign refusal form, was it documented on the form? **(100%)**

	A #	1	2	3	4	5
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
	PERCENTAGE					

Comments:

Corrective Action Plan(s) (if appropriate):

DIAGNOSTIC SERVICES AND SPECIALTY CARE ACCESS

Facility: **Quarter/Fiscal Year:**

Reviewer:

Purpose: To assess timeliness of off-site diagnostic services and specialty care.

Source: Statistics.

MLP or physician can review.

Sample: 10 specialty patients chosen by acuity or risk of harm if access is delayed, particularly in specialties where timely access has been a problem for detainees in this facility.

Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

Item #	Measure
1	Documented time urgency on order? **(90%)**
2	Accomplished within 45 days of order or within ordered timeframe, e.g., "return in 90 days"? **(100%)**
3	Documented re-evaluation of patient for deterioration each 30 days in excess of time urgency on order? **(90%)**
4.	Clinician acknowledgement and report in medical record within 7 days? **(90%)**
5.	Detainee informed of results or reason for delay if not scheduled? **(90%)**

	A #	Clinic	1	2	3	4	5
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
	PERCENTAGES						

Comments:

Corrective Action Plan(s) (if appropriate):

LABORATORY AND DIAGNOSTICS

Facility: **Quarter/Fiscal Year:**

Reviewer:

Purpose: To assess timeliness, continuity, and coordination of care.

Source: Laboratory log.
RN, MLP or physician can review.

Sample: 10 most recent orders for acute labs, not including routine testing for detainees with chronic illness.

Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

Item #	Measure
1	Up to date certification for CLIA-waived testing accessible? **(100%)**
2	Documentation of applicable staff training for performing CLIA-waived tests? **(100%)**
3	Blood drawn or test done within 1 business day of ordered date? **(100%)**
4	Results received within 24 hours or as appropriate? **(100%)**
5	Clinician acknowledgment of results documented? **(100%)**
6	Detainee informed of results; if not, reason documented in medical record? **(100%)**

	A #	1	2	3	4	5	6
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
	PERCENTAGES						

Comments:

Corrective Action Plan(s) (if appropriate):

CREDENTIALING

Facility: **Quarter/Fiscal Year:**

Reviewer:

Purpose: To assess credentials of all health care professionals, ensuring they are legally qualified to provide services consistent with licensure, certification, and registration requirements of the practicing jurisdiction.

Source: Up to 10 files for each of all licensed health care professionals.

Sample: HSA or AHSA will review.

Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

10 chosen at random.

Item #	Measure
1	Documentation of primary source validation (e.g., internet) of current license, certification or registrations for all applicable licensed professionals? **(100%)**
2	Validation of DEA license for physicians, psychiatrists, and dentists? **(100%)**
3	Current CPR certificate (100%)
4	Documentation upon hire and annually thereafter of National Practitioner Data Bank inquiry of licensed independent providers (LIPs)? (100%)

	Title	1	2	3	4
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
	PERCENTAGES				

Comments:

Corrective Action Plan(s) (if appropriate):

MORTALITY REVIEW

Facility: **Quarter/Fiscal Year:**
Reviewer:

Purpose: To determine the appropriateness of clinical care; to ascertain whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

Source: Minutes, notes, medical records, emergency response, and other pertinent documents. MLP or physician will review. Mark as "Y" for yes, "N" for no, and "N/A" for not applicable.

Sample: All in-custody deaths, including those in hospital, within the past quarter.

Item #	**Measure**
1	Mortality review (clinical, administrative) completed within 45 calendar days of death? **(100%)**
2	Documented assessment as to whether the medical response was appropriate on the day of death or transfer to the hospital? **(100%)**
3	Documented assessment as to whether earlier intervention was possible and whether that would have changed the outcome? **(100%)**
4	Analysis of ways to improve patient care, independent of the cause of death or RCA completed? **(100%)**
	For suicides only
5	Was there a psychological autopsy ordered/completed? **(100%)**
6	Was an after-action report completed with all staff involved in the event? **(100%)**
7	Was post-event counseling offered to staff involved in the event? **(100%)**
8	Was treating staff informed of the clinical mortality review and administrative findings? **(100%)**

Definition:
Clinical mortality review is an assessment of clinical care provided and the circumstances leading up to the death. Its purpose is to identify areas of patient care or system policies and procedures that can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

Administrative morality review is an assessment of correctional and emergency response actions surrounding the detainee's death. Its purpose is to identify areas where facility operations, policies and procedures can be improved. (This information is collected by the HSA, IHSC Compliance Investigations and Risk Management)

	A #	1	2	3	4	5	6	7	8
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
	Total								

Comments:
Corrective Action Plan(s) (if appropriate):

MEDICAL RECORDKEEPING PRACTICES

Facility: **Quarter/Fiscal Year:**
Reviewer:

Instructions: This worksheet should be filled out following the performance-based reviews. For all answers that are "partial compliance" or "non-compliance," the reviewer should write a comment. For example, if most of the progress notes are legible, but one or two practitioners' notes are barely legible; the appropriate comment would be "Dr. XX.s notes are not legible."

Reviewer can be any health care provider.

Sample: 10 records reviewed on detainees with chronic disease.

		Yes	Partial	No	N/A	Comments
1	Patient identifying information (100%)					
2	Current problem list (100%)					
3	Receiving screen and health assessment forms (100%)					
4	Progress notes (100%)					
5	Clinician orders for medication, signed (100%)					
6	MARs (100%)					
7	Lab and diagnostic reports (100%)					
8	Flow sheets (100%)					
9	Consent, refusal, and release of information forms (100%)					
10	Results of specialty consultations and referrals (100%)					
11	Discharge summaries from ED and hospitalizations (100%)					
12	Special needs treatment plan documented, if applicable (100%)					
13	Immunizations records, where applicable (100%)					
14	Date and time of each encounter (100%)					
15	Integrated medical, dental, and mental health record (100%)					
16	Timely filing, within 72 hours (100%)					
17	Consolidated medical record (100%)					
18	Content organized for easy retrieval (100%)					
19	EHR password protected, by individual, if applicable(100%)					
20	Integrated health information with EHR, if applicable (100%)					

Comments:
Corrective Action Plan(s) (if appropriate):

Attachment 14 was a repeat of the Security Standards that are in Article 7. This attachment was deleted.

From: Casterline, Arnold P <Arnold.P.Casterline@ice.dhs.gov>
Sent: Wednesday, May 8, 2019 8:27 AM
To: Metcalf, Natasha <Natasha.Metcalf@corecivic.com>; Quigley, William <William.Quigley@ice.dhs.gov>; Harrell, Brandon <Brandon.Harrell@ice.dhs.gov>
Cc: Aitken, Timothy <Timothy.Aitken@corecivic.com>; Verhulst, Bart <Bart.Verhulst@corecivic.com>; Cason, Stacey <Stacey.Cason@corecivic.com>; Morris, Broderick <Broderick.Morris@ice.dhs.gov>
Subject: RE: Torrance IGSA

Good Morning,

OAQ is going to get you a finalized copy of the IGSA today so that CoreCivic can send it on to the county for signature.

1. I have reviewed the comments in the IGSA concerning the 95% staffing and leadership is in agreement with the change. The proposed 714 GM staffing is being reviewed by ERO and other offices.
2. Attached is the updated security language for FY19 that will be inserted into Article 7. Please review the updated language. We will remove Attachment 14 being it is redundant.
3. I have inserted a statement to Article 36 concerning Space requirements.

Let me know if you have any concerns.

Thank you,

Arnold Casterline Jr.
Detention, Compliance & Removals (DCR) | Contracting Officer
DHS | ICE | Office of Acquisition Management (OAQ)
Phone: 202-732-2394

Mobile Phone: 202-878-1663
Email: arnold.p.casterline@ice.dhs.gov

CoreCivic

Torrance County Detention Facility
Indoor/Outdoor Recreation Schedule

		SUN	MON	TUE	WED	THU	FRI	SAT
7:00am-9:00am	South	High/High Medium ICE	High/High Medium ICE	High/High Medium ICE	High/High Medium ICE	High/High Medium ICE	High/High Medium ICE	High/High Medium ICE
	West	500	500	500	500	500	500	500
9:00am-11:00am	South	200	200	200	200	200	200	200
	West	600	600	600	600	600	600	600
12:00pm-2:00pm	South	100	100	100	100	100	100	100
	West	700	700	700	700	700	700	700
2:00pm-4:00pm	South	TCSO Females 2-3pm TCSO Males 3-4pm	TCSO Females 2-3pm TCSO Males 3-4pm	TCSO Females 2-3pm TCSO Males 3-4pm	TCSO Females 2-3pm TCSO Males 3-4pm	TCSO Females 2-3pm TCSO Males 3-4pm	TCSO Females 2-3pm TCSO Males 3-4pm	TCSO Females 2-3pm TCSO Males 3-4pm
	West	800	800	800	800	800	800	800

The schedule will rotate every 30 days and times are subject change based on inclement weather and or facility needs.

CoreCivic

Torrance County Detention Facility

MEMO

TO: **Detainee Population**

FROM: **Facility Staff**

DATE:

RE: **Visitation Schedule**

Below are scheduled dates and times for contact social visitation at Torrance County Detention Facility. Special requests/considerations can be made through a request to your unit team.

Time	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
8:00am-10:00am	Unit 100 Unit 200 Unit 600	Closed	Closed	Closed	Segregation (non-contact)	Unit 500 Unit 700 Unit 800	High-High Medium Custody
10:00am-12:00pm	Unit 500 Unit 700 Unit 800	Closed	Closed	Closed	Segregation (non-contact)	High Custody	Unit 100 Unit 200 Unit 600
12:00pm-2:00pm	High-High Medium Custody	Closed	Closed	TCSO Female (non-contact)	TCSO Males (non-contact)	Unit 100 Unit 200 Unit 600	Unit 500 Unit 700 Unit 800
4:00pm-6:00pm	Closed	Closed	Closed	High-High Medium Custody	Closed	Closed	Closed
6:00pm-8:00pm	Closed	Closed	Closed	Low-Low Medium Custody	Closed	Closed	Closed

CoreCivic

TORRANCE COUNTY DETENTION FACILITY
ACTIVATION RAMP PLAN

Ramp Week	Intake Day	Intake Number	Total Population	Planned Pod Housing
Week 1	TBD	120	120	2A/2B/1D
Week 2	TBD	120	240	2A/2B/1D/1C/1B
Week 3	TBD	120	360	2A/2B/1D/1C/1B/6A/6B/6C
Week 4	TBD	120	480	Unit 5 and 6/2A/2B/1D
Week 5	TBD	120	600	Units 5,6,7,8
Week 6	TBD	120	720	Units 5,6,7,8/2A/2B
Week 7	TBD	120	840	Units 5,6,7,8/2A/2B/1D/1C
Week 8	TBD	60	900	All planned

The monthly invoice amount during the ramp up period will be negotiated prior to the issuance of the first task order and will be based on the detainee population. The agreed upon FP monthly amount of $1.9 for detainees 1 - 714 will only be paid if the GM is met.

ATTACHMENT 4-DHS PREA STANDARDS

This document incorporates the requirements from Subpart A of the U.S. Department of Homeland Security (DHS) regulation titled, "Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities," 79 Fed. Reg. 13100 (Mar. 7, 2014) that are specifically applicable to detention facilities. Requirements that are applicable to the agency only have not been included, and accordingly, the numbering and sequential order within each of the below sections may not necessarily reflect those contained in Subpart A. Where any requirements of the DHS standards may conflict with the terms of the ICE detention standards currently applicable at the facility, the DHS PREA standards shall supersede:

115.6 Definitions Related to Sexual Abuse and Assault

(1) Sexual abuse includes –
   (a) Sexual abuse and assault of a detainee by another detainee; and
   (b) Sexual abuse and assault of a detainee by a staff member, contractor, or volunteer.

(2) Sexual abuse of a detainee by another detainee includes any of the following acts by one or more detainees, prisoners, inmates, or residents of the facility in which the detainee is housed who, by force, coercion, or intimidation, or if the victim did not consent or was unable to consent or refuse, engages in or attempts to engage in:
   (a) Contact between the penis and the vulva or anus and, for purposes of this subparagraph, contact involving the penis upon penetration, however slight;
   (b) Contact between the mouth and the penis, vulva, or anus;
   (c) Penetration, however, slight, of the anal or genital opening of another person by a hand or finger or by any object;
   (d) 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
   (e) Threats, intimidation, or other actions or communications by one or more detainees aimed at coercing or pressuring another detainee to engage in a sexual act.

(3) Sexual abuse of a detainee by a staff member, contractor, or volunteer includes any of the following acts, if engaged in by one or more staff members, volunteers, or contract personnel who, with or without the consent of the detainee, engages in or attempts to engage in:
   (a) Contact between the penis and the vulva or anus and, for purposes of this subparagraph, contact involving the penis upon penetration, however slight;
   (b) Contact between the mouth and the penis, vulva, or anus;
   (c) Penetration, however slight, of the anal or genital opening of another person by a hand or finger or by any object that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;
   (d) Intentional touching of the genitalia, anus, groin, breast, inner thighs or buttocks, either directly or through the clothing, that is unrelated to official duties or where

the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;

(e) Threats, intimidation, harassment, indecent, profane or abusive language, or other actions or communications, aimed at coercing or pressuring a detainee to engage in a sexual act;

(f) Repeated verbal statements or comments of a sexual nature to a detainee;

(g) Any display of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate, detainee, or resident, or

(h) Voyeurism, which is defined as the inappropriate visual surveillance of a detainee for reasons unrelated to official duties. Where not conducted for reasons relating to official duties, the following are examples of voyeurism: staring at a detainee who is using a toilet in his or her cell to perform bodily functions; requiring an inmate detainee to expose his or her buttocks, genitals, or breasts; or taking images of all or part of a detainee's naked body or of a detainee performing bodily functions.

PREVENTION PLANNING

115.11 Zero tolerance of sexual abuse; Prevention of Sexual Assault Coordinator.

(1) Each facility shall have a written policy mandating zero tolerance toward all forms of sexual abuse and outlining the facility's approach to preventing, detecting, and responding to such conduct. The agency shall review and approve each facility's written policy.

(2) Each facility shall employ or designate a Prevention of Sexual Assault Compliance Manager (PSA Compliance Manager) who shall serve as the facility point of contact for the ICE PSA Coordinator and who has sufficient time and authority to oversee facility efforts to comply with facility sexual abuse prevention and intervention policies and procedures.

115.13 Detainee supervision and monitoring.

(1) Each facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse.

(2) Each facility shall develop and document comprehensive detainee supervision guidelines to determine and meet the facility's detainee supervision needs, and shall review those guidelines at least annually.

(3) In determining adequate levels of detainee supervision and determining the need for video monitoring, the facility shall take into consideration generally accepted detention and correctional practices, any judicial findings of inadequacy, the physical layout of each facility, the composition of the detainee population, the prevalence of substantiated and unsubstantiated incidents of sexual abuse, the findings and recommendations of sexual abuse incident review reports, and any other relevant factors, including but not limited to the length of time detainees spend in agency custody.

(4) Each facility shall conduct frequent unannounced security inspections to identify and deter sexual abuse of detainees. Such inspections shall be implemented for night as well

as day shifts. Each facility shall prohibit staff from alerting others that these security inspections are occurring, unless such announcement is related to the legitimate operational functions of the facility.

115.15 Limits to cross-gender viewing and searches.

(1) Searches may be necessary to ensure the safety of officers, civilians and detainees; to detect and secure evidence of criminal activity; and to promote security, safety, and related interests at immigration detention facilities.
(2) Cross-gender pat-down searches of male detainees shall not be conducted unless, after reasonable diligence, staff of the same gender is not available at the time the pat-down search is required or in exigent circumstances.
(3) Cross-gender pat-down searches of female detainees shall not be conducted unless in exigent circumstances.
(4) All cross-gender pat-down searches shall be documented.
(5) Cross-gender strip searches or cross-gender visual body cavity searches shall not be conducted except in exigent circumstances, including consideration of officer safety, or when performed by medical practitioners. Facility staff shall not conduct visual body cavity searches of juveniles and, instead, shall refer all such body cavity searches of juveniles to a medical practitioner.
(6) All strip searches and visual body cavity searches shall be documented.
(7) Each facility shall implement policies and procedures that enable detainees to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing.
(8) The facility shall not search or physically examine a detainee for the sole purposes of determining the detainee's genital characteristics. If the detainee's gender is unknown, it may be determined during conversations with the detainee, by reviewing medical records, or, if necessary, learning that information as part of a standard medical examination that all detainees must undergo as part of intake or other processing procedure conducted in private, by a medical practitioner.

115.16 Accommodating detainees with disabilities and detainees who are limited English proficient.

(1) The agency and each facility shall take appropriate steps to ensure that detainees with disabilities (including, for example, detainees who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech disabilities) have an equal opportunity to participate in or benefit from all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse. Such steps shall include, when necessary to ensure effective communication with detainees who are deaf or hard of hearing, providing access to in-person, telephonic, or video interpretive services that enable effective, accurate, and impartial interpretation, both receptively and

expressively, using any necessary specialized vocabulary. In addition, the agency and facility shall ensure that any written materials related to sexual abuse are provided in formats or through methods that ensure effective communication with detainees with disabilities, including detainees who have intellectual disabilities, limited reading skills, or who are blind or have low vision. An agency or facility is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans with Disabilities Act, 28 CFR 35.164.

(2) The agency and each facility shall take steps to ensure meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary.

(3) In matters relating to allegations of sexual abuse, the agency and each facility shall provide in-person or telephonic interpretation services that enable effective, accurate, and impartial interpretation, by someone other than another detainee, unless the detainee expresses a preference for another detainee to provide interpretation, and the agency determines that such interpretation is appropriate and consistent with DHS policy. The provision of interpreter services by minors, alleged abusers, detainees who witnessed the alleged abuse, and detainees who have a significant relationship with the alleged abuser is not appropriate in matters relating to allegations of sexual abuse.

115.17 Hiring and promotion decisions.

(1) An agency or facility shall not hire or promote anyone who may have contact with detainees, and shall not enlist the services of any contractor or volunteer who may have contact with detainees, who has engaged in sexual abuse in a prison, jail, holding facility, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); who has been convicted of engaging or attempting to engage in sexual activity facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or who has been civilly or administratively adjudicated to have engaged in such activity.

(2) An agency or facility considering hiring or promoting staff shall ask all applicants who may have contact with detainees directly about previous misconduct described in paragraph (1) of this section, in written applications or interviews for hiring or promotions and in any interviews or written self-evaluations conducted as part of reviews of current employees. Agencies and facilities shall also impose upon employees a continuing affirmative duty to disclose any such misconduct. The agency, consistent with law, shall make its best efforts to contact all prior institutional employers of an applicant for employment, to obtain information on substantiated allegations of sexual abuse or any resignation during a pending investigation of alleged sexual abuse.

(3) Before hiring new staff who may have contact with detainees, the agency or facility shall conduct a background investigation to determine whether the candidate for hire is suitable for employment with the facility or agency, including a criminal background

records check. Upon request by the agency, the facility shall submit for the agency's approval written documentation showing the detailed elements of the facility's background check for each staff member and the facility's conclusions. The agency shall conduct an updated background investigation every five years for agency employees who may have contact with detainees. The facility shall require an updated background investigation every five years for those facility staff who may have contact with detainees and who work in immigration-only detention facilities.

(4) The agency or facility shall also perform a background investigation before enlisting the services of any contractor who may have contact with detainees. Upon request by the agency, the facility shall submit for the agency's approval written documentation showing the detailed elements of the facility's background check for each contractor and the facility's conclusions.

(5) Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination or withdrawal of an offer of employment, as appropriate.

(6) In the event the agency contracts with a facility for the confinement of detainees, the requirements of this section otherwise applicable to the agency also apply to the facility and its staff.

115.18 Upgrades to facilities and technologies.

(1) When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the facility or agency, as appropriate, shall consider the effect of the design, acquisition, expansion, or modification upon their ability to protect detainees from sexual abuse.

(2) When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology in an immigration detention facility, the facility or agency, as appropriate, shall consider how such technology may enhance their ability to protect detainees from sexual abuse.

RESPONSIVE PLANNING

115.21 Evidence protocols and forensic medical examinations.

(1) To the extent that the agency or facility is responsible for investigating allegations of sexual abuse involving detainees, it shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. The protocol shall be developed in coordination with DHS and shall be developmentally appropriate for juveniles, where applicable.

(2) The agency and each facility developing an evidence protocol referred to in paragraph (1) of this section, shall consider how best to utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention and counseling to most appropriately address victims' needs. Each facility shall establish procedures to make available, to the full extent possible, outside victim services following incidents of sexual abuse; the facility shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available

to provide victim advocate services, the agency shall provide these services by making available a qualified staff member from a community-based organization, or a qualified agency staff member. A qualified agency staff member or a qualified community-based staff member means an individual who has received education concerning sexual assault and forensic examination issues in general. The outside or internal victim advocate shall provide emotional support, crisis intervention, information, and referrals.

(3) Where evidentiarily or medically appropriate, at no cost to the detainee, and only with the detainee's consent, the facility shall arrange for an alleged victim detainee to undergo a forensic medical examination by qualified health care personnel, including a Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) where practicable. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified health care personnel.

(4) As requested by a victim, the presence of his or her outside or internal victim advocate, including any available victim advocacy services offered by a hospital conducting a forensic exam, shall be allowed for support during a forensic exam and investigatory interviews.

(5) To the extent that the agency is not responsible for investigating allegations of sexual abuse, the agency or the facility shall request that the investigating agency follow the requirements of paragraphs (1) through (4) of this section.

115.22 Policies to ensure investigation of allegations and appropriate agency oversight.

(1) The agency shall establish an agency protocol, and shall require each facility to establish a facility protocol, to ensure that each allegation of sexual abuse is investigated by the agency or facility, or referred to an appropriate investigative authority.

(2) The agency shall ensure that the agency and facility protocols required by paragraph (a) of this section, include a description of responsibilities of the agency, the facility, and any other investigating entities; and require the documentation and maintenance, for at least five years, of all reports and referrals of allegations of sexual abuse.

(3) The agency shall post its protocols on its Web site; each facility shall also post its protocols on its Web site, if it has one, or otherwise make the protocol available to the public.

(4) Each facility protocol shall ensure that all allegations are promptly reported to the agency as described in paragraphs (5) and (6) of this section, and, unless the allegation does not involve potentially criminal behavior, are promptly referred for investigation to an appropriate law enforcement agency with the legal authority to conduct criminal investigations. A facility may separately, and in addition to the above reports and referrals, conduct its own investigation.

(5) When a detainee, prisoner, inmate, or resident of the facility in which an alleged detainee victim is housed is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as the appropriate ICE Field Office Director, and, if it is potentially criminal, referred to an appropriate law enforcement agency having jurisdiction for investigation.

(6) When a staff member, contractor, or volunteer is alleged to be the perpetrator of detainee sexual abuse, the facility shall ensure that the incident is promptly reported to the Joint

Intake Center, the ICE Office of Professional Responsibility or the DHS Office of Inspector General, as well as to the appropriate ICE Field Office Director, and to the local government entity or contractor that owns or operates the facility. If the incident is potentially criminal, the facility shall ensure that it is promptly referred to an appropriate law enforcement agency having jurisdiction for investigation.

TRAINING AND EDUCATION

115.31 Staff training.

(1) The agency shall train, or require the training of, all employees who may have contact with immigration detainees, and all facility staff, to be able to fulfill their responsibilities under this part, including training on:
   (a) The agency's and the facility's zero-tolerance policies for all forms of sexual abuse;
   (b) The right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse;
   (c) Definitions and examples of prohibited and illegal sexual behavior;
   (d) Recognition of situations where sexual abuse may occur;
   (e) Recognition of physical, behavioral, and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences;
   (f) How to avoid inappropriate relationships with detainees;
   (g) How to communicate effectively and professionally with detainees, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming detainees;
   (h) Procedures for reporting knowledge or suspicion of sexual abuse; and
   (i) The requirement to limit reporting of sexual abuse to personnel with a need-to-know in order to make decisions concerning the victim's welfare and for law enforcement or investigative purposes.

(2) All current facility staff, and all agency employees who may have contact with immigration detention facility detainees, shall be trained within one year of May 6, 2014, and the agency or facility shall provide refresher information every two years.

(3) The agency and each facility shall document that staff that may have contact with immigration facility detainees have completed the training.

115.32 Other training.

(1) The facility shall ensure that all volunteers and other contractors (as defined in paragraph (4) of this section) who have contact with detainees have been trained on their responsibilities under the agency's and the facility's sexual abuse prevention, detection, intervention and response policies and procedures.

(2) The level and type of training provided to volunteers and other contractors shall be based on the services they provide and level of contact they have with detainees, but all volunteers and other contractors who have contact with detainees shall be notified of the agency's and the facility's zero-tolerance policies regarding sexual abuse and informed how to report such incidents.

(3) Each facility shall receive and maintain written confirmation that volunteers and other contractors who have contact with immigration facility detainees have completed the training.
(4) In this section, the term *other contractor* means a person who provides services on a non-recurring basis to the facility pursuant to a contractual agreement with the agency or facility.

115.33 Detainee education.

(1) During the intake process, each facility shall ensure that the detainee orientation program notifies and informs detainees about the agency's and the facility's zero-tolerance policies for all forms of sexual abuse and includes (at a minimum) instruction on:
    (a) Prevention and intervention strategies;
    (b) Definitions and examples of detainee-on-detainee sexual abuse, staff-on-detainee sexual abuse and coercive sexual activity;
    (c) Explanation of methods for reporting sexual abuse, including to any staff member, including a staff member other than an immediate point-of-contact line officer (e.g., the compliance manager or a mental health specialist), the DHS Office of Inspector General, and the Joint Intake Center;
    (d) Information about self-protection and indicators of sexual abuse;
    (e) Prohibition against retaliation, including an explanation that reporting sexual abuse shall not negatively impact the detainee's immigration proceedings; and
    (f) The right of a detainee who has been subjected to sexual abuse to receive treatment and counseling.
(2) Each facility shall provide the detainee notification, orientation, and instruction in formats accessible to all detainees, including those who are limited English proficient, deaf, visually impaired or otherwise disabled, as well as to detainees who have limited reading skills.
(3) The facility shall maintain documentation of detainee participation in the intake process orientation.
(4) Each facility shall post on all housing unit bulletin boards the following notices:
    (a) The DHS-prescribed sexual assault awareness notice;
    (b) The name of the Prevention of Sexual Abuse Compliance Manager; and
    (c) The name of local organizations that can assist detainees who have been victims of sexual abuse.
(5) The facility shall make available and distribute the DHS-prescribed "Sexual Assault Awareness Information" pamphlet.
(6) Information about reporting sexual abuse shall be included in the agency Detainee Handbook made available to all immigration detention facility detainees.

115.34 Specialized training: Investigations.

(1) In addition to the general training provided to all facility staff and employees pursuant to § 115.31, the agency or facility shall provide specialized training on sexual abuse and effective cross-agency coordination to agency or facility investigators, respectively, who conduct investigations into allegations of sexual abuse at immigration detention facilities. All investigations into alleged sexual abuse must be conducted by qualified investigators.

(2) The agency and facility must maintain written documentation verifying specialized training provided to investigators pursuant to this section.

115.35 Specialized training: Medical and mental health care.

(1) The agency shall review and approve the facility's policy and procedures to ensure that facility medical staff is trained in procedures for examining and treating victims of sexual abuse, in facilities where medical staff may be assigned these activities.

ASSESSMENT FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

115.41 Assessment for risk of victimization and abusiveness.

(1) The facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. Each new arrival shall be kept separate from the general population until he/she is classified and may be housed accordingly.
(2) The initial classification process and initial housing assignment should be completed within twelve hours of admission to the facility.
(3) The facility shall also consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization:
    (a) Whether the detainee has a mental, physical, or developmental disability;
    (b) The age of the detainee;
    (c) The physical build and appearance of the detainee;
    (d) Whether the detainee has previously been incarcerated or detained;
    (e) The nature of the detainee's criminal history;
    (f) Whether the detainee has any convictions for sex offenses against an adult or child;
    (g) Whether the detainee has self-identified as gay, lesbian, bisexual, transgender, intersex, or gender nonconforming;
    (h) Whether the detainee has self-identified as having previously experienced sexual victimization; and
    (i) The detainee's own concerns about his or her physical safety.
(4) The initial screening shall consider prior acts of sexual abuse, prior convictions for violent offenses, and history of prior institutional violence or sexual abuse, as known to the facility, in assessing detainees for risk of being sexually abusive.
(5) The facility shall reassess each detainee's risk of victimization or abusiveness between 60 and 90 days from the date of initial assessment, and at any other time when warranted based upon the receipt of additional, relevant information or following an incident of abuse or victimization.
(6) Detainees shall not be disciplined for refusing to answer, or for not disclosing complete information in response to, questions asked pursuant to paragraphs (3)(a), (3)(g), (3)(h), or (3)(i) of this section.
(7) The facility shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive

information is not exploited to the detainee's detriment by staff or other detainees or inmates.

115.42 Use of assessment information.

(1) The facility shall use the information from the risk assessment under § 115.41 of this part to inform assignment of detainees to housing, recreation and other activities, and voluntary work. The agency shall make individualized determinations about how to ensure the safety of each detainee.
(2) When making assessment and housing decisions for a transgender or intersex detainee, the facility shall consider the detainee's gender self-identification and an assessment of the effects of placement on the detainee's health and safety. The facility shall consult a medical or mental health professional as soon as practicable on this assessment. The facility should not base placement decisions of transgender or intersex detainees solely on the identity documents or physical anatomy of the detainee; a detainee's self-identification of his/her gender and self-assessment of safety needs shall always be taken into consideration as well. The facility's placement of a transgender or intersex detainee shall be consistent with the safety and security considerations of the facility, and placement and programming assignments for each transgender or intersex detainee shall be reassessed at least twice each year to review any threats to safety experienced by the detainee.
(3) When operationally feasible, transgender and intersex detainees shall be given the opportunity to shower separately from other detainees.

115.43 Protective custody.

(1) The facility shall develop and follow written procedures consistent with the standards in this subpart for each facility governing the management of its administrative segregation unit. These procedures, which should be developed in consultation with the ICE Enforcement and Removal Operations Field Office Director having jurisdiction for the facility, must document detailed reasons for placement of an individual in administrative segregation on the basis of a vulnerability to sexual abuse or assault.
(2) Use of administrative segregation by facilities to protect detainees vulnerable to sexual abuse or assault shall be restricted to those instances where reasonable efforts have been made to provide appropriate housing and shall be made for the least amount of time practicable, and when no other viable housing options exist, as a last resort. The facility should assign detainees vulnerable to sexual abuse or assault to administrative segregation for their protection until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days.
(3) Facilities that place vulnerable detainees in administrative segregation for protective custody shall provide those detainees access to programs, visitation, counsel and other services available to the general population to the maximum extent practicable.
(4) Facilities shall implement written procedures for the regular review of all vulnerable detainees placed in administrative segregation for their protection, as follows:

(a) A supervisory staff member shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted; and
(b) A supervisory staff member shall conduct, at a minimum, an identical review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first 30 days, and every 10 days thereafter.

(5) Facilities shall notify the appropriate ICE Field Office Director no later than 72 hours after the initial placement into segregation, whenever a detainee has been placed in administrative segregation on the basis of a vulnerability to sexual abuse or assault.

REPORTING

115.51 Detainee reporting.

(1) The agency and each facility shall develop policies and procedures to ensure that detainees have multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The agency and each facility shall also provide instructions on how detainees may contact their consular official, the DHS Office of the Inspector General or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents.

(2) The agency shall also provide, and the facility shall inform the detainees of, at least one way for detainees to report sexual abuse to a public or private entity or office that is not part of the agency, and that is able to receive and immediately forward detainee reports of sexual abuse to agency officials, allowing the detainee to remain anonymous upon request.

(3) Facility policies and procedures shall include provisions for staff to accept reports made verbally, in writing, anonymously, and from third parties and to promptly document any verbal reports.

115.52 Grievances.

(1) The facility shall permit a detainee to file a formal grievance related to sexual abuse at any time during, after, or in lieu of lodging an informal grievance or complaint.

(2) The facility shall not impose a time limit on when a detainee may submit a grievance regarding an allegation of sexual abuse.

(3) The facility shall implement written procedures for identifying and handling time-sensitive grievances that involve an immediate threat to detainee health, safety, or welfare related to sexual abuse.

(4) Facility staff shall bring medical emergencies to the immediate attention of proper medical personnel for further assessment.

(5) The facility shall issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. Facilities shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process.

(6) To prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties.

115.53 Detainee access to outside confidential support services.

(1) Each facility shall utilize available community resources and services to provide valuable expertise and support in the areas of crisis intervention, counseling, investigation and the prosecution of sexual abuse perpetrators to most appropriately address victims' needs. The facility shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers or, if local providers are not available, with national organizations that provide legal advocacy and confidential emotional support services for immigrant victims of crime.
(2) Each facility's written policies shall establish procedures to include outside agencies in the facility's sexual abuse prevention and intervention protocols, if such resources are available.
(3) Each facility shall make available to detainees information about local organizations that can assist detainees who have been victims of sexual abuse, including mailing addresses and telephone numbers (including toll-free hotline numbers where available). If no such local organizations exist, the facility shall make available the same information about national organizations. The facility shall enable reasonable communication between detainees and these organizations and agencies, in as confidential a manner as possible.
(4) Each facility shall inform detainees prior to giving them access to outside resources, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

115.54 Third-party reporting.

(1) Each facility shall establish a method to receive third-party reports of sexual abuse in its immigration detention facilities and shall make available to the public information on how to report sexual abuse on behalf of a detainee.

OFFICIAL RESPONSE FOLLOWING A DETAINEE REPORT

115.61 Staff reporting duties.

(1) The agency and each facility shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse that occurred in a facility; retaliation against detainees or staff who reported or participated in an investigation about such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency shall review and approve facility policies and procedures and shall ensure that the facility specifies appropriate reporting procedures, including a method by which staff can report outside of the chain of command.
(2) Staff members who become aware of alleged sexual abuse shall immediately follow the

reporting requirements set forth in the agency's and facility's written policies and procedures.

(3) Apart from such reporting, staff shall not reveal any information related to a sexual abuse report to anyone other than to the extent necessary to help protect the safety of the victim or prevent further victimization of other detainees or staff in the facility, or to make medical treatment, investigation, law enforcement, or other security and management decisions.

115.62 Protection duties.

(1) If an agency employee or facility staff member has a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse, he or she shall take immediate action to protect the detainee.

115.63 Reporting to other confinement facilities.

(1) Upon receiving an allegation that a detainee was sexually abused while confined at another facility, the agency or facility whose staff received the allegation shall notify the ICE Field Office and the administrator of the facility where the alleged abuse occurred.
(2) The notification provided in paragraph (1) of this section shall be provided as soon as possible, but no later than 72 hours after receiving the allegation.
(3) The agency or facility shall document that it has provided such notification.
(4) The agency or facility office that receives such notification, to the extent the facility is covered by this subpart, shall ensure that the allegation is referred for investigation in accordance with these standards and reported to the appropriate ICE Field Office Director.

115.64 Responder duties.

(1) Upon learning of an allegation that a detainee was sexually abused, the first security staff member to respond to the report, or his or her supervisor, shall be required to:
    (a) Separate the alleged victim and abuser;
    (b) Preserve and protect, to the greatest extent possible, any crime scene until appropriate steps can be taken to collect any evidence;
    (c) If the abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim not to take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
    (d) If the sexual abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.
(2) If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence and then notify security staff.

115.65 Coordinated response.

(1) Each facility shall develop a written institutional plan to coordinate actions taken by staff first responders, medical and mental health practitioners, investigators, and facility leadership in response to an incident of sexual abuse.
(2) Each facility shall use a coordinated, multidisciplinary team approach to responding to sexual abuse.
(3) If a victim of sexual abuse is transferred between DHS immigration detention facilities, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services.
(4) If a victim is transferred between DHS immigration detention facilities or to a non-DHS facility, the sending facility shall, as permitted by law, inform the receiving facility of the incident and the victim's potential need for medical or social services, unless the victim requests otherwise.

115.66 Protection of detainees from contact with alleged abusers.

(1) Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation.

115.67 Agency protection against retaliation.

(1) Staff, contractors, and volunteers, and immigration detention facility detainees, shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force.
(2) For at least 90 days following a report of sexual abuse, the agency and facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff, and shall act promptly to remedy any such retaliation.

115.68 Post-allegation protective custody.

(1) The facility shall take care to place detainee victims of sexual abuse in a supportive environment that represents the least restrictive housing option possible (e.g., protective custody), subject to the requirements of § 115.43.
(2) Detainee victims shall not be held for longer than five days in any type of administrative segregation, except in highly unusual circumstances or at the request of the detainee.
(3) A detainee victim who is in protective custody after having been subjected to sexual abuse shall not be returned to the general population until completion of a proper re-assessment, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse.
(4) Facilities shall notify the appropriate ICE Field Office Director whenever a detainee victim has been held in administrative segregation for 72 hours.

INVESTIGATIONS

115.71 Criminal and administrative investigations.

(1) If the facility has responsibility for investigating allegations of sexual abuse, all investigations into alleged sexual abuse must be prompt, thorough, objective, and conducted by specially trained, qualified investigators.

(2) Upon conclusion of a criminal investigation where the allegation was substantiated, an administrative investigation shall be conducted. Upon conclusion of a criminal investigation where the allegation was unsubstantiated, the facility shall review any available completed criminal investigation reports to determine whether an administrative investigation is necessary or appropriate. Administrative investigations shall be conducted after consultation with the appropriate investigative office within DHS, and the assigned criminal investigative entity.

(3) (a) The facility shall develop written procedures for administrative investigations, including

provisions requiring:

i. Preservation of direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data;
ii. (ii) Interviewing alleged victims, suspected perpetrators, and witnesses;
iii. (iii) Reviewing prior complaints and reports of sexual abuse involving the suspected perpetrator;
iv. (iv) Assessment of the credibility of an alleged victim, suspect, or witness, without regard to the individual's status as detainee, staff, or employee, and without requiring any detainee who alleges sexual abuse to submit to a polygraph;
v. (v) An effort to determine whether actions or failures to act at the facility contributed to the abuse; and
vi. (vi) Documentation of each investigation by written report, which shall include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings; and
vii. (vii) Retention of such reports for as long as the alleged abuser is detained or employed by the agency or facility, plus five years.

(b) Such procedures shall govern the coordination and sequencing of the two types of investigations, in accordance with paragraph (2) of this section, to ensure that the criminal investigation is not compromised by an internal administrative investigation.

(4) The agency shall review and approve the facility policy and procedures for coordination and conduct of internal administrative investigations with the assigned criminal investigative entity to ensure non-interference with criminal investigations.

(5) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

(6) When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

DISCIPLINE

115.76 Disciplinary sanctions for staff.

(1) Staff shall be subject to disciplinary or adverse action up to and including removal from their position and the Federal service for substantiated allegations of sexual abuse or for violating agency or facility sexual abuse policies.
(2) The agency shall review and approve facility policies and procedures regarding disciplinary or adverse actions for staff and shall ensure that the facility policy and procedures specify disciplinary or adverse actions for staff, up to and including removal from their position and from the Federal service for staff, when there is a substantiated allegation of sexual abuse, or when there has been a violation of agency sexual abuse rules, policies, or standards. Removal from their position and from the Federal service is the presumptive disciplinary sanction for staff who have engaged in or attempted or threatened to engage in sexual abuse, as defined under the definition of sexual abuse of a detainee by a staff member, contractor, or volunteer, paragraphs (a) - (d) and (g) - (h) of the definition of "sexual abuse of a detainee by a staff member, contractor, or volunteer" in § 115.6.
(3) Each facility shall report all removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to appropriate law enforcement agencies, unless the activity was clearly not criminal.
(4) Each facility shall make reasonable efforts to report removals or resignations in lieu of removal for violations of agency or facility sexual abuse policies to any relevant licensing bodies, to the extent known.

115.77 Corrective action for contractors and volunteers.

(1) Any contractor or volunteer who has engaged in sexual abuse shall be prohibited from contact with detainees. Each facility shall make reasonable efforts to report to any relevant licensing body, to the extent known, incidents of substantiated sexual abuse by a contractor or volunteer. Such incidents shall also be reported to law enforcement agencies, unless the activity was clearly not criminal.
(2) Contractors and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation.
(3) The facility shall take appropriate remedial measures, and shall consider whether to prohibit further contact with detainees by contractors or volunteers who have not engaged in sexual abuse, but have violated other provisions within these standards.

115.78 Disciplinary sanctions for detainees.

(1) Each facility shall subject a detainee to disciplinary sanctions pursuant to a formal disciplinary process following an administrative or criminal finding that the detainee engaged in sexual abuse.
(2) At all steps in the disciplinary process provided in paragraph (1), any sanctions imposed shall be commensurate with the severity of the committed prohibited act and intended to encourage the detainee to conform with rules and regulations in the future.
(3) Each facility holding detainees in custody shall have a detainee disciplinary system with progressive levels of reviews, appeals, procedures, and documentation procedure.
(4) The disciplinary process shall consider whether a detainee's mental disabilities or mental

illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

(5) The facility shall not discipline a detainee for sexual contact with staff unless there is a finding that the staff member did not consent to such contact.

(6) For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

MEDICAL AND MENTAL CARE

115.81 Medical and mental health assessments; history of sexual abuse.

(1) If the assessment pursuant to § 115.41 indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow-up as appropriate.

(2) When a referral for medical follow-up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment.

(3) When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral.

115.82 Access to emergency medical and mental health services.

(1) Detainee victims of sexual abuse shall have timely, unimpeded access to emergency medical treatment and crisis intervention services, including emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care.

(2) Emergency medical treatment services provided to the victim shall be without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

115.83 Ongoing medical and mental health care for sexual abuse victims and abusers.

(1) Each facility shall offer medical and mental health evaluation and, as appropriate, treatment to all detainees who have been victimized by sexual abuse while in immigration detention.

(2) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

(3) The facility shall provide such victims with medical and mental health services consistent with the community level of care.

(4) Detainee victims of sexually abusive vaginal penetration by a male abuser while incarcerated shall be offered pregnancy tests. If pregnancy results from an instance of sexual abuse, the victim shall receive timely and comprehensive information about lawful

pregnancy-related medical services and timely access to all lawful pregnancy-related medical services.

(5) Detainee victims of sexual abuse while detained shall be offered tests for sexually transmitted infections as medically appropriate.

(6) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

(7) The facility shall attempt to conduct a mental health evaluation of all known detainee-on-detainee abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

DATA COLLECTION AND REVIEW

115.86 Sexual abuse incident reviews.

(1) Each facility shall conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report within 30 days of the conclusion of the investigation recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse. The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so in a written response. Both the report and response shall be forwarded to the Field Office Director, for transmission to the ICE PSA Coordinator.

(2) The review team shall consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility.

(3) Each facility shall conduct an annual review of all sexual abuse investigations and resulting incident reviews to assess and improve sexual abuse intervention, prevention and response efforts. If the facility has not had any reports of sexual abuse during the annual reporting period, then the facility shall prepare a negative report. The results and findings of the annual review shall be provided to the facility administrator and Field Office Director or his or her designee, who shall transmit it to the ICE PSA Coordinator.

115.87 Data collection.

(1) Each facility shall maintain in a secure area all case records associated with claims of sexual abuse, including incident reports, investigative reports, offender information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment, if necessary, and/or counseling in accordance with these standards and applicable agency policies, and in accordance with established schedules.

(2) On an ongoing basis, the PSA Coordinator shall work with relevant facility PSA Compliance Managers and DHS entities to share data regarding effective agency response methods to sexual abuse.

AUDITS AND COMPLIANCE

115.93 Audits of standards.

(1) The agency may require an expedited audit if the agency has reason to believe that a particular facility may be experiencing problems relating to sexual abuse. The agency may also include referrals to resources that may assist the facility with PREA-related issues.

ADDITIONAL PROVISIONS IN AGENCY POLICIES

115.95 Additional provisions in agency policies.

(1) The regulations in this subpart A establish minimum requirements for agencies and facilities. Agency and facility policies may include additional requirements.

Attachment 6: G-391 Data Collection Categories and Descriptions

The below table provides all the data collection categories required by ICE for every ground transportation movement. This data will be collected in the excel-based format provided by the COR upon award and submitted to the COR every month, with every invoice.

Required G-391 Data Collection Categories and Descriptions

This table defines the data collection requirements associated with transportation of aliens by contractor staff for the purpose of completing the monthly G-391 contractor report.

1. **Contract Details** – This section is filled out by the prime contractor.
   - **AOR**: Three letter abbreviation for the Area of Responsibility (e.g., SNA, MIA).
   - **Prime Contractor**: Company or Government Agency who was awarded the transportation contract.
   - **Contract Number:** The number associated with the awarded contract for transportation services.
   - **COR:** The Contracting Officer Representative who is responsible for managing the contract.
   - **Time Period:** The beginning and end dates for the time period when trips were collected for this report.
   - **Total Monthly Invoice Amount:** The total invoice amount associated with the contract and time period reported.

2. **Transportation Activities** – This section is filled out by the prime contractor for each movement during the time period.

   General
   - **Mission Number:** A uniquely identifiable number associated with each transportation movement.
   - **Mission Date:** The date that the trip began (MM/DD/YYYY).

   Vehicle
   - **Vehicle Owner:** Owner of the vehicle used for the mission (e.g. Contractor or the Government).
   - **Vehicle Type:** Type of vehicle used to perform the mission (e.g., Sedan, Van, and Bus).
     - Bus - Any vehicle with a passenger seat capacity greater of 25 or greater.
     - Van - Any vehicle with a passenger seat capacity between 6 and 24.
     - SUV / Mini-Van - Any vehicle with a passenger seat capacity between 3 and 5.
     - Sedan - Any vehicle with a passenger seat capacity of 2 or less.
   - **Vehicle Number:** Vehicle identification number for the ICE or contractor vehicle used to complete the mission.

   Movement
   - **Provider:** The name of the company that provided the movement (subcontractor, prime contractor, or ICE if applicable).
   - **Movement Type:** See descriptions below:
     - **Air Removal** - Ground transportation of aliens to an airport for final removal via air.
     - **Air Transfer** - Transporting aliens in custody to or from an airport for domestic transfers.
     - **Land Removal** - Ground transportation of aliens to their country of origin for final removal. (e.g., busing or walking aliens into Mexico).
     - **Legal** - Transporting of aliens for legal appointments (i.e. court, lawyer or consulate visits).
     - **Medical** - Transporting detainees to a hospital or clinic for medical reasons.
     - **Ambulatory** - Chasing an ambulance.
     - **Pick Up** - Apprehension of an alien from a non-ICE location. (e.g., pick up from jail / prison).

- **Release** - Transporting aliens that have been released from custody to a U.S. domestic location (i.e. bus terminal).
- **Transfer** - Transporting detainees in ICE custody from one facility to another.
- **Stationary Duty** - Time spent performing detention related guard duties (e.g. front gate guard duty, facility patrols, interview escorts, detainee in/out processing, and other guard duties including remote post duties such as in-patient medical stays).
- **Other** - Transportation for a reason other than moving aliens (e.g. vehicle maintenance, file transfers).

- **Overtime:** Yes/No if overtime was needed for this trip.
- **Total Overtime Hours:** The number of overtime hours for the trip.
- **Contract Officers:** Number of contract staff participating in the mission's transportation team.
- **ICE Officers:** Number of ICE employees participating in the mission's transportation team.

Total Aliens Moved

- **Males:** Number of adult males transported.
- **Females:** Number of adult females transported.
- **Transgender:** Number of transgender aliens transported.
- **Juvenile:** Number of juvenile aliens transported.
- **Family Unit:** Yes/No if a family unit was transported.

3. **Trip Details** – This section is filled out by the prime contractor for each movement during the time period.

Start

- **Start Location:** Location where the trip began.
- **Start Odometer:** The odometer reading of the vehicle before the vehicle leaves the start location.
- **Start Departure Time:** The time (HH:MM) when the vehicle left the start location.
- **Start Pick Up:** The number of aliens in the vehicle at the time of departure.

Stop 1 - 10

- **Stop 1-10 Location:** Location where the stop occurred.
- **Stop 1-10 Odometer:** Odometer reading from the vehicle after arriving at the stop location.
- **Stop 1-10 Arrival Time:** The time (HH:MM) when the vehicle arrived at the stop location.
- **Stop 1-10 Departure Time:** The time (HH:MM) when the vehicle left the stop location.
- **Stop 1-10 Pick Up:** The number of aliens that were picked up at the stop location.
- **Stop 1-10 Drop Off:** The number of aliens that were dropped off at the stop location.

End

- **End Location:** Location where the trip ended.
- **End Odometer:** The odometer reading of the vehicle when the vehicle arrives at the end location.
- **End Arrival Time:** The time (HH:MM) when the vehicle arrived at the end location.
- **End Drop Off:** The number of aliens dropped off at the time of arrival at the end location.

4. **Comments** – Any comments regarding the trip that are relevant to the invoice or trip details.

ICE ERO TMO
Contractor G-391 Upload Template | *Version 6*

The purpose of this tool is to automate the upload of G-391 data templ

Automation Tool Instructions:

1. Click "Enable Content.", if prompted by the Excel security warning shown to the r
2. Fill in all required information on the "Input" Tab.
3. Populate User Defined columns and change User Defined column headers, if desi through EM) are available to store additional information for the consolidated data through FB) will be removed before being uploaded to the TMO SharePoint site. PII columns provided that users securely transfer the file.
4. Click on "Vendors: Click Here to Validate G-391 Workbook" to run validation proc This step does not remove User Defined PII columns and does not upload the temp
5. Click on "Vendors: Click Here to Delete Extra Columns" to delete content from th through FB). This step is optional as the Upload G-391 Workbook also will remove U
6. Verify that there is no Sensitive PII in the spreadsheet other than in the User Defi
7. Press the blue "Upload G-391 Workbook" within the "Input" tab. This button dele through 10 (columns ES through FB) and uploads the G-391 templete to the TMO SI ***the TMO SharePoint site and have access to the ICE intranet (e.g., VPN, LAN) to su***

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U.S. Immigration and Customs Enforcement

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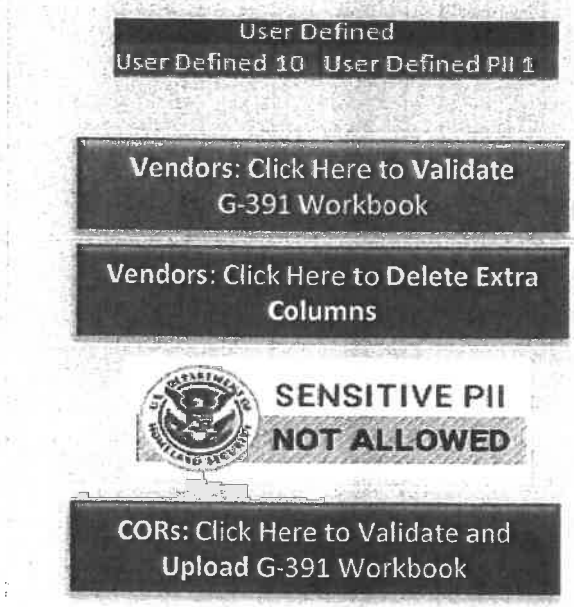
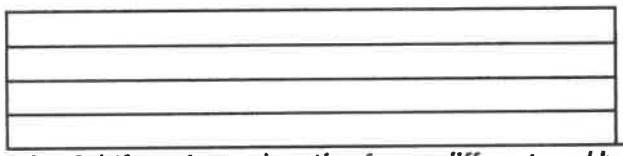
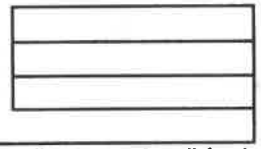
harePoint site. ***Please note users must have access to***
ccessfully upload.







Vendo

Upload Template Version 6 * If copying and pasting from a different workbook, it is highly recommended to use "Paste Values" (ctrl + alt + v, then

General	Vehicle	Movement

rs: Click Here to Validate G-391 Workbook

Vendors: Click Here to Delete Extra Columns

CORs: Click Here to Validate and Upload G-391 Workbook

SENSITIVE PII NOT ALLOWED

V alues). Add rows only to the bottom of the table below. Add columns only to the right of EC.

	Total Aliens Moved	Start

Use start and end fields for starting and end location information. Stops should only be used for sto

	Stop 1

ps made between the starting and end location.

Stop 1	Stop 2

Stop 2	Stop 3	Stop 3


Stop 4
Stop 4
Stop 5

Stop 5	Stop 6

(+ +) Unhide all stops

(+) Unhide additional stop

Stop 6	End

General	User Defined (Remains in Ten				
	User Defined 1	User Defined 2	User Defined 3	User Defined 4	User Defined 5

plate and Included in Upload)									User De
User Defined 6	User Defined 7	User Defined 8	User Defined 9	User Defined 10	User Defined PII 1	User Defined PII 2	User Defined PII 3	User Defined PII 4	

fined PII (Removed from Template Prior to Upload)					
User Defined PII 5	User Defined PII 6	User Defined PII 7	User Defined PII 8	User Defined PII 9	User Defined PII 1

AOR:	ATL	Time Period:	
Prime Contractor:	Transport Company A	Invoice #	
Contract Number:	ABCDE-XX-XXXXX		
COR:	John Smith		

General		Vehicle		
Mission #	Mission Date	Vehicle Owner	Vehicle Type	Vehicle Number
AOR-MMYY-XXXX	MM/DD/YYYY	Contractor or ICE	Select from list	XX0001

	Jan 17 - Feb 17
	XXXXXXXX

SENSITIVE PII
NOT ALLOWED

Movement				
Provider	Movement Type	Overtime	Total Overtime Hours	Contract Officers
Prime / Subcontractor	Transfer	Yes / No	10.00	2

	Total Aliens Moved					Start
ICE Officers	Male	Female	Transgender	Juvenile	Family Unit	Start Location
0	5	5	0	0	Yes / No	Stewart Detention C

			Stop 1	
Start Odometer	Start Departure Time	Start Pick Up	Stop 1 Location	Stop 1 Odometer
50000.00	10:00	5	Atlanta City Detentioi	50250.00

					Stop 2
Stop 1 Arrival Time	Stop 1 Departure Time	Stop 1 Pick Up	Stop 1 Drop Off	Stop 2 Location	
13:30	14:00	2	2		

Stop 2 Odometer	Stop 2 Arrival Time	Stop 2 Departure Time	Stop 2 Pick Up	Stop 2 Drop Off

Stop 3				
Stop 3 Location	Stop 3 Odometer	Stop 3 Arrival Time	Stop 3 Departure Time	Stop 3 Pick Up

	Stop 4			
Stop 3 Drop Off	Stop 4 Location	Stop 4 Odometer	Stop 4 Arrival Time	Stop 4 Departure Time

		Stop 5		
Stop 4 Pick Up	Stop 4 Drop Off	Stop 5 Location	Stop 5 Odometer	Stop 5 Arrival Time

			Stop 6	
Stop 5 Departure Time	Stop 5 Pick Up	Stop 5 Drop Off	Stop 6 Location	Stop 6 Odometer

				Stop 7
Stop 6 Arrival Time	Stop 6 Departure Time	Stop 6 Pick Up	Stop 6 Drop Off	Stop 7 Location

Stop 7 Odometer	Stop 7 Arrival Time	Stop 7 Departure Time	Stop 7 Pick Up	Stop 7 Drop Off

Stop 8				
Stop 8 Location	Stop 8 Odometer	Stop 8 Arrival Time	Stop 8 Departure Time	Stop 8 Pick Up

	Stop 9			
Stop 8 Drop Off	Stop 9 Location	Stop 9 Odometer	Stop 9 Arrival Time	Stop 9 Departure Time

		Stop 10		
Stop 9 Pick Up	Stop 9 Drop Off	Stop 10 Location	Stop 10 Odometer	Stop 10 Arrival Time

			End	
Stop 10 Departure Time	Stop 10 Pick Up	Stop 10 Drop Off	End Location	End Odometer
			Stewart Detention	50500.00

		General		
End Time	End Drop Off	Comments	AOR	Prime
16:30	5	Daily Trip from Stewart to Atlanta	ATL	Transport Compan

Contract Number	COR	Time Period	Invoice Amount
ABCDE-XX-XXXXX	John Smith	Jan 17 - Feb 17	XXXXXXXX

Grand Total	Grand Total	Grand Total
7	10	25
Critical incomplete count	Count of incomplete warning	Total incomplete
7	17	17

Grand Total
8

Count of inaccurate rows

Definitions - ICE Electronic G-391 Database

This tab defines acronyms and commonly used terms associated with transportation of aliens by ERO officers an contractor staff for the purpose of completing the monthly G-391 contractor report. ***Please note that Sensitive***

1. **Contract Details –** This section is filled out by the prime contractor.

- **AOR:** Three letter abbreviation for the Area of Responsibility (e.g., SNA, MIA).
- **Prime Contractor:** Company or Government Agency who was awarded the transportation contract
- **Contract Number:** The number associated with the awarded contract for transportation services.
- **COR:** The Contracting Officer Representative who is responsible for managing the contract.
- **Time Period:** The beginning and end dates for the time period when trips were collected for this re
- **Total Monthly Invoice Amount:** The total invoice amount associated with the contract and time pe

2. **Transportation Activities** – This section is filled out by the prime contractor for each movement during t

General

- **Mission Number:** A uniquely identifiable number associated with each transportation movement.
- **Mission Date:** The date that the trip began (MM/DD/YYYY).

Vehicle

- **Vehicle Owner:** Owner of the vehicle used for the mission (e.g. Contractor or the Government).
- **Vehicle Type:** Type of vehicle used to perform the mission (e.g., Sedan, Van, Bus).
  - **Bus** - Any vehicle with a passenger seat capacity greater of 25 or greater.
  - **Van** - Any vehicle with a passenger seat capacity between 6 and 24.
  - **SUV / Mini-Van** - Any vehicle with a passenger seat capacity between 3 and 5.
  - **Sedan** - Any vehicle with a passenger seat capacity of 2 or less.
- **Vehicle Number:** Vehicle identification number for the ICE or contractor vehicle used to complete t

Movement

- **Provider:** The name of the company that provided the movement (subcontractor, prime contractor
- **Movement Type:** See descriptions below:
  - **Air Removal** - Ground transportation of aliens to an airport for final removal via air.
  - **Air Transfer** - Transporting aliens in custody to or from an airport for domestic transfers.
  - **Land Removal** - Ground transportation of aliens to their country of origin for final removal. (e.g.
  - **Legal** - Transporting of aliens for legal appointments (i.e. court, lawyer or consulate visits).
  - **Medical** - Transporting detainees to a hospital or clinic for medical reasons.
  - **Ambulatory** - Chasing an ambulance.
  - **Pick Up** - Apprehension of an alien from a non-ICE location. (e.g., pick up from jail / prison).
  - **Release** - Transporting aliens that have been released from custody to a U.S. domestic location (
  - **Transfer** - Transporting detainees in ICE custody from one facility to another.
  - **Stationary Duty** - Time spent performing detention related guard duties (e.g. front gate guard duty, facility patrols, interview escorts, detainee in/out processing, and other guard duties including
  - **Other** - Transportation for a reason other than moving aliens (e.g. vehicle maintenance, file tran
- **Overtime:** Yes/No if overtime was needed for this trip.
- **Total Overtime Hours:** The number of overtime hours for the trip.
- **Contract Officers:** Number of contract staff participating in the mission's transportation team.
- **ICE Officers:** Number of ICE employees participating in the mission's transportation team.

Total Aliens Moved

- **Males:** Number of adult males transported.
- **Females:** Number of adult females transported.

- **Transgender:** Number of transgender aliens transported.
- **Juvenile:** Number of juvenile aliens transported.
- **Family Unit:** Yes/No if a family unit was transported.

3. **Trip Details** – This section is filled out by the prime contractor for each movement during the time period.

Start

- **Start Location:** Location where the trip began
- **Start Odometer:** The odometer reading of the vehicle before the vehicle leaves the start location
- **Start Departure Time:** The time (HH:MM) when the vehicle left the start location.
- **Start Pick Up:** The number of aliens in the vehicle at the time of departure.

Stop 1 - 10

- **Stop 1-10 Location:** Location where the stop occurred.
- **Stop 1-10 Odometer:** Odometer reading from the vehicle after arriving at the stop location.
- **Stop 1-10 Arrival Time:** The time (HH:MM) when the vehicle arrived at the stop location.
- **Stop 1-10 Departure Time:** The time (HH:MM) when the vehicle left the stop location.
- **Stop 1-10 Pick Up:** The number of aliens that were picked up at the stop location.
- **Stop 1-10 Drop Off:** The number of aliens that were dropped off at the stop location.

End

- **End Location:** Location where the trip ended.
- **End Odometer:** The odometer reading of the vehicle when the vehicle arrives at the end location.
- **End Arrival Time:** The time (HH:MM) when the vehicle arrived at the end location.
- **End Drop Off:** The number of aliens dropped off at the time of arrival at the end location.
- **Comments:** Any comments regarding the trip that are relevant to the invoice or trip details.

ɔrt.
od reported.
ɜ time period.

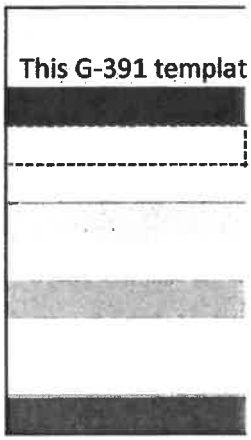
e mission.

or ICE if applicable).

busing or walking aliens into Mexico).

e. bus terminal).

fers).


This G-391 templat

Validation Explanations

e includes validation mechanism that highlights missing or invalid data inputs. Please refer to the table below fo

Cells with red dotted borders indicate critical key fields that are missing. These fields must be populated in ord

- *Critical Key Fields:* AOR, Prime Contractor, Contract Number, COR, Time Period, Mission #, Mission Da

Rows with yellow highlighted Mission # indicate that one or more trip fields are incomplete or have invalid input. Look for cells highlighted in orange or with red borders to identify missing or invalid input. If Mission # is

Cells that are highlighted in orange indicate missing or invalid data input.

- *Examples of Invalid Input:* input does not match drop-down choices and/or incorrect data format such as number, date, etc.; Total trip miles equal 0 or exceed 2000 miles; last stop and end location are

Mission # and Mission Dates cells highlighted in blue indicate duplicate trips. There should not be duplicate trip

r for the upload to be successfully completed.
e, Vehicle Owner, Vehicle Type, Provider, Movement Type

included in the G-391 upload.

CONTRACT FOR INMATE CONFINEMENT

THIS CONTRACT, made and entered into this ___ day of _____, 2019 by and between Torrance County, New Mexico ("County") and CoreCivic, Inc. ("CoreCivic").

WHEREAS, CoreCivic is the owner and operator of the Torrance County Detention Facility located at 209 County Road AO49, Estancia, New Mexico 87016 ("Facility") which, from time to time, has vacant bed space; and

WHEREAS, the County, from time to time, needs such space for housing detained inmates by the proper authorities of the County;

WHEREAS, CoreCivic is willing to contract for the confinement of County inmates at the Facility;

NOW, THEREFORE, CoreCivic and the County agree as follows:

Section 1. Purpose. Depending on CoreCivic's determination that space is available at the Facility, CoreCivic shall confine and supervise at the Facility those County inmates that the County may deliver to CoreCivic from time to time. CoreCivic may house County inmates with federal inmates housed at the Facility as appropriate based upon classification.

Section 2. Compensation. The County shall pay to CoreCivic the sum of $61.00 per inmate for adult male and female inmates for each day or part thereof in which the inmate is confined by CoreCivic. Beginning on the first day of the second contract year and on the first day of each contract year thereafter, the per diem rate shall automatically increase by 2.5% or CPI, whichever is less.

Any moneys due to the County pursuant to the Management Services Contract will be applied as set forth in that contract to sums due CoreCivic pursuant to this Contract for Inmate Confinement.

Section 3. Billings. CoreCivic shall bill the County monthly together with such documentation as the County may require. The County shall forward payment to CoreCivic within thirty (30) days of billing. Charges not paid within thirty (30) days may be assessed a ten (10) percent late charge.

Section 4. Booking. CoreCivic shall perform the process of admitting and booking inmates in accordance with CoreCivic policy. The County will provide written authorization to CoreCivic to confine and supervise County inmates prior to the inmates' detention and will provide written authorization to release County inmates prior to the inmates' release. At a minimum, the County shall furnish an arrest report or court order when an inmate is delivered to the Facility. Within 5 days, the County shall furnish an information packet consisting of all available jail, medical and court records concerning the inmate. CoreCivic shall provide the County with access to CoreCivic's Offender Management System (OMS) allowing the County to view inmate records, including inmate records created for admitting and booking.

Section 5. Transportation. The County shall be responsible for all transportation of inmates. CoreCivic shall provide transportation in a medical emergency and shall bill the County accordingly. If an ambulance or other emergency service is required the County shall reimburse CoreCivic for the cost of this service. The County shall reimburse CoreCivic for the actual costs of security including mileage at the prevailing GSA mileage rate. The current hourly guard rate is $36.99 per hour. CoreCivic is not required to obtain pre-authorization to transport an inmate in the event of a medical emergency; however CoreCivic shall provide the County notice within a reasonable time thereafter.

Section 6. Inmate Possessions. CoreCivic shall be responsible for the proper storage and safe keeping of all inmate personal property that CoreCivic removes from the inmate or the transporting officer at the time of arrival at the Facility. The County will not transport inmate property to the Facility if the property violates CoreCivic's policies or procedures. Any property delivered by the County to the Facility that violates CoreCivic's policies and procedures will be mailed out of the Facility at the County's expense.

Section 7. Medical Care. CoreCivic shall provide routine medical care within the Facility; however, the County shall reimburse CoreCivic for the costs of medications required for the treatment of AIDS/HIV and Hepatitis C. The County shall also be responsible for all medical, dental and/or mental health care costs provided away from the Facility, including the cost of providing security during a hospital confinement. The County shall reimburse CoreCivic for the actual costs of security including mileage at the prevailing GSA mileage rate. The current hourly guard rate is $36.99 per hour. Pre-authorization from the County is required for all non-emergency care provided away from the Facility.

Section 8. Inmate Work Programs. County inmates may be assigned to programs designed to simulate real world work experience by the Contractor. It is understood and agreed that this provision does not create an employer/employee relationship subject to the Federal Fair Labor Standards Act; and that such work is performed as part of the custodial arrangement.

Section 9. Term. This Contract will continue in force and effect for a period of one year and will automatically renew annually on the anniversary date unless otherwise terminated. Either party may terminate this Contract upon giving ninety (90) days written notice to the non-terminating party.

Section 10. Administration of Contract. The CoreCivic Facility Warden shall be responsible for administering this Contract for CoreCivic. The Sheriff or the Sheriff's designee shall be responsible for administering this Contract for the County.

Section 11. Notices. Any notice provided for in this Agreement shall be in writing and served by personal delivery or by certified mail, return receipt requested, postage prepaid, or by a national overnight courier service at the addresses listed in below until such time as written notice of a change is received from the other party. Any notice so mailed and any notice served by personal

delivery shall be deemed delivered and effective upon receipt or upon attempted delivery. This method of notification will be used in all instances, except for emergency situations when immediate notification is required pursuant to the appropriate sections of this Agreement.

CoreCivic:
Cole Carter, General Counsel
CoreCivic, Inc.
10 Burton Hills Blvd.
Nashville, TN 37215

Torrance County:
Wayne Johnson
Torrance County Manager
P.O. Box 48
Estancia, NM 87016

Section 12. Governing Law. This Contract shall be governed by the laws of the State of New Mexico as to interpretation, construction and performance.

Section 13. Amendments. This Contract may be amended, changed or modified only by written agreement executed by the parties hereto. No waiver of any provision of the Contract shall be valid unless in writing and signed by the party charged.

Section 14. Assignment. Neither party shall assign or transfer any interest in this Contract without the prior written approval of the other party, except that CoreCivic may assign, subcontract, or otherwise transfer its interest in the Contract to a CoreCivic affiliate without notice to or consent from the County.

Section 15. Invalidity and Severability. In the event that any provision of this Contract shall be held to be invalid, such provisions shall be null and void and the validity of the remaining provisions of the Contract shall not in any way be affected thereby.

Section 16. Counterparts. This Contract may be executed in multiple counterparts, each of which shall be deemed to be an original and all of which shall constitute one Contract, notwithstanding that all parties are not signatories to the original or the same counterpart, or that signature pages from different counterparts are combined, and the signature of any party to any counterpart shall be deemed to be a signature to and may be appended to any other counterpart.

Section 17. Non-Discrimination. CoreCivic is an Equal Opportunity Employer. If this Contract is subject to Executive Order 11246, as amended, a copy of the Federal Contract Supplement is made a part hereof. To the extent required by applicable laws and regulations, this Contract also is subject the affirmative action clauses concerning protected veterans (41 CFR 60-300) and employment of individuals with disabilities (41 CFR 60-741), and the appropriate clauses are either attached hereto or incorporated herein by reference.

Section 18. Third Party Rights. This Contract shall benefit and burden the parties hereto in accordance with its terms and conditions and is not intended, and shall not be deemed or construed, to confer any rights, powers, benefits, or privileges on any person or entity other than the parties to this Contract. This Contract is not intended to create any rights, benefits,

liberty, interests, or entitlements in favor of any detainee. The contract is intended only to set forth the contractual rights and responsibilities of the Contract parties.

Section 19. Scope of Contract. This Contract incorporates all agreements, covenants and understandings between the parties hereto concerning the subject matter thereto. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Contract.

Section 20. Indemnification. CoreCivic shall indemnify, defend and hold harmless the County and its officers and employees from liability and any claims, suits, judgments and damages to the extent such claims, suits, judgments and damages arise as a result of CoreCivic's acts and/or omissions in the performance of this Contract. Nothing herein shall be construed to require CoreCivic to defend or indemnify any party for any claims, lawsuits, damages, expenses, costs or losses arising from the actions or omissions of the County, its departments, its officers, agents or employees or allegations regarding the County's authority to enter into this Contract. Neither shall anything herein be construed to require CoreCivic to defend or indemnify any party for any claims, lawsuits, damages, expenses, costs or losses arising with respect to any Habeas Corpus action.

IN WITNESS WHEREOF, intending to be legally bound, the parties have caused their authorized representatives to execute this Contract.

TORRANCE COUNTY	**CORECIVIC, INC.**
Wayne Johnson, County Manager	Natasha K. Metcalf Vice President, Partnership Development

AMENDMENT NUMBER 4 TO THE
MANAGEMENT SERVICES CONTRACT
BETWEEN
TORRANCE COUNTY
AND
CORECIVIC, INC.

THE MANAGEMENT SERVICES CONTRACT entered into by and between TORRANCE COUNTY ("THE COUNTY") and CORECIVIC, INC. (formerly Corrections Corporation of America or CCA) is hereby amended as follows:

1. Corrections Corporation of America has legally changed its name and is now CoreCivic, Inc. The terms "Contractor," "Corrections Corporation of America" and "CCA," wherever found in the contract, now refer to CoreCivic, Inc. ("CoreCivic").

2. Section B. Payment is amended to read as follows:

   B. Payment. The County will pay to CoreCivic all funds received by the County pursuant to the Agreements.

   CoreCivic agrees to comply with the billing procedures and submit the proper documentation for payment pursuant to the Agreements. The County will pay amounts due to CoreCivic within fifteen (15) working day after receipt of funds pursuant to the Agreements. In those instances where allowed under the Agreement, CoreCivic will be designated the Payee and funds due pursuant to the Agreements will be paid directly to CoreCivic.

   If the amount to be paid to CoreCivic is disputed by the County, then the County, on or before the date the invoice is payable, shall advise CoreCivic of the basis for the dispute and, in the manner provided above, pay the amount of such invoice which is not in dispute. If the parties cannot resolve the dispute within thirty (30) days of such advice, either party may initiate dispute proceedings as provided herein.

   CoreCivic will pay the County fifty cents ($0.50) per day per inmate housed at the facility pursuant to the Agreements. This payment will be paid monthly within thirty (30) days after expiration of the month for which payment is due.

   Any sums due from CoreCivic to the County pursuant to this Contract will, each month, be applied as credit to any sums owed CoreCivic by the County pursuant to the Inmate Confinement Agreement entered between the parties.

3. Section G.14. Notices is amended to delete the current County and CoreCivic contacts and insert the following:

County of Torrance:

Wayne Johnson
Torrance County Manager
P.O. Box 48
Estancia, NM 87016

CoreCivic:

Cole Carter
General Counsel
CoreCivic, Inc.
10 Burton Hills Boulevard
Nashville, Tennessee 37215

This Amendment Number 4 is effective _____, 2019.

TORRANCE COUNTY

BY:_____

DATE: _____

ATTEST:

_____
CLERK OF THE BOARD

CORECIVIC, INC.

BY:_____
Natasha Metcalf
Vice President, Partnership Development

DATE: _____

Agenda Item
No. 3-B

PO Box 48
205 9th Street
Estancia, NM 87016
(505) 544-4700 Main Line (505) 384-5294 Fax
www.torrancecountynm.org

REQUEST TO BE PLACED ON THE TORRANCE COUNTY COMMISSION AGENDA

This form must be returned to the County Manager's Office **ONLY**!

Deadline for inclusion of an item is WEDNESDAY, NOON prior to the subsequent meeting.
All fields must be filled out for consideration.

Name: Leonard Lujan _____ Bard _____
First Last Department / Company / Organization Name

Today's Date: 5-8-19 **Mailing Address:** _____
(Departments/employees of Torrance County need not include their address)

Telephone number/Extension: _____ **Fax Number:** _____
Would you like this Agenda Faxed to you? Yes No

Email Address: _____

Is this request for the next Commission meeting? (YES) NO **If no, date of Commission Meeting:** 5-15-19

Brief explanation of business to be discussed:

Request funding from FY19 Budget to complete paving of Admin Bldg parking lot.
Need $30,000.00

Is this a Resolution, Contract, Agreement, Grant Application, Other? NO

Has this been reviewed by Grant Committee? YES NO **If yes, corresponding paperwork must be attached.**

Has this been reviewed by the County Attorney? **YES** **NO**

If this is a contract, MOU, or Joint Powers Agreement there must be a signature line for the County Attorney on the original contract.

Has this been reviewed by the Finance Dept? YES NO **Initials:** _____

No Impact
Change in current fund
Raise Budget (allow 45 days after Commission approval)
Change in funds (allow 45 days after Commission approval)
Reduction
Transfer funds (allow 45 days after Commission approval)

Other: _____

ALL ORIGINALS REQUIRING SIGNATURES AND/OR PRESENTATION MATERIALS MUST BE ATTACHED TO THIS REQUEST! YOU WILL BE TAKEN OFF THE AGENDA IF THE COUNTY MANAGER'S OFFICE DOES NOT HAVE THE ORIGINALS BY THE ABOVE MENTIONED DEADLINE.

FAXED ORIGINALS WILL NOT BE ACCEPTED.

PROVIDE THE ORIGINAL/PRESENTATION MATERIALS +7 COPIES OF EACH. NO STAPLES!!!!

Deadline for inclusion of an item is
WEDNESDAY, NOON
Prior to the subsequent meeting.

- **Regular meetings are the second and fourth Wednesday of each month. November and December may vary due to holiday schedule changes.**
- **The Manager's Office prepares a packet, which includes copies of the agenda, contracts, action items and other requests. Packets are mailed to the Commissioners as soon as they are ready. Changes will not be made to the Agenda if packets have already been mailed out.**
- **Agendas are faxed to all news media in the area, as well as posted to the website.**
- **If you have submitted a request, please note that you will be placed on the Agenda unless otherwise notified. If you have not been notified, please make arrangements for either yourself or a representative to be present at the above-mentioned meeting.**
- **To ensure the County Clerk's Office has a copy of ALL executed documents, ALL signed originals will be returned by the County Manager's Office following the Commission Meeting. You will no longer be allowed to leave the Commission Meeting with the signed originals.**
- **Please tab Signature pages.**

IF YOU HAVE TIME CONSTRAINTS, MAKE SURE YOU PLAN AHEAD.

If you have any questions, please feel free to contact Annette at (505) 544-4757.

A CHECKLIST FOR YOU!

Review by Finance [] Review by County Attorney[] Filled out request completely [] Made 7 copies [] Turned in request, original(s) with tabbed signature page(s), and copies to Manager's office []

Agenda Item
No. 3-C

Current Salaies

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534

Operating Budget Request 2019-2020

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534
New Positions		Within Current Budget						
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Total with new positions			$544,993	$41,692	$52,047	$10,900	$129,160	$778,791
Increase in budget of			$74,880	$5,728	$7,151	$1,498	$30,000	$119,257
Road department is moving from within their General Fund 402-60-607								$150,000
							Remaining	$30,743

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health		Total
Jail									
	420-74-102								
Sprunk	Transport Sgt	3	80	$40,040	$581	$4,264	$801	$18,130	$45,686
Cervantes-Lopez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$11,218	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Dominguez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$1,000	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Hoover	Transport Deputy	4	80	$37,960	$550	$4,043	$759	$20,145	$43,312
	Sub-Total			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261

Operation Budget Request for 2019-2020									
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Jail									
	420-74-102								
Sprunk	Transport Sgt	80	$46,280	$671	$4,929	$926	$18,130	$52,805	13%
Cervantes-Lopez	Transport Deputy	80	$35,360	$513	$3,766	$707	$11,218	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Dominguez	Transport Deputy	80	$35,360	$513	$3,766	$707	$1,000	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Hoover	Transport Deputy	80	$39,520	$573	$4,209	$790	$20,145	$45,092	4%
	Sub-Total		$227,240	$3,295	$24,201	$4,545	$76,493	$259,281	
Current Salaries			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261	
Difference			$14,040	$204	$1,495	$281	$0	$16,020	
Asking for an increase to current salaries, and a pay scale for years of service									
Starting Pay	$35,360								
After Probation 1ye	$37,440								
2+ years of service	$39,520								

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Sheriff									
	401-50-102								
Tyrolt	Undersheriff	Appointed	A	$66,320	$962	$7,063	$1,326	$411	$75,671
Dunlap	Administrator	Appointed	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671
Zamora	Records Manager	5	80	$36,400	$528	$3,877	$728	$18,065	$41,532
Salas	Records Clerk	2	80	$30,160	$437	$3,212	$603	$581	$34,413
Stocum	Evidence Officer	11	80	$39,146	$568	$4,169	$783	$13,630	$44,666
Ballard	Detective	12	80	$47,840	$694	$5,095	$957	$6,313	$54,585
Arreola	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$6,197	$43,312
Cobb	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$13,641	$48,059
Cordova-Collier	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$7,277	$43,312
Duran	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$306	$43,312
Garcia	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$10,846	$48,059
Schwerdel	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$15,166	$43,312
Watts	Sheriff's Deputy	5	80	$42,120	$611	$4,486	$842	$14,777	$48,059
Whitson	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$18,141	$43,312
Woodard	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$19,936	$43,312
Young	Sheriff's Deputy	14	80	$44,096	$639	$4,696	$882	$18,148	$50,314
Hernandez	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$13,000	$43,312
	Sub-Total			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677

Operation Budget Request for 2019-2020										
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage	
Sheriff										
	401-50-102									
Tyrolt	Undersheriff	A	$66,320	$962	$7,063	$1,326	$411	$75,671	0%	
Dunlap	Administrator	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671	0%	
Zamora	Records Manager	80	$36,400	$528	$3,877	$728	$18,065	$41,532	0%	
Salas	Records Clerk	80	$30,160	$437	$3,212	$603	$581	$34,413	0%	
Stocum	Evidence Officer	80	$42,785	$620	$4,557	$856	$13,630	$48,818	9%	
Ballard	Detective	80	$51,480	$746	$5,483	$1,030	$6,313	$58,739	7%	
Any	Patrol Sgt.	80	$52,000	$754	$5,538	$1,040	$13,000	$59,332	16% - 27%	
Arreola	Sheriff's Deputy	80	$45,750	$663	$4,872	$915	$6,197	$52,201	17%	
Cobb	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$13,641	$52,212	8%	
Cordova-Collier	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$7,277	$52,212	17%	
Duran	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$306	$52,212	17%	
Garcia	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$10,846	$52,212	8%	
Schwerdel	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$15,166	$52,212	17%	
Watts	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$14,777	$52,212	8%	
Whitson	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,141	$52,212	17%	
Woodard	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$19,936	$52,212	17%	
Young	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,148	$52,212	4%	
	Sub-Total		$803,055	$6,635	$48,733	$9,152	$188,640	$522,110		
Current Salaries			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677		
Difference			$80,693	$310	$2,280	$428	$0	$83,711		
One deputy position promoted to Sgt. All deputies will be able to apply for new position.										
Extra Request										
Extra	Patrol Sgt	$80	$52,000	$754	$5,538	$1,040	$13,000	$59,332		
Total difference in budget			$132,693	$1,064	$7,818	$1,468	$13,000	$156,043		

Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Assessor									
	401-40-102								
Humphrey	Deputy Assessor	Less than 1	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226
V. Sedillo	Office Manager	22	80	$37,523	$544	$3,677	$750	$1,462	$43,957
D. Sedillo	Property assessment	18	80	$33,344	$483	$3,268	$667	$6,197	$43,959
Jones	Customer Service	12	80	$29,935	$434	$2,934	$599	$13,542	$47,443
Vacant	Appriaser Apprentice		80	$24,000	$348	$2,352	$480	$14,000	$41,180
Vacant	Chief Appraiser		80	$44,812	$650	$4,392	$896	$6,197	$56,947
Garcia	Appraiser	5	80	$23,920	$347	$2,344	$478	$6,131	$33,220
Sasnow	Appraiser	2	80	$23,400	$339	$2,293	$468	$15,062	$41,563
Holt	Appraiser	9	80	$28,464	$413	$2,789	$569	$876	$33,111
	610-40-102								
Sandy	Reappraisal	1	80	$22,880	$332	$2,242	$458	$18,030	$43,942
	Sub-Total			$331,894	$4,812	$32,526	$6,638	$99,678	$475,548

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Assessor									
Employee	**401-40-102**								
Humphrey	Deputy Assessor	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226	0%
V. Sedillo	Office Manager	80	$37,523	$544	$3,677	$750	$1,462	$43,957	0%
Sedillo, Sandy	Customer Service	80	$33,344	$483	$3,268	$667	$6,197	$43,959	0%
Jones, Sandy	Customer Service	80	$29,935	$434	$2,934	$599	$13,542	$47,443	0%
Vacant	Appraiser Assistant	80	$22,880	$332	$2,242	$458	$14,000	$39,912	-4%
Garcia,Holt, Sasnow	Lead Appraiser	80	$35,880	$520	$3,516	$718	$10,000	$50,634	20%-35%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$15,062	$52,752	15%-30%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$876	$38,566	15%-30%
	58% 610-40-102 42% 401-40-102								
Any	Appraisal Database Analyst/Reapprasal Coordinator	80	$35,360	$513	$3,465	$707	$18,030	$58,075	25%-39%
	Sub-Total		$325,098	$4,714	$31,860	$6,502	$97,350	$465,523	
Current Salaries			$331,894	$4,812	$32,256	$6,638	$99,678	$475,548	
Difference			$6,796	$98	$396	$136	$2,328	$10,025	
All employees are encouraged to apply for New positions.									
Extra Requests									
Position Taken	Appraiser	80	$23,150	$336	$2,269	$463	$10,000	$36,217	
Total difference in budget			($16,354)	($238)	($1,872)	($327)	($7,672)	($26,193)	

Current Salaies

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534

Operating Budget Request 2019-2020

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534
New Positions		Within Current Budget						
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Total with new positions			$544,993	$41,692	$52,047	$10,900	$129,160	$778,791
Increase in budget of			$74,880	$5,728	$7,151	$1,498	$30,000	$119,257
Road department is moving from within their General Fund 402-60-607								$150,000
							Remaining	$30,743

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health		Total
Jail									
	420-74-102								
Sprunk	Transport Sgt	3	80	$40,040	$581	$4,264	$801	$18,130	$45,686
Cervantes-Lopez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$11,218	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Dominguez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$1,000	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Hoover	Transport Deputy	4	80	$37,960	$550	$4,043	$759	$20,145	$43,312
	Sub-Total			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261

Operation Budget Request for 2019-2020									
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Jail									
	420-74-102								
Sprunk	Transport Sgt	80	$46,280	$671	$4,929	$926	$18,130	$52,805	13%
Cervantes-Lopez	Transport Deputy	80	$35,360	$513	$3,766	$707	$11,218	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Dominguez	Transport Deputy	80	$35,360	$513	$3,766	$707	$1,000	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Hoover	Transport Deputy	80	$39,520	$573	$4,209	$790	$20,145	$45,092	4%
	Sub-Total		$227,240	$3,295	$24,201	$4,545	$76,493	$259,281	
Current Salaries			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261	
Difference			$14,040	$204	$1,495	$281	$0	$16,020	
Asking for an increase to current salaries, and a pay scale for years of service									
Starting Pay	$35,360								
After Probation 1ye	$37,440								
2+ years of service	$39,520								

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Sheriff									
	401-50-102								
Tyrolt	Undersheriff	Appointed	A	$66,320	$962	$7,063	$1,326	$411	$75,671
Dunlap	Administrator	Appointed	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671
Zamora	Records Manager	5	80	$36,400	$528	$3,877	$728	$18,065	$41,532
Salas	Records Clerk	2	80	$30,160	$437	$3,212	$603	$581	$34,413
Stocum	Evidence Officer	11	80	$39,146	$568	$4,169	$783	$13,630	$44,666
Ballard	Detective	12	80	$47,840	$694	$5,095	$957	$6,313	$54,585
Arreola	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$6,197	$43,312
Cobb	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$13,641	$48,059
Cordova-Collier	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$7,277	$43,312
Duran	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$306	$43,312
Garcia	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$10,846	$48,059
Schwerdel	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$15,166	$43,312
Watts	Sheriff's Deputy	5	80	$42,120	$611	$4,486	$842	$14,777	$48,059
Whitson	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$18,141	$43,312
Woodard	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$19,936	$43,312
Young	Sheriff's Deputy	14	80	$44,096	$639	$4,696	$882	$18,148	$50,314
Hernandez	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$13,000	$43,312
	Sub-Total			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677

Operation Budget Request for 2019-2020										
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage	
Sheriff										
	401-50-102									
Tyrolt	Undersheriff	A	$66,320	$962	$7,063	$1,326	$411	$75,671	0%	
Dunlap	Administrator	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671	0%	
Zamora	Records Manager	80	$36,400	$528	$3,877	$728	$18,065	$41,532	0%	
Salas	Records Clerk	80	$30,160	$437	$3,212	$603	$581	$34,413	0%	
Stocum	Evidence Officer	80	$42,785	$620	$4,557	$856	$13,630	$48,818	9%	
Ballard	Detective	80	$51,480	$746	$5,483	$1,030	$6,313	$58,739	7%	
Any	Patrol Sgt.	80	$52,000	$754	$5,538	$1,040	$13,000	$59,332	16% - 27%	
Arreola	Sheriff's Deputy	80	$45,750	$663	$4,872	$915	$6,197	$52,201	17%	
Cobb	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$13,641	$52,212	8%	
Cordova-Collier	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$7,277	$52,212	17%	
Duran	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$306	$52,212	17%	
Garcia	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$10,846	$52,212	8%	
Schwerdel	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$15,166	$52,212	17%	
Watts	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$14,777	$52,212	8%	
Whitson	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,141	$52,212	17%	
Woodard	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$19,936	$52,212	17%	
Young	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,148	$52,212	4%	
	Sub-Total		$803,055	$6,635	$48,733	$9,152	$188,640	$522,110		
Current Salaries			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677		
Difference			$80,693	$310	$2,280	$428	$0	$83,711		
One deputy position promoted to Sgt. All deputies will be able to apply for new position.										
Extra Request										
Extra	Patrol Sgt	$80	$52,000	$754	$5,538	$1,040	$13,000	$59,332		
Total difference in budget			$132,693	$1,064	$7,818	$1,468	$13,000	$156,043		

Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Assessor									
	401-40-102								
Humphrey	Deputy Assessor	Less than 1	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226
V. Sedillo	Office Manager	22	80	$37,523	$544	$3,677	$750	$1,462	$43,957
D. Sedillo	Property assessment	18	80	$33,344	$483	$3,268	$667	$6,197	$43,959
Jones	Customer Service	12	80	$29,935	$434	$2,934	$599	$13,542	$47,443
Vacant	Appriaser Apprentice		80	$24,000	$348	$2,352	$480	$14,000	$41,180
Vacant	Chief Appraiser		80	$44,812	$650	$4,392	$896	$6,197	$56,947
Garcia	Appraiser	5	80	$23,920	$347	$2,344	$478	$6,131	$33,220
Sasnow	Appraiser	2	80	$23,400	$339	$2,293	$468	$15,062	$41,563
Holt	Appraiser	9	80	$28,464	$413	$2,789	$569	$876	$33,111
	610-40-102								
Sandy	Reappraisal	1	80	$22,880	$332	$2,242	$458	$18,030	$43,942
	Sub-Total			$331,894	$4,812	$32,526	$6,638	$99,678	$475,548

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Assessor									
Employee	**401-40-102**								
Humphrey	Deputy Assessor	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226	0%
V. Sedillo	Office Manager	80	$37,523	$544	$3,677	$750	$1,462	$43,957	0%
Sedillo, Sandy	Customer Service	80	$33,344	$483	$3,268	$667	$6,197	$43,959	0%
Jones, Sandy	Customer Service	80	$29,935	$434	$2,934	$599	$13,542	$47,443	0%
Vacant	Appraiser Assistant	80	$22,880	$332	$2,242	$458	$14,000	$39,912	-4%
Garcia,Holt, Sasnow	Lead Appraiser	80	$35,880	$520	$3,516	$718	$10,000	$50,634	20%-35%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$15,062	$52,752	15%-30%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$876	$38,566	15%-30%
	58% 610-40-102 42% 401-40-102								
Any	Appraisal Database Analyst/Reapprasal Coordinator	80	$35,360	$513	$3,465	$707	$18,030	$58,075	25%-39%
	Sub-Total		**$325,098**	$4,714	$31,860	$6,502	$97,350	$465,523	
Current Salaries			$331,894	$4,812	$32,256	$6,638	$99,678	$475,548	
Difference			$6,796	$98	$396	$136	$2,328	$10,025	
All employees are encouraged to apply for New positions.									
Extra Requests									
Position Taken	Appraiser	80	$23,150	$336	$2,269	$463	$10,000	$36,217	
Total difference in budget			($16,354)	($238)	($1,872)	($327)	($7,672)	($26,193)	

Current Salaies

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534

Operating Budget Request 2019-2020

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534
New Positions		Within Current Budget						
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Total with new positions			$544,993	$41,692	$52,047	$10,900	$129,160	$778,791
Increase in budget of			$74,880	$5,728	$7,151	$1,498	$30,000	$119,257
Road department is moving from within their General Fund 402-60-607								$150,000
							Remaining	$30,743

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health		Total
Jail									
	420-74-102								
Sprunk	Transport Sgt	3	80	$40,040	$581	$4,264	$801	$18,130	$45,686
Cervantes-Lopez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$11,218	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Dominguez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$1,000	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Hoover	Transport Deputy	4	80	$37,960	$550	$4,043	$759	$20,145	$43,312
	Sub-Total			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261

Operation Budget Request for 2019-2020									
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Jail									
	420-74-102								
Sprunk	Transport Sgt	80	$46,280	$671	$4,929	$926	$18,130	$52,805	13%
Cervantes-Lopez	Transport Deputy	80	$35,360	$513	$3,766	$707	$11,218	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Dominguez	Transport Deputy	80	$35,360	$513	$3,766	$707	$1,000	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Hoover	Transport Deputy	80	$39,520	$573	$4,209	$790	$20,145	$45,092	4%
	Sub-Total		$227,240	$3,295	$24,201	$4,545	$76,493	$259,281	
Current Salaries			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261	
Difference			$14,040	$204	$1,495	$281	$0	$16,020	
Asking for an increase to current salaries, and a pay scale for years of service									
Starting Pay	$35,360								
After Probation 1ye	$37,440								
2+ years of service	$39,520								

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Sheriff									
	401-50-102								
Tyrolt	Undersheriff	Appointed	A	$66,320	$962	$7,063	$1,326	$411	$75,671
Dunlap	Administrator	Appointed	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671
Zamora	Records Manager	5	80	$36,400	$528	$3,877	$728	$18,065	$41,532
Salas	Records Clerk	2	80	$30,160	$437	$3,212	$603	$581	$34,413
Stocum	Evidence Officer	11	80	$39,146	$568	$4,169	$783	$13,630	$44,666
Ballard	Detective	12	80	$47,840	$694	$5,095	$957	$6,313	$54,585
Arreola	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$6,197	$43,312
Cobb	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$13,641	$48,059
Cordova-Collier	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$7,277	$43,312
Duran	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$306	$43,312
Garcia	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$10,846	$48,059
Schwerdel	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$15,166	$43,312
Watts	Sheriff's Deputy	5	80	$42,120	$611	$4,486	$842	$14,777	$48,059
Whitson	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$18,141	$43,312
Woodard	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$19,936	$43,312
Young	Sheriff's Deputy	14	80	$44,096	$639	$4,696	$882	$18,148	$50,314
Hernandez	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$13,000	$43,312
	Sub-Total			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677

Operation Budget Request for 2019-2020										
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage	
Sheriff										
	401-50-102									
Tyrolt	Undersheriff	A	$66,320	$962	$7,063	$1,326	$411	$75,671	0%	
Dunlap	Administrator	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671	0%	
Zamora	Records Manager	80	$36,400	$528	$3,877	$728	$18,065	$41,532	0%	
Salas	Records Clerk	80	$30,160	$437	$3,212	$603	$581	$34,413	0%	
Stocum	Evidence Officer	80	$42,785	$620	$4,557	$856	$13,630	$48,818	9%	
Ballard	Detective	80	$51,480	$746	$5,483	$1,030	$6,313	$58,739	7%	
Any	Patrol Sgt.	80	$52,000	$754	$5,538	$1,040	$13,000	$59,332	16% - 27%	
Arreola	Sheriff's Deputy	80	$45,750	$663	$4,872	$915	$6,197	$52,201	17%	
Cobb	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$13,641	$52,212	8%	
Cordova-Collier	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$7,277	$52,212	17%	
Duran	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$306	$52,212	17%	
Garcia	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$10,846	$52,212	8%	
Schwerdel	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$15,166	$52,212	17%	
Watts	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$14,777	$52,212	8%	
Whitson	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,141	$52,212	17%	
Woodard	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$19,936	$52,212	17%	
Young	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,148	$52,212	4%	
	Sub-Total		**$803,055**	$6,635	$48,733	$9,152	$188,640	$522,110		
Current Salaries			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677		
Difference			$80,693	$310	$2,280	$428	$0	$83,711		
One deputy position promoted to Sgt. All deputies will be able to apply for new position.										
Extra Request										
Extra	Patrol Sgt	$80	$52,000	$754	$5,538	$1,040	$13,000	$59,332		
Total difference in budget			$132,693	$1,064	$7,818	$1,468	$13,000	$156,043		

Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Assessor									
	401-40-102								
Humphrey	Deputy Assessor	Less than 1	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226
V. Sedillo	Office Manager	22	80	$37,523	$544	$3,677	$750	$1,462	$43,957
D. Sedillo	Property assessment	18	80	$33,344	$483	$3,268	$667	$6,197	$43,959
Jones	Customer Service	12	80	$29,935	$434	$2,934	$599	$13,542	$47,443
Vacant	Appriaser Apprentice		80	$24,000	$348	$2,352	$480	$14,000	$41,180
Vacant	Chief Appraiser		80	$44,812	$650	$4,392	$896	$6,197	$56,947
Garcia	Appraiser	5	80	$23,920	$347	$2,344	$478	$6,131	$33,220
Sasnow	Appraiser	2	80	$23,400	$339	$2,293	$468	$15,062	$41,563
Holt	Appraiser	9	80	$28,464	$413	$2,789	$569	$876	$33,111
	610-40-102								
Sandy	Reappraisal	1	80	$22,880	$332	$2,242	$458	$18,030	$43,942
	Sub-Total			$331,894	$4,812	$32,526	$6,638	$99,678	$475,548

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Assessor									
Employee	**401-40-102**								
Humphrey	Deputy Assessor	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226	0%
V. Sedillo	Office Manager	80	$37,523	$544	$3,677	$750	$1,462	$43,957	0%
Sedillo, Sandy	Customer Service	80	$33,344	$483	$3,268	$667	$6,197	$43,959	0%
Jones, Sandy	Customer Service	80	$29,935	$434	$2,934	$599	$13,542	$47,443	0%
Vacant	Appraiser Assistant	80	$22,880	$332	$2,242	$458	$14,000	$39,912	-4%
Garcia,Holt, Sasnow	Lead Appraiser	80	$35,880	$520	$3,516	$718	$10,000	$50,634	20%-35%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$15,062	$52,752	15%-30%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$876	$38,566	15%-30%
	58% 610-40-102 42% 401-40-102								
Any	Appraisal Database Analyst/Reapprasal Coordinator	80	$35,360	$513	$3,465	$707	$18,030	$58,075	25%-39%
	Sub-Total		**$325,098**	$4,714	$31,860	$6,502	$97,350	$465,523	
Current Salaries			$331,894	$4,812	$32,256	$6,638	$99,678	$475,548	
Difference			$6,796	$98	$396	$136	$2,328	$10,025	
All employees are encouraged to apply for New positions.									
Extra Requests									
Position Taken	Appraiser	80	$23,150	$336	$2,269	$463	$10,000	$36,217	
Total difference in budget			($16,354)	($238)	($1,872)	($327)	($7,672)	($26,193)	

Current Salaies

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534

Operating Budget Request 2019-2020

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534
New Positions		Within Current Budget						
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Total with new positions			$544,993	$41,692	$52,047	$10,900	$129,160	$778,791
Increase in budget of			$74,880	$5,728	$7,151	$1,498	$30,000	$119,257
Road department is moving from within their General Fund 402-60-607								$150,000
							Remaining	$30,743

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health		Total
Jail									
	420-74-102								
Sprunk	Transport Sgt	3	80	$40,040	$581	$4,264	$801	$18,130	$45,686
Cervantes-Lopez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$11,218	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Dominguez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$1,000	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Hoover	Transport Deputy	4	80	$37,960	$550	$4,043	$759	$20,145	$43,312
	Sub-Total			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261

Operation Budget Request for 2019-2020									
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Jail									
	420-74-102								
Sprunk	Transport Sgt	80	$46,280	$671	$4,929	$926	$18,130	$52,805	13%
Cervantes-Lopez	Transport Deputy	80	$35,360	$513	$3,766	$707	$11,218	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Dominguez	Transport Deputy	80	$35,360	$513	$3,766	$707	$1,000	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Hoover	Transport Deputy	80	$39,520	$573	$4,209	$790	$20,145	$45,092	4%
	Sub-Total		$227,240	$3,295	$24,201	$4,545	$76,493	$259,281	
Current Salaries			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261	
Difference			$14,040	$204	$1,495	$281	$0	$16,020	
Asking for an increase to current salaries, and a pay scale for years of service									
Starting Pay	$35,360								
After Probation 1ye	$37,440								
2+ years of service	$39,520								

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Sheriff									
	401-50-102								
Tyrolt	Undersheriff	Appointed	A	$66,320	$962	$7,063	$1,326	$411	$75,671
Dunlap	Administrator	Appointed	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671
Zamora	Records Manager	5	80	$36,400	$528	$3,877	$728	$18,065	$41,532
Salas	Records Clerk	2	80	$30,160	$437	$3,212	$603	$581	$34,413
Stocum	Evidence Officer	11	80	$39,146	$568	$4,169	$783	$13,630	$44,666
Ballard	Detective	12	80	$47,840	$694	$5,095	$957	$6,313	$54,585
Arreola	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$6,197	$43,312
Cobb	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$13,641	$48,059
Cordova-Collier	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$7,277	$43,312
Duran	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$306	$43,312
Garcia	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$10,846	$48,059
Schwerdel	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$15,166	$43,312
Watts	Sheriff's Deputy	5	80	$42,120	$611	$4,486	$842	$14,777	$48,059
Whitson	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$18,141	$43,312
Woodard	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$19,936	$43,312
Young	Sheriff's Deputy	14	80	$44,096	$639	$4,696	$882	$18,148	$50,314
Hernandez	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$13,000	$43,312
	Sub-Total			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677

Operation Budget Request for 2019-2020										
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage	
Sheriff										
	401-50-102									
Tyrolt	Undersheriff	A	$66,320	$962	$7,063	$1,326	$411	$75,671	0%	
Dunlap	Administrator	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671	0%	
Zamora	Records Manager	80	$36,400	$528	$3,877	$728	$18,065	$41,532	0%	
Salas	Records Clerk	80	$30,160	$437	$3,212	$603	$581	$34,413	0%	
Stocum	Evidence Officer	80	$42,785	$620	$4,557	$856	$13,630	$48,818	9%	
Ballard	Detective	80	$51,480	$746	$5,483	$1,030	$6,313	$58,739	7%	
Any	Patrol Sgt.	80	$52,000	$754	$5,538	$1,040	$13,000	$59,332	16% - 27%	
Arreola	Sheriff's Deputy	80	$45,750	$663	$4,872	$915	$6,197	$52,201	17%	
Cobb	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$13,641	$52,212	8%	
Cordova-Collier	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$7,277	$52,212	17%	
Duran	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$306	$52,212	17%	
Garcia	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$10,846	$52,212	8%	
Schwerdel	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$15,166	$52,212	17%	
Watts	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$14,777	$52,212	8%	
Whitson	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,141	$52,212	17%	
Woodard	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$19,936	$52,212	17%	
Young	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,148	$52,212	4%	
	Sub-Total		$803,055	$6,635	$48,733	$9,152	$188,640	$522,110		
Current Salaries			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677		
Difference			$80,693	$310	$2,280	$428	$0	$83,711		
One deputy position promoted to Sgt. All deputies will be able to apply for new position.										
Extra Request										
Extra	Patrol Sgt	$80	$52,000	$754	$5,538	$1,040	$13,000	$59,332		
Total difference in budget			$132,693	$1,064	$7,818	$1,468	$13,000	$156,043		

Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Assessor									
	401-40-102								
Humphrey	Deputy Assessor	Less than 1	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226
V. Sedillo	Office Manager	22	80	$37,523	$544	$3,677	$750	$1,462	$43,957
D. Sedillo	Property assessment	18	80	$33,344	$483	$3,268	$667	$6,197	$43,959
Jones	Customer Service	12	80	$29,935	$434	$2,934	$599	$13,542	$47,443
Vacant	Appriaser Apprentice		80	$24,000	$348	$2,352	$480	$14,000	$41,180
Vacant	Chief Appraiser		80	$44,812	$650	$4,392	$896	$6,197	$56,947
Garcia	Appraiser	5	80	$23,920	$347	$2,344	$478	$6,131	$33,220
Sasnow	Appraiser	2	80	$23,400	$339	$2,293	$468	$15,062	$41,563
Holt	Appraiser	9	80	$28,464	$413	$2,789	$569	$876	$33,111
	610-40-102								
Sandy	Reappraisal	1	80	$22,880	$332	$2,242	$458	$18,030	$43,942
	Sub-Total			**$331,894**	$4,812	$32,526	$6,638	$99,678	$475,548

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Assessor									
Employee	**401-40-102**								
Humphrey	Deputy Assessor	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226	0%
V. Sedillo	Office Manager	80	$37,523	$544	$3,677	$750	$1,462	$43,957	0%
Sedillo, Sandy	Customer Service	80	$33,344	$483	$3,268	$667	$6,197	$43,959	0%
Jones, Sandy	Customer Service	80	$29,935	$434	$2,934	$599	$13,542	$47,443	0%
Vacant	Appraiser Assistant	80	$22,880	$332	$2,242	$458	$14,000	$39,912	-4%
Garcia,Holt, Sasnow	Lead Appraiser	80	$35,880	$520	$3,516	$718	$10,000	$50,634	20%-35%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$15,062	$52,752	15%-30%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$876	$38,566	15%-30%
	58% 610-40-102 42% 401-40-102								
Any	Appraisal Database Analyst/Reapprasal Coordinator	80	$35,360	$513	$3,465	$707	$18,030	$58,075	25%-39%
	Sub-Total		$325,098	$4,714	$31,860	$6,502	$97,350	$465,523	
Current Salaries			$331,894	$4,812	$32,256	$6,638	$99,678	$475,548	
Difference			$6,796	$98	$396	$136	$2,328	$10,025	
All employees are encouraged to apply for New positions.									
Extra Requests									
Position Taken	Appraiser	80	$23,150	$336	$2,269	$463	$10,000	$36,217	
Total difference in budget			($16,354)	($238)	($1,872)	($327)	($7,672)	($26,193)	

Current Salaies

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534

Operating Budget Request 2019-2020

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
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Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
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Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534
New Positions		Within Current Budget						
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Total with new positions			$544,993	$41,692	$52,047	$10,900	$129,160	$778,791
Increase in budget of			$74,880	$5,728	$7,151	$1,498	$30,000	$119,257
Road department is moving from within their General Fund 402-60-607								$150,000
							Remaining	$30,743

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health		Total
Jail									
	420-74-102								
Sprunk	Transport Sgt	3	80	$40,040	$581	$4,264	$801	$18,130	$45,686
Cervantes-Lopez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$11,218	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Dominguez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$1,000	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Hoover	Transport Deputy	4	80	$37,960	$550	$4,043	$759	$20,145	$43,312
	Sub-Total			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261

Operation Budget Request for 2019-2020									
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Jail									
	420-74-102								
Sprunk	Transport Sgt	80	$46,280	$671	$4,929	$926	$18,130	$52,805	13%
Cervantes-Lopez	Transport Deputy	80	$35,360	$513	$3,766	$707	$11,218	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Dominguez	Transport Deputy	80	$35,360	$513	$3,766	$707	$1,000	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Hoover	Transport Deputy	80	$39,520	$573	$4,209	$790	$20,145	$45,092	4%
	Sub-Total		$227,240	$3,295	$24,201	$4,545	$76,493	$259,281	
Current Salaries			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261	
Difference			$14,040	$204	$1,495	$281	$0	$16,020	
Asking for an increase to current salaries, and a pay scale for years of service									
Starting Pay	$35,360								
After Probation 1ye	$37,440								
2+ years of service	$39,520								

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Sheriff									
	401-50-102								
Tyrolt	Undersheriff	Appointed	A	$66,320	$962	$7,063	$1,326	$411	$75,671
Dunlap	Administrator	Appointed	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671
Zamora	Records Manager	5	80	$36,400	$528	$3,877	$728	$18,065	$41,532
Salas	Records Clerk	2	80	$30,160	$437	$3,212	$603	$581	$34,413
Stocum	Evidence Officer	11	80	$39,146	$568	$4,169	$783	$13,630	$44,666
Ballard	Detective	12	80	$47,840	$694	$5,095	$957	$6,313	$54,585
Arreola	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$6,197	$43,312
Cobb	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$13,641	$48,059
Cordova-Collier	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$7,277	$43,312
Duran	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$306	$43,312
Garcia	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$10,846	$48,059
Schwerdel	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$15,166	$43,312
Watts	Sheriff's Deputy	5	80	$42,120	$611	$4,486	$842	$14,777	$48,059
Whitson	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$18,141	$43,312
Woodard	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$19,936	$43,312
Young	Sheriff's Deputy	14	80	$44,096	$639	$4,696	$882	$18,148	$50,314
Hernandez	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$13,000	$43,312
	Sub-Total			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677

Operation Budget Request for 2019-2020										
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage	
Sheriff										
	401-50-102									
Tyrolt	Undersheriff	A	$66,320	$962	$7,063	$1,326	$411	$75,671	0%	
Dunlap	Administrator	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671	0%	
Zamora	Records Manager	80	$36,400	$528	$3,877	$728	$18,065	$41,532	0%	
Salas	Records Clerk	80	$30,160	$437	$3,212	$603	$581	$34,413	0%	
Stocum	Evidence Officer	80	$42,785	$620	$4,557	$856	$13,630	$48,818	9%	
Ballard	Detective	80	$51,480	$746	$5,483	$1,030	$6,313	$58,739	7%	
Any	Patrol Sgt.	80	$52,000	$754	$5,538	$1,040	$13,000	$59,332	16% - 27%	
Arreola	Sheriff's Deputy	80	$45,750	$663	$4,872	$915	$6,197	$52,201	17%	
Cobb	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$13,641	$52,212	8%	
Cordova-Collier	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$7,277	$52,212	17%	
Duran	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$306	$52,212	17%	
Garcia	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$10,846	$52,212	8%	
Schwerdel	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$15,166	$52,212	17%	
Watts	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$14,777	$52,212	8%	
Whitson	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,141	$52,212	17%	
Woodard	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$19,936	$52,212	17%	
Young	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,148	$52,212	4%	
	Sub-Total		**$803,055**	$6,635	$48,733	$9,152	$188,640	$522,110		
Current Salaries			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677		
Difference			$80,693	$310	$2,280	$428	$0	$83,711		
One deputy position promoted to Sgt. All deputies will be able to apply for new position.										
Extra Request										
Extra	Patrol Sgt	$80	$52,000	$754	$5,538	$1,040	$13,000	$59,332		
Total difference in budget			$132,693	$1,064	$7,818	$1,468	$13,000	$156,043		

Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Assessor									
	401-40-102								
Humphrey	Deputy Assessor	Less than 1	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226
V. Sedillo	Office Manager	22	80	$37,523	$544	$3,677	$750	$1,462	$43,957
D. Sedillo	Property assessment	18	80	$33,344	$483	$3,268	$667	$6,197	$43,959
Jones	Customer Service	12	80	$29,935	$434	$2,934	$599	$13,542	$47,443
Vacant	Appriaser Apprentice		80	$24,000	$348	$2,352	$480	$14,000	$41,180
Vacant	Chief Appraiser		80	$44,812	$650	$4,392	$896	$6,197	$56,947
Garcia	Appraiser	5	80	$23,920	$347	$2,344	$478	$6,131	$33,220
Sasnow	Appraiser	2	80	$23,400	$339	$2,293	$468	$15,062	$41,563
Holt	Appraiser	9	80	$28,464	$413	$2,789	$569	$876	$33,111
	610-40-102								
Sandy	Reappraisal	1	80	$22,880	$332	$2,242	$458	$18,030	$43,942
	Sub-Total			$331,894	$4,812	$32,526	$6,638	$99,678	$475,548

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Assessor									
Employee	**401-40-102**								
Humphrey	Deputy Assessor	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226	0%
V. Sedillo	Office Manager	80	$37,523	$544	$3,677	$750	$1,462	$43,957	0%
Sedillo, Sandy	Customer Service	80	$33,344	$483	$3,268	$667	$6,197	$43,959	0%
Jones, Sandy	Customer Service	80	$29,935	$434	$2,934	$599	$13,542	$47,443	0%
Vacant	Appraiser Assistant	80	$22,880	$332	$2,242	$458	$14,000	$39,912	-4%
Garcia,Holt, Sasnow	Lead Appraiser	80	$35,880	$520	$3,516	$718	$10,000	$50,634	20%-35%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$15,062	$52,752	15%-30%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$876	$38,566	15%-30%
	58% 610-40-102 42% 401-40-102								
Any	Appraisal Database Analyst/Reapprasal Coordinator	80	$35,360	$513	$3,465	$707	$18,030	$58,075	25%-39%
	Sub-Total		$325,098	$4,714	$31,860	$6,502	$97,350	$465,523	
Current Salaries			$331,894	$4,812	$32,256	$6,638	$99,678	$475,548	
Difference			$6,796	$98	$396	$136	$2,328	$10,025	
All employees are encouraged to apply for New positions.									
Extra Requests									
Position Taken	Appraiser	80	$23,150	$336	$2,269	$463	$10,000	$36,217	
Total difference in budget			($16,354)	($238)	($1,872)	($327)	($7,672)	($26,193)	

Current Salaies

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534

Operating Budget Request 2019-2020

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins.	Total
Road	402-10-102							
Padilla	Administrative Assist.	80	$29,702	$2,272	$2,837	$594	$13,534	$48,939
Lujan	Foreman	80	$50,003	$3,825	$4,775	$1,000	$11,568	$71,171
Chavez	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$5,830	$35,582
Lopez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$188	$32,420
Lujan J.	Equipment Operator	80	$29,702	$2,272	$2,837	$594	$6,183	$41,588
Master	Equipment Operator	80	$32,036	$2,451	$3,059	$641	$633	$38,820
Medina A	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$479	$32,710
Medina J	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$188	$29,940
Montano	Equipment Operator	80	$42,617	$3,260	$4,070	$852	$18,075	$68,874
Rodriguez	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,534	$45,765
Romero	Equipment Operator	80	$33,860	$2,590	$3,234	$677	$13,547	$53,908
Romero P	Equipment Operator	80	$27,040	$2,069	$2,582	$541	$13,514	$45,746
Sanchez	Equipment Operator	80	$44,192	$3,381	$4,220	$884	$1,482	$54,159
Lucero	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
Smythe	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$203	$29,955
	Sub-Total		$470,113	$35,964	$44,896	$9,402	$99,160	$659,534
New Positions		Within Current Budget						
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
vacant	Equipment Operator	80	$24,960	$1,909	$2,384	$499	$10,000	$39,752
Total with new positions			$544,993	$41,692	$52,047	$10,900	$129,160	$778,791
Increase in budget of			$74,880	$5,728	$7,151	$1,498	$30,000	$119,257
Road department is moving from within their General Fund 402-60-607								$150,000
							Remaining	$30,743

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health		Total
Jail									
	420-74-102								
Sprunk	Transport Sgt	3	80	$40,040	$581	$4,264	$801	$18,130	$45,686
Cervantes-Lopez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$11,218	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Dominguez	Transport Deputy	Less than 1 year	80	$33,800	$490	$3,600	$676	$1,000	$38,566
Vacant	Transport Deputy		80	$33,800	$490	$3,600	$676	$13,000	$38,566
Hoover	Transport Deputy	4	80	$37,960	$550	$4,043	$759	$20,145	$43,312
	Sub-Total			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261

Operation Budget Request for 2019-2020									
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Jail									
	420-74-102								
Sprunk	Transport Sgt	80	$46,280	$671	$4,929	$926	$18,130	$52,805	13%
Cervantes-Lopez	Transport Deputy	80	$35,360	$513	$3,766	$707	$11,218	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Dominguez	Transport Deputy	80	$35,360	$513	$3,766	$707	$1,000	$40,346	4%
Vacant	Transport Deputy	80	$35,360	$513	$3,766	$707	$13,000	$40,346	4%
Hoover	Transport Deputy	80	$39,520	$573	$4,209	$790	$20,145	$45,092	4%
	Sub-Total		$227,240	$3,295	$24,201	$4,545	$76,493	$259,281	
Current Salaries			$213,200	$3,091	$22,706	$4,264	$76,493	$243,261	
Difference			$14,040	$204	$1,495	$281	$0	$16,020	
Asking for an increase to current salaries, and a pay scale for years of service									
Starting Pay	$35,360								
After Probation 1ye	$37,440								
2+ years of service	$39,520								

Current Salaies									
Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Sheriff									
	401-50-102								
Tyrolt	Undersheriff	Appointed	A	$66,320	$962	$7,063	$1,326	$411	$75,671
Dunlap	Administrator	Appointed	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671
Zamora	Records Manager	5	80	$36,400	$528	$3,877	$728	$18,065	$41,532
Salas	Records Clerk	2	80	$30,160	$437	$3,212	$603	$581	$34,413
Stocum	Evidence Officer	11	80	$39,146	$568	$4,169	$783	$13,630	$44,666
Ballard	Detective	12	80	$47,840	$694	$5,095	$957	$6,313	$54,585
Arreola	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$6,197	$43,312
Cobb	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$13,641	$48,059
Cordova-Collier	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$7,277	$43,312
Duran	Sheriff's Deputy	1	80	$37,960	$550	$4,043	$759	$306	$43,312
Garcia	Sheriff's Deputy	4	80	$42,120	$611	$4,486	$842	$10,846	$48,059
Schwerdel	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$15,166	$43,312
Watts	Sheriff's Deputy	5	80	$42,120	$611	$4,486	$842	$14,777	$48,059
Whitson	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$18,141	$43,312
Woodard	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$19,936	$43,312
Young	Sheriff's Deputy	14	80	$44,096	$639	$4,696	$882	$18,148	$50,314
Hernandez	Sheriff's Deputy	Less than 1 year	80	$37,960	$550	$4,043	$759	$13,000	$43,312
	Sub-Total			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677

Operation Budget Request for 2019-2020										
Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage	
Sheriff										
	401-50-102									
Tyrolt	Undersheriff	A	$66,320	$962	$7,063	$1,326	$411	$75,671	0%	
Dunlap	Administrator	A	$66,320	$962	$7,063	$1,326	$12,205	$75,671	0%	
Zamora	Records Manager	80	$36,400	$528	$3,877	$728	$18,065	$41,532	0%	
Salas	Records Clerk	80	$30,160	$437	$3,212	$603	$581	$34,413	0%	
Stocum	Evidence Officer	80	$42,785	$620	$4,557	$856	$13,630	$48,818	9%	
Ballard	Detective	80	$51,480	$746	$5,483	$1,030	$6,313	$58,739	7%	
Any	Patrol Sgt.	80	$52,000	$754	$5,538	$1,040	$13,000	$59,332	16% - 27%	
Arreola	Sheriff's Deputy	80	$45,750	$663	$4,872	$915	$6,197	$52,201	17%	
Cobb	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$13,641	$52,212	8%	
Cordova-Collier	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$7,277	$52,212	17%	
Duran	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$306	$52,212	17%	
Garcia	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$10,846	$52,212	8%	
Schwerdel	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$15,166	$52,212	17%	
Watts	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$14,777	$52,212	8%	
Whitson	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,141	$52,212	17%	
Woodard	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$19,936	$52,212	17%	
Young	Sheriff's Deputy	80	$45,760	$664	$4,873	$915	$18,148	$52,212	4%	
	Sub-Total		$803,055	$6,635	$48,733	$9,152	$188,640	$522,110		
Current Salaries			$722,362	$6,325	$46,453	$8,724	$188,640	$497,677		
Difference			$80,693	$310	$2,280	$428	$0	$83,711		
One deputy position promoted to Sgt. All deputies will be able to apply for new position.										
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Extra	Patrol Sgt	$80	$52,000	$754	$5,538	$1,040	$13,000	$59,332		
Total difference in budget			$132,693	$1,064	$7,818	$1,468	$13,000	$156,043		

Department	Job Title	Years of Service	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total
Assessor									
	401-40-102								
Humphrey	Deputy Assessor	Less than 1	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226
V. Sedillo	Office Manager	22	80	$37,523	$544	$3,677	$750	$1,462	$43,957
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Jones	Customer Service	12	80	$29,935	$434	$2,934	$599	$13,542	$47,443
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Vacant	Chief Appraiser		80	$44,812	$650	$4,392	$896	$6,197	$56,947
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	610-40-102								
Sandy	Reappraisal	1	80	$22,880	$332	$2,242	$458	$18,030	$43,942
	Sub-Total			$331,894	$4,812	$32,526	$6,638	$99,678	$475,548

Department	Job Title	HR	Annual Salary	FICA	PERA	Retiree Health	Health Ins	Total	Annual Salary Increase Percentage
Assessor									
Employee	**401-40-102**								
Humphrey	Deputy Assessor	80	$63,616	$922	$6,234	$1,272	$18,181	$90,226	0%
V. Sedillo	Office Manager	80	$37,523	$544	$3,677	$750	$1,462	$43,957	0%
Sedillo, Sandy	Customer Service	80	$33,344	$483	$3,268	$667	$6,197	$43,959	0%
Jones, Sandy	Customer Service	80	$29,935	$434	$2,934	$599	$13,542	$47,443	0%
Vacant	Appraiser Assistant	80	$22,880	$332	$2,242	$458	$14,000	$39,912	-4%
Garcia,Holt, Sasnow	Lead Appraiser	80	$35,880	$520	$3,516	$718	$10,000	$50,634	20%-35%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$15,062	$52,752	15%-30%
Garcia, Holt, Sasnow	Appraiser	80	$33,280	$483	$3,261	$666	$876	$38,566	15%-30%
	58% 610-40-102 42% 401-40-102								
Any	Appraisal Database Analyst/Reapprasal Coordinator	80	$35,360	$513	$3,465	$707	$18,030	$58,075	25%-39%
	Sub-Total		**$325,098**	$4,714	$31,860	$6,502	$97,350	$465,523	
Current Salaries			$331,894	$4,812	$32,256	$6,638	$99,678	$475,548	
Difference			$6,796	$98	$396	$136	$2,328	$10,025	
All employees are encouraged to apply for New positions.									
Extra Requests									
Position Taken	Appraiser	80	$23,150	$336	$2,269	$463	$10,000	$36,217	
Total difference in budget			($16,354)	($238)	($1,872)	($327)	($7,672)	($26,193)	

Agenda Item
No. 4-A