FAP BANPH Project: An Evaluation of Year 1

Forensic AIDS Project (FAP), 2012

a program of the San Francisco Department of Public Health, Jail Health Services

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Table of Contents

Background and Methodology....................1

Review of the Planning Process....................2

Adjustment to Initial Project Plans....................3

Current Project Status and Lessons Learned....................7

Conclusions....................9

Background and Methodology

The Bay Area Network for Positive Health (BANPH) is managed by Cynthia Gomez and the Health Equity Institute at San Francisco State University. The BANPH team at SFSU leads a consortium of 12 agencies from the Oakland/San Francisco Bay Area committed to reducing the number of local HIV-positive persons out of care. This is being done through a coordinated effort that locates these individuals, strengthens their peer and social networks that help in linking them to care, and reduces provider-based barriers.

BANPH agencies include those who are able to reach the most marginalized and disenfranchised persons including those living in poverty, transitioning out of jail or prison, substance users, immigrants, transgender persons, and people of color. Forensic AIDS Project (FAP) is one of the agencies with a key role in the BANPH project; FAP's BANPH program was launched in September 2010. FAP has provided HIV prevention and care services to adults incarcerated in the San Francisco county jails for over 25 years. With a current staff of 12, where half of the staff is part-time, the resources for serving adults returning to community are limited. Between February and November 2009, FAP identified a total of 85 HIV-positive individuals who came through the San Francisco Intake jail but were not in custody long enough to link to FAP's HIV care services (also known as their Center of Excellence, or CoE), and were subsequently identified as "not engaged in care."

Through BANPH, FAP was able to hire a part-time Engagement and Linkage Specialist, which has for the first time allowed FAP to work with HIV-positive adults who are out of care and incarcerated less than 72 hours. Prior to the actual launch of the BANPH program in fall of 2010, FAP undertook a comprehensive planning process, which included hiring a consultant to interview current staff, make program recommendations, and develop clear, written protocols for the program. Now well into year 2, this same consultant has been hired to review the efficacy of the planning process, document changes to the FAP BANPH program over the two years of implementation, and summarize lessons learned through FAP's implementation of this innovative program.

To complete this evaluation, the consultant conducted brief qualitative interviews with five FAP staffpeople, including the Medical Director (Dr. Milton Estes), Executive Director (Kate Monico Klein), Project Director (Isela González), Engagement and Linkage Specialist (Allyse Gray), and HIV care nurse (Valerie Barall). She also interviewed Nicholas Alvarado, the BANPH Network Coordinator based at SFSU. The information gathered through these interviews was combined with a thorough review of the current, working program protocols, compared with the initial protocols designed during the planning process for BANPH, to determine what changes had been made to the program after implementation, and the reasons behind those shifts.

This report is a summary of this brief evaluation of the FAP BANPH program. It is intended as a tool for reflection on the BANPH process already experienced, and a guide for work during the remainder of the BANPH program and for all future work that FAP or other city jail systems may wish to undertake with this high-need target population.

Review of the Planning Process

It is always challenging to begin a new project. No matter how much planning takes place, actually beginning to implement a previously theoretical idea comes with bumps, surprises, and adjustments. This is especially true in a correctional setting, where so much of what happens is inflexible and controlled by others. FAP staff is accustomed to the challenges of working within the San Francisco county jail system, but this poses a special challenge to partnering with non-criminal justice agencies (such as BANPH partners at SFSU) who are not familiar with that system and its roadblocks and slowdowns.

As previously stated, FAP hired an external consultant to assist them in planning and writing the program protocols. Upon reflection, one FAP team member said, "I think…having someone coming in from the outside [was very helpful]…Looking at our systems, thinking about our policies and procedures, setting something up that was…specific for us to use but also something we could share with other people – I don't think we could actually [have done that ourselves] because we're too close to it." Having an external consultant also helped to facilitate internal agency dialogue about the project, because it's "someone who's not invested either way in what we were planning to do." This dialogue was critical to BANPH, as much of the planning period was used to generate internal support for the program prior to launch. One staffperson said, "Often when you try and introduce a new project into the system, there is resistance to anything new. This [planning process] sort of offset some of that resistance. It meant that people really did sort of swing together to make it work."

Having such a significant, formal planning period is something of a rarity. It is not uncommon for grant funding to be awarded and program implementation then expected within a matter of a few months, or even weeks. As one staff member said, "Sometimes that doesn't allow for really thinking [things] through, and then you're playing catch up. Just having that period of time to prepare for actual program implementation [as happened with BANPH] is good…..it really sets up a different tone for the program." Another said that with this type of formal planning process "there were fewer surprises," which helped implementation feel much more smooth and seamless than might otherwise have been true.

Still, as always, there *were* some surprises. For one, FAP's Executive Director was out on medical leave following surgery when the BANPH program finally did launch. This created an unanticipated staffing shortage – although the Executive Director's role in BANPH program implementation was limited, her absence meant that the Project Director had additional responsibilities external to BANPH and therefore had more restricted availability to support project launch. There were also some assumptions made by FAP staff during planning that didn't bear out, and this became clear right from the start of implementation. Examples of this were the expectation that there would be numerous referrals to the FAP BANPH program (there were not), that the Pre-Trial Diversion Project (PDP) would be a major resource within the BANPH program (that never materialized), and that the nursing staff would be a minimal resource to BANPH (when in fact, they turned out to be much more of a resource than

anticipated). These are all great examples of the mismatch that often exists between planning and implementation. One FAP staffperson noted, “We couldn’t really know [these things] without trying it.” Upon reflection, a few things could have been done differently during this planning phase. The first is that more dialogue with BANPH leadership at SFSU would have been helpful. There were certainly project-wide meetings prior to implementation, but more informal back-and-forth discussion of the planning of the FAP portion of BANPH would have been useful. One FAP staffperson remarked, “They sort of left us to our own devices, maybe because they were in their own planning period.” The BANPH Network Coordinator reflected that “we’ve particularly struggled with…clarity and communication with what our expectations are, but not overstepping our boundaries.” Although the BANPH Network Coordinator stated that, “What worked really well was the communication and the planning efforts they put out to make this as successful as possible,” everyone involved recognized that by implementation, unrealistic expectations had been established for FAP’s BANPH outcome objectives. SFSU BANPH leadership had not been to the jails to visit the site for implementation, and a strong precedent for clear, open dialogue about the FAP BANPH program and process had not been set between the two entities. This created challenges to communication in the future after implementation.

Another thing that FAP would do differently if they could repeat the planning process was to have more staff who would be working with the Engagement and Linkage Specialist involved in the initial planning, including nurses. The Project Director noted, “In the first year [of implementation] we went through some of those growing and learning pains that we could have [gone through] in the initial planning phase. Six months into the actual program implementation, the nurses were still asking us questions. If they would have been on board from the planning phase period, that probably would have been different.” The Engagement and Linkage Specialist herself wasn’t hired until after the planning phase was complete. She was hired for her inside knowledge and expertise with the BANPH target population, and her insight would probably have been useful had she been hired toward the middle or end of the planning process, rather than when it was time to lead implementation of a program others had planned.

In short, the FAP BANPH program benefited from a longer, more formal planning period than exists for many programs of this nature. However, more open and consistent communication with BANPH leadership, and greater involvement of more front-line program staff in the planning would have helped to make the planning process even more useful, and likely would have eased implementation as well.

Adjustment to Initial Project Plans

As noted in the previous section, there were a number of changes to the FAP BANPH project plans. This section will review what those changes were, and why they were needed.

One of the major shifts to the BANPH program at FAP was to the target population and the way they were reached through BANPH. The FAP Executive Director described it well: “We projected initially that

there were about 80 people that would fit the BANPH criteria, and I thought these were just 80 of our regular clients; that it just happened that sometimes they didn't stay in custody long enough for us to see them, and that they were lost to care because they were getting their care primarily from us, and if they were released quickly they remained out of care. In fact, what we have learned is that these are people who have really stayed under everyone's radar. They are a whole different group of people. They are people who are flying under the radar in *every* place where they might otherwise receive care." So how did this change the FAP BANPH strategy? "What we're doing now is our BANPH person is doing all the intakes, so that she is able to identify people before they are released from jail. That was not part of our original design. Originally, she was on the back end. We would…rely on our charge nurse and our case managers to refer people to her. That got us a good core of referrals; those are probably our most solid BANPH referrals. But we weren't finding nearly as many people as we expected. By putting her at the front end, she has less time to deal with the clients once they're found, but we're finding more of them…which in the long run will be a better fit for the program."

In fact, the number of people reached by the BANPH program in Year 1 was a major issue that became evident almost immediately. FAP's objectives stated that in Year 1 they would link 100 HIV-positive individuals into appropriate care, and at least an additional 100 or more individuals into activities believed to help them eventually get into care. Yet by the end of Year 1 FAP had only achieved 10-15% of those numbers. Some believe that this low achievement is a symptom of FAP simply being too ambitious during the planning period and setting unrealistic objectives. Some of it may be attributable to issues in implementation that caused slowdowns and made reaching the projected numbers more challenging – although the numbers have not increased significantly in Year 2. However, one staffperson explained it this way: "This is really the last hold-out of people who aren't getting HIV care anywhere. That's part of what frustrated us in the beginning – our projections didn't match our numbers at all, because it turned out that it was just a much bigger program than we expected. It was so labor-intensive to reach these people with such intractable problems, so it took longer [than anticipated] and we could see fewer people." The Engagement and Linkage Specialist supported this idea, stating, "I think now that we know the barriers that people face, it was really unrealistic. A lot of people [we've reached through BANPH] were homeless, had mental health issues, put their drug abuse first. They were in jail because they all committed such little crimes, like petty theft, possession of drugs, etc. [They were released quickly] so they never got a chance to engage and get real support. We went into it thinking 'We can catch these people before they're released,' but we never really understood exactly why they really didn't get into care and why they kept coming back to jail so frequently. None of the clients that I've been working with even knew the services that FAP offered. And, there were a lot of people in denial about their status. Understanding that now, we're able to set realistic goals."

As a result of this, in Year 1 FAP changed the BANPH eligibility criteria to include people in "tenuous care." The original goal was to find people who were HIV-positive within the first 72 hours of their incarceration, and to engage them in care if they were not already in care. But as the Engagement and Linkage Specialist said, "I realized I needed to start connecting with these people more than once before they were released. A lot of people within those 72 hours, when I did try to see them, they were in

court, they were seeing the doctor, they were detoxing, etc. Sometimes it worked but sometimes it didn't." The program became more substantial after expanding focus to all FAP clients (in or out of jail) who are HIV-positive and out of care entirely or who need extra support to get in or stay in care (otherwise known as "tenuous care"). This happens in two ways. First, the FAP nurse runs the FAP referral list (of HIV-positive prisoners) each day, and reviews their records to see whether they've been engaged in care. If not, she contacts the BANPH Engagement and Linkage Specialist to do follow-up. At the start of the project, the only people who were referred to BANPH were those who did not have record of two HIV medical appointments in the last year. As the program criteria expanded to include "tenuous care," however, any client who was not clearly engaged in HIV medical care began to be referred, even if they had had more than two HIV visits in the past 12 months. As a result, the Engagement and Linkage Specialist now does more initial intakes, and brings people into the BANPH project and into FAP – a role previously reserved for case managers. FAP case managers follow up with clients who have been re-engaged with FAP, but it is the BANPH Engagement and Linkage Specialist who tries to bring them back to FAP in the first place. As a result, she is doing more active engagement work – not simply making the initial contacts but doing more intensive, on-going follow-up until they are successfully re-engaged.

This again raises the issue of misunderstandings between BANPH leadership and FAP BANPH staff about objectives and the challenges to achieving those objectives. One FAP staffperson said, "I think that any organization that provides services in a correctional setting, when they're working with a grant funder or an external group like BANPH [at SFSU], we need to give them a tour of the jail; a real-life walk-through of the actual protocol. We should have invited [BANPH leadership] to walk through in the very beginning, but we didn't and that still hasn't happened. Initially they said, 'We want to support you, you are the experts, and we're relying on you to do this,' but now they're still questioning us. They don't understand that it often really takes 5 hours to see somebody. It's not really a failure of leadership, a failure of communication, disorganization, things like that – ultimately it's about them just not understanding what it's like to work in the jails." In agreement, the BANPH Network Coordinator at SFSU noted that he didn't know what systems were in place at FAP that support or hinder the BANPH program. On a day to day basis, it is unclear to BANPH leadership what pieces of the BANPH protocol are being clearly and consistently implemented, which are not, and what the reasons are for any inconsistencies. As a result, it is impossible for BANPH leadership to be truly supportive of FAP's processes and understanding of their failure to achieve the objectives set forth early in the project.

Under the BANPH program, a major part of the Engagement and Linkage Specialist's responsibility is for outreach to eligible clients. Despite a significant investment of time, this part of the program has not been particularly fruitful. To address this, the BANPH Outreach Coordinator from SFSU has begun meeting twice a month with the FAP Engagement and Linkage Specialist to support FAP in their outreach activities. The amount of time that it takes the Engagement and Linkage Specialist to meet with the BANPH Outreach Coordinator, recount recent activities, discuss strategies for future outreach efforts, and explain challenges to outreach takes away from the already limited time the Engagement and

Linkage Specialist has for client engagement, however, these meetings have highlighted some of the on-the-ground challenges of this project.

The limited hours of the Engagement and Linkage Specialist are a source of many of the challenges FAP faces with BANPH implementation. Cost-savings from other agencies who left the BANPH network in Year 1 allowed FAP to increase the Engagement and Linkage Specialist's hours from 20 to 30 per week, which was a considerable help. However, given the great number of hours that must be invested in each BANPH client as described earlier, 30 hours per week does not give the Engagement and Linkage Specialist enough time to meet her administrative requirements, integrate into the FAP agency as a whole, *and* have sufficient time to engage with clients and realize the potential that BANPH has for reaching the most underserved clients in the San Francisco county jail system. One concrete example of this is related to data collection for BANPH. The Project Director pointed out, "Electronic data collection was supposed to make things easy, but it actually made things a lot harder. Allyse is here part-time and she's getting emails about BANPH not getting surveys, she's supposed to figure out why they're not uploaded correctly, and then she's supposed to see clients, too, in 30 hours a week?" Given the unexpected difficulty in reaching the target population, it is not surprising, therefore, that FAP has been challenged in meeting their target numbers.

One other way that the FAP BANPH project plans changed between the planning stage and Year 2 was formalization of the processes to transition FAP BANPH clients to the FAP Center of Excellence (CoE) or the FAP Navigator Program. If a FAP BANPH client becomes sufficiently engaged to transition to the regular FAP CoE team, this can be done but only on a case-by-case basis. Given the difficulty with which BANPH clients – by definition – engage in care, it is important to continue to support the relationship built with BANPH and not transition to the standard CoE program too early. Only when a genuinely successful and apparently sustainable transfer to the CoE is evident will the client be transitioned out of the BANPH client roster. With the FAP Navigator Study, if a BANPH client is approached for the Navigator Study and is enrolled in the study, the BANPH Engagement and Linkage Specialist and the Coordinator of the PDP Navigator Project are jointly responsible for coordinating and documenting successful transition of that client from BANPH to the Navigator Study. Both of these mechanisms for client transition have been formalized as an addendum in the BANPH project protocols.

Finally, the FAP BANPH project plans evolved to include a specific written procedure for client sharing between FAP and Centerforce's BANPH programs. Centerforce is the organization serving HIV+ adults incarcerated in the Northern California prison system (the prison-based BANPH partner). According to this procedure, the client lists between these two programs are shared via fax every other week, or as updated. This system helps keep both agencies on alert if a client comes in to the other agency for services, as they transition from jail to prison or are released from prison into San Francisco. Both the FAP BANPH staff and the Centerforce BANPH staff work closely to coordinate services for shared clients. It is important to note that FAP can only notify Centerforce about shared BANPH clients when there is a signed BANPH release of information on file.

Current Project Status and Lessons Learned

As year 2 rapidly moves toward a close, FAP's BANPH project is in full swing. Although there are still challenges, the Engagement and Linkage Specialist has settled into her job. She noted, "We have been able to focus where my time should be spent [given] new policies, new added tasks on my plate….I think we're really going in the right direction." As a result, she has a better handle on how to successfully balance administrative requirements with client time. This has required some shifting in FAP's internal structure of her job. The Project Director underlined, "For us, at the end of the day it's always about using that position to support those clients who are out of care."

One of the lessons learned is the increased knowledge that our perspectives are different: FAP has been serving this population for many years and for BANPH staff this is new territory, thus establishing realistic program goals has been a challenge. As an example, the BANPH Network Coordinator said, "We seem to have overestimated that amounts of people who are HIV-positive and not linked to care [within the jail system]," while a key FAP staffperson described instead the revelation that there were a whole group of people who were not being reached at all by FAP, or by anyone – that they are "people who are flying under the radar in *every* place where they might otherwise receive care." While the absolute numbers might be smaller than anticipated, the BANPH project does seem to have resulted in engagement with a previously unreached group of people. As FAP's HIV care nurse said, "Allyse has definitely managed to connect with some people who never managed to come in here before. So…it's really working pretty well." Where there is clearly *no* disagreement is with the challenges inherent in reaching this difficult population. The BANPH Network Coordinator noted, "This is the hardest work I've ever done, and some of the hardest work that others in this project have ever done…And especially for FAP, these [clients] are even more challenged." Yet he also pointed out, "We [at SFSU have] particularly struggled with this issue of limitations of role, with how far we really go with these most difficult patients." The real question at this phase of the project is how much time is reasonable to spend on each hard-to-reach client. At what point does the project become completely cost-inefficient and therefore unsustainable in a time of limited resources? This is an issue about which BANPH staff at FAP and at SFSU are not in complete agreement – this will no doubt need to be debated through the remainder of the project.

In concrete terms, the biggest outstanding issue at this point seems to be communication between FAP and the BANPH leadership at SFSU. One FAP staffperson described, "I might meet with one person and we come to an agreement, and then I meet with someone else and there's confusion. I have to keep taking time to keep going over that kind of stuff with them every time we meet." Yet the BANPH Network Coordinator said, "We're just trying to find out ways to be more effective with [FAP], in supporting their work and to help them be more efficient and effective." Intentions are good but clear communication remains a challenge. BANPH leadership is looking for FAP to be more openly communicative about what they're doing and what questions they may have, or to initiate discussions early regarding any quality assurance issues that may arise. It is clear that both groups agree that the

ideal scenario is that BANPH leadership and FAP BANPH staff work in partnership, but more active discussion is needed to determine how to get there.
Regardless of the challenges that have been and still are faced within BANPH, the project has been innovative and in many ways is a model for others who may wish to reach this difficult population within other county jail systems. To that end, FAP staff recalled a number of lessons learned that might be useful for others trying to replicate this type of project:

1. **This is not a fast process.** It's important to understand that while of course the goal is to connect HIV-positive people to medical care as quickly as possible, with this type of target population, sometimes it just takes a *long* time. When people are newly arrested and they are detoxing, or they're in denial about their HIV status, or are dealing with other complicated issues, it simply might not be the right time to link them to care. It may not even be the right time to begin *talking* with them about linking to care. In those cases, it is important to remember what the FAP HIV care nurse noted, "The best way to do it is to just try to be nice, get that rapport, really build the trust…It might take a while to finally engage them, it might be a lot of work, but eventually they get engaged."
2. **The background of the Engagement and Linkage Specialist is critical.** FAP staff unanimously described the hiring of Allyse Gray as a highlight of the BANPH project. The Medical Director recounted, "Allyse is somewhat unique for people who work in Jail Health Services, in that she has been an inmate. I think she wasn't as verbal as many of us are; I think she was reticent at first. But she's just grown remarkably in her ability to assess people and to follow up with people and relate to them…[I've learned from this that] it's worthwhile taking a chance on staff members who are inexperienced, from different cultural backgrounds, etc." Another FAP staffperson said, "The best thing out of this is giving Allyse an opportunity to grow professionally and give her input into how this program should work. She, being a formerly incarcerated person, brings a whole level of expertise that we've never really had." Because this client population is previously unreached and has very special needs, hiring an Engagement and Linkage Specialist with unique ability to relate to and understand the needs of these clients is a critical step.
3. **Documentation is critical.** As is true with so many projects, when a series of experts are doing familiar work, it can seem superfluous to spend time writing things down. But when asked about lessons learned from BANPH, one of the first things the FAP Executive Director said was, "Put everything in writing. Don't assume that because we've said it, others get it – we don't always realize what people outside the system don't know." This is true anytime because it supports the longevity and sustainability of a project, but it's especially true when there are multiple agencies working in partnership, as is true with BANPH.
4. **The earlier you ask questions, the better you can serve clients.** BANPH led to the expansion of the intake form FAP uses with their clients. This was a good opportunity for FAP to see ways that their services could be improved above and beyond BANPH. By expanding the intake form to try and reach people who are HIV-positive and not in care, FAP staff are now able to discover much more about all of their clients from the beginning, rather than finding out down the line.
5. **Boundaries are important.** As was discussed earlier, finding the balance between time with clients and time meeting administrative requirements can be very challenging. The Engagement and Linkage Specialist suggested, "I think it's probably a good idea to set out one day in your week to do

all your administrative work, so you don't have to constantly deal with it every day. That takes away from client time." She also offered, "The other thing that's helped me is to set some boundaries. Sometimes, [with what's asked of me administratively], I have to tell them, 'That's impossible. Condense it down; let me add it to something I already have [to do].' You just have to have boundaries so you can protect your commitment to the client population."

6. **Experience matters when it comes to outreach.** The Engagement and Linkage Specialist pointed out, "If you had multiple part-time Engagement and Linkage Specialists, that might be better [than the current setup]. With more people, you have more opportunity for outreach, because each of those people can bring different expertise, [familiarity with] different neighborhoods, etc." However, it is important to note that one position can't be equally split in half or in thirds. One Engagement and Linkage Specialist working 30 hours a week is not equivalent to three Engagement and Linkage Specialists working only 10 hours a week. Each of them will have their own administrative time, and need to connect with the team overall. To truly do justice reaching this extremely difficult population, 3 Engagement and Linkage Specialists each working 20 hours per week might actually be the most realistic fit if funding permitted.

Conclusions

In summary, the BANPH project has been an important learning experience for FAP so far. Most importantly, FAP staff have been surprised by the hidden population of HIV-positive prisoners in the San Francisco county jails who are in "tenuous care" and need extra support – and have learned a lot about the lengthy, intensive effort it takes to engage these clients. These are clients who, on average, take 14-17 contacts to successfully link them to care – an unparalleled level of investment required to finally see success. Interestingly, it has proven so far to be the female clients whose lives are the most chaotic and time-consuming. Related to this, it is now clear that there is no black and white distinction between being "in care" or "out of care," as was presumed when BANPH was beginning. Instead, engagement with HIV medical care is complex and truly exists along a spectrum, and efforts to link all HIV-positive prisoners to care must take this entire spectrum into account.

Along those same lines, BANPH has made apparent that, as the Medical Director put it, "One can't assume that all the psychosocial factors involved in people who are in jail, and particularly people with HIV in jail, all can be lumped into one big melting pot of case management." The people targeted by BANPH need a different type of attention, and a different type of services than the average FAP client. Regardless of the future funding of the BANPH project specifically, it is clear that, as the Medical Director remarked, "Having someone on staff who pays attention to those who have been very hard to reach, chronically out of care...that is a really important function. [We've clearly learned that] one can't expect people who are dealing with already hard-to-handle people like HIV-positive people in jail who are *in* care, to then *also* reach the hardest-to-reach people, the ones who are out of care. You just can't do everything. You need someone dedicated to that, [like the BANPH Engagement and Linkage Specialist]."

To highlight the three most important lessons FAP would share with those interested in improving services and linkage for HIV-positive incarcerated populations, after Year 1 of BANPH:

- Within incarcerated populations there exists a group of HIV-positive people who are the last frontier of HIV-positives who are not in care,
- Implementing this type of program and service takes time to gain momentum, and
- It is vital to have a designated staff person who is completely focused on the "out of care" and "tenuous care" clients.

In closing, the difficulty – and importance – of linking people in this target population to care has been stated throughout this report, but cannot be underlined enough. As the FAP Executive Director said, "This is the last frontier of people who are not already receiving HIV services. These are much more chaotic clients, with much greater needs [than we anticipated]." Developing a program to reach people who require such an investment of time and commitment to building rapport takes a long time. For FAP, BANPH is really a new program, distinct from their other services, and it is just beginning to gain momentum. In fact, one FAP staffperson said, "It probably takes a couple of years to get these people mainstreamed, while identifying new people." For this reason, it is vital that FAP continue to maintain the capacity of an Engagement and Linkage Specialist who is separate from the regular HIV case management team. Ideally this person would be full-time, or would even be a team of two or three part-time employees whose combined FTE was even greater than 1.0. By maintaining this commitment to this unique population, FAP will continue its legacy of being a cutting-edge, client-centered jail services program that sets the standard for excellent prisoner care for the rest of the United States.