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**Correctional Association of NY
Jack Beck, Director, Prison Visiting Project**

**Testimony before the NYS Assembly
Committees on Correction and Health
re: Healthcare in NY State Prisons**

October 30, 2017

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The Correctional Association of NY (CA) would like to thank Chairpersons David Weprin and Richard Gottfried of the NYS Assembly Committees on Correction and Health for the opportunity to present testimony on this important and timely subject of medical care in facilities operated by the Department of Corrections and Community Supervision (DOCCS). The CA has had authority granted by the New York State legislature since 1846 to visit New York's prisons and to report to the legislature, other state policymakers, and the public about conditions of confinement. Our access provides us with a unique opportunity to observe and document actual prison practices, to learn from incarcerated persons and staff what are the strengths and barriers of the healthcare system, and to make findings and recommendations about how practices and outcomes can be improved. Based on over 170 years of experience monitoring state prisons, and based on what we have learned from incarcerated persons, staff, administrators, and DOCCS officials, the CA is very pleased that the legislature is exploring this subject and appreciative of the opportunity to share its own insights and ideas.

This testimony will focus on the following topics: (1) an overview of healthcare services in DOCCS facilities, (2) an analysis of staffing and other resources provided by the state for medical care in our prisons, (3) an assessment of the care provided during the past five years to the incarcerated population based upon our observations and responses from prison residents during CA visits to 25 prisons, (4) an evaluation of the need for enhanced oversight of the prison healthcare system, with an assessment of the impact of the DOH Oversight Law, requiring that the NY State Department of Health (DOH) monitor HIV and hepatitis C (HCV) care in the prisons and (5) efforts to enhance discharge planning for patients returning home.

As the CA has documented for decades, the NYS prisons have a population that has significant health needs that are more challenging than those existing in the general population. With greater chronic illnesses than the public, the well-documented syndrome that incarcerated persons exhibit medical conditions that reflect a person 10-15 years older than the incarcerated person's actual age, and the increase in the percentage of the prison population who are 50 years or older, the demand for medical services inside our prison is significant and ever increasing. Unfortunately, DOCCS has struggled to meet this need both because of challenges in maintaining adequate staffing and in hiring staff that are empathetic and engaged with their patients. As a result, incarcerated persons consistently report great dissatisfaction with healthcare inside, in survey responses provided to the CA and as reflected in the large number of grievances submitted in DOCCS. During the past five years, mid-2012 through mid-2017, the CA has processed more than 4,500 survey responses from persons at 25 state prisons. Overall, only 11% of the respondents rated medical as good, 42% assessed it as fair, and 47% found it to be poor. These assessments are much worse than comparable ratings for other services in the

prisons, including mental healthcare and educational and vocation programs. Healthcare has consistently one of the two highest numbers of grievances filed throughout DOCCS, with the other issue being misconduct by prison staff. Evaluating the reasons for this dissatisfaction generally focuses on two problems. First, in many prisons, there is insufficient medical staff, often due to the inability of DOCCS to hire people to fill existing vacancies. As a result, patients experience significant delays in getting to a medical provider. Second, even when a medical encounter occurs, many patients report that their medical issues are not appropriately addressed in a timely manner and/or that some providers are disrespectful, inattentive, or fail to exhibit a caring attitude. The assessment of healthcare varies among the prisons, and this variability raises concerns about the adequacy of meaningful oversight of the provision of care throughout the Department.

Although we have documented some serious concerns about the DOCCS healthcare system, we have also observed progress in some areas of care and initiatives that appear to improve some outcomes for the patient population inside prisons and for those who have been recently released. In particular, as a result of the long-standing relationship between DOCCS and DOH focused on HIV and HCV care, which, in part, is codified in the DOH Oversight Law, it appears that DOCCS has significantly improved the identification and treatment of HIV- and HCV-infected patients. As is more fully discussed in section D (1), the HIV-infected prison population has declined, and a much greater percentage of DOCCS HIV-infected patients have revealed and/or been identified as HIV-positive and are engaged in care. DOCCS has become the national leader in the treatment of HCV-infected patients; during 2016, about 500 individuals received the highly effective new HCV therapies, a rate that is more than 10 times the rate existing in most other state correctional systems.

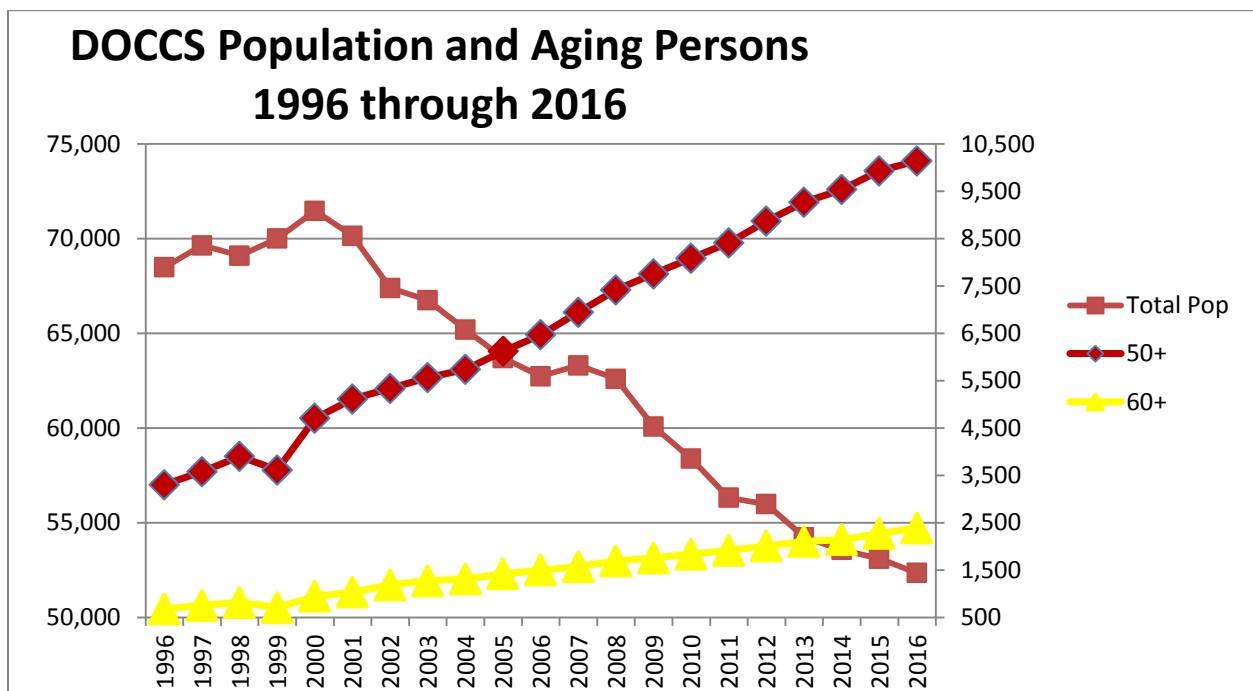
Following successful DOCCS-DOH programs to foster better continuity of care for HIV- and HCV-infected patients returning home, DOH is undertaking measures to enhance the continuity of care for HIV-infected patients returning to their communities through peer care coordinators. For the past few years, DOCCS has expanded its efforts to get its soon-to-be-released patients enrolled in Medicaid by employing DOCCS staff to assist incarcerated patients preparing for release to submit their Medicaid application prior to discharge. In addition, DOCCS and DOH have been working on mechanisms to facilitate the enrollment of patients with significant health issues in the Medicaid Health Homes program in the community; this has been facilitated by several pilot programs throughout the state with community providers who have been connected to soon-to-be-released patients to assist them in getting prompt care in their community upon release. Finally, this year DOCCS has hired discharge-planning staff to assist patients with chronic illnesses other than HIV and HCV in making connections with community providers so that there can be improved continuity of care upon release.

Despite these encouraging developments, much more is needed to ensure that all DOCCS patients are receiving appropriate care inside DOCCS facilities and that all returning citizens are

given the necessary assistance prior to release to get enrolled promptly in health insurance programs and to be connected to appropriate community-based programs to ensure continuity of care.

A. Overview of DOCCS Healthcare Services

DOCCS operates 54 facilities confining about 51,000 persons, of which 4.7% are women. In the men's facility, 44% are in maximum security prisons, 51% in medium security facilities, and only 5% are in minimum security prisons, work release facilities, or drug treatment centers. The male incarcerated population has been aging during the past two decades, with those who are 50 years old or older rising from 6,945, and 11.0% of the prison population, in January 2007 to 10,140, and 19.4% of the reduced prison population, in January 2016. This is a 77% increase in the percentage of the prison population considered elderly in just nine years. As the recent Office of the NY Comptroller 2017 report - *New York State's Aging Prison Population* – notes, it is well recognized that the aging population in prison is more costly to confine "primarily due to their increased need for medication and other medical care." ¹



The DOCCS population also suffers from high percentages of chronic illnesses. During the five-year period from 2012 - 2017, the CA collected data from 25 prisons on the number of patients with certain chronic conditions. **Table 1 - DOCCS Patients with Chronic Conditions** summarizes this data, noting the average percentage of patients with asthma, diabetes, hypertension, hepatitis C, and HIV. These range from a high of 15.7% with asthma to 2.1%

¹ Office of NYS Comptroller, *New York State's Aging Prison Population*, at 2 (April 2017).

infected with HIV. **Appendix A - DOCCS Chronic Conditions 2012-17 CA-Visited Prisons** contains the results for each of these 25 prisons.

TABLE 1 - DOCCS PATIENTS WITH CHRONIC CONDITIONS										
Medical Condition	Asthma		Diabetes		Hypertension		Hepatitis C		HIV	
	#	%	#	%	#	%	#	%	#	%
DOCCS Data	4,293	15.6%	1,903	6.9%	3,935	14.3%	2,062	7.5%	600	2.2%
Survey Responses		25.8%		11.8%		20.5%		11.7%		5.2%

We also received surveys from many residents of these prisons concerning their assessment of their medical care and their medical status. More than half of these respondents reported that they have a serious or chronic medical problem. When asked to identify their specific condition, of those who responded, 26% reported they had asthma, 12% indicated they were diabetic, 12% reported some form of hepatitis, 5.2% said they were HIV-infected, and 21% indicated they had hypertension or some other heart-related problem. These figures are consistent with the trends noted from the DOCCS-reported data, although the absolute rates were much higher because most survey participants identified their condition only if they had a chronic health problem.

Given the substantial disease burden in DOCCS, it is clear that the Department requires significant medical resources. Nearly all the prisons are classified as a medical code 1 facility, meaning that any persons with even serious medical problems could be incarcerated in that facility as long as the person did not need infirmary care. DOCCS has closed 14 infirmaries during the past several years, but there are still 35 prisons with an active infirmary with a total capacity for 1,140 patients; as of August 2017, there were 649 persons in an infirmary bed.

This infirmary capacity includes five Regional Medical Units (RMUs) at Bedford Hills, Coxsackie, Fishkill and Wende C.F., and the Walsh Medical Center in Mohawk C.F., with a total of 402 beds for patients who require skilled nursing care. The RMUs provide services to patients requiring extensive nursing care, those who are post-operative or receiving complex therapy such as chemotherapy, and individuals who need palliative care. Reviewing the ages of persons in the RMUs, as of January 2016, 64% (183 patients) of the total RMU population were 50 or older, and 47% (135 patients) were 65 or older. The RMUs have much greater staff resources than regular prison infirmaries and entail greater expense per patient. However, DOCCS often must continue to house these patients even though they could be eligible for medical parole or direct release to the community. We repeatedly have heard of elderly RMU patients who required nursing home care but who cannot be discharged from DOCCS because the Department cannot identify any appropriate skilled nursing care facility that will accept these individuals. The reasons for denying a community admission is often based upon the crimes these patients may have committed decades earlier in their youth and despite the obvious physical limitations they now are experiencing that would obviate any concern about future criminality.

Unfortunately, some DOCCS patients die while in DOCCS custody. As **Table 2 - DOCCS Deaths 2005-2016** illustrates, the Department has experienced variations in the number of deaths during the past 12 years. Unfortunately, in 2016, DOCCS had the highest rate of deaths for the entire period. As will be discussed later, given the limited number of DOCCS patients who are being released through medical parole, it is very disturbing that so many patients with medical issues are held in prison when they could be with their families in the community when they die. Particularly disturbing is that 58 of these deaths occurred in the RMUs, which would indicate that there probably was sufficient notice of the likelihood of death for a compassionate release.

TABLE 2 - DOCCS DEATHS 2005 - 2016												
YEAR	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total Deaths	172	131	147	134	144	124	118	115	143	122	111	144
Suicide	19	8	18	10	10	20	11	14	13	12	11	16
Natural Causes	148	117	128	116	129	101	101	93	118	102	88	110
Other	5	6	1	8	5	3	6	8	12	8	12	18
Population	63698	62732	63304	62599	60081	58378	56315	55804	54865	54180	52932	52344
Rate / 10K	27	20.9	23.2	21.4	24	21.2	21	20.6	26.1	22.5	21	27.5

Most medical services are provided by DOCCS employees. As is discussed in greater detail in section B, the more than 1,000 health staff are distributed throughout the Department and are in every prison providing nurses for sick call; clinicians for patients seen at call-outs in the medical area; pharmacy staff in most prisons to distribute medications; clinicians, nurses and sometime nursing assistants to serve patients in the infirmaries and RMUs, staff to assist contracted specialists who come to the prisons and RMUs to provide specialty care, and dental staff to provide restorative care, extractions, cleanings, and dentures. Unfortunately, there is often insufficient staff to meet the needs of all of the patients at each prison, resulting in high levels of patient dissatisfaction, as described below in section C (1).

B. Medical Staffing and Resources for Prison Healthcare

The CA has been monitoring medical staffing for at least two decades, and we have observed that the limitations on medical staffing have contributed to the overall dissatisfaction of the incarcerated population in the healthcare they are provided, and have resulted in inconsistent and sometimes inadequate quality of care for all patients. At some prisons, residents report they have reasonable access to care and rate the care as generally satisfactory. At other prisons, however, there appears to be insufficient staff to meet the needs of the patient population, resulting in delayed and inadequate care. Compounding the issue of insufficient staffing are structural barriers in the ability of DOCCS to recruit and retain staff, due in part to limitations on salary in the current state contracts for healthcare employees. We strongly urge the legislature to thoroughly investigate the situation and provide mechanisms to ensure that appropriate levels of competent medical staff are maintained at all DOCCS facilities. This is not happening now.

1. *Funding for Medical Staffing*

While the specific positions authorized at each facility vary based on the size and needs of the population incarcerated there, most facilities tend to have the following types of positions: nurse administrators, physicians, physicians’ assistants and nurse practitioners (who also see patients at clinic call-outs), nurses (both RN and LPN), pharmacists (including the Pharmacy Supervisor position), and pharmacy aides. We have analyzed these positions at the 25 prisons we visited from mid-2012 through mid-2017, based on data provided by the prisons at the time of our visit or during subsequent calls with the facility staff after the Department reviewed the CA’s draft report about our assessment of prison conditions, including medical staffing and treatment. This analysis is summarized in **Appendix B – Analysis of DOCCS Medical Staffing for Clinicians and Nurse 2s – 2012-17** and is discussed in greater detail below.

The CA also has been monitoring overall DOCCS funding and staffing for medical care services in the state prisons. We have analyzed the number of medical staff items for the period FY 2011-12 (FY2012) through FY 2017-18 (FY2018) and the non-personnel budget for healthcare. **Table 3 – DOCCS Budget FY 2012 through FY 2018** summarizes this data.

TABLE 3 - DOCCS BUDGET FY 2012 through FY 2018								
YEAR	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	% Change FY12
DOCCS Budget	2418.614	2504.187	2611.102	2606.804	2722.59	2661.078	2662.133	9.15%
DOCCS Population	55,980	55,471	54,142	52,932	52,415	51,406	51,298	-9.13%
Health Services	324.471	326.22	325.66	333.485	377.353	391.342	404.437	19.77%
Personal Service	137.776	138.64	137.965	139.152	146.02	141.642	145.461	5.28%
Staff	2,003	1,700	1,678	1,664	1,644	1,651	1,651	-21.32%
Non-Personal	222.747	187.585	185.787	194.333	231.33	249.7	258.976	13.99%
Supplies	87.05	74.924	74.298	81.716	113.312	127.617	131.607	33.86%
Contract Service	134.405	111.528	110.356	111.484	116.888	120.95	126.236	-6.47%
Equipment	0.869	0.762	0.762	0.762	0.862	0.862	0.862	-0.81%
Programs Services	210.832	204.79	204.999	205.693	228.094	222.247	227.351	7.27%
Personal Service	193.81	176.12	176.612	177.599	200	194.103	199.207	2.71%
Staff	3,132	2,772	2,739	2,717	2,946	2,949	2,957	-5.92%
Non-Personal	40.447	28.669	28.387	28.094	28.094	28.144	28.144	-43.71%
Supervision of Pop	1309.831	1392.507	1511.551	1523.522	1582.78	1582.112	1517.791	13.70%
Personal Service	1421.155	1375.9	1493.65	1505.7	1564.96	1510.29	1497.97	5.13%
Staff	19,844	19,402	19,340	19,087	19,141	19,268	19,378	-2.40%
Non-Personal	23.934	16.578	17.899	17.821	17.821	17.821	19.821	-20.75%
Support Services	401.572	402.563	407.088	385.831	382.425	366.891	256.835	-56.35%
Personal Service	178	158.19	165.051	161.133	160.727	124.695	112.975	-57.56%
Staff	3,105	2,977	2,908	1,644	2,677	2,679	1,708	-81.79%
Non-Personal	268	244.372	242.037	221.698	221.698	242.196	243.92	-9.87%

Reviewing the authorized staffing figures reveals drastic cuts in staffing for health services in the past seven years, far greater than the amount of decrease in the prison population, and a reduction much greater than for the security staff. Specifically, from FY 2012 to FY 2018, the authorized staffing for health services was reduced by 21%, while the prison population declined only 9%. In stark contrast to the health staff reduction, security staff, listed under “supervision of population,” only was reduced by 2.4%, a rate nearly **nine times** less than that for healthcare. The CA is aware of extensive pressure from the correction officers’ union to avoid reductions, and in fact, security staff has experienced an increase in positions during the past three years while the incarcerated population has declined by 1,600 persons. As we describe in greater detail below, these reductions in medical staff seem to be driven not by some assessment of reduced medical care needs, but rather by the fact that DOCCS has experienced great difficulties in hiring health staff, and the cuts are elimination of items that may have been difficult to fill. This practice obscures the serious problems DOCCS is experiencing in hiring competent medical providers, but ultimately results in decreased services and improper care.

2. Funding for Non-Personal Services

In contrast to the reduction in medical staffing, DOCCS has increased funds for non-personal medical services, a decision we strongly support. The most significant change is in the “supplies” category, which primarily includes expenses for medication. From FY 2015 to FY 2018, this item has increased from \$81.7M to \$131.6M. A significant portion of the increase has been allocated to the expensive, but very effective, hepatitis C medications, which DOCCS is providing to many HIV-infected patients. We applaud this effort and believe it represents the possibilities for improved care when DOCCS and DOH leaders collaborate to create care standards that are comparable to those in the community. The positive changes in HCV treatment is discussed in greater detail in section D (1) below.

In contrast to the “supplies” item, the contract services element of DOCCS healthcare non-personal services budget has been reduce since FY 2012, although, in the past two budgets, some increases have been made but not to a level comparable to that which existed in FY 2012. This item of the budget primarily represents funding to outside contractors who provide specialty care to the incarcerated population. Given the patient population’s concerns about adequate access to specialty services, we are concerned whether adequate funding is being provided for these operations. In addition, we urge the legislature to increase funding in this area to address the serious staffing crisis that DOCCS is experiencing. We will be proposing that DOCCS clinical staff be augmented by contract services by outside agencies to provide doctors when the Department is not capable of identifying a suitable candidate for a vacant clinic provider in a timely manner.

3. Medical Staff Vacancies

For more than a decade, the CA has consistently observed during its prison visits that essential medical positions remained unfilled, sometimes for years, resulting in excessively high staff-to-

patient ratios. We submitted a FOIL request to DOCCS as soon as we were informed of this hearing requesting a system-wide summary of DOCCS health service items and a listing of all vacant items. Unfortunately, the Department has not provided the materials prior to the hearing.

In lieu of a system-wide analysis, we have reviewed staffing data we have received from each of the 25 prisons we have visited in the past five years. Specifically, we have analyzed the total number of permanent healthcare staff items, the number of staff that were working either at the time of the visit or at a later point when we received updated information from the prison about their medical staffing situation. In addition, we compared the number of staff items available from our visit data to the medical staff items that existed in 2012, when we performed a system-wide analysis of all staff. There were more than 28,000 persons at these 25 prisons, representing more than half of the entire DOCCS. They include prisons from throughout the state, and include maximum and medium security facilities and large and small prisons.

Table 4 – DOCCS Medical Staff at CA-Visited Prisons 2012-2017 contains a summary of this data. It reveals very high levels of vacancies, particularly for clinicians who provide the most essential care to DOCCS patients. Overall, there was a 24% vacancy rate for all 25 prisons. Similarly, there were high rates for nurses (16%), nurse administrators (15%), pharmacists (14%), and dentists (16%).

Table 4 – DOCCS Medical Staff at CA-Visited Prisons 2012-2017			
POSITION	# of Staff Items	# of Vacancies	Percent Vacant
Physician	55	14.25	25.9%
Phys. Assist/ Nurse Practitioner	26	5	19.2%
<i>Total Clinicians</i>	81	19.25	23.8%
RN/ Nurse 2s	354.5	55	15.5%
LPN	18.5	4.5	24.3%
<i>Total Nurses</i>	373	59.5	16.0%
Nurse Administrator	26	4	15.4%
Pharmacist	18	2.5	13.9%
Pharmacy Aides	16	0	0.0%
Dentist	44	7	15.9%
Dental Assistant/Hygienist	43	3	7.0%

But this global rate does not reflect the dire circumstances that exist at many of these prisons. There is great variability in the number of doctors, physician assistants, nurse practitioners, and nurses assigned to each prison in terms of the number of patients each staff member is expected to serve at these facilities. **Table 5 - Patient-Provider Ratios for Clinicians and Nurses -CA Visits 2012-17** contains a summary for the 25 prisons we visited. It demonstrates drastically different ratios at certain prisons, which inevitably results in delayed care and often inadequate care.

TABLE 5 - Patient-Provider Ratios for Clinicians and Nurses - CA Visits 2012-17

Prison	Date	Pop	Doctors		PA/NP		Clinician	Nurse 2		Nurse
			Items	Vacancy	Items	Vacancy	Ratio	Items	Vacancy	Ratio
Adirondack	12/6/2013	393	1	0	0	0	393	6	1	79
Altona	7/12/2012	470	1	0	0	0	470	5.5	2.5	157
Cape Vincent	4/18/2013	861	1	0	1	1	861	10	2	108
Cayuga	7/15/2013	952	2	1	0	0	952	11	1	95
Clinton	5/1/2014	2834	4	2	2	0	709	22	0	129
Collins	1/1/2015	1048	2	0	1	0	349	15.5	0	68
Eastern	7/28/2014	913	1.5	0	0	0	609	10	1.5	107
Elmira	1/27/2016	1602	2	1	2	0	534	18	2	100
Fishkill	8/1/2013	1650	6.5	2.75	1	0	347	48	6.5	40
Five Points	6/16/2016	1384	1.5	0.5	2	0	461	18	6	115
Great Meadow	12/8/2014	1335	2.5	0	1	0	381	13	4	148
Green Haven	6/24/2014	1952	8	4	3	0	279	28	4	81
Greene	10/1/2014	1768	2	0.5	1	0	707	14	3.5	168
Groveland	10/30/2013	1059	2	0	1	0	353	16	3	81
Livingston	12/7/2012	845	1	0	1	1	845	10	3	121
Marcy	4/24/2014	1153	2.5	0.5	0	0	577	20	0	58
Shawangunk	4/22/2016	507	1	0	0	0	507	8	0	63
Sing Sing	10/5/2015	1638	4	1	5	2	273	17	7	164
Southport	2/18/2015	601	1	0	1	0	301	13	1	50
Sullivan	10/31/2013	459	1	0	1	0	230	11.5	0	40
Washington	6/22/2016	848	2	0	0	0	424	8	3	170
Watertown	10/1/2016	497	1	0	0	0	497	7	0	71
Willard DTC	10/20/2017	776	1	1	1	0	776	9	2	111
Woodbourne	2/15/2012	824	1.5	0	1	1	549	7	2	165
Wyoming	2/21/2014	1681	2	0	1	0	560	9	0	187
TOTALS		28,050	55	14.25	26	5	454	354.5	55	94

4. Clinician Staff Vacancies and Provider Ratios

Examining both **Tables 4 and 5** illustrates the serious shortage that exists at many prisons for clinicians - doctors, physician’s assistants and nurse practitioners - who are responsible for diagnosing and treating the prison population. With one in four items not filled, it is clear that the Department cannot provide necessary care to all its patients. But the situation becomes even more disturbing when one examines the great variability in clinician-patient ratios in **Table 5**. With an average clinician-patient ratio of 450 persons for each clinician, it is extremely difficult to properly monitor and promptly treat each patient. There were six prisons with a ratio over 600 patients, and three over 800 patients. These are nearly impossible ratios to sustain and can result in extensive delays for even routine services. At Willard DTC, when we visited in early 2017,

there was no doctor present at the facility and only one PA for the nearly 800 residents. Less than 3% of the survey respondents assessed their medical care as good, and 64% reported it as bad. At Clinton CF, there were only four clinicians for more than 2,800 patients, a ratio over 700 patients per provider. In reviewing the survey answers, 82% of the respondents said they experienced delays in seeing a clinician, less than 6% reported the care they received was good, and 73% said that the follow-up to a specialist's recommendation was not good. Moreover, some of these vacancies had extended for very long periods of time. For example, at Elmira, the medical staff reported to us that they had been unable to fill a physician item for **five years**, despite repeated attempts to hire someone. It is not unusual for a clinician item to be unfilled for many months up to a year or more before a replacement can be identified. These delays are caused by several factors. First, the prison must receive approval from DOCCS Central Office to post for the item. Next, the prison must first offer this item to other DOCCS and state employees to determine if these providers would be willing to transfer to the facility. If that fails, the prison must then get approval from Central Office to advertise the item to the public. Not all items can be filled because every prison is also subject to a budget fill level that is less than full staffing. The medical department is competing against the need to fill vacancies for teachers, vocational instructors, and other professional staff at the prison.

Specifically for physicians, we have repeatedly learned from prison executive staff that in their community the salary levels for doctors is not competitive with the salaries in community health centers. Even with geographical additions to the salaries for DOCCS physicians under the state union contract, which have been approved for most prisons, the rate is often \$10,000 or more below community salaries.

In 2013, the CA performed a system-wide analysis of DOCCS medical staffing, which we reported in an extensive report we provided to DOCCS and DOH entitled *Correctional Association of NY 2013 Comments Concerning DOH Oversight of HIV/HCV Care in New York State Prisons*.² In that report, we analyzed all 59 facilities, based upon documents provided by the DOCCS Budget and Finance Office from March 2012 and the DOCCS Medical Personnel Job Roster for May 2012. At that time, we found a vacancy rate of 27% for clinicians, very similar to the rate for our subsequent prison visits during 2012-17. However, in 2012, the 25 prisons we are summarizing in this analysis had an authorized staff level of 89.25 clinicians in comparison to only 81 clinicians at the time of our visit or subsequent updated roster. **Appendix B – Analysis of DOCCS Medical Staff for Clinicians and Nurse 2s - 2012-17** contains a listing of the 25 CA-visited prisons with the vacancy rates for physicians and Nurse 2 items, along with the 2012 authorized staff levels for doctors, PA/NPs and Nurse 2s. The elimination of 2012 staff items represents an additional 9% reduction in clinic staffing, during a time when the actual population of incarcerated persons at these facilities declined by only 3.5%. The impact of

² Correctional Association, *2013 Comments Concerning DOH Oversight of HIV/HCV Care in New York State Prisons*, at 20-25 (2013) available at: <http://www.correctionalassociation.org/wp-content/uploads/2013/10/CA-Memo-2013-Comments-DOH-Oversight-Law-Final-Draft.pdf>.

the current vacancy rates is even more significant than when our analysis was presented in 2012 because they do not reflect these cutbacks. We do not believe any of these reductions in authorized staff were the result of an assessment that these clinicians were not needed at the prisons. Rather, given the persistent vacancies DOCCS was experiencing with these positions, it appears they eliminated the items because the position could not be filled and the facility was under pressure to reduce staff due to budget fill level limitations.

5. Nurse Vacancies and Nurse-Patient Ratios

The situation with nursing staff vacancies is similar to the problem encountered with clinicians. Overall, the vacancy rate was 16% for the 25 CA-visited prisons. Again, there was very wide variation in the number of nurses authorized at the various facilities in comparison to the number of patients and in the amount of vacancies. Concerning vacancies, the rate ranged from 0% to as high as 46% of the permanent staff. Nine prisons had Nurse 2 vacancies of 25% or more, and only six facilities had no vacancies. Unlike with clinicians, however, prisons can potentially hire outside agency nurses on a temporary basis. Of the 25 prisons we visited, it appears only two prisons employed agency nurses: (a) Five Points CF, which was missing 11 nurses (including six vacancies and five nurses on long-term leave), had hired eight FTE agency nurses; and (b) Greene CF, which at the time of our visit was missing 40% of its nursing staff, hired four agency nurses. Another mechanism employed by a few prisons with serious nursing shortages is to use their per diem nurse item, which is generally one FTE item that is filled with multiple nurses who generally work on a per diem basis to fill in for a day or two for permanent staff on vacation or out sick, to replace an empty full-time item. One prison, Altona CF, reported that they employed six extra service nurses to fill one FTE item, but this mechanism is rarely utilized by prisons and is not an adequate solution to resolve missing staff items. Finally, some prisons have temporary nurses employed at other facilities or other state agencies working as extra service nurses, meaning that they work on a part-time basis to fill in for missing nurses out for vacation or who are sick, but this is not a replacement for long-term staff shortages.

As with the clinician items, we repeatedly were informed about nurse vacancies that had existed for extended periods of time. At Cayuga CF, we were told that one position had been unfilled for three years at the time of our visit. At Cape Vincent, two vacancies were reported for more than 15 months when we were there. Several prisons reported to us that they had not received permission to fill vacant nursing items due to budget limitation. Others facilities, such as Washington CF, which had three vacant nursing items, could not fill any because every candidate to whom they offered the job refused because of the low pay they would receive. Many staff reported to us that the salary for nurses in the community was significantly higher than in DOCCS.

We also compared the number of nursing items assigned to each of the 25 CA-visited prisons to the levels of authorized staff at these facilities in 2012 (see **Appendix B**) and discovered, as with the clinician items, that there had been reductions. In 2012, these prisons had a total of 377

Nurse 2 items authorized; it was lowered to 354.5 items at the time of our visit or subsequent updated staffing information. This represents a 6% reduction in potential nurse items when the actual prison population in these facilities was reduced by only 3.5%.

As a result of the low number of authorized staff at each prison and the high vacancies rates, the nurse-patient ratios were extremely variable. Historically, most prisons without a large infirmary or RMU would have a nurse-patient ratio in the range of 1:100. As seen in **Table 5**, there were eight facilities with ratios over 1:125, and five had ratios above 1:150, which is more than 50% higher than the average ratio. These patients at these prisons consistently reported problems with access to care and with the quality of the encounters they experienced with the sick call nursing staff. For example, at Sing Sing, Great Meadow, and Greene CFs, only 40% to 50% of the patients who responded to CA surveys at these prisons reported they could access sick call when they needed it, and, more importantly, only 7.5% to 11.5% assessed sick call as good, and 50% to 65% said it was poor. Inadequate staff not only delays care, but rushed encounters often lead to inadequate care and disrespectful provider-patient relationships.

6. Pharmacy Staffing

DOCCS has struggled to maintain prison pharmacies, in large part due to the inability to hire pharmacists at the current salaries dictated by state pay rates. Seventeen of the 25 prisons we visited did not have an operational pharmacy, although many were receiving medications from regional pharmacies at other prisons. Several prisons, however, had to purchase their medications from outside pharmacy providers. Of the eight prisons with a pharmacist, two had vacancies. In section C (2) below, we report on incarcerated persons' experiences in getting appropriate and timely medications.

7. Dental Staffing and Vacancies

All 25 CA-visited prisons provided dental services, although five of these facilities experienced dental vacancies. Elmira CF, with more than 1,600 incarcerated persons, had two dental items that were both vacant at the time of our visit. Other prisons that were missing a dentist were significantly impacted because the typical allocation for a prison is only one to two dentists. Consequently, instead of having one dentist for approximately every 750 incarcerated persons, five prisons (Cayuga, Clinton, Collins, Great Meadow, and Groveland CFs) had a dentist-patient ratio of 1:945 to 1:1,335. **Appendix C – Analysis of DOCCS Staff of LPN, Pharmacy, and Dental Services 2012-17** contains a summary of the dental staff, vacancies, and provider-patient ratios for the 25 CA-visited prisons.

C. General Healthcare in DOCCS Facilities

The CA has been thoroughly examining the medical care provided to incarcerated persons so that we can accurately inform the legislators and the public about what is occurring in our state prisons. For every prison visit, the CA (1) submits a pre-visit questionnaire to the prison

administration to obtain data about the staffing and services at the facility, (2) conducts interviews with the leadership of the prison medical department, usually with the Nurse Administrator and sometimes with the Facility Health Services Director, (3) speaks with members of the Inmate Liaison Committee and the Inmate Grievance Committee, and (4) solicits confidential written surveys from as many persons in the prison as we can speak to during our typical two-day visit to the facility. We have followed this practice for more than a decade and have amassed extensive information from the incarcerated population about all aspect of conditions of confinement.

Concerning medical care, our survey asks each respondent to describe the frequency of their interactions with medical staff, to assess the quality of care provided by clinicians, nurses, and dental staff, and to rate the overall quality of the services they have received. During the period mid-2012 through mid-2017, we obtained 3,773 surveys from persons in the general population in 21 prisons.³ For the same five-year period, we also have 808 surveys from persons residing in the facilities' disciplinary confinement unit, Special Housing Units (SHUs), or in the supermax prisons, Southport and Upstate CFs, which are designed to house primarily SHU residents and are not included in the general prison data summary. In total, we have surveys from 23 prisons and 4,500 residents. Based upon the information we received from the prison administration, the interviews with the prison executive team and facility staff, and interviews and surveys from the incarcerated population, we have developed a comprehensive view of what is occurring at the prisons and evaluated what aspects of services are functioning well and where the prisons and its residents are experiencing challenges in meeting the medical needs of the incarcerated population.

Healthcare in the prisons is a triage system whereby residents must go through several levels of care in order to obtain the services they need. This starts with sick call, which is the only aspect of medical care the patient can initiate; incarcerated persons can request to see a prison nurse to voice their concerns about their medical status and request medical care. If the nurse's assessment is that the patient requires an evaluation by the prison clinic staff - doctors, physician assistants, or nurse practitioners - the patient will be scheduled to be seen at the clinic for a medical call-out. This could take days or even months to occur, and the patient has no mechanism to directly access a clinician. If the clinician determines that the patient needs more expert evaluation and/or treatment, the clinician can order an appointment for the patient to be seen by a specialist. The specialty care may occur at a prison or one of DOCCS Regional Medical Units (RMUs) or the patient might be sent out of the facility to see a specialist at an outside hospital or other community-based healthcare center. If the patient is suffering from a medical condition that necessitates that s/he cannot be safely housed in the patient's housing area, the patient may be sent to a prison infirmary or one of the five RMUs. For hospital care, the

³ The data we provide for general population residents is from 21 prisons, but in the listing in the Appendixes there are 24 entries since we separated Clinton data into four units - Clinton (Main Building), Clinton Annex, Clinton APPU and Merle Cooper. When we refer to Clinton, we are referring to the Clinton Main, although the data for the other three units are similar to the problems encountered in the Main Building.

patient may be sent to a hospital near the prison or if the patient needs specialized care, the person could be sent to one of the many hospitals throughout the state that provide treatment to DOCCS patients. Finally, medications are provided to DOCCS patients at all prisons. Some of these medications are distributed through a pharmacy in the prison, or are obtained from a pharmacy at another prison that services several prisons in the area or purchased from an outside pharmacy service in the area. Dental services are provided in most prisons, but a patient may be sent to another prison to receive care, go to one of the RMUs for more complex dental procedures, or even be sent to an outside specialist for certain dental services. We will review each of essential components to provide our assessment of DOCCS services at the 21 CA-visited prisons.

1. Patients' Assessment of Overall Healthcare in New York Prisons

Only 11% of the survey respondents from the 21 general population CA-visited prisons rated the overall medical care as good, and 47% assessed it as poor. Medical care is the most grieved issue in the Department, although DOCCS has not issued a system-wide report on grievance since 2013. **Table 6 - Summary of CA Survey Responses about Medical Care for Visits from 2012-17** contains a compilation of responses from 3,773 persons general population in the 21 CA-visited prisons.

Table 6 – Summary of CA Survey Responses about Medical Care for Visits from 2012-17

Medical Service	Yes	Some times	No	Range of No/Freq	Good	Fair	Poor	Range of Poor	APP #
Can you access sick call when needed	56%	32%	12%	2%-20%					D
Rate sick call nursing care					15%	37%	48%	30%-74%	E
Do you experience delays in seeing a clinic provider *	40%	38%	22%	28%-56%					F
Rate physician care					14%	37%	49%	32%-69%	G
Interactions with medical staff confidential	40%		60%	47%-75%					
Experience delays in specialty care	47%	16%	37%	17%-70% (Yes)					
Good follow-up to specialists	37%		64%	52%-85%					
Problems getting medication **	34%	21%	46%	20%-47% (Yes)					
Rate overall healthcare					11%	42%	47%	36%-64%	H

* The three categories for this variable are: Yes= Frequently; Sometimes=Once or once in a while; and No=Never.

** The data contained here represents the percentage of respondents who were on medication and does not include persons who responded that they did not take any medication. The range figure represents an affirmative response of only those who were on medications.

This column indicates the Appendix item that contains data on each of the 21 surveyed prisons concerning the specified survey question.

The survey data contained in **Table 6** demonstrate several serious concerns about the care being provided at many of DOCCS prisons, including both reasonable access to care providers and the quality of care the patients receive once a medical encounter occurs. It is important to differentiate problems with access to care, which may require additional resources and improvements in procedures, from issues of quality of care, which may be due to high caseloads for providers or may not relate to resources, but rather the commitment and attitude of the provider to rendering competent care in an engaged manner. The latter problems require a significantly different remedy, which would have to focus on supervision and quality reviews of provider performance.

A few examples can demonstrate the breadth of these problems. Willard DTC, which we visited earlier this year, had no physician and only one Nurse Practitioner for more than 700 residents who are enrolled in a 90+ program as an alternative to returning to a general prison. At Willard, only 3% of the residents assessed care as good. Residents reported that they cannot get seen in a timely manner and that when they have serious physical limitations due to their medical condition, they cannot get a timely medical exemption from the rigorous boot-camp exercises they are required to perform as part of the program. Because of the failure to properly evaluate these patients, some have elected to leave the program and return to prison in order to protect their health. This problem is clearly related to a staffing problem, but is exacerbated by a lack of cooperation between the medical department and the security staff.

At Clinton Main and the three other units (Annex, APPU and Merle Cooper), there were no nurse vacancies, but the patients were critical of the sick call nurses, asserting that many nurses failed to adequately assess them during sick call, only provided ibuprofen or other analgesics in response to nearly all complaints rather than referring them to a clinician, and often treated them with disrespect or a negative attitude. Fifty-one percent of respondents from Clinton Main rated the nurses' care as poor. Clinton was missing one-third of their clinicians, and survey respondents reported one of the highest rates of delays in access to their providers of any prison. But their responses also noted difficulties with the clinician during call-outs, asserting that some clinicians do not take their complaints seriously, were reluctant to thoroughly examine patients, and failed to provide prompt follow-up to serious medical problems. Survey participants also raised concerns that their medical encounters lacked privacy, with officers overhearing confidential medical information and then sometimes talking about this information to other staff in inappropriate ways and contexts. Only 5% of Clinton respondents rated overall care as good, and 56% rated it as poor. Multiple interventions will be needed to correct the problems at Clinton, the largest prison complex in the state.

Patients' concerns about sick call focus more on the quality of the sick call encounters rather than on access to the sick call nurses. Only 12% of the respondents reported that they could not get access when needed, although another 32% stated that they sometimes had access difficulties. In contrast, the rating of the sick call nurses was much more critical; 48% of the survey participants

assessed these encounters as poor, with patients at four prisons (Groveland, Great Meadow, Greene, and Willard) providing poor ratings in the 56% to 74% range. The complaints of many survey participants primarily centered on the quality of the encounters with the sick call nurses and the limited care provided after being seen. Specifically, at multiple prisons, patients reported that some nurses were dismissive of patients' complaints, skeptical of their assertions of a medical problem, and uncaring, disrespectful, and sometimes rude. In addition, survey respondents reported that some sick call nurses refused to refer the patient to a physician until they had repeatedly gone to sick call with the same complaint. Those who were dissatisfied felt that the staff did not believe they had a problem and were unwilling to provide meaningful care; these staff gave out over-the-counter medications and sent the patients back to their housing area with no referral. Not all sick call nurses responded in this way, but the pattern was repeated frequently at many prisons, prompting the CA to conclude that a careful review of the quality of sick call encounters is needed to ensure that these nursing are adequately responding to patients' needs.

The clinic call-outs process also had a relatively poor assessment of care, and had the added dimension that patients could not independently access such care but had to rely on a referral from sick call in order to see a doctor. As summarized in **Table 6**, nearly half of all survey participants rated clinician care as poor. One aspect of this problem is delays in getting to the clinic, which can result in untimely or denied care. The median delay for all prisons was two weeks, but in many cases, the delays were much more. At several prisons, including Cayuga, Clinton, Great Meadow, Groveland, Livingston, and Shawangunk, delays of four weeks or more were reported by 32% to 52% of the survey respondents. In some cases, the delays were so long the patient's original condition had resolved but a new medical problem had emerged, which some providers refused to address since the clinic appointment had been schedule for the original problem.

Concerning the quality of the interactions with the clinician, a significant portion of the incarcerated population reported difficulties with their assigned provider. Frequent complaints related to failure to thoroughly examine the patient, inadequate and delayed response to a medical condition, uncaring or disrespectful attitude toward the patient, and failure to follow-up on a specialist's recommendation. We have repeatedly recommended that a review process be developed to ensure that all clinicians are providing appropriate and timely care.

2. Access to Medications

A majority of patients on medications in the prisons reported that they sometimes experienced problems getting their medications. About one-third said this was a regular issue. The difficulties with getting medications focused on two areas of concern. First, many prisons do not have a pharmacy in their facility, but rather must rely on a pharmacy at another prison to deliver the medications or the prison must get its medications from a commercial pharmacy in the community. DOCCS has closed a number of prison pharmacies due to an inability to hire

pharmacists. The use of regional DOCCS pharmacies has avoid purchases from the more expensive community-based pharmacies, but still results in a prison not having medication on hand when they might be needed. As we discussed earlier, of the 25 prisons we visited, 17 did not have their own pharmacy. Several prisons had to rely on outside pharmacy services, which also mean that the prisons had no electronic records of the medications a patient is receiving, an asset that does exist for prisons using DOCCS pharmacy services. For the eight facilities that did have a pharmacist in the prison, three had a vacancy, representing 14% of the pharmacist staff.

In addition to the problems of inadequate staff, patients also report other medication-related problems. Foremost is the difficulty many patients experience with getting appropriate pain care. Often the assumption by security staff and some medical personnel is that the patients are seeking pain medication for improper reason - to get high. Although some diversion of pain medication happens in prison, as it does in the community, the widespread reluctance to prescribe these medications at appropriate dosages is a consistent complaint we receive. Similarly, patients report that when they are transferred to another facility or come to DOCCS from a jail, medications they have been receiving for chronic condition are sometimes discontinued, often even without having a discussion with the patient prior to terminating the drugs or providing alternative therapy. Many patients have reported that the substitute medications are not as effective. Finally, a frequent problem is getting refills of long-standing medications a patient is receiving in a timely manner and getting their prescriptions renewed. Every prisons has a specified procedure for refills, requiring a patient to submit a refill request several days before they run out of their medications, but sometimes the refills are not provided according to the schedule and patients must go to sick call to find out why their drugs have not been delivered. All these factors contribute to the assessment by 54% of the survey respondents that they experience problems getting the required medication.

3. Dental Services

In the CA surveys, we ask people about access to dental services and quality of such care. Although better than overall medical care, 40% of respondents assessed the care as poor, and 28% said it was good. The most significant complaint deals with delays. For all 25 CA-visited prisons, the median delay was 21 days. But at several facilities, the median time was much greater - Clinton Annex (120 days), Great Meadow (75 days), Clinton Main (60 days), and Altona (45 days). Six other prisons had median delays of 30 days. Moreover, for all survey participants, 45% reported delays of one month for a dental appointment. Other concerns raised by survey respondents focused on the services provided. In particular, at many prisons, patients complained that the dentists concentrated on extractions and were less willing to perform restorative care to keep the patient's tooth. Data from the dentist confirm that at many prisons a significant portion of the work involved extractions. Finally, many dental patients were concerned that they could not get timely cleanings of their teeth. At numerous facilities, the dental staff did not include a dental hygienist. In these prisons, cleans can only occur if the

dentist or the dental assistant performs this activity, which takes them away from other dental treatment.

4. Healthcare in Solitary Confinement

Persons housed in solitary confinement cannot go to sick call and are rarely sent to the clinic, but rather receive medical services in the SHU. State law requires that every day medical staff visit persons in solitary confinement to ascertain whether they are in need of medical services. These cell-side encounters are often very brief, and patient frequently complain that they are not private, as security staff accompany the nurse during these rounds and can hear the conversation, and other SHU residents can also overhear what is being said, as the patient sometimes has to scream to be heard through the cell door. **Table 7 - Summary of SHU Survey Responses about Medical Care for Visits from 2012-17** contains a compilation of the responses of SHU residents to the CA survey. During this five-year period, we obtained 808 responses, including from persons held at Southport and Upstate CF, two prisons designated to house primarily persons sent to the SHU to extended periods of time. We found that SHU patients experienced similar difficulties with the quality of medical care and access to clinicians who must come to the unit to provide services.

Table 7 – Summary of SHU Survey Responses about Medical Care for Visits from 2012-17

Medical Service	Yes	Some times	No	Range of No/Freq	Good	Fair	Poor	Range of Poor	APP #
Can you access sick call when needed	52%	31%	17%	0%-50%					
Rate sick call nursing care					17%	37%	46%	12%-86%	I
Do you experience delays in seeing a clinic provider *	52%	24%	24%	0%-83%					J
Rate physician care					9%	31%	59%	0%-100%	K
Problems getting medication **	53%	25%	22%	0%-100% (Yes)					
Rate overall healthcare					9%	37%	54%	14%-82%	L

* The three categories for this variable are: Yes=Frequently; Sometimes=Once or once in a while; and No=Never.

** The data contained here represents the percentage of respondents who were on medication and does not include persons who responded that they did not take any medication. The range figure represents an affirmative response of only those who were on medications.

This column indicates the Appendix item that contains data on each of the 38 surveyed prisons concerning the specified survey question.

Patients were very concerned about long delays in getting to see a doctor. For all the SHUs, almost half of the survey respondents reported it takes four weeks or more to be seen by a clinician. At Southport CF, 58% of respondents reported it takes a month to see a clinician, and one-third said it takes 45 days or more. At Upstate CF, the other supermax prisons, nearly two-thirds of the respondents said it takes one month to see the clinician, and 29% reported it takes 60 days. These delays are totally unacceptable, given these patients are locked in their cell, readily available at any time to be seen and are often in deteriorating medical and mental health

while they are in isolation. Concerning the quality of the care, only 9% of all SHU residents rated physician care as good, and nearly 60% said it was poor. At nine SHUs, not a single person said physician care was good, and at four SHUs (Great Meadow, Marcy, Watertown, and Woodbourne) between 82% and 100% of the residents assessed doctor care as poor. At the 24 SHUs we surveyed, 54% of SHU residents rated overall care as poor, and only 9% considered it good. Clearly, greater attention must be directed at how SHU residents access care and the quality of those encounters.

D. DOH Oversight Law, HIV and HCV Care, and Cooperation between DOCCS and OMH

The CA has been closely monitoring the care provided HIV- and HCV-infected patients for more than two decades. During that time, we have issued a number of reports about medical care at specific prisons and more comprehensive documents analyzing system-wide prison healthcare and HIV- and HCV-specific treatment issues.⁴ Throughout these reports and comments to DOCCS and OMH, we have been concerned about (1) encouraging persons in DOCCS to learn their HIV and HCV status by being tested, (2) providing infected and non-infected patients with information about HIV and HCV so they can make informed decisions about whether and how to get tested and obtain effective care, (3) ensuring that DOCCS identifies HIV- and HCV-infected patients, and engages and retains them in DOCCS care, (4) ensuring that HIV and HCV information is kept confidential and that encounters with these patients are private; and (5) providing treatment to these patients with the most effective therapies available in the community and ensuring appropriate continuity of care for these patients as they are transferred among DOCCS facilities, and, more importantly, when they are released and return to their communities. Much improvement has occurred during these two decades in each of these categories, but some additional measures are needed to ensure that all patients are receiving community standards of care and are given the best opportunity to address these illnesses and have productive and healthy lives.

We believe much of the gains that have been achieved in the treatment of DOCCS patients with HIV and HCV are due to the long-standing cooperation between DOCCS and the AIDS Institute (AI) of NYS DOH. This relationship was encouraged in the late 1990s and in the early 2000s due to activities of the AIDS Advisory Council, which issued an extensive report about HIV care in the prisons, and the Assembly's Health and Correction Committees, which held a public

⁴ CA, *HIV Services for Women in New York State Prisons* (2015) available at <http://www.correctionalassociation.org/wp-content/uploads/2015/10/WIPP-WOMEN-HIV-REPORT-FINAL-08-19-15-1.pdf>; CA, *2013 Comments Concerning DOH Oversight of HIV/HCV Care in New York State Prisons* (2013) available at available at: <http://www.correctionalassociation.org/wp-content/uploads/2013/10/CA-Memo-2013-Comments-DOH-Oversight-Law-Final-Draft.pdf>.; CA, Memorandum to NYS Department of Health Implementation of Public Health Law § 206(26) (June 30, 2011), CA, *Healthcare in New York State Prisons 2004-2007* (2009) available at <http://www.correctionalassociation.org/resource/healthcare-in-new-york-prisons-2004-2007>; CA, *Health Care in New York State Prisons* (2000) available at http://www.correctionalassociation.org/wp-content/uploads/2012/05/healthcare_report.pdf.

hearing in 2004 about healthcare in our prisons. We commend both DOCCS and AI for these efforts.

1. HIV and HCV Prevalence and Treatment in DOCCS Facilities

In the CA's 2013 Comments on the DOH Oversight Law, we explained in great detail the processes of identifying and treating HIV- and HCV-infected patients and will only briefly summarize this process and highlight more recent developments. In 2013, based upon available data from DOCCS and OMH, we estimated that there were between 2,700 to 3,000 HIV-infected persons in the Department, but acknowledged that this was a questionable estimate due to the fact that DOCCS did not test all of its patients for HIV. Similarly, we estimated that there were 6,000 to 6,600 DOCCS patients infected with HCV.

As we reported then, NYS DOH, Bureau of HIV/AIDS Epidemiology (BHAEE), had been performing studies of newly admitted persons to DOCCS approximately every two years from 1988 and has continued this process through 2015. The HIV-infected rate has consistently declined from 1988 to 2012 for both men (18% to 2.4%) and women (20% to 3.7%), and the latest figures for 2015 fell to 1.9% for men and 2.8% for women. Given the advocates' repeated concern that there were many unidentified HIV-infected patients in DOCCS, in 2015 DOH and DOCCS agreed to share information about the DOCCS patient population to compare these individuals to DOH's HIV surveillance data to match patients to determine if any HIV-infected persons were in DOCCS but their status was unknown to DOCCS' medical department. As a result of this study, DOH identified 1,108 HIV-infected persons in state prisons, of which 10%, approximately 110 patients, were not known to DOCCS. DOH then undertook an initiative to meet with these patients to encourage them to reveal their HIV status to DOCCS. It is our understanding that this process has been relatively successful and that many of these patients decided to disclose their status to DOCCS and engage in care. We further understand that this process has continued with matching of DOCCS and DOH records to identify patients not in DOCCS care and DOH outreach to encourage unidentified HIV-infected incarcerated persons to engage in HIV care in the prisons. We applaud these efforts and commend both DOCCS and DOH for undertaking this process.

It should be noted, however, that HIV-infected DOCCS patients are sometimes reluctant to disclose their status because of concerns about the lack of confidentiality in our prisons and concerns about the quality of care they will receive. Both of these issues are real, and although DOCCS is prescribing the current therapies and HIV-infected patients are doing well in prison, the general concerns of incarcerated persons about their access to care deter some patients from engaging in care when they are unsure about how they will be treated. For this reason, as we explain later, we strongly urge expanding the use of peer educators inside DOCCS.

Concerning identification of HCV-infected patients, there are some new developments that increase the likelihood of engaging this patient population in care. In 2013, we estimated that

there were 6,000 to 6,600 HCV-infected persons in DOCCS. At that time, DOCCS was not testing all of its population for HCV. It is our understanding that starting earlier this year, DOCCS initiated uniform HCV screening. We applaud this initiative. The DOH seroprevalence studies demonstrate that these efforts are needed, as the DOH data indicated that there may be an increase in HCV-infected patients in DOCCS. Specifically, in 2015, DOH found that 10.3% of newly admitted men and a shocking 24.2% of women were HCV-infected. Both groups recorded increases from prior years, but the increase for women was dramatic. For men, the HCV infection rate in 2009 and 2012 was 9.5% and 9.6%; for women it was 14.6% for both years. An increase to 24% reflects a 66% increase from prior years. Given the limited sample size for newly admitted women, typically in the range of 800-900 tests, one must be cautious in projecting long-term trends, but clearly DOCCS and OMH must closely monitor the situation to respond to any increase in the HCV-infected population to ensure that adequate resources and procedures are employed to treat this population. Concerning the increase for the men, there is some suggestion in the community that HCV infection rates are increasing with the increased use of opioids. If this means that there may be an increase in the percentage of younger patients who are HCV-infected, DOCCS policies and procedures may need to be adjusted to reach and treat this younger patient population.

DOCCS provides treatment to the vast majority of individuals who identify as HIV-infected and who are willing to take medications. The data we obtained from the prisons during the past five years confirm this trend. It also appears that this therapy is mostly effective. As part of the DOH Oversight Law, DOH has been monitoring care through chart reviews of patients in a limited number of facilities each year. During that time, DOH reported that viral load suppression of HIV, signifying that the medications are effectively reducing HIV in the patients' blood, ranged from 90% to 98%. These rates are comparable or even better than some community studies. We believe that additional resources are needed to expand DOH monitoring beyond the four to six prisons investigated each year, but these limited results suggest that effective HIV care is probably being provided at most DOCCS prisons.

Hepatitis C treatment has dramatically changed in the four years since the CA 2013 report. At that time, few DOCCS patients were on treatment. Since then, two major developments have occurred. First, much more effective and shorter term therapies have been developed. These treatments are very expensive but result in 90% or more of treated patients being cured. Second, DOCCS in FY 2015-16 increased its medication budget by \$23M so that it could provide HCV therapy to more patients. In 2016, DOCCS treated nearly 500 patients with the new therapies. Through September 2017, DOCCS has already treated 513 patients. The treatment protocols in DOCCS are also more aggressive than in many other corrections departments. Specifically, DOCCS will consider providing therapy to patients who are chronically infected and have a fibrosis level of 1 on a 0 to 4 scale. Many other jurisdictions will only consider patients for therapy if they have more advanced fibrosis, levels 3 or 4. We believe the treatment rates in

DOCCS are the highest in the country for prison-based HCV care; in many jurisdictions, fewer than 50 patients are being treated annually. We commend this effort.

Our only concern is that initiation of therapy requires facility-based providers to evaluate HCV-infected patients to determine if they are appropriate candidates for therapy and to then submit a request to DOCCS Chief Medical Officer to get approval for care. Anecdotally, we have received complaints from some patients that they have not been evaluated for potential therapy, despite being HCV-infected for an extended time and therefore at risk for the development of fibrosis. Unfortunately, the evaluations of HCV care by DOH are inadequate to assess whether this screening is occurring and whether appropriate candidates for treatment are being offered therapy and approved for the new medications.

2. Cooperation between DOCCS and DOH

The AIDS Institute (AI) has been involved with prison healthcare for more than two decades, and we believe the agency's engagement with DOCCS has had positive effects on the ability of the Department to provide care to HIV- and HCV-infected patients. Four aspects of AI activities with DOCCS have had a significant impact on the care being provided to incarcerated persons in the state prisons: (1) the support services provided by community providers contracted with AI to perform duties under the Criminal Justice Initiative (CJI); (2) Project START and the federally funded pilot program Positive Pathways Project, which was conducted to encourage incarcerated individuals to disclose their HIV status and/or to enter care; (3) the Ending the Epidemic initiative, including the Governor's HIV Blueprint and efforts to implement the Blueprint recommendations; and (4) the HCV continuity of care program.

The Criminal Justice Initiative entails multiple efforts in the prisons. For HIV-infected patients, CJI contractors provide three different services - counseling and support services for individuals and groups; transitional planning for HIV-infected persons going home; and support services for treatment adherence. For all DOCCS residents, the CJI contractors provide health education on HIV and HCV, with a focus on risk reduction, peer education training, and anonymous HIV testing and partner services. Two of its more recent initiatives included: (1) Project START, which involved a six-session individual-level risk reduction intervention that entailed two sessions pre-release and four session post-release that continued up to three months after the patient returned home; and (2) Positive Pathways, which entailed identifying new and existing HIV-infected DOCCS patients, attempting to engage them in care and continuing engagement with these patients for up to six months after they returned home.

We believe Project START and the Positive Pathways Program have apparently ended, but now the AIDS Institute has undertaken similar activities of identifying potential HIV-infected patients in DOCCS, attempting to engage them in care while they are incarcerated and providing support services to formerly incarcerated patients when they return home. It is our understanding that these efforts are being developed pursuant to the Ending the Epidemic initiative following the

approval of the Governor's *2015 Blueprint to End AIDS*. For example, recently DOH issued a request for community agencies to submit proposals for funding to provide support services to HIV-infected patients returning home from DOCCS in Queens.

Although we commend the efforts of DOCCS and OMH concerning the CJI program, we believe more could be done to improve the effectiveness of the CJI program. When we last received data about the services at specific prisons, it did not appear that every prison was receiving all the elements of the program. Moreover, even if a service was available, it was also not certain that every eligible patient was receiving the service provided by the CJI contractor. This lack of full coverage was particularly true for the peer education program and the HIV individual and group support programs. We urge the legislature to review the comprehensiveness of the CJI program and enhance resources to AI to ensure that all prisons are fully covered.

Another issue we raised in 2013 and still observe is that the peer education program is not realizing its full potential. Specifically, individuals who complete the training are not necessarily assigned to peer education projects in the prisons. Currently, this valuable resource is not being used by most DOCCS facilities. There is no consistent DOCCS policy of which we are aware that specifies how graduates of the CJI peer program will be incorporated into the prisons' HIV education programs, nor is there system-wide funding to pay these trained individuals to perform education and support services for the prison population. Although many peers attempt informally to educate others inside, we believe DOCCS is not fully utilizing the knowledge and skill of these peers, since most prisons do not assign these individuals to paying jobs and other programs in which they can consistently and regularly engage the prison population in formal and informal presentations on HIV education, prevention, and risk reduction. Conducting health education programs that are only HIV-specific is not the best method in which to get this information widely disseminated in the prison population because non-infected individuals are often reluctant to attend such an event, since their mere attendance can lead to an inference that they are HIV-positive. Therefore, HIV education must be regularly inserted into non-medical education and other support programs to reach a much wider audience. It is not feasible to do this throughout DOCCS with outside professionals or the prison medical staff. Peer educators could perform this function for limited additional funding so that the entire DOCCS population can repeatedly learn important facts of HIV and understand the benefits of learning one's status and entering care. We urge AI to initiate discussions with DOCCS on measures that can be taken to expand the role of its peer educators in all DOCCS programs.

Another proposal we believe DOCCS and OMH/AI should explore is the potential for enhancing the peer education program to prepare its participants to become community health care workers after they are discharged. This would not only help these returning citizens find meaningful employment, but also would help community-based programs engage and retain recently released patients by having care coordinators who can relate and assist these new patients navigate the difficult transition from prison care to community healthcare.

For more than a decade, DOH has been providing support for HCV-infected patients who are released from DOCCS while they are still receiving HCV treatment. Given the new shorter term treatment regimes now being used, we suspect there is less demand for this specific continuity of care, but we urge DOH to expand its effort for HCV-infected patients who have not started treatment, but are in need of evaluation for treatment and appropriate monitoring of their HCV condition. We urge DOH to explore mechanisms by which potential candidates for HCV therapy who have not been treated while incarcerated and who are returning home can be connected to community-based providers who can evaluate these patients for treatment, and for those who are not eligible for treatment, engage them in care to ensure that their HCV status is properly monitored.

3. *DOH Oversight Law Monitoring*

Section 206 (26) of the Public Health Law (DOH Oversight Law) requires DOH to annually review the policies and practices of DOCCS concerning HIV and HCV care, including prevention of these diseases, and to determine whether such policies and practices are "consistent with current, generally accepted medical standards and procedures used to prevent the transmission of HIV and HCV and to treat AIDS, HIV and HCV among the general public." Upon completion of each review, the law mandates DOH to, in writing, either approve DOCCS policies and practices or direct DOCCS to "implement a corrective plan to address deficiencies." The DOH Oversight Law authorizes DOH to visit prisons, interview staff and incarcerated persons, inspect policy and procedure manuals and medical protocols, review medical grievances, and inspect a representative sample of patients' medical records. Finally, the DOH Oversight Law requires DOH prior to initiating its review to notify the public of the scheduled review and invite them to provide relevant information.

During the first few years of implementation, DOH primarily reviewed protocols and DOCCS data, but did not assess the care provided to HIV- and HCV-infected patients. The CA was very critical of this limited review and raised these concerns in its 2010 and 2013 comments to DOCCS and DOH. As reflected in the 2016 *DOH Review of Corrections HIV and HCV Policy and Procedures - 2015 Status Report*, the review of DOCCS prisons now entails a chart review of patients in one of the nine hubs of DOCCS prisons. Starting in 2013, it appears that this process has assessed care at 19 prisons.⁵ As noted earlier, the review found that for HIV care, greater than 90% of the treated patients have suppressed viral load, suggesting that they are receiving effective care. We commend DOCCS on this accomplishment and urge DOH to expand its monitoring efforts to reach a much wider group of prisons.

⁵ NYSDOH, AIDS Institute, *DOH Review of Corrections HIV and HCV Policy and Procedures - 2015 Status Report* (September 2016) available at https://www.health.ny.gov/diseases/aids/providers/reports/docs/corrections_policy.pdf

The DOH Oversight Law also mandates assessment of HCV care. For this disease, we are much less satisfied with the review process. Particularly in the last two years, it is clear that the vast majority of HCV-infected patients can be cured if they are prescribed the new HCV medications. The metrics DOH are using to assess HCV care do not address the evaluation of patients for potential therapy, whether therapy was provided, or the results of such treatment. We strongly urge DOH to modify its protocol to include these measures in next year's review. Overall, we believe DOH will need additional resources to perform its legislative duties under the DOH Oversight Law, thereby visiting more prisons each year and enhancing the scope of review for HCV care. We urge the legislature to appropriate what is needed so that at least every four years all prisons could be evaluated. Given the evolution of HCV care, it is important that DOH ensure that care at each prison is consistent with current community standards of care.

E. DOCCS and DOH Efforts to Improve Discharge Planning

Persons leaving DOCCS to return home face numerous obstacles in making this transition, with health concerns only one of many needs they must address. For most DOCCS patients with chronic medical conditions, the Department provides them with a two-week supply of medication and a prescription for their drugs that they could use once they are home. DOCCS has a comprehensive medical summary form in which a patient's medical condition and needs are described, but it is unclear what percentage of patients are actually given this documentation prior to release. Until recently, very few patients prior to release had an appointment with a community provider or had contact with a community provider who is prepared to continue their treatment. Moreover, few soon-to-be-released individuals have had the means to pay for community healthcare. New York wisely passed a law requiring the state to suspend, rather than terminate, Medicaid for individuals entering DOCCS who are currently enrolled in Medicaid when incarcerated. Unfortunately, that law impacted only a minority of patients.

In the past two years, the situation has improved. There are now about 18 staff hired to assist DOCCS patients prepare a Medicaid application while they are still incarcerated and then submit this documentation to the appropriate offices for processing so that the patients can promptly get their Medicaid insurance when they return home. This effort is being conducted throughout the state prison system. We are unaware of any published data on the number of individuals who have filled Medicaid applications before their release, but believe several thousand applications have been submitted.

A proposal that was pursued, but eventually was withdrawn, by the state, was an application to get a Medicaid waiver for New York to allow it to provide high-need incarcerated persons with Medicaid coverage 30 days prior to their release. The purpose of this waiver proposal was to enhance the ability of soon-to-be-released patients to connect with community-based providers prior to their release by permitting those providers to be reimbursed for activities they perform to engage this incarcerated population. This would have allowed for better transition for patients

with medical and behavior health needs. The state decided to withdraw the request once President Trump took office. We urge the state to re-examine this waiver proposal to ascertain if it could be approved in the future.

For the past few years, DOCCS and DOH have been meeting and developing pilot programs to enhance services for patients going home through New York's Medicaid Redesign Program. The primary focus has been in the development of pilot programs to enroll recently discharged patients in the Medicaid Health Home programs around the state. These pilots have been successful in ensuring that patients discharged from DOCCS have appropriate continuity of care by getting connected to comprehensive community care programs funded through the Health Home program. We urge that these efforts be expanded and that the evaluation of the effectiveness of the program be continued to identify barriers to enrollment and best practices to ensure that returning citizens with serious medical conditions are promptly enrolled in appropriate community-based care.

Finally, DOCCS Division of Health Services (DHS) created a new initiative this year to provide enhanced medical discharge planning for patients with chronic medical problems other than HIV and HCV. Because the CJI discharge planning program only assisted patients with HIV/HCV, patients with other serious medical conditions generally were not receiving comparable services to help them in obtaining appropriate care in the community. DOCCS DHS initiated a program through the Medical Department in DOCCS' Central Office to provide discharge planning for patients who should be promptly enrolled in care once they are released. Without having any designated funding, DHS managed to identify a program coordinator and five staff members to facilitate the collection of medical information and to contact community providers who could provide services to these patients. It is our understanding that 2,500 patients have been served so far this year and these efforts are expanding. We believe this is an important initiative that requires dedicated funding with increased staffing beyond the current staffing levels. We commend DOCCS for starting this program, and we urge DOCCS, the Governor, and the legislature to enhance funding for this project.

F. Need for Greater Oversight of DOCCS Healthcare

Two years ago, the CA and many other advocates testified before the Assembly's Correction Committee urging greater oversight of DOCCS operations.⁶ The CA provided extensive testimony about the inadequacies of internal DOCCS oversight mechanisms and the limitations of existing external oversight. In our testimony we emphasized the need for transforming the agency-level investigations and accountability, including the revamping the defective grievance system and limitation on investigations conducted by DOCCS' Office of Special Investigations.

⁶ Correctional Association Testimony before the NYS Assembly Committee on Correction re Oversight and Investigations of the Department of Corrections and Community Supervision (December 2, 2015). An Executive Summary of this testimony is available at <http://www.correctionalassociation.org/wp-content/uploads/2015/12/CA-Testimony-Executive-Summary-and-Recommendations-Dec-2-2015.pdf>.

Concerning medical care, we described the limitations generally of the State Commission of Correction (SCOC), and detailed its power through its Forensic Medical Unit to review any death occurring in DOCCS facilities. We noted that in 2014, there were six full Board reviews of DOCCS deaths and abridged reviews of seven additional cases. It must be noted, however, that there were 122 deaths that year, so only a small portion of deaths received any close scrutiny. More importantly, we found no evidence that the Board was exercising its broader authority to report on systems for delivery of medical care. We are unaware of any examples of SCOC or its Forensic Medical Unit investigating medical care systems in the state prisons outside of a specific investigation of a death. Moreover, there are no reports by the SCOC indicating that it is performing these investigations or has made any recommendations to DOCCS on how to improve general medical delivery systems.

Based upon our assessment of the inadequacies of current oversight of DOCCS medical operation, we believe several measures are needed to ensure appropriate care of DOCCS patients. Given the evidence that the current DOCCS-DOH relationship is producing positive results for HIV and HCV care, we believe it is essential that DOH jurisdiction be expanded to all medical services conducted by DOCCS including services provided by outside providers treating DOCCS patients. A proposal to apply DOH Article 28 jurisdiction to the prisons would likely accomplish this purpose. It will be important to ensure that DOH has full access to all relevant health records, including those prepared by outside providers serving this population. This authorization should also permit DOH to promulgate prison-specific regulations to the extent that community-based standard may not be appropriate in limited cases due to the unique conditions inside correctional institutions.

We also believe there must be greater transparency and accountability concerning the care and treatment of incarcerated persons. Besides reforming the defective grievance system, we support the legislation proposed in the Assembly to create a Correctional Ombudsman (A.1904), which would establish an independent public oversight agency to monitor conditions in the prison, to investigate complaints raised by incarcerated persons or others in the community about treatment of DOCCS residents, and to report to the Governor, Legislature, DOCCS and the public about what it has learned and what remedial measures are needed to correct noted deficiencies. The Ombudsman would have authority to investigate medical issues both systemically and individual complaints.

We also believe there needs to be greater public oversight and transparency that would expand media access to the prisons and require mandatory public reporting by DOCCS and other state agencies, including DOH, about the conditions within the prisons and the results of any investigations conducted by these entities.

Finally, we urged the legislature to support independent oversight by those outside state government. This could include federal investigations by the Department of Justice and access

by the UN Special Rapporteur against Torture and other national and international investigative bodies. We also urged the augmentation of the authority of the Correctional Association by requiring DOCCS to respond to the CA's findings in writing and develop corrective action where necessary, as well as authorizing the CA to utilize unannounced visits, access to all relevant documents, confidential communications with incarcerated people during monitoring visits, and unencumbered access to speak with staff.

We believe with greater oversight DOCCS could improve healthcare through collaboration with outside monitors, expand its information about barriers that exist to providing quality care, and gain the support it needs to enhance its resources to provide effective care.

G. Recommendations

1. Enhance DOCCS Medical Staff

- A. Fill Vacant Medical Positions Expeditiously** – DOCCS facilities need more healthcare providers, including physician, physician assistants, nurse practitioners, nurses, pharmacy staff and dental staff. In order to hire and retain these providers, the state must develop mechanisms to enhance the pay for these state workers.
- B. Assess Medical Staff Needs and Add Staff to Prisons with the Most Serious Deficiencies** – A comprehensive evaluation is needed to ascertain where additional medical staff is needed in DOCCS facilities. Once this analysis is completed, the state should approve funding to provide these positions.
- C. Enhance Reviews of Medical Staff Performance** – DOCCS should more closely monitor the performance of its providers and require that staff identified as needing improvements participate in mandatory training.

2. Improve Routine Care within the prisons

- A. Enhance Sick Call Services** – Expand DOCCS Quality Improvement (QI) program to examine the quality of sick call encounters. This should include a determination of the adequacy of the staff assigned to sick call, timeliness of sick call services, evaluation of the quality of interactions between sick call nurses and patients and the degree to which timely follow-up occurs in response to sick call examinations.
- B. Ensure Patients Have Timely Access to Clinic Providers and receive Appropriate Care during Clinic Call-outs** – DOCCS QI program should include a regular assessment of the clinicians to determine whether adequate personnel is assigned to clinic call-outs and to evaluate the adequacy of clinic encounters.

3. **Inmate Deaths**

- A. **System Death Review** - DOCCS should perform a systemic analysis of the causes of inmate deaths and evaluate whether recent increases in deaths are due to any policies or procedures of DOCCS or practices in any DOCCS facilities.
- B. **Medical Parole Law** – Amend the Medical Parole Law to simplify and expedite the review process and expand eligibility.

4. **Enhance Oversight of DOCCS Healthcare System**

- A. **Expand DOH Oversight of DOCCS Prisons by Applying Article 28 Jurisdiction to all Correctional Facilities and to Patients receiving Medical Care while Incarcerated** – Make DOH Article 28 apply to all DOCCS prisons and ensure that DOH has full access to all relevant health records, including those prepared by outside providers serving this population. This authorization should also permit DOH to promulgate prison-specific regulations to the extent that community-based standard may not be appropriate in limited cases due to the unique conditions inside correctional institution.
- B. **Pass the Correctional Ombudsman Bill (A.1904)** – Create an Office of Correctional Ombudsman that would be an independent public oversight agency to monitor conditions in the prison, to investigate complaints raised by incarcerated persons or others in the community about treatment of DOCCS residents and to report to the Governor, Legislature, DOCCS and the public about what it has learned and what remedial measures are needed to correct noted deficiencies.
- C. **Expand Independent Outside Monitoring and Enhance Media and Public Access to the Prisons** – The legislature should permit independent oversight by entities outside state government, including federal investigations by the Department of Justice and access by the UN Special Rapporteur against Torture and other national and international investigative bodies. The authority of the Correctional Association should be expanded by requiring DOCCS to respond to the CA’s findings in writing and to develop corrective action where necessary, as well as authorizing the CA to utilize unannounced visits, access to all relevant documents, confidential communications with incarcerated people during monitoring visits, and unencumbered access to speak with staff. The media should have better access to the incarcerated population, and DOCCS and other state agencies should be required to publish information about medical care inside and the results of any investigations about deficiencies in the prisons.

5. **Improve HIV and HCV Care**

- A. **Enhance Funding for DOH’s Criminal Justice Initiative** – Ensure there is adequate funding so that all the elements of the CJ program are provided at each DOCCS facility.

- B. Increase Funding to Implementation of the DOH Oversight Law** – Expand the resources for the DOH Oversight Law so that more facilities can be reviewed each year and that more rigorous reviews can occur for HCV treatment.
- C. Enhance the Use of CJI-trained Peer Educators and Initiate a Program to Qualify them to be Community Health Care Workers when they are released** – Expand the opportunities of peers trained by CJI contractors to assist persons inside the prison to learn about HIV and HCV and engaged in appropriate care. Explore the possibility of creating a program in prison to train these peer educators to be eligible to become Community Health Care Workers upon release.

6. Enhance General Discharge Planning for Persons Released from Prison

- A. Expand the Program Helping DOCCS Patients Apply for Medicaid Prior to Release** – Evaluate the effectiveness of the DOCCS program to help currently incarcerated persons to submit applications for Medicaid prior to their discharge and provide additional resource to ensure all soon-to-be-released persons are given an opportunity to prepare a Medicaid application.
- B. Expand the Pilot Programs to Connect Incarcerated Patients with Significant Medical Needs to a Health Home Program prior to Discharge** – Increase the efforts to encourage other Health Home providers in the community to connect with DOCCS patients prior to release who will need such services when they come home.
- C. Enhance Resources for the DOCCS Discharge Planning Initiative for Patients Leaving Prison who will need Healthcare in the Community** - Expand the new DOCCS initiative to provide meaningful discharge planning for all patients who will need health services in the community.
- D. Ensure Comprehensive Discharge Planning and Post-release Assistance to HIV- and HCV-infected Patient returning Home** – Adequately fund Ending the Epidemic initiatives to provide assistance to HIV- and HCV-infected patients prior to discharge and to continue such assistance for at least six months after they are released.