

Healthcare in New York Prisons 2004-2007

A REPORT BY
THE CORRECTIONAL ASSOCIATION
OF NEW YORK



The Correctional Association of New York

“Because the dangers of abuse inherent in the penitentiary are always present, the work of the Correctional Association—an organization of knowledgeable experts unaffected by political forces—is so important.”

Judge Morris E. Lasker, Former U.S. District Court Judge, Southern District of New York

The Correctional Association of New York (CA) was formed in 1844 by citizens concerned about prison conditions and the lack of services for inmates returning to their communities. In 1846, the New York State Legislature granted the CA authority to inspect prisons and report on its findings. Through four projects — Juvenile Justice, Prison Visiting, Public Policy/Drug Law Repeal, and Women in Prison — the CA advocates for a more humane prison system and a more safe and just society.

The **Prison Visiting Project** is the arm of the Correctional Association that carries out this unique legislative authority for the male prisons. Each year, the Project visits seven to ten of New York’s 70 state correctional facilities, branching out to all corners of the prison including cellblocks and dormitories, classrooms and industry shops, psychiatric units, medical clinics, protective custody and disciplinary housing. The Project interviews inmates, correction officers, teachers, counselors and medical staff. In addition, the Project collects data about the facility from prison officials and hundreds of surveys from inmates. After evaluating this information, the Project prepares a comprehensive report focusing on such areas as medical and mental health care, educational, vocational and re-entry programs, inmate jobs, relations among inmates and staff, the physical state of a facility, and other issues of concern to the individuals who live and work behind the prison wall. The Project presents its findings and recommendations in these reports to prison officials, the Commissioner of the Department of Correctional Services (DOCS), high-level state policymakers and the public. All the prison reports prepared by the Project since 2004 are available on the Correctional Association web page.

For more information about the Prison Visiting Project, please call 212-254-5700 or visit <http://www.correctionalassociation.org/PVP/index.htm>

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HEALTHCARE IN NEW YORK PRISONS, 2004-2007

INTRODUCTION

The New York State Assembly has requested that the Correctional Association (CA) provide its Health and Corrections Committees with an assessment of healthcare in New York State prisons. The CA has statutory authority to visit state prisons and report to the public and policymakers about the conditions it observes and its recommendations for improvements. Correctional Association staff last testified about healthcare before these committees in December 2003.

As part of its current analysis, the CA has developed a new series of recommendations for the governor, the New York State Department of Correctional Services (DOCS), the New York State Department of Health (DOH) and the legislature to address the status of medical care provided to state inmates.

As of April 2008, DOCS confined 62,070 inmates in 69 correctional facilities and the Willard Drug Treatment Center. Between September 2004 and May 2007, the CA conducted general monitoring visits to 17 state prisons and obtained medical data from two additional prisons that were visited for a limited inspection concerning prison violence. These 19 facilities confine 28,250 inmates, representing approximately 45% of the state's total inmate population.

Much of the analysis in this document is based on information from the on-site monitoring visits. (See page 17 for an explanation of the CA visit procedure.) In addition, the CA reviewed DOCS's computer records, documents and reports about the entire prison system concerning medical staffing, inmate grievances, specialty care services and DOCS's Division of Health Services medical quality improvement program. The CA also analyzed system-wide information concerning appeals of medical grievances to the DOCS Central Office. The CA has based its observations and recommendations for improvements in the delivery of medical services on both the prison visits and the system-wide information.¹

The CA has also published an Addendum to this report, provided under separate cover, containing excerpts from the medical sections of CA prison reports issued after 24 prison monitoring visits during the period September 2004 through June 2008.

¹ Due to time and resource constraints, this report does not include a full analysis of health services for women in the state's correctional facilities. Evaluating these services is a critical part of assessing DOCS's ability to meet women's specific healthcare needs, and the CA plans to issue a separate report in the future with more in-depth analysis.

EXECUTIVE SUMMARY

Each of the 69 state prisons run by the New York State Department of Correctional Services (hereinafter referred to as “DOCS” or “the Department”), as well as the Willard Drug Treatment Center, has a medical department in which DOCS medical personnel provide healthcare.² DOCS also runs approximately 45 prison infirmaries and five Regional Medical Units and provides tens of thousands of in-house and external specialty care consultations per year. DOCS had a budget of \$356 million in Fiscal Year 2008-09 for prison health services and employed more than 1,950 medical personnel to care for the 62,070 inmates (as of April 2008) in state prisons. (See **Table 2**, page 20, for a summary of DOCS medical staffing as of May 2007 and **Table 4**, page 23, for medical staffing as of the date the CA visited the 19 prisons whose services are analyzed in this report.)

Providing quality medical care in prison is good public health policy because prisons provide an opportunity to diagnose and treat patients with chronic medical conditions who will return to communities throughout the state. Educating inmates about proper health care and enrolling them in a care system benefits them, as well as their families and communities.

Currently, there are an estimated 4,000 state inmates with HIV. Thus, New York prisons remain the epicenter of this disease within the U.S. prison system, representing 20% of all HIV-infected state inmates in the country.³ DOCS is the largest provider of HIV services in New York State. New York State prisons also have 8,400 inmates infected with hepatitis C, and many others suffering from other chronic diseases such as hypertension (6,500), diabetes (2,500) and asthma (9,000).

DOCS faces significant challenges in providing care to so many patients with serious illnesses, many of whom received inadequate care even before becoming incarcerated. These challenges include: limited resources; an annual turnover rate of inmates whereby nearly 40% of the prison population changes (27,000 to 28,000 inmates are admitted or released each year); and civil service guidelines that restrict salary levels and negatively affect the ability to recruit and retain qualified care providers. While many medical staff in the prisons are dedicated individuals striving to provide appropriate care to people suffering from serious medical conditions, certain prisons cannot meet the needs of their patients because resources and support systems are insufficient to provide proper care to all inmates and/or because the medical staff lack the skill, expertise or motivation to provide appropriate care. Thus, the quality of healthcare varies throughout the state prison system, with some facilities providing timely access to care that meets community standards and others providing substandard care.

In the nine years since the CA last issued a report on healthcare, DOCS has made some significant improvements in the provision of medical care. For example:

² Each prison is given a medical classification indicating the level of medical care that can be provided at the facility, ranging from class one to class three. Class one prisons have the highest level of care, including a physician on-site or on-call 24 hours a day, a 24-hour nurse presence on site and an on-site infirmary.

³ Maruschak, L., *HIV in Prisons, 2006*, U.S. Department of Justice, Bureau of Justice Statistics, Table 1 (April 2008). <http://www.ojp.usdoj.gov/bjs/pub/html/hivp/2006/hivp06.htm>.

- The DOCS Division of Health Services (DHS) has promulgated several clinical practice guidelines on conditions such as hepatitis B, hepatitis C, asthma and men's health. It has also updated existing practice guidelines on HIV, hypertension, diabetes and female health appraisal.
- DHS has substantially enhanced its efforts to monitor the care provided in the prisons by implementing a meaningful Continuing Quality Improvement (CQI) program that includes development of audit instruments used by DHS and prison medical staff to assess compliance with the practice guidelines at each prison.
- The Department reduced some of the chronic medical staffing vacancies that have persisted for several years and increased some staffing levels even while the prison population declined.
- There are fewer AIDS deaths due to more effective treatments, and the Department has identified and is treating substantially more inmates who are infected with hepatitis C.

However, in spite of these improvements, significant problems persist. Among the most significant themes emerging from the CA's investigation were the wide variation in the quality of healthcare among prisons and often among hubs⁴ and inmate dissatisfaction with care. At some prisons, there are delays in the delivery of care and the treatment provided is inadequate. At most prisons the CA visited, healthcare accounted for more inmate grievances than any other issue. In fact, during the last few years, medical grievances have become the most highly grieved issue in the entire system.

During CA prison visits and in DOCS's formal grievance process, inmates repeatedly expressed concerns about:

- denials of and delays in access to healthcare;
- inadequate examinations by nurses and physicians;
- failures to treat chronic medical problems expeditiously;
- delays in access to specialists and inadequate follow-up by prison providers to specialists' recommendations; and
- problems receiving medications and the health education needed to comply with complex medication regimens.

Concerning inconsistency of care, it is essential to describe healthcare in the Department not only from a system-wide perspective but at the level of individual facilities, because each prison operates, to a substantial degree, independently. Consequently, the level of staffing, utilization of services and quality of patient care vary greatly from one prison to another. The challenge is to identify those prisons where care is not meeting community standards of care and DOCS's own standards, and to assess why such deficiencies exist. At some prisons, the barrier to effective care is partially a question of resources (e.g., inadequate staffing or insufficient access to specialists) where the remedy will likely require the governor and legislature to authorize additional funding for DOCS. At other prisons, certain providers are unable (due to inadequate

⁴ The Department has divided the state prisons into nine hubs, each of which is a group of neighboring prisons that share administrative support and program services. **Exhibit A** contains a map of the hub system and the location of each state prison.

training or expertise) or unwilling to respond fully to inmates' medical needs or to promptly follow-up on their patients' medical problems. At these institutions, the poor quality of the medical personnel compromises the delivery of healthcare. Better scrutiny of care and an effective system of accountability will help identify where changes in policies, practices or staff are needed at a system-wide or facility level.

The Department appears committed to providing medical care consistent with that in the community. Although DOCS has not fully achieved this objective, it can realize this goal if it continues to improve services and if the state adopts the measures suggested in the CA's recommendations.

Key Findings

Medical Grievances

Medical care is the most highly grieved issue in the Department, representing about 8,300 medical grievances a year and 18% of all grievances filed by inmates during the last six years. The CA generally observed the most significant healthcare problems at those facilities with the greatest percentage of medical grievances.

Medical Staffing and Staff Training

During the period 2004 to 2007, the Department has reduced system-wide vacancies for nurses from 14% to 8% and doctors' vacancies to 3%. Despite this progress, at some prisons, the number of medical staff is insufficient to perform the complex tasks needed to serve the large number of patients with chronic illnesses and serious medical problems. Moreover, high vacancy rates still exist for physician assistants (14%) and pharmacists (13%).

- ◆ For example, Great Meadow is missing 40% of its physicians, half of its physician assistants, and nearly 30% of its nurses; Bedford Hills has a 40% nursing vacancy rate; and Attica is missing two of its three physician assistants and three of its 17 nurses.

Some medical positions have remained unfilled for a year or more due in part to applicants' unwillingness to face the challenges in providing care in the prisons and because the state provides noncompetitive salaries for certain medical positions.

- ◆ Great Meadow reported during a CA visit in 2006 that it had nurse vacancies for more than two years, and Eastern reported in 2005 that it had an open nurse position for more than a year. Both of these prisons still had nurse vacancies as of May 2007.

Even at full staffing levels, some prisons do not have enough medical personnel to meet the needs of their inmate-patients. The number of nurses and clinic provider staff—including physicians, physician assistants and nurse practitioners—varies greatly among the prisons. These significant staff discrepancies are not justified by differences in the medical needs of the inmate populations at different prisons. In analyzing the adequacy of medical staffing, the CA determined the ratio of nurses and clinic providers to inmates at each prison and compared ratios among prisons.

- ◆ The CA identified prisons (such as Clinton and Auburn) with insufficient numbers of nurses (i.e., one nurse for every 120 to 150 inmates). At other facilities (such as Green

Haven and Fishkill), CA found substantially better ratios, such as one nurse for every 70 to 80 inmates.

◆ The CA found that at several prisons (such as Clinton, Elmira, Coxsackie and Wyoming), there were insufficient clinic staff (e.g., one clinic provider for every 600 to 850 inmates). At other prisons (such as Fishkill, Green Haven, Oneida, Sing Sing and Sullivan), there was one clinic provider for every 400 or fewer inmate-patients.

In conjunction with outside health agencies, the Department has offered voluntary medical training to its staff on specific medical topics, with a focus on HIV and hepatitis C care. Some of these programs, including the HIV-related presentations coordinated by Albany Medical Center, are nationally recognized and offer the up-to-date information crucial to providing expert care in the prisons. However, because this training is not mandatory, the Department cannot ensure that all of its providers participate in these programs and does not appear to monitor their participation. At some prisons, medical staff members are so overburdened that they often cannot attend continuing medical education programs. And while medical staff are required to participate in annual general DOCS training, there is no medical training requirement addressing the treatment of chronic diseases, even though rates for many chronic diseases are five to ten times greater among inmates than among the general public.

Routine Healthcare

At some prisons the CA visited, inmates raised numerous complaints about inadequate access to sick call—the time when inmates are seen by a nurse who determines whether further care is required (see page 27). They also made complaints about receiving improper care when they are seen. Again, there are wide discrepancies among the various prisons.

- ◆ Clinton only sees 20-40 inmates at sick call for a population of 2,000. Other prisons, such as Attica and Eastern, see inmates at twice that rate.
- ◆ At Coxsackie, the sick call nurse averages only two minutes per patient—insufficient time to adequately assess and document a patient's condition.
- ◆ Patients at many prisons complained that some sick call nurses were disrespectful and failed to refer patients to a doctor when needed.
- ◆ Fifty percent or more of inmates at Great Meadow and Wyoming rated sick call as poor.

Due to understaffed medical departments, delays in access to clinic providers are commonplace at some facilities. These delays are a direct result of the insufficient number of clinic providers at these prisons.

- ◆ At several prisons (such as Attica, Auburn and Great Meadow), inmates reported that it can take several weeks to a few months to be seen for routine care.
- ◆ Medical providers at some prisons (such as Elmira) admitted to backlogs for routine appointments of 30 to 45 days.
- ◆ When the CA visited Attica, the facility had an 11-page list of inmates waiting to be seen in the clinic.

Some inmates complained that providers were dismissive of their medical problems, failed to conduct thorough exams or adequately evaluate their complaints or symptoms, and delayed addressing their serious medical problems.

- ◆ Sixty percent of the Auburn inmates rated healthcare as poor; two-thirds of the inmates at Upstate rated the doctors as poor, and half of the inmates at Wyoming said the physicians provided poor care.

By contrast, at prisons with adequate staffing (such as Oneida and Green Haven), inmates had prompt access to providers and their medical complaints were generally addressed in a timely manner.

- ◆ Two-thirds of Oneida's inmates rated the physicians as good or fair.

Chronic Disease Care

The care provided to inmates with chronic diseases (e.g., HIV, hepatitis B and C, asthma, diabetes, hypertension, etc.) varies greatly within the Department. DOCS's Division of Health Services has made significant efforts to standardize policies and develop monitoring protocols, but some prisons are unable to fully conform to these clinical standards, and some prisons do not assign a specific provider to treat each inmate with a chronic condition.

Identification and Care of HIV-infected Inmates

Although DOCS estimates that there are 4,000 inmates with HIV in its prisons, representing HIV infection rates of 6% for men and 12% for women, it has identified only about 1,700 HIV-infected inmates—45% of the potential pool of HIV-infected inmates. There are significant unexplained differences among prisons in the percentage of identified HIV-infected inmates. There is also greater variation among prisons in HIV rates than in hepatitis C (HCV) rates and significant differences between HIV and HCV rates at the same prisons.

- ◆ In certain prisons, less than 2% of their population is identified as HIV-infected, whereas in other prisons with the same medical classification, the known HIV-infected populations represents twice that rate.
- ◆ One in four state inmates with HCV have not been tested for HIV.

Although DOCS, Department of Health (DOH) and outside community-based agencies are performing 12,000-14,000 HIV tests per year, these entities are not able to identify many HIV-infected inmates. DOCS and DOH must increase their use of peer educators to encourage more at-risk inmates to get tested and to motivate inmates who know they are HIV-infected, but are not identified as such by prison medical staff, to seek care.

- ◆ In 2006, DOH and the community-based agencies tested more than 8,000 inmates, but identified fewer than 30 patients as HIV-infected.
- ◆ It appears that inmates who are not ill and are about to be discharged (also known as the "worried well") request HIV testing, but few of the estimated 2,000 unidentified inmates with HIV seek testing and treatment.

DOCS and community standards require that HIV-infected patients who are receiving treatment but are unable to fully repress the virus should be evaluated by an HIV specialist to determine whether adjustments to their treatment regimen should be made. Unfortunately, these evaluations may not be occurring in all appropriate cases. There is significant variation, with no identifiable reason, in the use of infectious disease (IFD) specialists by the state prisons.

- ◆ Prisons in the Watertown hub had a utilization rate of IFD specialists that was one-tenth the rate in prisons in the southern region of the state.

- ◆ Use of IFD specialists also varied greatly among individual prisons within the same hub, with some prisons in a hub frequently utilizing IFD specialists, while other prisons rarely refer patients outside the prison for such services. For example, the ten male prisons with the greatest utilization of IFD services are located in five of the nine hubs. This IFD utilization rate was ten times the rate in the 14 prisons (spread throughout seven of the nine hubs) with the lowest rate. (See **Exhibit D**.) These wide disparities in IFD utilization cannot be explained by the medical classification of these prisons or differences in their patient population.
- ◆ Access to IFD specialists also varied greatly in the female prisons. Albion had only eight IFD appointments in Fiscal Year (FY) 2006-07, while Bedford Hills had 537 appointments.

DOCS's effort to implement a program to certify its physicians as HIV specialists is laudable. As of June 2007, 17 of DOCS's 150 physicians, physician assistants and nurse practitioners were certified at 16 prisons. Unfortunately, this figure has remained relatively constant for several years, and most prisons do not have a clinic provider with HIV expertise.

DOH AIDS Institute's Criminal Justice Initiative (CJI) contracts with 15 outside agencies to provide services to HIV-infected inmates throughout the system. These services include HIV prevention, HIV training of peer educators, HIV counseling and testing, HIV support services and HIV discharge planning. This important program provides some services at 60 of the state's 70 facilities. However, the peer training program exists at only half the prisons, and HIV support groups occur at approximately 40% of the prisons. Moreover, some CJI services, such as discharge planning, are not sufficient to meet the needs of all HIV-infected inmates going home; less than 60% of discharged inmates with HIV were involved in discharge planning efforts in a recent one-year period. To meet the needs of the HIV prison population and educate all inmates about the importance of HIV testing and care, the state must allocate greater resources for this impressive program.

In addition, independent peer-led HIV support programs in the prisons—such as AIDS Counseling and Education (ACE) in the female prisons and Prisoners for AIDS Counseling and Education (PACE) in the male prisons—provide effective education and support programs that should be expanded.

DOCS implemented an HIV Continuous Quality Improvement program that will assist DHS officials in monitoring the care provided in the prisons and help prison providers to identify issues that may impede the delivery of HIV care. While this represents a positive step, DHS should demand more of the prisons in meeting the audit standards and require more comprehensive corrective plans to address areas where the prisons do not fully comply with DOCS's HIV practice guidelines.

Identification and Care of Inmates Infected with Hepatitis C

Based on several DOH studies of hepatitis C (HCV) infection in newly admitted inmates, an estimated 8,400 HCV-infected inmates currently reside in the prisons, constituting approximately 13% of the male population and 22% of the female population. DOCS has improved its efforts to identify HCV-infected inmates in the last few years, resulting in an approximately 40%

increase in the number known to DOCS. But 30% of the estimated male HCV-infected population and 35% of the female HCV-infected population have still not been identified by DOCS and are consequently not being treated for this serious disease.

- ◆ At most of the male prisons, 8-10% of the population has been identified as HCV-infected, but at several prisons the rate is much lower. The reasons for these disparities should be investigated.
- ◆ The rate of known HCV-infected women in the prisons ranges from 12.25% at Bedford Hills to 17% at Albion. The Albion rate is nearly 40% higher than Bedford Hills. Department officials should investigate why Bedford Hills has the lowest HCV-infection rate of any female prison, particularly since it has the only female Regional Medical Unit and the largest female medical program.

In the community, approximately 70% of patients with HCV eventually become chronically infected. DOCS is not doing an adequate job of identifying those with chronic infection, reporting only 41% of its known male HCV-infected population as chronically infected and a surprisingly low 20% of its known female HCV-infected population as such. Since diagnosis of chronic HCV infection is the first step in evaluating a patient for treatment, the failure to diagnose such infections can result in the failure to provide life-saving therapy.

Ordinarily, HCV-infected inmates must be evaluated by a gastroenterologist (GI specialist) and receive a liver biopsy to determine whether they should receive therapy. There were significant variations among the prisons in access to GI specialists and in the frequency of liver biopsies.

- ◆ For example, Five Points, Cayuga, Great Meadow and Bare Hill have a combined population of 5,784 inmates, 524 of whom are known to be infected with HCV. But these facilities had only 12 HCV-infected patients on therapy and ordered only 23 liver biopsies during FY 2006-07—one-third the system-wide average rate. In contrast, Livingston, Marcy, Mid-State and Sing Sing, with a combined population of 5,366 inmates, 576 of whom are known to be HCV-infected, treated 52 HCV-infected inmates and ordered 125 liver biopsies. The rate of HCV therapy for Livingston group is four times the rate of the Five Points group (spread through three hubs). Similarly, the rate of liver biopsies for the Livingston group is six times the Five Point group rate. (See **Exhibit E.**) There are no significant patient differences to justify such variation in the use of specialty services and the number of treated inmates.

Although not all chronically infected HCV-infected inmates require treatment, inmates with serious liver fibrosis need therapy to avoid liver failure. As of September 2007, DOCS had initiated treatment for 2,078 inmates since the start of its treatment for this disease. As of May 2007, 383 inmates were receiving HCV therapy, more than twice the number in 2003. However, there were significant variations among prisons in the percentage of HCV-infected inmates on therapy, disparities not explained by differences in prison populations. While access to specialty services is essential to evaluate the need for treatment, low treatment rates may also be influenced by a failure to educate patients about the risks and benefits of treatment or to provide sufficient support to enable patients to complete the difficult course of therapy.

- ◆ The prisons in three hubs (Clinton, Great Meadow and Wende) are treating HCV-infected inmates at half the treatment rate of prisons in the Watertown, Sullivan and New York City hubs.

- ◆ Setting aside the analysis by hub, there are even more significant variations in treatment rates among prisons. The 15 prisons providing the most HCV care are treating known HCV-infected inmates at five times the rate of the 15 prisons with the lowest percentage of HCV treatment. (See **Exhibit F.**)

Disparities in HCV treatment effectiveness within DOCS is similar to that in communities outside of DOCS, but DOCS's plan to stop monitoring the outcomes of HCV treatment on a system-wide basis is ill-advised, since it is extremely useful in assessing the HCV treatment program. This decision should be reconsidered.

- ◆ Therapy is deemed successful if a patient no longer has the HCV virus six months after the one-year treatment regimen is completed. In a group of 411 DOCS inmates who have undergone HCV therapy and have been tracked by DOCS, 58% of the Caucasian HCV-infected inmates, 37% of the Hispanic inmates, and only 19% of the African American inmates reached sustained suppression of the virus. These figures reflect the lower response rates experienced by African American patients in the community.

DOCS's efforts to assess compliance with its Hepatitis C Practice Guidelines through a quality improvement program are commendable. The initial results of the HCV audit revealed that prisons have a few areas of noncompliance with the audit's 12 indicators, including documentation of patient education and refusal of treatment, and several other areas that could use improvement. DOCS is developing a new HCV Case Management Review Form that has the potential to significantly improve the data retrieved in the HCV audits. These changes are necessary to accurately assess HCV care in the prisons.

Other Chronic Conditions

DOCS has implemented practice guidelines concerning asthma, hypertension and chronic Hepatitis B. The 2007 audit of asthma care revealed that state prisons had several areas of noncompliance with the audit indicators and that more should be done to implement the new asthma guidelines. Similarly, the prisons should improve compliance with the hepatitis B guidelines. DHS's efforts to improve care for these chronic conditions and to make practices uniform throughout the Department are commendable, but prisons should also enhance their efforts to ensure that all patients with these illnesses are receiving adequate care.

Chronic Care System

The Department has undertaken meaningful efforts to implement a chronic care system with practice guidelines and quality improvement programs, but more progress is needed. Practice guidelines do not exist for several chronic conditions, such as high blood cholesterol. More training is necessary to ensure that providers are adequately skilled in treating chronic medical problems. Prison-based chronic care coordinators and computer-based tracking systems are not used in all prisons to manage the care of chronically ill inmates. Patients with chronic conditions are not consistently assigned to one clinic provider responsible for managing patient progress and coordinating specialty care services.

Specialty Care

When prison providers need expert assistance in diagnosing or treating their patients, they can request a consultation with a specialist. Specialists see patients in the prisons, Regional Medical

Units, outside hospitals or other outside medical facilities. DOCS utilizes a Department-wide, computer-based system to schedule specialist appointments and monitor requests for specialty care to ensure that only needed services are provided. After specialty care appointments, the specialists document their findings and recommendations, which are then presented to the prison provider who is responsible for determining what follow-up action to take. Access to specialists and follow-up to specialists' recommendations vary greatly throughout the Department without apparent justification.

- ◆ For example, 80% or more of Great Meadow and Sullivan inmates reported experiencing delays in access to specialists, and approximately 70% of inmates from these facilities stated that follow-up to specialists' recommendations was inadequate. Inmates at these prisons reported delays of three to four months in scheduling some appointments.
- ◆ Analysis of DOCS data for FY 2006-07 confirms low utilization of specialty services in certain hubs; the prisons in the Watertown hub use essential specialty care services at only one-third the rate of prisons in the Green Haven hub. There is even greater variation among prisons in access to certain specialty services; some prisons use services such as cardiology, dermatology and neurology at only 10% to 30% of the system-wide rates. Albion uses several specialty care services for its women inmates at rates that are four to nine times less than the rates for Bedford Hills inmates.

Prisons do not routinely monitor whether their providers adequately follow up on specialists' recommendations and/or schedule follow-up appointments in a timely manner. The Department must improve its monitoring of the use and outcomes of the specialty care system.

Pharmacy Operation

DOCS operates prison pharmacies that serve approximately 50 prisons in New York State. Since DOCS has experienced problems hiring pharmacists to work in many facilities, 20 prisons are using outside pharmacy services that are 27% more expensive than if the medications were provided by DOCS's Central Pharmacy. This practice results in additional yearly costs of approximately \$3.8 million for the Department. Although DOCS is developing plans for its Central Pharmacy to take over this operation, the new system will take years to implement.

Inmates reported several problems with the medication system at certain prisons, including: delays in renewing and/or refilling prescriptions; running out of essential medications for chronic conditions; failures to provide inmates with sufficient information about medications they are taking and their potential side effects; and failures to provide medications in a confidential manner. Although DOCS is making significant efforts to improve its pharmacy services with a new computer system and more staff, the state must implement additional measures to ensure that all patients receive their medications in a timely and appropriate manner.

DOCS Quality Improvement Program

DOCS's Division of Health Services has implemented a meaningful Continuing Quality Improvement (CQI) Program that attempts to standardize clinical protocols and monitor their implementation. Despite these efforts, the quality improvement programs at some prisons are inadequate. The CQI program should enhance its efforts to compel prisons to develop remedial plans to address areas in which facilities are not fully complying with clinical standards.

Medical Services for Inmates with Limited English Skills

Most prisons have very few or no medical staff members who speak a foreign language, even though 5% to 10% or more of the inmates do not speak sufficient English to communicate effectively with medical staff about their health problems. Almost all the prisons use inmates, and sometimes security staff, as translators for most of the medical encounters, raising troubling issues surrounding patient confidentiality.

Continuity of Care

Inmates are regularly transferred from one prison to another, and 27,000 to 28,000 are released back to the community each year. Inmates at some prisons assert that they are not promptly seen and evaluated when transferred. Many inmates are being discharged from custody leave without adequate documentation of their medical status and without appropriate medication or a medical discharge plan.

Legislation passed in 2007 requires the Department of Health to suspend, rather than terminate, the Medicaid benefits of inmates enrolled at the time of incarceration. Unfortunately, this provision will only apply to the approximately 20% to 25% of the prison population who meet this criterion. For the vast majority of other inmates, no application for Medicaid is made while they are in custody, and when they apply for Medicaid eligibility after they return home, they must wait 45 days to several months before receiving Medicaid benefits. The FY 2008-2009 budget allocated funds for DOCS, the Department of Health and the Division of Parole to undertake a pilot project to develop a method to file and process Medicaid applications for a small number of soon-to-be-released inmates who were not on Medicaid when incarcerated; the relevant state agencies need to do much work, however, to initiate this pilot.

Care for the Aging Inmate Population

The percentage of state inmates who are 50 years or older has more than doubled (from 4.8% to 10.3%) in the ten-year period from 1996 to 2006. With this increase, it was inevitable that there would be a commensurate increase in medical conditions associated with an elderly population. A US Department of Justice report demonstrated that inmates 45 years or older are four times more likely to have cancer; three times more likely to have diabetes; and two times likely to have heart problems, hypertension or liver problems than younger inmates. DOCS must assess its medical staff and medical facilities to ensure that it can meet the needs of its increasingly aged population.

We commend DOCS for opening a 30-bed Unit for the Cognitively Impaired, which houses inmates who are suffering from Alzheimer's, AIDS, Parkinson's or Huntington's diseases at Fishkill. This unit opened in 2006 and the Department should periodically evaluate its entire prison population to determine whether the unit's capacity is sufficient to meet the needs of DOCS's cognitively impaired inmates.

Inmate Deaths

The annual number of DOCS deaths has consistently declined since the 1990s, when many HIV-infected inmates died in prison. In 1995, AIDS-related deaths peaked at 257 but rapidly declined to just 10 by 2000. This dramatic reduction was due to the development of effective treatments

for HIV which have been provided to the HIV-infected population in prison. However, the number of DOCS deaths during 2001-2004 was the fourth highest among U.S. prisons, and the average rate of death due to illness for New York inmates was the third highest for all states excluding the southern region of the country, where much higher mortality rates generally exist. Given these data, the state should do more to reduce inmates' deaths by augmenting medical training and quality improvement activities focused on illnesses (such as heart disease and cancer) that are most likely to result in inmate mortalities.

Approximately 170 inmates have died each year in DOCS custody since 2001, yet only about a dozen inmates have been released each year on Medical Parole. In order to expand the number of compassionate releases of seriously ill or incapacitated inmates, the state should expand the Medical Parole Law consistent with proposals in the Department's FY 2008-09 budget, that were not included in the budget enacted by the Legislature. An Assembly Bill (A10863), with provisions similar to the Department's proposals is currently pending before the Legislature but does not have a Senate sponsor.

Women-Specific Healthcare Needs

In addition to particular gynecological, reproductive, nutritional and other health requirements, women's specific life experiences and circumstances have significant implications for their healthcare needs. An overwhelming majority of women in New York prisons are survivors of violence and trauma. Approximately 72% of incarcerated women are parents; incarcerated mothers frequently note that separation from their children causes depression, anxiety and low self-esteem. Incarcerated women also suffer from serious mental illness at considerably higher rates than male inmates. Training providers on the concept of women-centered healthcare (which views the complex circumstances of women's lives as integral to their treatment plans) is an important step toward enhancing providers' ability to communicate with, assess and treat female patients. We are unaware of any such training for DOCS medical staff.

Most state facilities for women provide gynecological care through on-site specialty clinics. As a result of this system, incarcerated women (unlike incarcerated men) require routine access to and follow-up from specialists, whether or not they are ill. Women also need at least yearly Pap smear tests and mammograms after they reach a certain age and have specific needs related to personal hygiene items and nutrition. Some inmates reported delays in getting abnormal gynecological test results and in receiving adequate follow-up care for gynecological issues. The Department seems to lack a comprehensive quality improvement program to monitor these and other women-specific health services.

Monitoring of Healthcare Within DOCS

Although the New York State Department of Health monitors the quality of medical care at private hospitals and clinics throughout the state pursuant to Article 28 of the Public Health Law, neither DOH nor any other state agency outside of DOCS assesses the quality of care provided within the prisons. The DOH's AIDS Institute has played a limited role in advising DOCS about protocols for prison HIV and hepatitis C care, but DOH has not interpreted the Public Health law as authorizing it to evaluate the adequacy of prison medical services.

The State Commission of Correction (SCOC) has an inmate mortality review panel, but in recent years this panel's reviews of DOCS inmate deaths due to natural causes have generally been pro forma statements, and the panel's efforts have never included any assessment of the overall quality of healthcare in DOCS. Moreover, these reviews are often delayed and generally do not require any response from DOCS. The SCOC is not monitoring DOCS medical care and would not be an effective agency to be assigned this task due to its limited resources and lack of relevant expertise.

RECOMMENDATIONS

To ensure that all inmates in DOCS custody receive appropriate healthcare, regardless of where they are confined, state policymakers should take steps to address deficiencies within the Department's healthcare system. These efforts should include regular monitoring at each prison to identify deficiencies and the development and implementation of targeted remedial plans. Corrective plans will require additional resources. The governor and the legislature should make policy decisions that enable the Department to provide healthcare conforming to community standards and consistent among all prisons in the system.

Pursuant to deficiencies identified in this report, the CA recommends that DOCS, the governor, other state agencies and the legislature implement the following recommendations with appropriate additional resources (See the full list of recommendations beginning on page 78):

Enhance Medical Staffing

- Promptly fill DOCS medical staff vacancies and increase state salaries for medical positions that are difficult to fill, bringing compensation rates in line with those for comparable providers in the community.
- Perform a staffing analysis of medical positions at each prison to determine where augmented staff is most needed and allocate additional resources for these new positions.
- Enhance medical staff skills by requiring training for providers with limited background in the care of frequently encountered medical problems and those found through reviews to need improvement. Facilitate the participation of all medical staff in training programs through incentives and by other means. Enhance training of nurses and clinicians to ensure that they are receptive to and respectful of their patients and that they provide appropriate care during all medical exams.

Improve Access to and Quality of Routine Care

- Improve the monitoring of the quality of both sick call and clinic call-outs to ensure that (1) inmates have timely access to providers, (2) medical staff provide adequate evaluation and timely and respectful treatment, and (3) these encounters occur in locations that permit confidential conversations between medical staff and inmates.

Improve Care of the Chronically Ill

- Assign each patient with a chronic illness to a single provider who is responsible for overseeing his/her care.

- Develop a chronic care system that includes chronic care coordinator positions at each prison and a computer-based record-keeping system to manage and monitor this complex care.
- Improve care provided to HIV-infected inmates and ensure that this care meets community standards at each prison. Take more aggressive measures to identify HIV-infected inmates by: increasing the use of paid peer educators; enhancing counseling, testing, and education by the community-based providers, AIDS Institute and DOCS; providing patient education about HIV at optimal times; and investigating prisons with low rates of known HIV-infected inmates to determine how to persuade more inmates to be tested and persuade those who are HIV-positive to seek care. Improve monitoring of HIV care to ensure that HIV-infected inmates are periodically evaluated by HIV specialists and that such specialists are consulted when a patient is failing on his/her current medications. Investigate prisons with low usage of HIV specialists and monitor whether prisons are promptly following up on specialists' recommendations. Use CQI results to ensure adherence to practice guidelines and provide effective treatment to all HIV-infected inmates.
- Improve care provided to inmates infected with hepatitis C (HCV) and ensure that such care meets community standards at each prison. Enhance efforts to identify more HCV-infected inmates by screening all inmates and testing those at risk. Ensure that all inmates chronically infected with HCV are properly diagnosed and that treatment is provided to those needing therapy. Investigate prisons with low rates of known HCV-infected inmates, inmates with HCV disease and inmates on therapy. Review practices at prisons that have low utilization rates of gastroenterology and liver biopsy services. Abandon the plan to stop monitoring the response of HCV-infected inmates receiving treatment. Improve the HCV quality improvement program by requiring more rigorous compliance with the HCV Practice Guidelines.
- Increase funding for the AIDS Institute's Criminal Justice Initiative to enhance its HIV prevention activities, especially peer training, support services and discharge planning.

Enhance Access to Specialty Care Services

- Enhance access to specialty care services by monitoring the utilization of specialty services by the prisons, ensuring that inmates needing these services are promptly referred to a specialist and improving the timeliness of specialty care appointments.
- Ensure that prison providers follow up on specialists' recommendations appropriately by promptly implementing the recommended care or by clearly documenting the reasons for rejecting the specialists' suggestions in the patient's chart.

Improve Pharmacy Services

- Increase the salary authorized for DOCS pharmacists and fill vacant pharmacy positions.
- Expedite implementation of the computerized pharmacy program and the plan for DOCS's Central Pharmacy to provide medications directly to patients at prisons that do not have a pharmacy in order to improve care, expedite treatment and save money.

Enhance DOCS's Quality Improvement Program

- Ensure that all prisons have a fully operational quality improvement committee that analyzes medical grievances, performs chart reviews at least four times a year and routinely assesses healthcare staff and systems utilizing DOCS's Quality Assessment Tools Manual.
- Conduct regular meetings at each prison with the Inmate Liaison Committee, Inmate Grievance Representatives, prison medical staff and prison executive team to discuss inmates' concerns about prison healthcare.
- Increase the activities of the DOCS Division of Health Services' Continuous Quality Improvement Committee, which oversees the reviews of prison healthcare by DHS Central Office medical personnel, and require prison medical administrators to develop action plans to address deficiencies. Document any failure to meet specific quality indicators and increase the threshold for compliance to 80% or higher.

Improve Services for Inmates with Limited English Skills

- Improve translation services for medical encounters with inmates who have limited English skills by providing incentives (e.g., pay differentials) for bilingual (especially Spanish-speaking) medical personnel to join DOCS and by utilizing appropriate translation services, such as the AT&T translation phone line.
- Provide medical documentation and educational materials to patients in their native language.

Improve Continuity of Care for Inmates with Medical Problems

- Improve the continuity of care for inmates transferred among DOCS facilities to prevent delays in care or interruptions in treatment.
- Develop a medical discharge plan for all inmates with serious or chronic medical problems being released from prison, including information about their condition and treatment, adequate medication, and help in scheduling an appointment with a community provider. Implement a pilot program to be coordinated among DOCS, DOH and the Division of Parole (as funded in the FY 2008-09 budget) to ensure that inmates nearing release are enrolled in Medicaid. Enact regulations and/or legislation to require that a Medicaid application be filed and processed for all eligible inmates being released from custody so they can access healthcare immediately upon returning to the community.

Improve Care for the Aging Inmate Population

- Enhance the training of medical staff concerning illnesses frequently encountered by patients over 50 and assess medical staff and facilities to ensure that adequate resources are available to treat this expanding inmate population.

Improve the Care of Seriously Ill Inmates and Expand Medical Parole

- Enhance medical training and quality improvement activities for medical conditions (such as heart disease and cancer) that are likely to result in inmate mortalities.

- Expand the Medical Parole Law to allow parole of inmates who, even if they are not dying, are so physically or cognitively incapacitated that they are no longer a danger to society.

Improve Healthcare Services for Women Inmates

- Require medical providers working in women's facilities to be trained in concepts of women-centered healthcare, including issues of trauma, domestic violence and the physical and mental health implications of abuse.
- Enhance quality improvement mechanisms intended to monitor women-specific health services. Develop more comprehensive policies and standards for women-specific health care.

Initiate External Monitoring of Prison Healthcare by DOH and Enhance that by SCOC

- Enact legislation to require the New York State Department of Health to monitor and evaluate prison medical care. Alternatively, accomplish this goal through a directive from the governor, who could, without additional statutory authority, order DOH to act pursuant to its authority under Public Health Law, Article 28.
- Improve monitoring of prison healthcare by the New York State Commission of Correction and encourage more rigorous reviews of state inmate deaths through the SCOC's mortality review committee.