



Testimony

of

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before the

**New York City Council Committee on Mental Health, Mental Retardation, Alcoholism,  
Drug Abuse, and Disability Services and the Committee on Fire and Criminal Justice  
Services**

concerning

**New York City's Compliance with the Brad H. Settlement and Administration of Discharge  
Planning for People with Mental Illness in City Jails**

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250 Broadway  
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Good morning, Chairpersons Koppell and Crowley and members of the Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse, and Disability Services and the Committee on Fire and Criminal Justice Services. My name is Dr. Amanda Parsons, and I am the Deputy Commissioner for the Division of Health Care Access and Improvement at the New York City Department of Health and Mental Hygiene. This division houses the Bureau of Correctional Health Services, which is responsible for providing comprehensive healthcare, including Brad H discharge planning, to individuals in New York City jails. Seated with me is the Assistant Commissioner for Correctional Health Services, Dr. Homer Venters. On behalf of Commissioner Farley, thank you for this opportunity to update you on the discharge planning process for people who receive care for mental illness while incarcerated in New York City jails.

As you know, the Department is responsible for providing health care to New Yorkers in the 12 City jails. Approximately 60,000 individuals are incarcerated per year; about 13,000 of whom qualify as Brad H class members, under the terms of a 2003 stipulation that requires the Department and other City agencies to provide discharge planning.

Discharge planning refers to the process by which a patient's post-discharge mental health needs are identified by a clinician, a plan of care is created based on those needs, and appropriate referrals are made. This ensures that patients can continue to receive the required care and transition smoothly from incarceration to the community.

The Department views discharge planning as part of the broader continuum of healthcare that we provide for individuals who are in jail. In this area, we work with Correctional Medical Associates of New York, P.C. to provide a wealth of health services, including comprehensive initial medical intakes, chronic care management, sick call, urgent care, mental health services and discharge planning. Each month, in our entire system of care, there are approximately: 6,500 intake visits, the initial visit where our clinical providers meet with patients and conduct comprehensive physical evaluations (and refer patients for mental health examinations); 60,000 medical visits; 2,500 specialty clinic visits; and 22,000 mental health visits. When you factor in that 30 percent of patients are discharged within three days, and half leave jail within a week, you can appreciate how work gets done around the clock to meet the needs of our patients.

The Brad H stipulation requires the Department and other City entities to provide discharge planning to class members in a manner that exceeds the scope and scale of any known jail-based mental health program in the nation. The stipulation obligates the City to provide class members with a broad array of services within specified timeframes. These services include: arranging for post-release medical and mental health care; applying for or reactivating Medicaid; applying for public assistance; providing a supply of and prescription for medications; arranging for transportation; arranging for appropriate shelter for homeless class members; and organizing post-release follow up. Consequently, the Department dedicates considerably more resources to discharge planning, per capita, than any other correctional health system (jail or prison) in the United States. For example, while most large jail systems employ 5-10 staff members for discharge planning, the Department dedicates almost 100 staff members to discharge planning of patients with mental health and medical concerns. Over two-thirds of these resources are dedicated to discharge planning for Brad H class members. Our staff is unfailingly dedicated in their jobs, and committed to providing this comprehensive array of services to this vulnerable population we serve.

At the time that the stipulation was signed, it was unprecedented. The parties did not have a model to look at for guidance, and there were many unknowns about what could realistically be achieved in a jail setting. As a result, there are many aspects to the stipulation that made sense nine years ago, but don't make sense now that we have more experience and knowledge in running a comprehensive discharge planning program in our system. For example, the stipulation puts in place metered tasks that must be done within certain time frames to achieve compliance. If we successfully complete a discharge plan for a client prior to when that individual is discharged, but several of the tasks did not meet the legal deadlines, then we are out of compliance with some performance measures even though the patient received the necessary treatment. In fact, if we were measured solely on our ability to provide each eligible patient with a discharge plan, we would score above 93 percent, which was our most recent compliance score for timely completion of a comprehensive treatment and discharge plan, not factoring in performance that does not measure timeliness but whether the job was done.

We are not measured simply on the basis of procedures completed prior to an inmate's discharge from a City jail. Instead, the Brad H stipulation contains performance goals to measure our compliance, including: timely assessment of class members; appropriate assessment of whether class members are seriously mentally ill; and appropriate assessment of whether individuals assessed as needing further mental healthcare are treated as likely seriously mentally ill. There are two court-appointed monitors who produce regular reports rating compliance on these metrics. These monitors, in turn, have expanded the 13 performance categories in the stipulation into 44 performance indicators; each with a compliance threshold that ranges from 90 to 99 percent. These thresholds, which were unilaterally established by the monitors, are unreasonably high, when compared to any performance thresholds established or achieved in the community setting. For example, the Joint Commission, the national accreditor of healthcare facilities, sets its compliance threshold at 85 percent for timely discharge planning, while the City is held to a 95 percent threshold.

We are confident that New Yorkers can be proud of our system; the vast majority of patients who require healthcare are being identified, connected to the appropriate care, and getting services that are unparalleled elsewhere. In the most recent report, over 93 percent of eligible class members had comprehensive treatment and discharge plans done by the time they left jail. This is despite all the difficulties related to being able to meet with clients, including: security events that shut down all movements, unexpected staffing shortages, patients initially refusing and then changing their minds, and identifying community resources that can, or are willing, to take our clients. While a 93 percent rating is not perfect, and it means we have not reached everyone we need to, we are working hard to improve our services.

The stipulation does not deem us compliant based solely on the ability to provide effective discharge plans. The Department has to meet 90 to 99 percent thresholds for 44 different, complex indicators. For example, when looking at whether a mental health evaluation can be done within 72 hours of referral, we are confronted by: patients' movements being restricted due to security concerns; patients refusing to come down for the first or second time they are called; or patients not being seen because they are hospitalized.

Overall, in the last year, we've enhanced our Quality Assurance (QA) program to help us ensure that processes are as optimized as they can be, instituting systematic chart reviews and issuing corrective action plans where needed. We are learning, from our QA work, the areas we can improve upon including: more staff training, clarification of our policies, routine feedback to

frontline staff and simplifying our electronic data capture sheets. We are also working on reducing the redundant data entry between different Information Technology (IT) systems and have built a new Brad H database that will be able to interface with the electronic medical records implemented across the jails in recent years. This means that much of the data we'll be reporting on will be derived directly from the source, as opposed to having to be rekeyed into a separate reporting database. We also continue to meet regularly with court-appointed monitors to help them better understand the key issues and challenges we face, and provide them with useful updates on the evolving health care landscape and its impact on our discharge planning processes. Lastly, we've been meeting with the various health homes in New York City, to develop their care coordination network and achieve even better outcomes for our patients.

In summary, we have an extraordinary complement of staff that offers comprehensive discharge planning services to some of the neediest, most underserved New Yorkers. We are committed, and we are proud of the work we do to promote health, prevent illness and coordinate care. Thank you for the opportunity to testify before you today. I'm happy to answer any questions you might have.