

New York City Board of Correction

Access to Health and Mental Health Care (July-December 2017)

May 2018

Background

Ensuring the delivery of health and mental health services to people in custody is a critical part of the Board of Correction's (BOC or the Board) mission. The Board, an independent oversight authority for the City's jails, monitors compliance with longstanding regulations that require services consistent with accepted professional standards and sound professional judgment and practice.¹ Health and Hospitals' Correctional Health Services (CHS) is responsible for providing health and mental health care in the jails while the Department of Correction (the Department or DOC) provides security for and transportation to these services.

To monitor compliance with its Minimum Standards, BOC works closely with CHS and DOC on efforts to track and report on health and mental health services and outcomes. Starting in April 2016, the Board required CHS produce a monthly access report monitoring each month's approximately 55,000 scheduled health and mental health visits, 10,000 sick call visits, 4,000 health intakes, over 600 mental health referrals, and various other health encounters at each of the twelve DOC facilities and overall. In the spring of 2017, the Board and CHS reviewed and updated the access report to include a wider range of information, allowing for better identification of underlying barriers to access. The CHS monthly access reports represents the most comprehensive ongoing reporting on health and mental health care access in jails nationally. They are available on the web at <http://www1.nyc.gov/site/boc/reports/correctional-health-authority-reports.page>.

Despite great challenges to providing care in the jail setting, CHS has consistently reported that overall, around 80% of all scheduled appointments are completed, with higher completion rates at half of DOC's facilities: the George Motchan Detention Center (GMDC, 80%), Eric M. Taylor Center (EMTC, 83%), George R. Vierno Center (GRVC, 84%), Rose M. Singer Center (RMSC, 86%), West Facility (WF, 90%), and the North Infirmity Command (NIC, 92%). Notwithstanding these rates and improved transparency, significant gaps in reporting on the Standards and persistent challenges affecting access to care remain. Additionally, jails and services differ in the barriers to care, and not all jails are equal in their ability to provide care – for example, completion rates range from 67% at the Vernon C. Bain Center (VCBC) to 92% at NIC.

This report summarizes findings on the outcomes of scheduled health and mental health services using data reported in the CHS monthly access reports for the last six months of 2017. These findings indicate there is more work to be done to improve coordination and compliance with the Minimum Standards in key areas.

Board Action & DOC/CHS Action Plan

Access to health and mental health care in NYC jails has been discussed in eight public Board meetings since January 2016 and is the subject of significant BOC staff monitoring in the jails. Thirty-one percent (31%, n=679) of all complaints received by CHS in fiscal year 2017 were about access to care.² Key recurring topics of Board concern related to access to care include production, escorting, transportation, sick call, and specialty clinic policies.³ Discussions on these issues have repeatedly confronted the need for improved tracking and outcomes related to the Minimum Standards on Health and Mental Health Care. This information is necessary to effectively remove barriers and improve access to care via measurable reforms.

¹ N.Y.C. Board of Correction, Mental Health Minimum Standards Chapter 2 and Health Care Minimum Standards Chapter 3 (eff. May 15, 1991).

² NYC Health + Hospitals Correctional Health Services FY 2017 Complaint Data (on file with the Board of Correction).

³ See N.Y.C Board of Correction Meeting Minutes ([February 9, 2016](#)); ([March 8, 2016](#)); ([June 14, 2016](#)); ([September 13, 2016](#)), ([October 11, 2016](#)); ([January 10, 2017](#)); ([February 14, 2017](#)); ([September 12, 2017](#)). Escorting was discussed in five meetings, transportation in three, and specialty clinic appointments in five meetings.

At the Board's February 2017 public meeting, DOC and CHS announced their development of an action plan to improve access. In June 2017, DOC and CHS presented the Board with an action plan that included independent and joint strategies related to staffing, scheduling, transportation, tracking people in custody, and communication.⁴ Joint efforts by DOC and CHS included two pilot initiatives: 1) a cohort housing initiative to reduce the need for escorts for patients with similar health needs in cohort housing areas through centralized medical, nursing, and sick call visits, and 2) a coordinated patient scheduling initiative intended to reduce over-scheduling and scheduling conflicts, and assess the differential impacts in escorted vs. unescorted facilities.

CHS and DOC report that the cohort housing initiative has been successful in achieving many of the goals of the pilot, but further coordination between DOC and CHS is necessary to understand why all patients eligible for this housing referred by CHS were not placed in these units and whether there is room for improvement or expansion of this approach. In January 2018, CHS and DOC ended their coordinated patient scheduling pilot finding little to no impact on targeted outcomes because there were not, in fact, enough scheduling conflicts to be a significant barrier to access.⁵ Outcomes in the monthly access reports have not changed since the implementation of this action plan to improve access.

Both CHS and DOC have independently improved their internal tracking and reporting mechanisms. However, the monthly access report still lacks reliable and reconcilable information about the reasons for non-production, sick call, intake, rescheduling, patient refusals of services, or whether services are timely delivered.⁶ DOC and CHS should implement a coordinated approach to reporting and tracking so that there can be a mutual understanding of how access can be improved.

⁴ The Department publicly presented their action plan at the September 2017 Board meeting.

⁵ NYC Health + Hospitals Correctional Health Services, *NIC Cohort and Coordinated Patient Scheduling Evaluation* (on file at BOC) (noting only 38 individuals or 15% of those identified as eligible by CHS were placed in cohort housing, and only 2% - 7% of patients required some level of appointment coordination across all pilot facilities).

⁶ DOC tracks and reports reasons for non-production, such as no escort, alarm, tactical search operation, lockdown, and other not produced. But these numbers do not currently reconcile with CHS numbers. CHS only reports non-production by DOC as a service outcome, with no further detail. This report only analyzes CHS reports.

Key Findings

July- December 2017

Overall:

- From July through December 2017, CHS scheduled 343,003 services.
- Forty-one percent (41%) of scheduled services were Mental Health appointments (n = 139,434).

Completed Services:

- Seventy-nine (79%) of services scheduled during this period were “completed” (n = 265,747). This means for 79% of scheduled appointments the patient either saw a clinician (“seen”) or the patient told a clinician that they did not want the scheduled service (“refused and verified”).
 - Ninety-three percent (93%, n = 246,081) of completed services were seen by a clinician, and 7% (n= 19,666) of completed services involved a patient refusing care.
 - Almost half (47%, n = 1,716) of completed Specialty Clinic – Off Island and 31% of completed On Island Specialty Clinic appointments (31%, n = 5,583) involved a patient refusing services.
- Completion rates varied widely by facility, ranging from a 67% (n = 15,902) overall completion rate at VCBC to a 92% (n = 17,029) completion rate at NIC.
- Completion rates for Medical and Dental services, in particular, varied widely across facilities. Medical services ranged from a 54% (n= 3,983) completion rate at Anna M. Kross Center (AMKC) to a 98% (n= 1,180) completion rate at MDC.

Non-Completed Services:

- Just over a fifth of all scheduled services were not completed (21%, n = 72,586).
 - Dental/Oral Surgery appointments, Mental Health appointments, and Specialty Clinic – On Island services were the least likely service categories to be completed—with non-completion rates of 32%, 29%, and 27%, respectively.
- The highest number of missed appointments were for mental health services. Over 39,500 mental health appointments were missed in this time period. This is over five times as many missed appointments as the next highest service categories with missed appointments-- medical services of which there were just over 7,400 missed appointments, and specialty on island services of which there were over 6,400 missed appointments.
- The main reason that patients missed appointments was because the patient was “Not Produced by DOC.” Sixty-seven (67%, n = 48,312) of all missed appointments were due to DOC not producing the person to the clinician
 - DOC non-production was the top reason for missed appointments each month studied, across all service categories.
 - Medical and Dental/Oral Surgery were the service categories reporting the highest rates of missed appointments due to DOC non-production. Eighty percent (80%, n = 5,922) of all missed medical appointments were due to DOC non-production and 75% (n = 3,887) of all missed Dental/Oral surgery were due to DOC having not produced patients.

- After DOC non-production, the next most common reasons for non-completion were that the scheduled services conflicted with a patient's court date (17% of all missed appointments, n = 12,010), or that the service was 'Rescheduled by CHS' (15% of all missed appointments, n = 10,686).
 - Nursing was the service category reporting the highest rate of missed appointments due to conflicts with a patient's court date. Twenty-four percent (24%, n = 2,025) of all missed nursing appointments were due to conflicts with a patient's court date.
 - Mental Health was the service category reporting the highest rate of missed appointments due to appointments being rescheduled by CHS. Nineteen percent (19%, n = 7,367) of all mental health appointments were missed due to CHS rescheduling it.

Recommendations for CHS and DOC

Ensuring the delivery of correctional health and mental health services is a critical part of the Board of Correction's mission. The following recommendations are intended to: 1) identify areas of concern based on this report's data findings regarding scheduled services; 2) address gaps in tracking care to better understand and minimize barriers to access for scheduled services; and 3) improve the ability of CHS, DOC, and the Board to monitor compliance with other key aspects of the Minimum Standards.

1. Substantive Areas of Concern Identified via Data Analysis:

- a. Develop a plan to track and address barriers to DOC production, the main cause of non-completed appointments.
- b. Examine reasons for the relatively high number and rate of non-completion for Mental Health services. This review should include identifying reasons for the relatively high rates of CHS rescheduling.
- c. Improve access to on- and off-island specialty appointments. This should involve conducting a detailed process review, clarification of policies related to patient refusals, and identification of strategies to address factors thought to be related to patient refusals such as overbooking, lengthy wait times, waiting area space and conditions, approach to scheduling patients with special security designations, and transportation challenges.
 - i. Implement policies and training to minimize health and mental health appointment conflicts with court, school, or other known conflicts with services or programs.

2. Gaps in Identifying and Understanding Barriers to Access:

- a. Identify and track underlying reasons for non-production, such as escorting, lockdowns, searches, scheduling conflicts, and other frequently occurring reasons identified by DOC.
- b. Identify and track underlying reasons for and time to rescheduling, such as CHS/DOC staffing shortages.
- c. Train both clinical and corrections staff to ensure consistency in data collection across facilities and service disciplines.
- d. Review best practices from jails with high rates of completed appointments, including North Infirmary Command, West Facility, and Rose M. Singer Center jails.

3. Key Gaps in Monitoring Compliance with Standards:

- a. Develop new tracking and reporting protocols to assess compliance with Minimum Standards on: (i) intake; (ii) sick call; (iii) timeliness of service delivery and completion; and (iv) substance use treatment services.
- b. Set benchmarks and targets for access to care.
- c. Update the CHS access to care report to address gaps in current reporting to better inform future action plans.

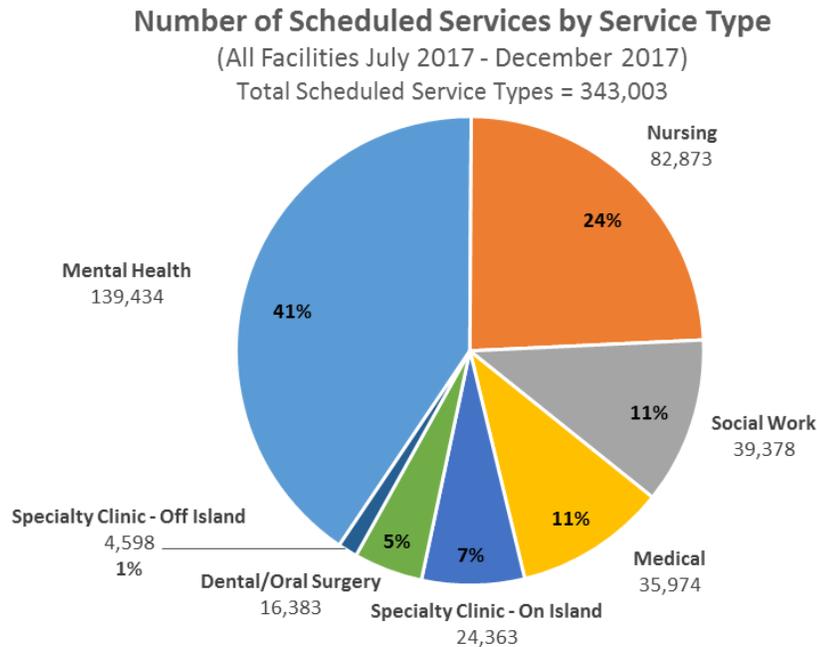
Providing access to health and mental health care to people in DOC custody requires coordination between clinical and corrections staff. The Board's Minimum Standards on Health and Mental Health Care reflect that premise and include many access to care and documentation requirements for CHS and DOC. Compliance for certain aspects of the Standards can only be demonstrated via coordinated CHS/DOC tracking and reporting (e.g. intake screening, timeliness of service delivery, sick call).

Number & Type of Scheduled Services

From July to December 2017, there were 343,003 scheduled services. The service category with the highest percentage of scheduled services was Mental Health (41%, n = 139,434), followed by Nursing (24%, n = 82,873), Social Work (11%, n = 39,378) and Medical (11%, n = 35,974).

Table 1 includes more detail on each service type.

Figure 1



Source: CHS Access Reports July - December 2017

Table 1

Description of Service Types	
Scheduled Service Types	Description
Medical	Includes a scheduled interaction with a clinician or nursing staff, outside of Nursing, Mental Health, Social Service, Dental/Oral, and Specialty physicians.
Nursing	Excludes: finger sticks, wound care, and labs collected.
Mental Health	Includes a scheduled interaction with a psychiatric professional.
Social Work	Involves a scheduled interaction between a social services employee and the person in custody.
Dental/Oral Surgery	Includes a scheduled interaction with a Dental/Oral professional.
Specialty Clinic – On Island	Includes: Audiology, Cardiology, Dermatology, Dialysis, ENT, Gynecology, Hand Specialist, ID Specialist, Nephrology, Neurology, Optometry, Orthopedic, Podiatry, Post-Partum, Pre-Natal, Rehab Physical Therapy, Reproduction, and Surgery appointments conducted on island.
Specialty Clinic – Off Island	Includes: Audiology, Breast, Cardiology, Cardiovascular, Chest, Dermatology, Endocrinology, ENT, Gastroenterology, General Surgery, Gynecology, Hand, Hematology, ID/Virology, Neurosurgery, Oncology, Ophthalmology, Oral Surgery, Orthopedic, Pain Management, Plastic Surgery, Podiatry, Renal, Rheumatology, Trauma, Urology, and Vascular appointments conducted at a hospital off island.

Source: CHS Access Reports July - December 2017

Service Completion

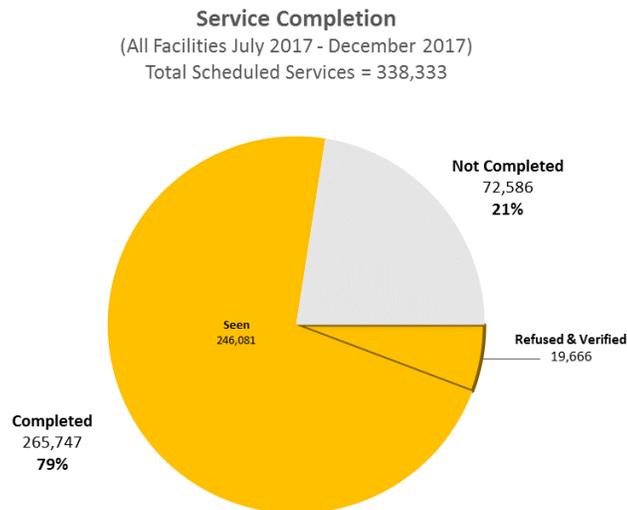
CHS considers an appointment completed if the patient has been 'Seen' and treated by a clinician, or the patient has refused their scheduled service and their refusal has been verified by a clinician ('Refused & Verified').

From July 2017 through December 2017, of the 338,333 scheduled services requiring completion, seventy-nine percent (79%, n = 265,747) were completed, and twenty-one percent (21%, n = 72,586) were not completed.⁷

Patients were 'Seen' by a clinician in 93% (n = 246,081) of completed services, and 7% (n = 19,666) of completed services involved a patient refusing care.

A description of each scheduled service outcome can be found in Table 2 below.

Figure 2



Source: CHS Access Reports July - December 2017

Table 2

Scheduled Service Outcome Dictionary		
Scheduled Service Outcomes	Definition	
Completed	Seen	All scheduled medical follow-up and nursing follow-up encounters that were conducted by a clinician or nursing staff.
	Refused & Verified	A patient has refused service and this refusal was witnessed/documentated by a clinician.
Not Completed	Not Produced by DOC	DOC was unable to produce the patient for their appointment.
	Out to Court	The patient was unable to honor their appointment due to a court appearance.
	Left Without Being Seen	The patient declined services without being seen or verified by a clinician.
	Rescheduled by CHS	The patient's appointment was rescheduled by Correctional Health.
	Rescheduled by Hospital	The patient's appointment was rescheduled by the Hospital.
No Longer Indicated	The patient's appointment was no longer clinically warranted.	

Source: CHS Access Reports July - December 2017

Note: Does not include appointments 'No Longer Indicated'

⁷ One percent (1%, n = 4,670) of scheduled services were 'No Longer Indicated' by the time of the scheduled appointment. There were 338,333 services requiring completion (99% of scheduled services). Services are 'No Longer Indicated' when the need for a patient's appointment has already been addressed via another scheduled or unscheduled clinic appointment, or when the appointment was scheduled in error.

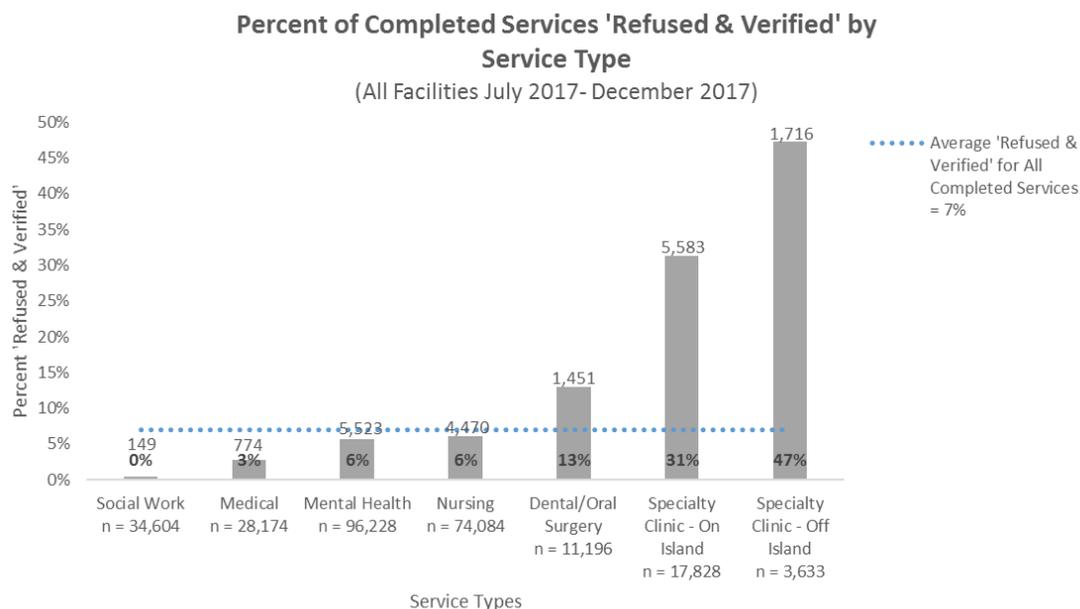
Completed Services - Patient Refusals

Board standards mandate that refusals for essential health services be made after consultation with health staff and that patients sign a waiver developed by the health authority.⁸ High rates of refusal suggest the need to review and explore ways to improve current protocols implementing this requirement.

From July to December 2017, there were 3,633 Off Island services completed. Of these completed services, nearly half (47%, n = 1,716) involved a patient refusal. Off Island services are reserved for advanced surgeries, procedures, and appointments that cannot be carried out on Rikers Island. People in custody and jail staff report that high rates of patient refusals for Off Island specialty clinic appointments are due to lengthy wait times, overbooking, waiting area conditions, and transportation challenges.

Thirty-one percent (31%, n = 5,583) of On Island services, and 13% (n = 1,451) of Dental/Oral Surgery services also reported above average rates of completion involving patient refusals. On Island services are also scheduled when treatment cannot be addressed at clinics in DOC facilities where patients are housed and require transportation to On Island clinic facilities.

Figure 3



Source: CHS Access Reports July - December 2017
 Completed Services for each Service Type = Total 'Seen' + Total 'Refused & Verified'
 n = Total Number of Completed Services within Each Service Category
 Total Completed = 265,747

Service Non-Completion

For services that are not completed, CHS tracks outcomes including: whether a patient was not produced by corrections staff for their appointment, whether a scheduled service conflicted with a patient's required court appearance, whether an appointment was rescheduled by medical staff, and whether a patient was produced for the appointment but left without being seen. Currently, while DOC has started to track reasons for non-production by corrections staff separately, CHS does not report detailed reasons for non-production (including whether the patient was not produced due to an

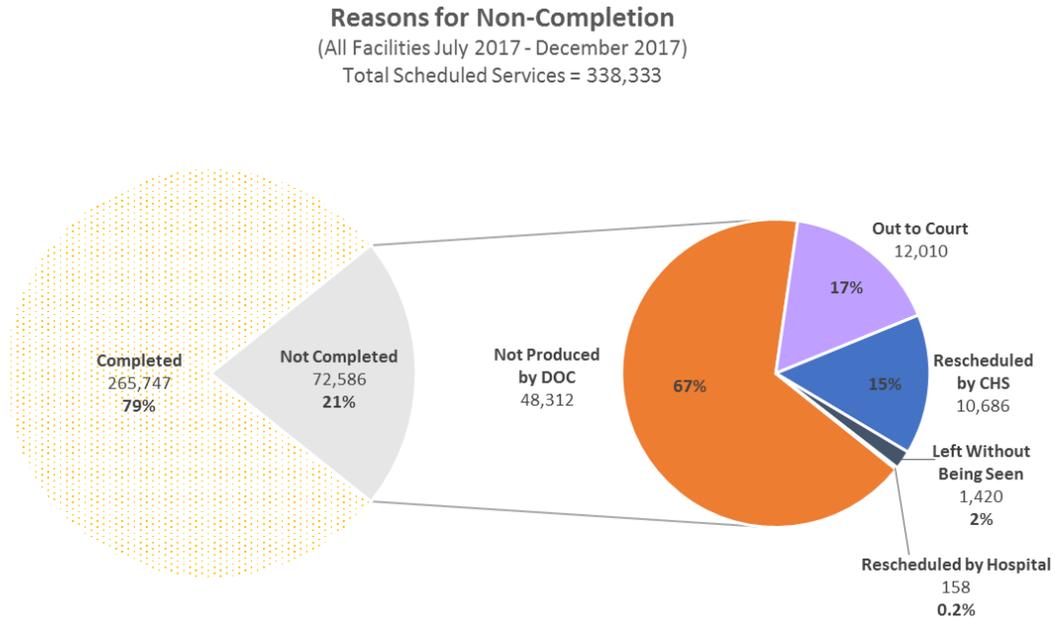
⁸ N.Y.C Board of Correction., Health Care Minimum Standards Chapter 3, § 3-06(l) Treatment (Dated April 10, 1991, eff. May 15, 1991).

alarm or lockdown, or whether the patient was not produced due to a corrections staff escort shortage, for example). These detailed reasons are not always readily known to clinical staff responsible for tracking.

'Not Produced by DOC,' 'Out to Court,' and 'Rescheduled by CHS' were the top three reasons for service non-completion every month from July 2017 to December 2017.

Of the twenty-one percent (21%, n = 72,586) of scheduled services that were not completed from July to December 2017, the majority were 'Not Produced by DOC' (67%, n = 48,312), 17% were 'Out to Court' (n = 12,010), 15% were 'Rescheduled by CHS' (n = 10,686), 2% 'Left Without Being Seen' (n = 1,420), and less than 1% were 'Rescheduled by Hospital' (n = 158).

Figure 4

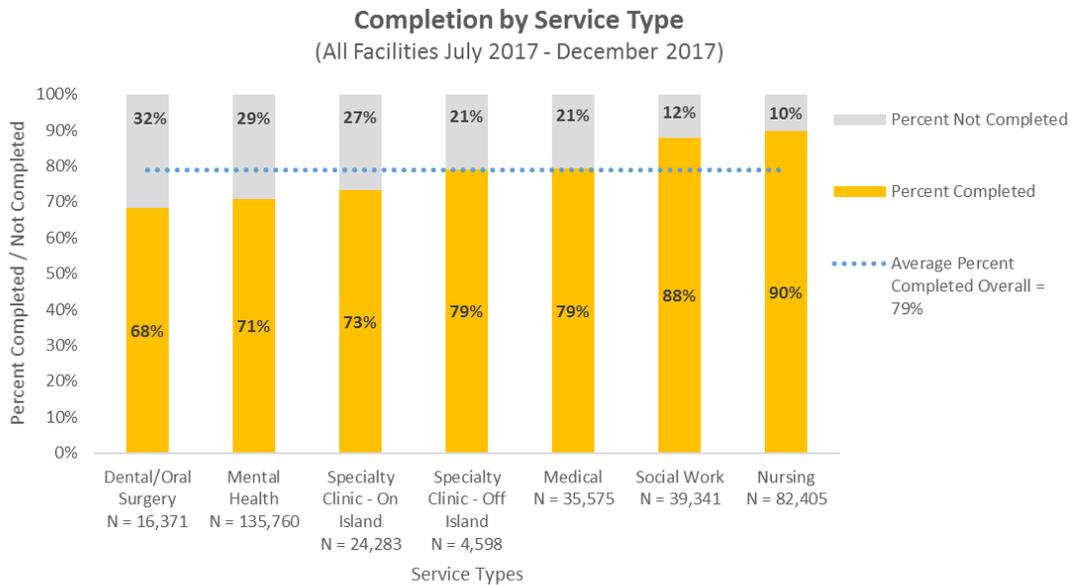


Source: CHS Access Reports July - December 2017
Note: Does not include appointments 'No Longer Indicated'

Completion vs. Non-Completion by Service Type

Dental/Oral Surgery, Mental Health, and Specialty Clinic – On Island services were the service categories *least* likely to be completed, with non-completion rates of 32%, 29%, and 27%, respectively.

Figure 5



Source: CHS Access Reports July - December 2017

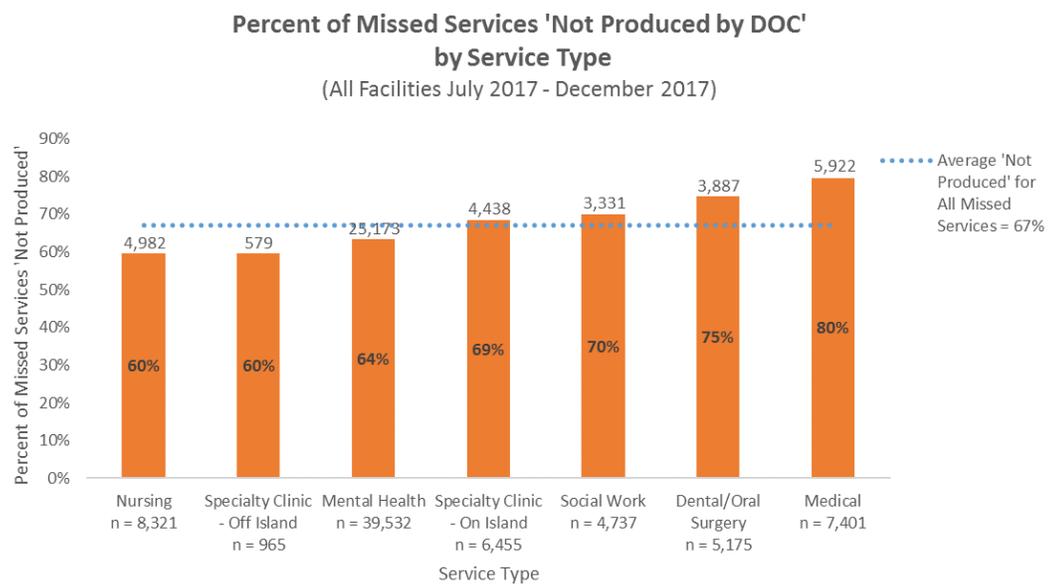
N = Total Number of Scheduled Services within Each Service Category – 'No Longer Indicated'

Total Scheduled Services Overall – 'No Longer Indicated' = 338,333

Reasons for Non-Completion by Service Type

Medical (80%, n = 5,922), Dental/Oral Surgery (75%, n = 3,887), Social Work (70%, n = 3,331), and Specialty Clinic On Island (69%, n = 4,438) reported the highest rates of non-completion due to patients not produced by DOC.

Figure 6



Source: CHS Access Reports July - December 2017

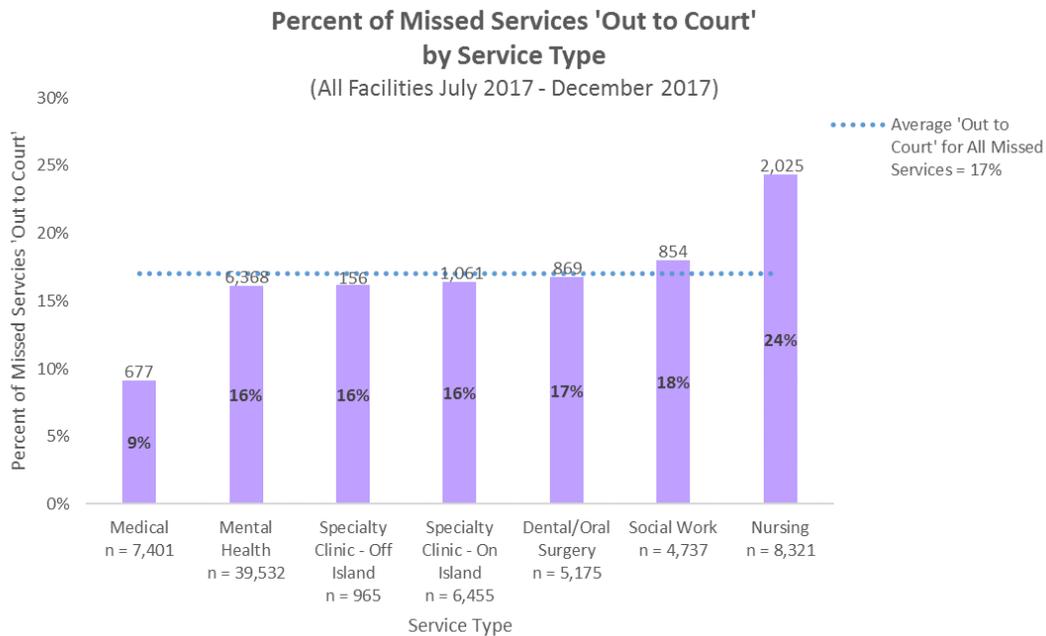
Scheduled Services for each Service Type = Total Services Not Completed - 'No Longer Indicated'

n = Total Number of Missed/Non-Completed Services within Each Service Category

Total 'Not Completed' – 'No Longer Indicated' = 72,586

Nursing (24%, n = 2,025) and Social Work (18%, n = 854) were the service categories with the highest rates of non-completion due to patients being 'Out to Court.' Note CHS employees have access to the Department of Correction's Inmate Information System which includes information on future court dates, though those dates are subject to change.

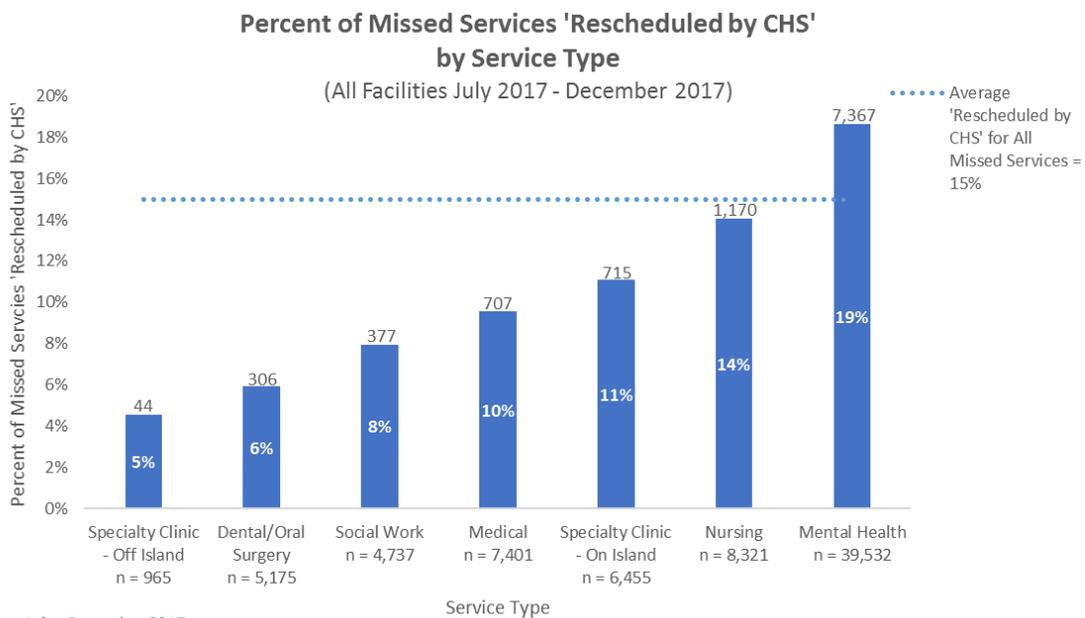
Figure 7



Source: CHS Access Reports July - December 2017
 Scheduled Services for each Service Type = Total Services Not Completed - 'No Longer Indicated'
 n = Total Number of Missed/Non-Completed Services within Each Service Category
 Total 'Not Completed' - 'No Longer Indicated' = 72,586

Mental Health services reported the greatest number and percentage of non-completed services due to CHS rescheduling (19%, n = 7,367).

Figure 8



Source: CHS Access Reports July - December 2017
 Scheduled Services for each Service Type = Total Services Not Completed - 'No Longer Indicated'
 n = Total Number of Missed/Non-Completed Services within Each Service Category
 Total 'Not Completed' - 'No Longer Indicated' = 72,586

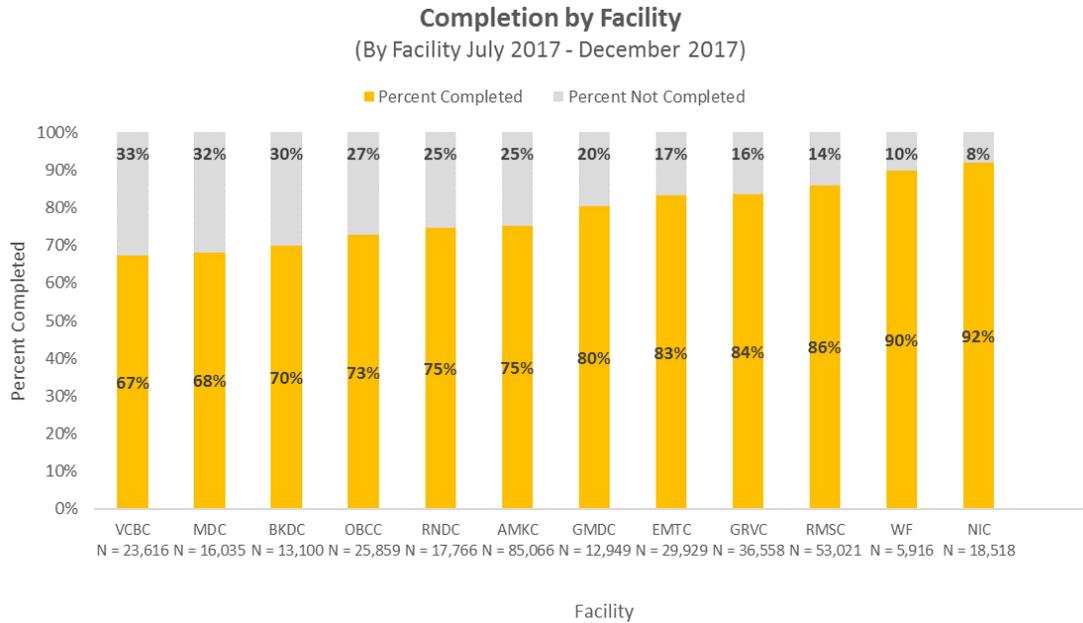
Completion by Facility

Completion rates also varied by facility. From July to December 2017, completion rates ranged from 67% at VCBC to 92% at NIC.

Completion rates varied even more significantly when analyzed by facility and service category. For example, Medical service completion rates, ranged from 54% at AMKC to 98% at MDC, and Dental/Oral surgery completion rates ranged from 48% at VCBC to 84% at RNDC.

The Board will be issuing facility-specific findings to facilitate implementation of the recommendations in this report.

Figure 9



Source: CHS Access Reports July - December 2017

N = Total Number of Scheduled Services within Each Service Category – 'No Longer Indicated'

Total Scheduled Services Overall – 'No Longer Indicated' = 338,333