

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.

Each month there are approximately 51,000 health and mental health visits, 9,500 sick call visits, 3,200 health intakes, over 600 mental health referrals, and various other health encounters scheduled to be provided by CHS staff.

Providing care in a jail setting is difficult and requires extensive and ongoing coordination between CHS and DOC staff. In 2018, more than half (55%, n=1,656)² of the 3,036 complaints received by CHS and nearly half (49%, n=3,663)³ of the 7,449 Medical and Mental Health complaints received by DOC were related to access to care.

Since April 2016, the Board has required CHS to produce a monthly report with metrics on access to care. These reports are available on the Board's website at <http://www1.nyc.gov/site/boc/reports/correctional-health-authorityreports.page>. While the CHS monthly access reports represent the most comprehensive ongoing reporting on health and mental health care access in jails nationally, these reports still lack reliable and reconcilable information about the reasons for non-production, sick call, intake, rescheduling, patient refusals of services, or whether services are timely delivered. The Board has encouraged CHS and DOC to implement a coordinated approach to reporting and tracking to address these gaps so that there can be a mutual understanding of how access can be improved.

This report summarizes findings on the outcomes of scheduled health and mental health services using data reported in the CHS monthly access reports for calendar year 2018. The findings in this and in prior Board reports indicate there is more work to be done to improve coordination and compliance with the Minimum Standards.

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 Includes complaint categorized by CHS Patient Relations as "Access," "Medication not received," and "Specialty Clinics" defined as follows: "Access" complaints relate to instances where the patient is unable to be seen by a primary care provider (not including specialty care). "Specialty Clinics" complaints relate to the lack of access to specialty clinic, including both on and off island clinics. "Medication Not Received" complaints relate to the non-receipt of a prescribed medication.

³ Includes complaints categorized by DOC's Office of Constituent and Grievance Services as "Access," "Dental Access," and "Specialty Clinics."

Key Findings (January-December 2018)

Overall:

- From January to December 2018, CHS scheduled 617,671 services.
- Forty-three percent (43%, n=265,486) of scheduled services were Mental Health appointments.

Completed Services:

- Seventy-seven percent (77%) of services scheduled were recorded as complete (n=471,435). This means for 77% of scheduled appointments, the patient either saw a clinician ('Seen') or the patient refused their scheduled service with a clinician's verification ('Refused & Verified').
 - Ninety-three percent (93%, n=437,626) of completed services were documented as 'Seen' while seven percent (7%, n=33,809) of completed services involved a patient refusal.
 - Almost half (45%, n=2,942) of completed Off Island and 35% (n=11,963) of completed On Island appointments involved a patient refusing care.
- Monthly completion rates ranged from 75% to 79% with an overall 2018 completion rate of 77%.
- Completion rates varied widely by facility, ranging from 67% (n=21,344 completed) at BKDC to 93% (n=38,188 completed) at NIC.

Non-Completed/Missed Services:

- Just under one-quarter of all scheduled services were not completed (23%, n=139,644).
 - Dental/Oral Surgery, Mental Health, and Specialty Clinic – On Island appointments were the service categories least likely to be completed with non-completion rates of 31%, 31%, and 27% respectively.
- Mental Health services recorded the highest number of missed appointments (n=79,419). This is approximately six times as many missed appointments as the next highest service categories with missed appointments – Nursing (n=13,382) and Specialty Clinic – On Island (n=13,021).
- Patients overwhelmingly missed appointments because the patient was 'Not Produced by DOC.' Sixty-four percent (64%, n=89,681) of all missed appointments were due to DOC not producing the patient to the clinic.
 - DOC non-production was the top reason for missed appointments each month studied, across all service categories.
 - Medical (72%, n=8,658) and Dental/Oral Surgery (70%, n=7,720) were the service categories reporting the highest rates of missed appointments due to DOC non-production.
- After DOC non-production, the next most common reasons for non-completion were that the service was 'Rescheduled by CHS' (17% of all missed appointments, n=24,141)

or the patient's appointment conflicted with the patient's court date (16% of all missed appointments, n=22,669).

- The Mental Health service category reported the highest rate of missed appointments due to rescheduling by CHS (22%, n=17,557).
- The Social Work service category reported the highest rate of missed appointments due to the patient being 'Out to Court' (23%, n=2,091).

Notable Comparisons Between the Board's 2018 Report (July to December 2017 reporting period)⁴ and Board's 2019 Report (January to December 2018 reporting period)

Number and Type of Scheduled Services

- Mental Health (43%, n=265,486), Nursing (18%, n=114,815), and Social Work (14%, n=84,835) services remained the top three categories of scheduled service types, making up three-quarters of all scheduled services in both reporting periods.

Service Completion

- Overall service completion decreased slightly from 79% (n=265,747) completed in the July to December 2017 reporting period to 77% (n=471,435) in the January to December 2018 reporting period.
- Dental/Oral Surgery (31%, n=10,970), Mental Health (31%, n=79,419), and Specialty Clinic – On Island (27%, n=638) service categories remain the top three service types least likely to be completed.

Completed Services – Patient Refusals

- For both reporting periods, seven percent (7%, n=33,809) of all completed services were completed as a result of a patient refusal.
- Specialty Clinic – On (35%, n=11,963) and Off (45%, n=2,942) Island services remain the service categories most likely to be completed with a patient refusal.

Reasons for Non-Completion

- 'Not Produced by DOC' (65%, n=89,681), 'Rescheduled by CHS' (17%, n=24,141), and 'Out to Court' (16%, n=22,669) remain the top three reasons for service non-completion.

Non-production

- Medical (72%, n=8,658) and Dental/Oral Surgery (70%, n=7,720) remain the top two service types with the most services missed due to non-production.
- Non-production increased in the following service categories:
 - Specialty Clinic – Off Island from 60% (n=579) to 67% (n=1,304) of missed services.

⁴ Note the Board's 2018 report covered only a 6 month reporting period (July-December 2017) and not a full calendar year due to changes in reporting metrics implemented in the first half of 2017.

- Nursing from 60% (n=4,982) to 70% (n=9,368) of missed services.
- Non-production decreased in the following service categories:
 - Medical from 80% (n=5,922) to 72% (n=8,658) of missed services.

Rescheduling

- Mental Health continues to be the service category with the highest rate of rescheduling by CHS (22%, n=17,557). From July to December 2017, 19% of missed Mental Health appointments (n=7,367) were missed due to CHS rescheduling, and in 2018, 22% (n=17,557) of missed Mental Health appointments were missed due to CHS rescheduling.

Out to Court

- In the July to December 2017 report, Nursing ranked highest for services missed due to the patient being 'Out to Court' (24%, n=2,025). This percentage decreased to 16% (n=2,175) in the January to December 2018 report.
- Specialty Clinic – Off Island appointments missed due to the patient being 'Out to Court' decreased from 16% (n=156) to 10% (n=190).
- Social Work appointments missed due to the patient being 'Out to Court' increased from 18% (n=854) to 23% (n=2,091).

Completion by Facility

- VCBC completion rates rose from 67% (n=15,902) to 80% (n=33,258).
- RNDC completion rates dropped from 75% (n=13,247) to 68% (n=19,835).
- GRVC completion rates dropped from 84% (n=30,536) to 73% (n=38,200).

Recommendations

In its [May 2018 report](#) on Access to Health and Mental Health Care, Board staff made nine recommendations 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. On May 31, 2019, DOC and CHS each provided responses and an update on progress toward implementing these recommendations. The Board's 2018 recommendations and responses are included as Appendixes E and F.

The findings presented in this report indicate CHS and DOC must do more to implement the Board's recommendations from 2018. Board staff remain concerned about the high number and rate of missed appointments in the New York City jails, particularly the number and rate of appointments that do not occur due to DOC not bringing a person to the appointment (non-production).

While the agencies' responses to the Board's 2018 recommendations document limited initiatives to improve access to care, the responses suggest little coordination between agencies to identify barriers to care and problem solve together. For example, the agencies have independent systems for tracking whether someone was brought to an appointment and, if they were not, why they were not. This leads to the agencies producing conflicting reports and explanations as to why people do not get to the clinic making it difficult to problem solve together. For example, in March 2019, CHS reported there were 50,746 scheduled services and 10,423 completed sick call encounters while DOC reported there were 48,812 scheduled services and 7,136 completed sick call encounters, a difference in reporting of nearly 2,000 scheduled services and over 500 sick call encounters in one month alone. Causing further alarm, more than half of all complaints received by CHS and nearly half of all medical and mental health complaints received by DOC are related to access to care. While the Board recognizes the inherent benefits and challenges of two agencies working together to ensure access to quality health and mental health care in the jails, collective problem solving and collaboration is the only way that people in jail will receive the care that clinicians have said they need.

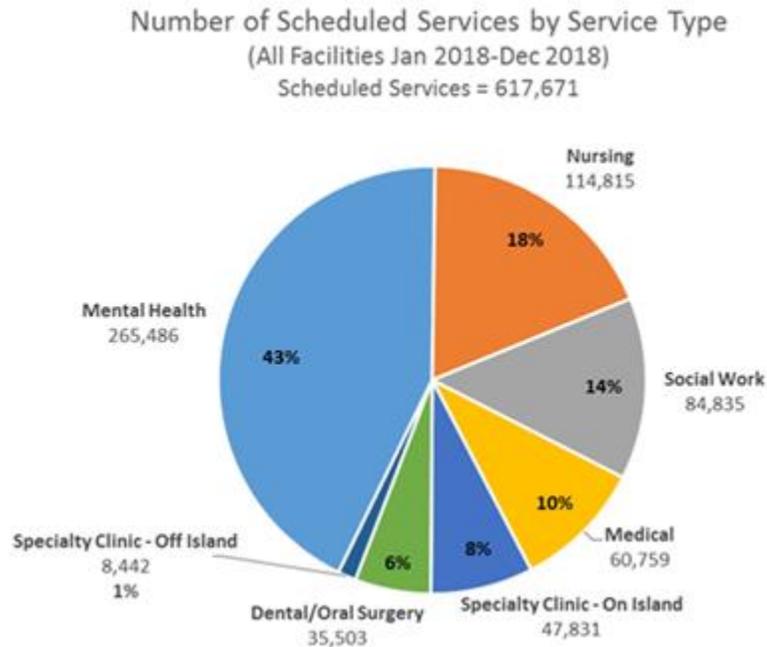
The Board is enhancing its capacity to monitor compliance with Minimum Standards on Health and Mental Health and now has a dedicated a Research Director who will work closely with DOC and CHS to improve access to care. This will involve facilitating and promoting the development of systems and structures to enhance collaboration between agencies while maintaining the independence of CHS in its clinical work. A critical component of this collaboration will be developing the metrics necessary to identify and address barriers to care.

Number and Type of Scheduled Services

From January to December 2018, there were 617,671 total scheduled services. Mental Health had the highest percentage of scheduled services (43%, n=265,486), followed by Nursing (18%, n=114,815) and Social Work (14%, n=84,845).

See Appendix A for the Service Type Dictionary.

Figure 1



Source: CHS Access Reports January-December 2018

Service Completion

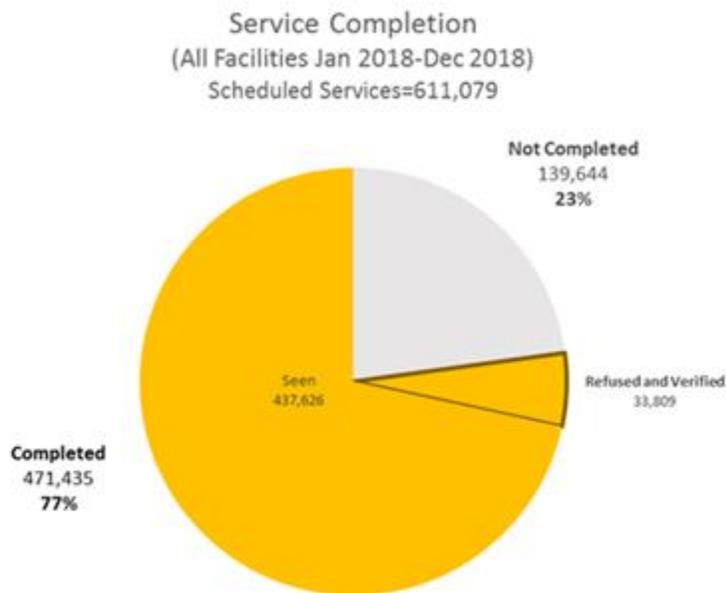
CHS reports an appointment as completed if the patient has been 'Seen' and treated by a clinician, or the patient has refused their scheduled service and their refusal has been verified by a clinician ('Refused & Verified').

From January to December 2018, of the 611,079 services scheduled,⁵ seventy-seven percent (77%, n=471,435) were completed while twenty-three percent (23%, n=139,644) were not completed.

Patients were 'Seen' by a clinician in 93% (n=437,626) of completed services, while 7% (n=33,809) of completed services involved a patient refusing care.

See Appendix A for the Scheduled Service Outcome Dictionary.

Figure 2



Source: CHS Access Reports January-December 2018

⁵ This total does not include services 'No Longer Indicated.' One percent (1%, n=6,592) of scheduled services were 'No Longer Indicated' by the time of the scheduled appointment. 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

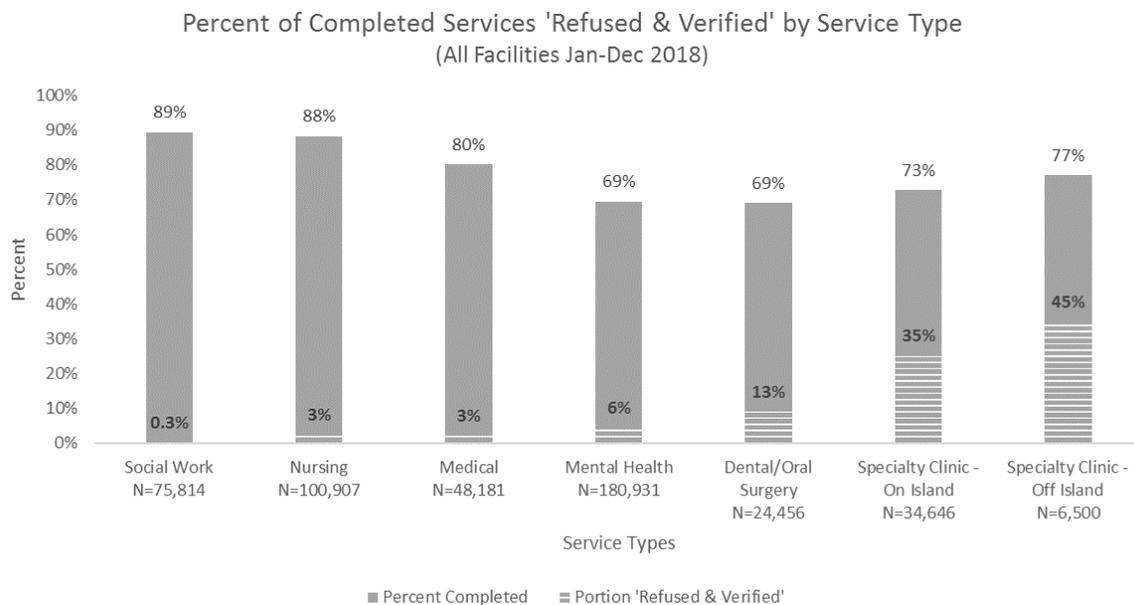
Board Standards mandate that refusals for essential health services be made after consultation with health staff and that patients sign a waiver developed by the health authority.⁶

Seven percent (7%, n=33,809) of all completed services (n=471,435) were recorded with a patient refusal. CHS continues to report higher rates of patient refusals for the Specialty Clinic – Off Island, Specialty Clinic –On Island, and Dental/Oral Surgery service types, with no significant changes between the July-December 2017⁷ and January-December 2018 reporting periods.

From January to December 2018, there were 6,500 Specialty Clinic – Off Island services completed. Of these completed services, nearly half (45%, n=2,492) 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.

In addition to Off Island services, completed Specialty Clinic – On Island⁸ and Dental/Oral Surgery also reported above average rates of patient refusals. Thirty-five percent (35%, n=11,963) of completed Specialty Clinic – On Island and 13% (n=3,211) of completed Dental/Oral Surgery appointments were recorded as ‘Refused & Verified.’

Figure 3



Source: CHS Access Reports January-December 2018
 N=total number of completed services within each service category
 Completed services for each service type=total 'Seen' + 'Refused & Verified'
 Total completed=471,435

⁶ N.Y.C Board of Correction., Health Care Minimum Standards Chapter 3, § 3-06(l) Treatment (Dated April 10, 1991, eff. May 15, 1991).

⁷ For the July-Dec 2017 reporting period, 0% of Social Work, 3% of Medical, 6% of Mental Health, 6% of Nursing, 13% of Dental/Oral Surgery, 31% of Specialty Clinic – On Island, and 47% of Specialty Clinic – Off Island of completed services were recorded as a patient refusal.

⁸ On Island services are scheduled when treatment cannot be addressed at clinics in DOC facilities where patients are housed and require transportation to On Island clinic facilities.

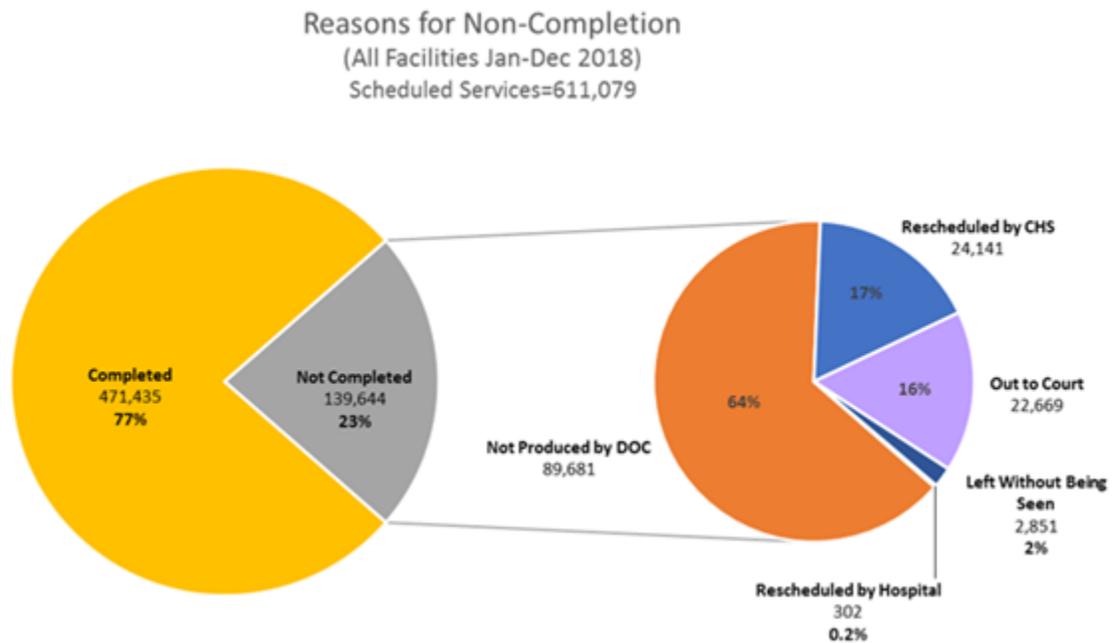
Reasons for Non-Completion

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. DOC continues to track reasons for non-production by corrections staff separately from CHS. CHS does not report detailed reasons for non-production (including whether the patient was not produced due to an alarm or lockdown, or whether the patient was not produced due to a corrections staff escort shortage, for example). This detailed information is not always made available to clinical staff responsible for tracking.

‘Not Produced by DOC,’ ‘Rescheduled by CHS,’ and ‘Out to Court’ remain the top three reasons for service non-completion.⁹ These were the top three reasons for service non-completion every month from January to December 2018.

Of the 23% (n=139,644) of scheduled services that were not completed in 2018, the majority were ‘Not Produced by DOC’ (64%, n=89,681). Appointments ‘Rescheduled by CHS’ accounted for 17% (n=24,141) and appointments ‘Out to Court’ accounted for 16% of missed appointments. Patients who ‘Left without Being Seen’ (2%, n=2,851) and appointments ‘Rescheduled by Hospital’ (0.2%, n=302) were the least documented reasons for non-completion.

Figure 4



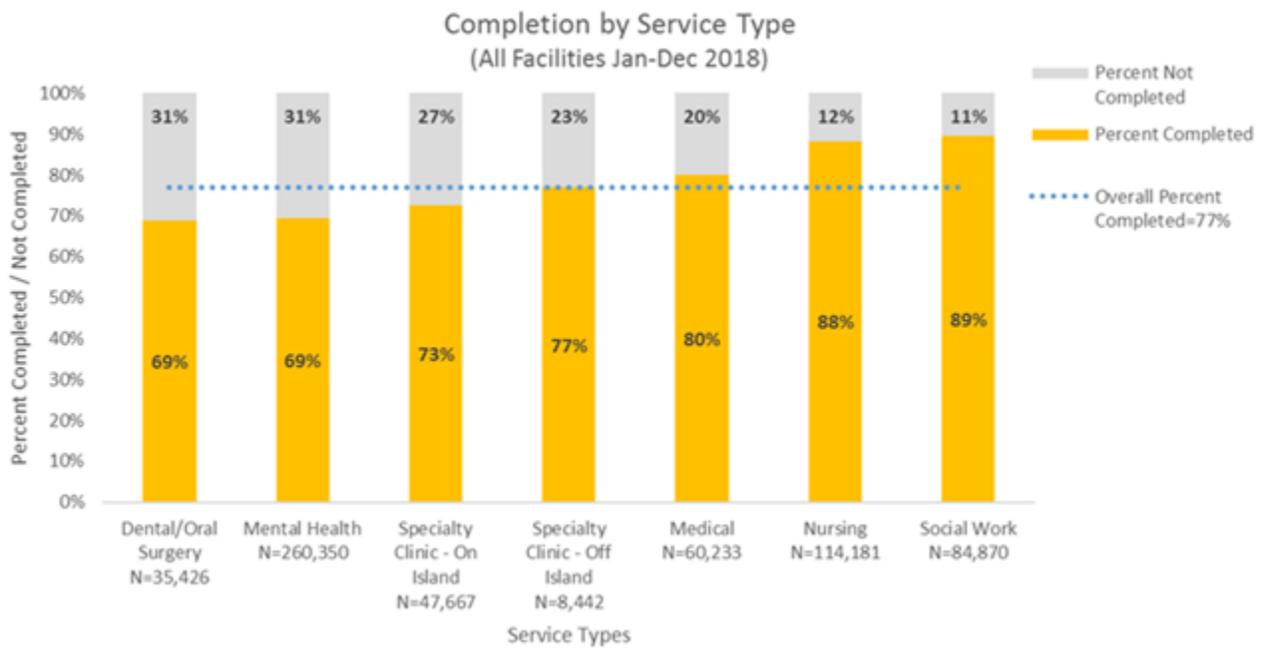
Source: CHS Access Reports January-December 2018
 Note: Does not include appointments ‘No Longer Indicated’

⁹ For the July-Dec 2017 reporting period, 67% of missed services were ‘Not Produced by DOC,’ 17% were ‘Out to Court,’ and 15% were ‘Rescheduled by CHS.’

Completion vs Non-Completion by Service Type

Dental/Oral Surgery, Mental Health, and Specialty Clinic – On Island service categories were the service categories least likely to be completed, with non-completion rates of 31%, 31%, and 27% respectively. These findings are consistent with those from the July to December 2017 reporting period, which also saw Dental/Oral Surgery (32%), Mental Health (29%) and Specialty Clinic – On Island (27%) as the top three service categories least likely to be completed.

Figure 5

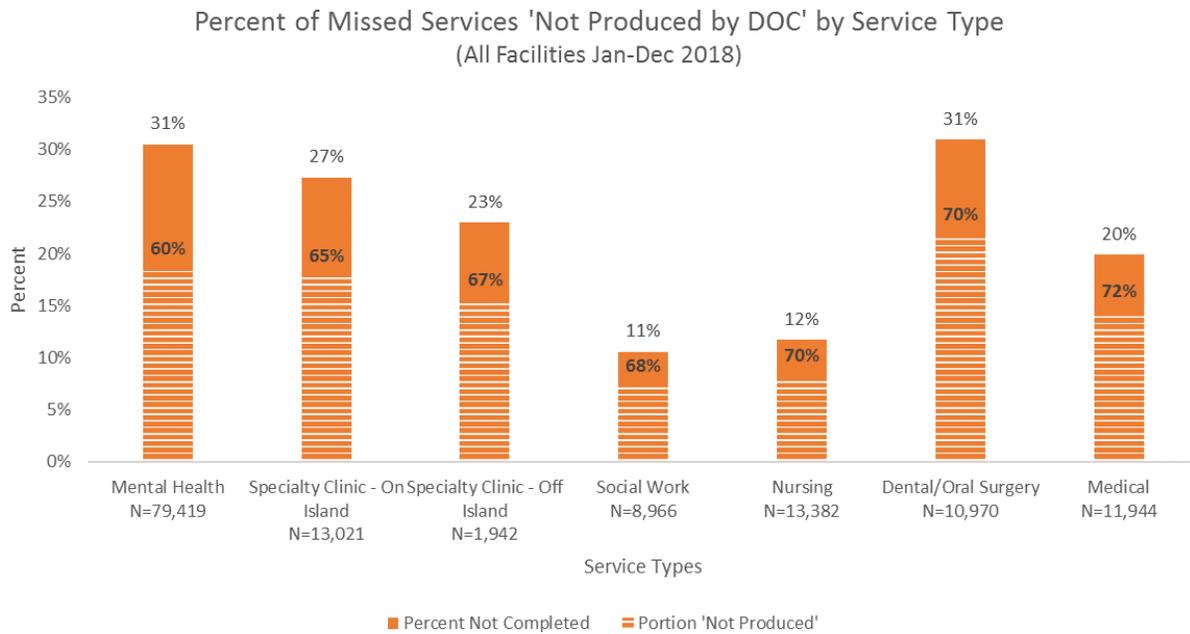


Source: CHS Access Reports January-December 2018
 N=Total number of scheduled services within each service category – 'No Longer Indicated'
 Total scheduled services overall – 'No Longer Indicated'=611,079

Reasons for Non-Completion by Service Type

Medical Dental/Oral Surgery, and Nursing service categories reported the highest rates of missed services due to patients 'Not Produced by DOC: 72% of missed Medical and 70% (n=8,658) of missed Dental (n=7,720) and Nursing services (n=9,368) were missed due to non-production. Medical and Dental/Oral Surgery were also the top two service types with the most services missed due to non-production in the July to December 2017 reporting period.

Figure 6

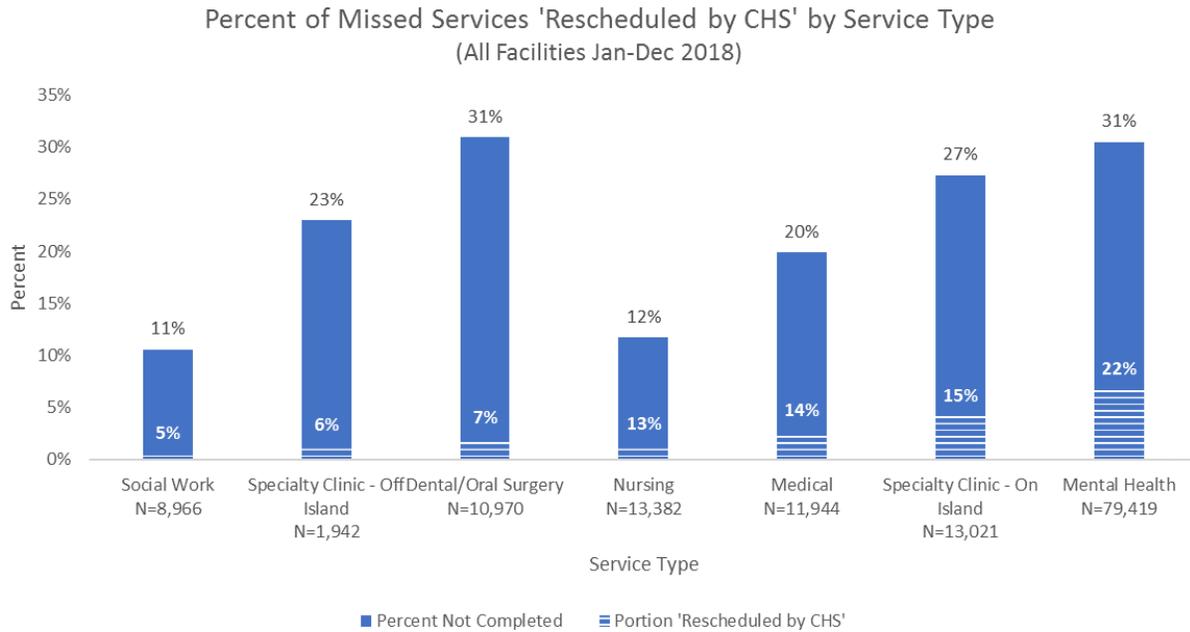


Source: CHS Access Reports January-December 2018
 N=Total number of missed services within each service category – 'No Longer Indicated'
 Total not completed – 'No Longer Indicated'=139,644

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 Access to Health and Mental Health Care (January-December 2018)
 June 2019

Mental Health services reported the greatest number and percentage of missed services due to CHS rescheduling (22%, n=17,557).

Figure 7

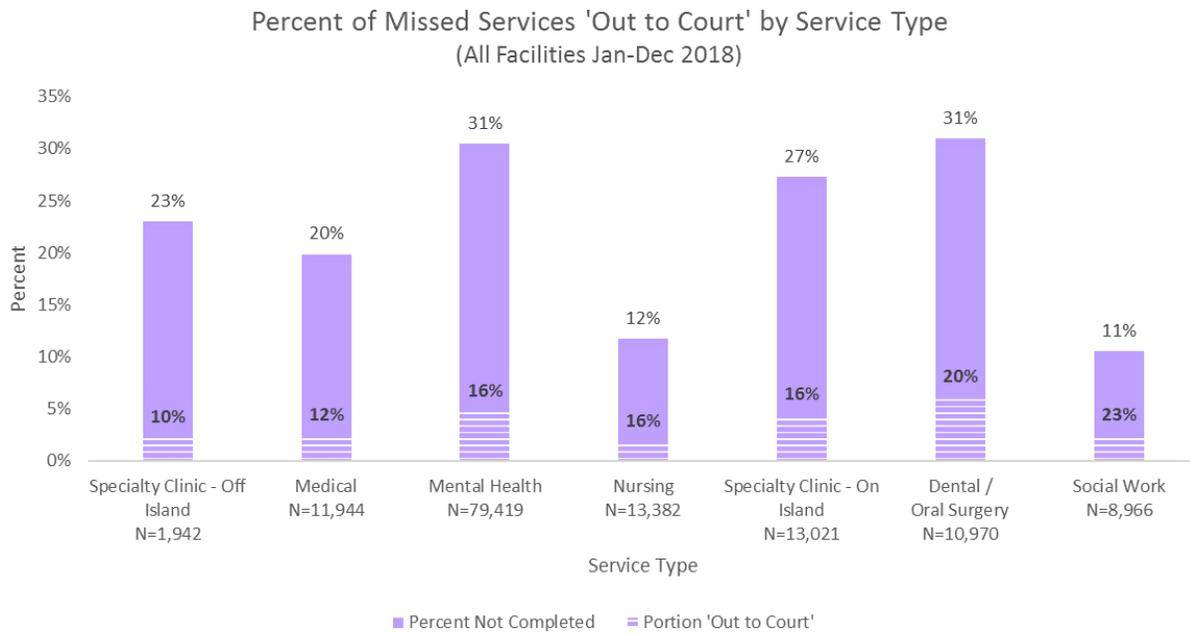


Source: CHS Access Reports January-December 2018
 N=Total number of missed services within each service category – 'No Longer Indicated'
 Total not completed – 'No Longer Indicated'=139,644

New York City Board of Correction
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Social Work (23%, n=2,091) and Dental/Oral Surgery (20%, n=2,178) services had the highest rates of missed services due to patients being 'Out to Court.'

Figure 8



Source: CHS Access Reports January-December 2018
 N=Total number of missed services within each service category – 'No Longer Indicated'
 Total not completed – 'No Longer Indicated'=139,644

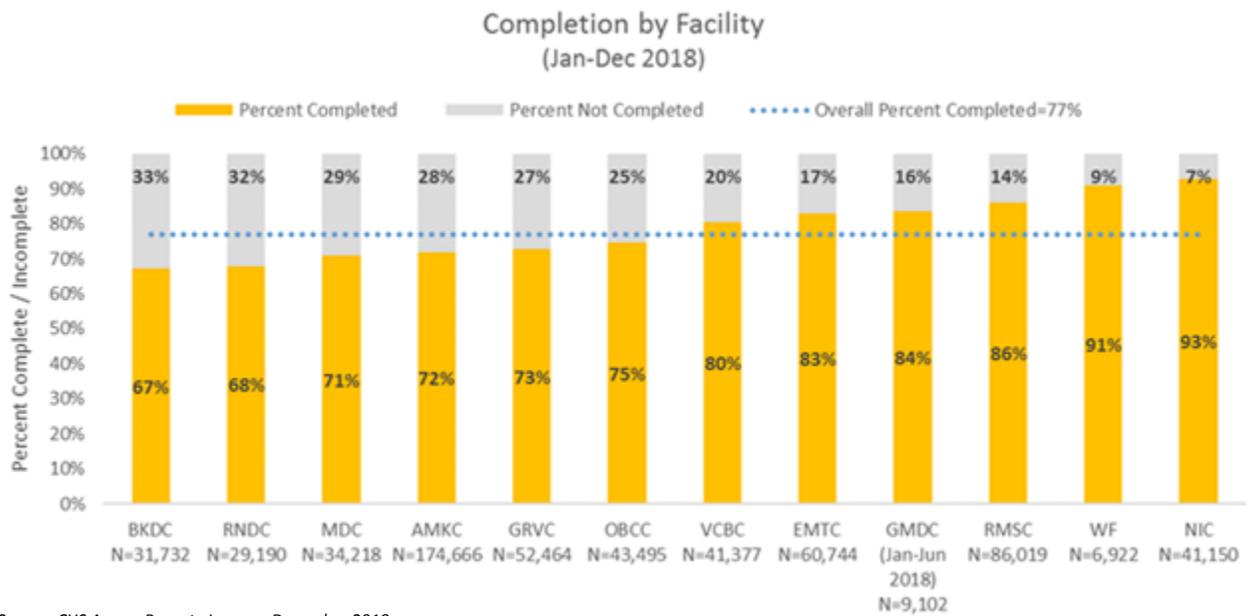
Completion by Facility

Completion rates also varied significantly by facility. From January to December 2018, completion rates ranged from 67% at BKDC to 93% at NIC.

Notable changes from the July to December 2017 reporting period include:

- VCBC completion rates rose from 67% in July to December 2017 to 80% in January to December 2018.
- RNDC completion rates dropped from 75% in July to December 2017 to 68% in January to December 2018.
- GRVC completion rates dropped from 84% in July to December 2017 to 73% in January to December 2018.

Figure 9



Source: CHS Access Reports January-December 2018
 N=Total number of scheduled services within each service category – 'No Longer Indicated'
 Total scheduled services overall – 'No Longer Indicated'=611,079
 Note: GMDC closed in June 2018.

Appendix A

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 January-December 2018

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 January-December 2018

New York City Board of Correction
 Access to Health and Mental Health Care (January-December 2018)
 June 2019

Appendix B

Access to Health and Mental Health Summary January – December 2018																	
	Scheduled Services	Medical		Nursing		Mental Health		Social Work		Dental/Oral Surgery		Specialty Clinic – On Island		Specialty Clinic – Off Island		Total	
	Service Outcomes	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Completed	Seen	46,808	77%	98,144	85%	169,586	64%	75,602	89%	21,245	60%	22,683	47%	3,558	42%	437,626	71%
	Refused & Verified	1,373	2%	2,763	2%	11,345	4%	212	0%	3,211	9%	11,963	25%	2,942	35%	33,809	5%
Not Completed	Not Produced by DOC	8,658	14%	9,368	8%	48,045	18%	6,129	7%	7,720	22%	8,457	18%	1,304	15%	89,681	15%
	Out to Court	1,454	2%	2,175	2%	12,434	5%	2,091	2%	2,178	6%	2,147	4%	190	2%	22,669	4%
	Left Without Being Seen	192	0%	163	0%	1,383	1%	292	0%	337	1%	448	1%	36	0%	2,851	0%
	Rescheduled by CHS	1,640	3%	1,676	1%	17,557	7%	454	1%	735	2%	1,969	4%	110	1%	24,141	4%
	Rescheduled by Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	302	4%	302
No Longer Indicated		634	1%	526	0%	5,136	2%	55	0%	77	0%	164	0%	N/A	N/A	6,592	1%
Total Scheduled Services		60,759	100%	114,815	100%	265,486	100%	84,835	100%	35,503	100%	47,831	100%	8,442	100%	617,671	100%

Source: CHS Access Reports January-December 2018

Appendix C

Access to Health and Mental Health Summary: Completed Services January – December 2018																	
	Scheduled Services	Medical		Nursing		Mental Health		Social Work		Dental/Oral Surgery		Specialty Clinic – On Island		Specialty Clinic – Off Island		Total	
	Service Outcomes	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Completed	Seen	46,808	78%	98,144	86%	169,586	65%	75,602	89%	21,245	60%	22,683	48%	3,558	42%	437,626	72%
	Refused & Verified	1,373	2%	2,763	2%	11,345	4%	212	0%	3,211	9%	11,963	25%	2,942	35%	33,809	5%
Total Completed Services		48,181	80%	100,907	88%	180,931	69%	75,814	89%	24,456	69%	34,646	73%	6,500	77%	471,435	77%

Source: CHS Access Reports January-December 2018

Appendix D

Access to Health and Mental Health Summary: Not Completed Services January – December 2018																	
	Scheduled Services	Medical		Nursing		Mental Health		Social Work		Dental/Oral Surgery		Specialty Clinic – On Island		Specialty Clinic – Off Island		Total	
	Service Outcomes	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Not Completed	Not Produced by DOC	8,658	14%	9,368	8%	48,045	18%	6,129	7%	7,720	22%	8,457	18%	1,304	15%	89,681	15%
	Out to Court	1,454	2%	2,175	2%	12,434	5%	2,091	2%	2,178	6%	2,147	5%	190	2%	22,669	4%
	Left Without Being Seen	192	0%	163	0%	1,383	1%	292	0%	337	1%	448	1%	36	0%	2,851	0%
	Rescheduled by CHS	1,640	3%	1,676	1%	17,557	7%	454	1%	735	2%	1,969	4%	110	1%	24,141	4%
	Rescheduled by Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	302	4%	302
Total Services Not Completed*		11,944	20%	13,382	12%	79,419	31%	8,966	11%	10,970	31%	13,021	27%	1,942	23%	611,079	23%

Source: CHS Access Reports January-December 2018

*Note: Services 'No Longer Indicated' were removed from this data

Appendix E

CHS Response to BOC Recommendations

1. Substantive Areas of Concern Identified via Data Analysis:

i. Develop a plan to track and address barriers to DOC production, the main cause of non-completed appointments.

CHS defers to DOC.

ii. 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.

CHS Response:

CHS' current electronic health record is an encounter based system and as a result, the number of rescheduled visits is artificially inflated with load balancing of clinic schedules. Any modification to a future appointment, whether moving forward or backward, results in a count of rescheduling. Attempts to correlate the aggregate number of rescheduled appointments to clinical appropriateness of scheduling patterns is misleading. By late summer, CHS expects to complete the transition to its new Correctional Health Electronic Record system (CHER) and early data exploration suggests that scheduling tasks can be appropriately accounted for in future reporting.

The Brad H stipulation requires certain services to be delivered to patients at predefined intervals in the care continuum. CHS coordinates and adjusts appointments to respond to production patterns, enabling compliance with timeliness thresholds. This process appears as a rescheduled visit.

iii. 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.

CHS Response:

CHS schedules according to clinical need. Every on- and off-island referral to specialty care is reviewed by senior medical staff and assigned a priority for scheduling. This process ensures that patients are scheduled to be seen at clinically appropriate intervals while also taking into account clinic capacity. It is unclear how the Board has linked overbooking with patient refusals using utilization frequency statistics.

CHS has implemented telehealth with both Bellevue and Elmhurst as well as on-site specialty services in seven facilities to reduce transportation needs and, when clinically appropriate, allow for encounters to occur without the need for lengthy transportation.

iv. Implement policies and training to minimize health and mental health appointment conflicts with court, school, or other known conflicts with services or programs.

CHS Response:

CHS actively avoids scheduling around conflicts with services and programs. As indicated in the April 2019 access report, only 4% (n=1800/50033) of all scheduled health and mental health appointments were missed due to court conflicts. When CHS learns of a conflict, clinic schedules are modified to ensure patients are seen. This process contributes to the rates of rescheduling noted in 1(ii).

It's important to note that the mental health workflow requires "court" to be documented, even in cases where the court date is known ahead of time and the appointment has already been rescheduled. The number of court and rescheduled appointments is not an appropriate measure for identifying barriers to care.

The act of scheduling and rescheduling appointments highlights CHS' commitment to minimizing access conflicts with services and programs.

2. Gaps in Identifying and Understanding Barriers to Access:

i. Identify and track underlying reasons for non-production, such as escorting, lockdowns, searches, scheduling conflicts, and other frequently occurring reasons identified by DOC.

CHS defers to DOC.

ii. Identify and track underlying reasons for and time to rescheduling, such as CHS/DOC staffing shortages.

CHS Response:

The current electronic health record does not lend itself to tracking this information. However, as indicated in 1(ii), with the implementation of our new system CHER, CHS is exploring new ways of tracking access to clinical services within predefined, clinically appropriate timelines which would not require the functions of scheduling and rescheduling appointments.

iii. Train both clinical and corrections staff to ensure consistency in data collection across facilities and service disciplines.

CHS Response:

All CHS electronic workflows already ensure consistency in data collection. CHS has quality assurance mechanisms in place, both technical and clinical, to ensure quality documentation.

iv. Review best practices from jails with high rates of completed appointments, including North Infirmery Command, West Facility, and Rose M. Singer Center jails.

CHS Response:

The three facilities above have unique patient populations and processes and should not be used as a benchmark without proper context. By definition, the infirmary is set up to provide increased access to care for CHS' sickest patients. West Facility houses a small number of patients and serves as CHS' communicable disease unit. The average daily population is approximately 22 patients. The Rose M. Singer Center is the only women's facility and is not subject to patient transfers between facilities. With the exception of off-island specialty services, all clinical services are provided on-site and significantly reduce the need for transportation to appointments.

3. Key Gaps in Monitoring Compliance with Standards:

i. 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.

CHS Response:

CHS already reports the number of completed medical intakes and the average time to completion as requested by BOC research staff.

CHS reports unscheduled services, including sick call.

CHS is exploring ways to analyze and report data on the timeliness of service completion and substance use treatment services with our new electronic health record, CHER.

ii. Set benchmarks and targets for access to care.

CHS Response:

As noted above, CHS is exploring new ways to measure access which will incorporate benchmarks and targets for comparable patient populations.

iii. Update the CHS access to care report to address gaps in current reporting to better inform future action plans.

CHS Response:

Addressed through comments above.

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

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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).

CHS Response:

CHS has used an electronic health record at all facilities since 2011 which is the sole source for CHS' access report. The electronic health record not only supports compliance with Board Standards but also with community and correctional specific clinical standards.

CHS coordinates with DOC by providing the necessary information so that they may facilitate patient production to appointments. CHS metrics appropriately reflect the extent to which patients receive clinical services, either requested by CHS or the patient.

Appendix F

DOC Response to BOC Recommendations

The Department is committed to addressing challenges to production for the various medical services. Ensuring that health and mental health appointments are offered to individuals in our custody is essential and we believe in the importance of affording such a vital service. The Department strives to improve the accuracy and consistency of data collected in addition to initiating new projects aimed toward improving the ability of the Department to address gaps and minimize barriers to access for scheduled services.

Below are the Department's update to the Board's 2018 Access to Care Report Recommendations.

1. Substantive Areas of Concern Identified via Data Analysis

i. Develop a plan to track and address barriers to DOC production, the main cause of non-completed appointments.

The Department remains committed to affording medical care to everyone in our custody. To that end, the Department has continued its practice of tracking production and non-production for scheduled medical appointments. At the end of each business day, DOC clinic captains communicate reasons for non-production to on-the-ground Correctional Health Services (CHS) staff so as to facilitate appointment rescheduling. During the weekends, the tour commanders and steady weekend officers email CHS Operations regarding any issues related to production in real time. DOC Health Affairs sends monthly aggregate production and non-production reports to facility leads and senior leadership which enables the Department to monitor this metric and identify relevant trends. In support of accurate and timely data collection DOC Health Affairs and Facility Operations continue to provide instruction and training to clinic staff. The Department is in the beginning phases of tracking clinic production through RFID scanners. These scanners, which read RFID chips in wristbands worn by individuals in the Department's custody, will allow for real-time clinic production tracking. RFID scanners have been placed in all clinical settings across the Department.

Over the past year, the Department has worked diligently to improve access to medical care. In partnership with Correctional Health Services (CHS), the Department opened a mini-clinic in AMKC. This mini-clinic has assisted the Department in improving access to sick call and enables production to clinic with less movement across the facility.

ii. 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.

Producing individuals with mental health concerns for mental health appointments remains a unique challenge. Over the past year, the Department has increased steady officers at certain mental health and escort posts so as to increase compliance in medical appointment production, including an increase of 30 additional mental health posts and 10 additional mental health posts at AMKC. Further, DOC Health

Affairs liaises with the facility tour commander and CHS tour supervisor in order to immediately resolve certain issues in real time, such as providing medical care for an individual who has reached out to 311 or making every effort to produce a high priority individual for their appointment. Although the Department no longer is notified of an individual's appointment type when they are called to clinic, the Department remains committed to supporting the mental health needs of all individuals in our custody.

The Department defers to CHS for questions related to scheduling and cancellations.

iii. 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.

Over the past year, DOC Health Affairs has continued to track, monitor, and produce reports related to on-and-off-island specialty clinics appointments. The Department and CHS have continued to discuss issues related to patient refusals as well as the terminology and tracking of those refusals. The Department has recently adopted new definitions for four distinct forms of refusals – “production refusal,” which is to be used when an individual refuses to be escorted to the clinic for an appointment; “verified refusal,” which is to be used when an individual refuses to participate in an appointment via a face-to-face encounter with a member of CHS’ staff; “walkout,” which is to be used if an individual is produced to clinic but leaves before an appointment without having any direct interaction with CHS staff; and “left without being seen,” which is to be used if an individual is produced to clinic but leaves before an appointment and does not have direct interaction with CHS staff. The Department will continue to work with CHS to further define shared terminology and build a cohesive data dictionary.

The Department continues to experience challenges regarding the waiting space at Bellevue Hospital. The current waiting space does not have enough holding cells to safely separate individuals of differing security classifications. The Department has received SCOC approval to address this issue by constructing several small holding cells in place of the two larger holding cells. Construction on this project is scheduled to begin August 2019 and completion of this project is anticipated by February 2020. This critical safety enhancement will enable the Department to more readily transport and produce individuals to their off-island appointments.

Although the Department makes every effort to produce individuals for their appointments, overcrowded waiting areas and the potential mixing of individuals with certain security classifications remains a serious concern. The Department has continued to discuss scheduling concerns with CHS at the facility level, through daily huddles and monthly warden meetings, as well as in regular interagency leadership conversations. The Department defers to CHS to provide an update on these topics.

iv. Implement policies and training to minimize health and mental health appointment conflicts with court, school, or other known conflicts with services and programs.

The Department has continued to work with CHS to address conflicts between medical appointments and scheduled services and programs. When an appointment conflicts with school, for example, the escort officer finds the individual in his classroom and offers him the opportunity to be produced for his

appointment or reschedule for a later date. If the individual chooses to have the appointment, the escort officer will produce him to the clinic and escort him back to his classroom following the completion of his medical services. If the individual chooses to forgo his appointment, the escort officer returns to the clinic and alerts CHS staff, who then work on re-scheduling the individual based on their internal review process. When an individual is at court but they have a medical appointment deemed as a priority by CHS, officers will escort that individual to the clinic upon their return to our facilities.

That said, scheduling health and mental health appointments is a function solely managed by CHS and it is ultimately the decision of the individual whether or not they accept to attend their appointment.

2. Gaps in Identifying and Understanding Barriers to Access:

i. Identify and track underlying reasons for non-production, such as escorting, lockdowns, searches, scheduling conflicts, and other frequently occurring reasons identified by DOC.

The Department tracks barriers to production through its monthly report circulated to facility leadership and senior leadership. This report is sent to all facilities on a monthly basis and the metrics tracked are Not Produced, No Escort, Alarm, Tactical Search Operations and Lock-ins.

In addition, medical services and the corresponding movement are allowed by Department policy while there is a facility and/or housing area emergency lock-in. In the event of an emergency lock-in, the Department will continue to work with CHS to provide their facility staff members with adequate notification of the pending emergency lock-in. In May 2019, Central Operations Desk (COD) began including H+H Operations in their emergency lock-in email notification.

In 2018, the Department began tracking emergency lock-ins through the Incident Reporting System (IRS). As reported to the Board in April 2019, we are further updating this section of IRS to include a list of mandated services that may be affected by emergency-ins, including sick call.

ii. Identify and track underlying reasons for and time to rescheduling, such as CHS/DOC staff shortages.

As the entity responsible for scheduling, the Department defers to CHS to answer this question.

Though the Department does not specifically track the reasons for rescheduling it does track the number of CHS cancellations and the reasons for non-production in its internal monthly report on clinic production, as discussed in 1(i).

iii. Train both clinical and corrections staff to ensure consistency in data collection across facilities and service disciplines.

DOC Health Affairs conducts in-service training for all Clinic Captains and Deputy Wardens for Programs on data collection so as to maintain and improve the accuracy and consistency of our data. In 2018, DOC Health Affairs conducted 7 such trainings, including one for a class of Captains, two for a class of Assistant Deputy Wardens, two for a class of Deputy Wardens, and two for a class of new recruits.

Refresher courses are also held on an as-needed basis and trainings are also provided to newly-assigned clinic staff.

Uniformed members of staff in facilities are also encouraged and reminded to review and share their collection of data with CHS counterparts in the clinics during their one-on-one meetings and in the daily huddles.

iv. Review best practices from jails with high rates of completed appointments, including North Infirmery Command, West Facility, and Rose M. Singer Center Jails.

The Department continues to review all clinic production trends, both positive and negative, across our facilities. However, due to the unique nature of the facilities, and the populations within them, there is no specific one-size-fits-all approach that can be gleaned from facilities that have higher rates of completed appointments. North Infirmery Command (NIC), and West Facility (WF), and Rose M. Singer Center (RMSC) have infirmaries and/or on-site specialty services within each facility. Individuals do not have to travel for their appointments, which may increase their compliance for treatment to be rendered. By eliminating their travel time, individuals in a facility with on-site specialty services may also experience fewer interruptions to services and programs they wish to attend.

3. Key Gaps in Monitoring Compliance with Standards:

The Department takes compliance with minimum standards and the provision of health services seriously and has taken steps to continue to monitor both. As this section relates to the CHS Access to Care Report, the Department defers to CHS to answer.

i. Develop new tracking and reporting protocols to assess compliance with Minimum Standards: (i) intake; (ii) sick call; (iii) timeliness of service delivery and completion; and (iv) substance use treatment services.

DOC Health Affairs currently tracks sick call on a daily basis, including the number of individuals who sign up for sick call, the number of individuals who attend sick call, and the number of individuals who walked out of sick call, and the number of completed sick call appointments. These reports are circulated to facility and senior leadership on a monthly basis.

ii. Set benchmarks and targets for access to care.

iii. Update the CHS access to care report to address gaps in current reporting to better inform future action plans.