CORRECTIONAL ASSOCIATION OF NEW YORK

APPENDIX R
MEDICAL CARE IN DOCCS PRISONS VISITED BY THE CORRECTIONAL ASSOCIATION FROM 2010-2012

CORRECTIONAL ASSOCIATION OF NY
2013 COMMENTS CONCERNING
DOH OVERSIGHT OF HIV/HCV CARE IN
NEW YORK STATE PRISONS

SEPTEMBER 10, 2013

Appendix R - Medical Care in DOCCS Prisons Visited by The Correctional Association from 2010-2012

This document provides excerpts from reports submitted by the CA to DOCCS, which provided findings and recommendations about medical care in 12 New York State prisons. The Prison Visiting Project (PVP) of the Correctional Association of New York (CA) conducted monitoring visits to each of these prisons between 2010 and 2012. The CA is an independent, non-profit organization founded by concerned citizens in 1844 and granted unique authority by the New York State Legislature to inspect New York State prisons and to report its findings and recommendations to the legislature, the public and the press. In carrying out the CA's mandate for men's prisons, PVP conducts monitoring visits to six to ten prisons a year, branching out to all corners of the prison including cellblocks and dormitories, academic classrooms and vocational shops, mental health and medical areas, and isolated confinement units. PVP interviews incarcerated persons, correction officers, teachers, counselors, and medical staff, obtain data from the facility and DOCCS, and receive surveys from incarcerated persons.

After such visits, PVP prepares a written report about all aspects of life within the prison, including healthcare, and makes recommendations about how conditions can be improved at that facility if we identify areas of concern. The resultant report is reviewed by DOCCS and the prison staff, and PVP has a conference call with these officials to afford them an opportunity to clarify or correct any misinformation contained in the report and to discuss both our findings and recommendations. This document is a compilation of excerpts from these prison reports pertaining to medical care at the particular prisons. Specifically, each excerpt contains an introduction to the prison and PVP's findings and recommendations concerning that prison's medical care.

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ATTICA

The Visiting Committee of the Correctional Association of New York visited Attica Correctional Facility on April 12th and 13th, 2011. Attica is a maximum-security prison located in Wyoming County in Western New York. Attica had a capacity of 2,253 people and confined 2,152 people at the time of the visit.

MEDICAL CARE

The Visiting Committee toured the medical area and spoke with the nurse administrator about medical services at the prison. We appreciate the detailed information provided prior to our visit and during our tour. The medical area contained two waiting areas for incarcerated persons, six examination rooms, and a pharmacy. At the time of our visit, unlike most prisons, Attica does not bring patients to the medical area for sick call; instead, sick call is conducted in small rooms in the housing blocks. The prison also has a 28-bed infirmary, and we were informed by staff that the infirmary usually serves 10 to 12 patients, including patients from other area prisons that do not have an infirmary. Staff told us the usual length of stay for infirmary patients was less than seven days.

Overall, survey participants rated prison medical care at a rate that was about average for all CA-visited prisons. The responses to most of the medical care questions in the survey placed the prison near the middle of rankings of all CA-visited prisons, except that the care by clinic providers ranked near the top third of all surveyed prisons. **Table A – Summary of Attica Survey Participants' Response about Prison** summarizes this data, along with the prison ranking.

Table A – Summary of Attica Survey Participants' Responses to Prison Medical Care

Medical Service	Yes	Sometimes	No	Rank*	Good	Fair	Poor	Rank*
Can you see RN when needed	49%	39%	12%	18				
Rate Nursing care					15%	36%	50%	17
Do you experience delays in seeing a clinic provider **	39%	42%	20%	18				
Rate Physician care					20%	35%	45%	10
Experience delays in specialty care	45%	11%	44%	18				
Good follow-up to specialists	47%	-	54%	9				
Problems getting medication	38%	17%	45%	17				
Rate Overall Healthcare					15%	39%	46%	13

* Attica's ranking from best access/care to worst based upon survey responses for all 29 CA-visited prisons.

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

Medical Staffing

Attica is authorized to have two full time equivalent (FTE) doctors, two physician assistants, one nurse practitioner (NP) and 17 registered nurses (RN). At the time of our visit, the nurse practitioner position had been vacant for nine months and one nursing item had been vacant for a month. In addition to the permanent medical staff, Attica regularly employed two per diem nurses who worked approximately two to three 10-hour shifts every two weeks. Due to the nurse practitioner vacancy, the facility had employed a doctor on a fee-for-service basis for approximately two to three days per week. Given the size of the facility, the facility does not have sufficient number of nurses; the nurse-patient staffing levels of one nurse for every 125 patients is significantly higher than the department-wide figure of one nurse per 80 to 100 patients. Since Attica is a medical Level-1 prison, signifying it can handle patients with the most serious medical problems, and has a larger than average infirmary, we urge DOCCS to evaluate Attica's nursing need to determine whether its nursing staff should be increased. With five authorized clinic providers (two FTE doctors, two PAs and one NP), Attica has a ratio of one provider for every 430 to 440 patients; this ratio is higher than the department-wide average of 1:400. The actual ratio is even higher, given the vacant NP position, which is not being fully replaced by the part-time, fee-for-services doctor. Once the NP item is filled, we believe the Department should assess whether additional clinic staff is also needed.

Sick Call

Sick call is conducted in the housing units in very small rooms at the front of the blocks. During the visit, we inspected several of these rooms and found them to be inadequate for a proper medical examination. The rooms we saw were dark and in poor condition, had old furniture, no examination table, and limited medical equipment. It is also difficult to monitor activity in these rooms, and several individuals commented that security staff often remained in or very near the room so that patients could not have a confidential conversation with the nurse during the sick call encounter.

During our December 2011 conference call with facility staff, we were informed that since our visit, the prison has altered its sick call procedures and has initiated a program to conduct sick call in the clinic area for all the housing units. At the time of our conference call, four of the five housing areas were attending early morning sick-call in the clinic area and the fifth housing area was scheduled to be changed over shortly. The CA commends the administration for implementing this change.

Sick call under this new procedure begins at 6:00 am and persons from all but housing Block-A are attending this early morning sick call. Patients who wish to attend sick call submit a request the previous night before the 10:00pm count and are then escorted to the clinic area at 5:45 a.m. the next day. The facility currently has four nurses attending to sick call patients and will assign additional staff if needed; an additional sick call nurse will be added when the last housing area starts attending sick call in the clinic area. The facility estimates that approximately 35 incarcerated persons from four of the housing blocks are seen each day for sick call. Medical staff will continue to make rounds to SHU, keeplock and PC every day for sick call. Incarcerated persons who have a medical emergency after sick call can request an emergency sick call (ESC)

visit to the medical clinic to be seen by a nurse. The facility estimated that 80 ESC encounters occur each month.

As summarized in **Table A** above, Attica survey participants had mixed views of the sick call process and the adequacy of the nursing care provided during these meetings. Approximately half of the survey participants said they sometimes experience delays in getting access to sick call, a response rate that places Attica in the lower 40% of the prisons we have visited for a sick call access. More importantly, half of the survey respondents said the care provided during sick call was poor, ranking the prison in the lower half of CA-visited prisons for quality of such care. We reviewed the nearly 270 Attica survey responses for individuals' comments about the nurses and sick call and found a disturbing pattern of explanations for their assessment of care. Many incarcerated persons said that the care provided during sick call varied substantially according to the staff providing the services. A frequent complaint was that some nurses exhibited a poor attitude towards their patients with some being rude, discourteous, or uncaring. Other complaints mentioned the failure to listen to the patients and to provide appropriate care, and follow-up. A minority of survey participants expressed a more positive review, with some complimenting the nurses that they saw for their prompt action and care. These comments strongly suggest that there is significant variability in the care being provided by the sick call nurses. We urge the prison to conduct an assessment of the care provided by all sick call providers to ensure that each is performing an effective examination of all patients.

Clinic Call-Outs

Attica has five FTE clinic providers, three permanent physicians (one full-time and two half-time doctors), two NPs and one fee-for-service doctor who works about two to four days per week. Clinic appointments are scheduled six days per week, with both morning and afternoon appointments. The facility estimated that each month 550 to 600 patients are seen by the clinic providers.

Overall, Attica survey participants had a more favorable view of the clinic providers than of the sick call nurses, but access to the clinic was still problematic. According to staff, it takes two to three weeks to see a clinic provider for a routine appointment. Based upon survey responses, the median time to see a provider was three weeks, placing the prison in the middle of all CA-visited prison for the length of time to see a doctor. Thirty-nine percent of survey participants said they frequently experienced delays in getting to the clinic, which placed the prison in the bottom 40% of all CA-visited prisons. We received numerous complaints from the survey participants that they were delayed in seeing their doctor or other provider. We believe the problems in access to the clinic may be a function of the limited clinic staff, particularly with the vacant nurse practitioner position, which is only partly being filled by a part-time doctor. We urge the prison medical staff and DOCCS Division of Health Services to evaluate whether additional clinic staff is needed.

In contrast to the mixed reviews on access to the clinic, as noted in **Table A** above, 55% of the respondents said the care provided by the clinic staff was good or fair, a rating that was better than two-thirds of the prisons we have visited. Survey participants' responses focused again on the variability in the care provided based upon the medical staff serving the patient.

Many incarcerated persons said that several of the clinic providers afforded them appropriate care when they were seen, but some respondents had significant problems with clinic providers they were seeing, asserting they were rude, uncaring or unresponsive to the patient's medical needs. Even many incarcerated persons who rated the medical care as fair said their experiences with the medical department were very dependent upon the individual who examined them. We urge the facility to review the care being provided by each member of the clinic medical team to ensure that all providers are adequately serving every patient.

Care for Patients with Chronic Medical Problems

As with most DOCCS facilities, Attica has a large population of incarcerated persons with chronic medical problems. **Table B – Summary of Individuals Confined in Attica with Chronic Medical Conditions** details the conditions experienced by the population at the time of our visit and the percentage of the population with these conditions. Patients with specific chronic conditions are generally not referred to a particular provider, but are distributed among all clinic staff. The prison does, however, attempt to have that patient seen by the same provider once initially assigned to a specific staff member. In addition, medical staff informed us that specific nurses are assigned to be chronic care coordinators to follow patients infected with HIV or viral hepatitis, or those who have diabetes, seizure disorder, asthma, or hypertension. The chronic care nurses are assigned to coordinating the care for these patients and performing patient education. In addition, the clinic providers see patients with chronic conditions at least every three months and also perform patient education.

Table B – Summary of Individuals Confined in Attica with Chronic Medical Conditions

	HIV	AIDS	HCV	HIV & HCV	Asthma	Diabetes	Hypertension
Infected	**49**	**20**	**208**	**40**	**312**	**142**	**397**
% Infected	**2.3%**	**0.9%**	**9.7%**	**1.9%**	**15.0%**	**6.6%**	**18.4%**
Treated	**30**		**4**		**200**	**100-10**	**300**

Attica has one provider, physician assistant Graf, who is certified as an HIV specialist by DOCCS. HIV-infected patients may also see an infectious disease specialist; the prison estimated that on average less than five HIV-infected patients are seen each month by this specialist. The percentage of persons incarcerated at Attica who are known to be HIV-infected is similar to the average for all DOCCS facilities; however, this figure is substantially less than the estimate of 5% to 6% of the entire DOCCS population who are believed to be infected with HIV based upon NY Department of Health studies.

With more than 200 persons infected with hepatitis C (HCV), representing nearly 10% of the prison population, Attica is similar to most New York State prisons in facing a significant medical burden from this disease. Attica's rate for individuals known to be HCV-infected is similar to the rate for the entire Department. In contrast, only four of the 208 HCV-infected patients, representing less than 2% of those infected, were receiving HCV treatment. This rate of treatment is less than the system-wide average of 5% and much less than treatment rates in the community. Prison staff told us that previously the prison typically treated six to seven HCV-infected patients at a time, but that figure has been lower recently. We urge the prison medical

staff to review the population of HCV-infected patients to determine whether any individuals not receiving treatment may be appropriate candidates for the therapy.

Specialty Care

Patients who require specialty care services are seen at the regional medical unit at Wende C.F., by specialists who come to the prison, or at area hospitals or other medical care locations outside the prison. Approximately one-third of the survey respondents said they had seen a specialist in the last two years, a rate similar to the average for all CA-visited facilities. As reported above in **Table B**, when survey participants were asked if they experienced delays in seeing a specialist, a majority reported experiencing delays at least some of the time, at rates placing Attica in the lower half of CA-visited prisons for access to specialists. In contrast with this negative assessment on access to specialists, 47% of respondents said that the clinic staff provided good follow-up to the specialists' recommendations, a rating that exceeds two-thirds of the prisons we have surveyed. Again, it appears that individuals are more satisfied with the quality of the care they receive from the clinic providers, but still express concerns with delayed care.

Medications

Attica has a pharmacy staffed by three pharmacists and three pharmacy aides, which also provides medications to nearby Wyoming C.F. Fifty-five percent of survey participants reported that they sometimes experienced problems in getting their medications, a rate that is about average for all CA-visited prisons. Some of the concerns expressed by survey respondents were that they experienced delays in getting their medications or that the medications prescribed by the doctor were changed without consultation with the patient, were not the medications suggested by the specialist or did not adequately treat their medical condition.

Quality Improvement Program

Attica's Quality Improvement (QI) Committee meets quarterly and consists of medical staff (facility health services director, nurse administrator, senior utilization review nurse, infection control nurse, pharmacy representative, and health information management technician), and prison administrative staff (deputy superintendents for administration and security). We were informed by the facility that during the period 2009 through the first quarter of 2011, the QI committee performed evaluations of hepatitis B and C, asthma, diabetes, infirmary care, emergency room referrals, periodic health appraisals, sick call, and consultations to specialists. We did not review the records of the QI committee, so we cannot comment on the thoroughness of these reviews, but we commend the committee for the scope of issues that it has covered during the past two years.

Medical Care Recommendations

- Fill all vacant medical positions and investigate whether additional nursing and clinic provider positions should be allocated to the prison to ensure that all persons get prompt access to sick call and clinic call-outs.

- Review the quality of care provided by all sick call nurses and clinic providers to ensure that medical conditions are properly diagnosed and promptly treated.
- Enhance efforts to reduce the delay in getting patients seen for medical call-outs.
- Implement measures to ensure that HCV-infected patients are thoroughly evaluated to determine if they are appropriate candidates for treatment.
- Review the utilization of specialty care services to determine if all patients are getting prompt access to all needed specialty care services.
- Review the delays dental patients experience in accessing dental care and institute measures to provide prompt access to such care.

AUBURN

The Correctional Association of New York visited Auburn Correctional Facility on April 15th and 16th, 2011. Auburn is a maximum-security prison located in Cayuga County. Attica had a capacity of 1,821 people and confined 1,724 people at the time of the visit.

MEDICAL CARE

The Visiting Committee toured the medical area and met with the nurse administrator and a registered nurse about medical services at the facility. We appreciate the detailed information provided prior to our visit and during our tour. The medical area at Auburn has a 15-bed infirmary separated into five rooms, three of which are isolation rooms. The infirmary houses, on average, about five to six individuals, and the average length of stay is about three days. Auburn also operates its own pharmacy.

Auburn's medical staff, unlike at most other facilities, conducts sick call in small rooms on the housing blocks. The CA toured two sick call rooms on the housing blocks; the room on C-Block did not include an exam table, but had two chairs and one small locked cabinet that contained basic medication and medical equipment such as, a thermometer, stethoscope, first aid supplies, scale, cough syrup, Tylenol, allergy meds, Motrin, and antihistamines. Many of the incarcerated persons we interviewed were concerned that their sick call meetings were not confidential because security staff and other patients were immediately outside the room and only some of the sick call nurses shut the sick call room's doors, while others left it open. The Visiting Committee also toured a sick call room on A-Block, which was much smaller than the sick call room on C-Block and was extremely filthy and in bad condition.

Auburn survey participants were generally dissatisfied with the prison's medical care. Responses to questions regarding both access and satisfaction with medical care rank the prison in the bottom third of all 31 CA-visited facilities for the adequacy of health services. **Table C- Summary of Auburn Survey Participants' Response about Prison Medical Care** summarizes this data, along with the prison ranking.

Table C- Summary of Auburn Survey Participants' Response about Prison Medical Care

Medical Service	Yes	Sometimes	No	Rank	Good	Fair	Poor	Rank
Can you see RN when needed	44%	37%	19%	28				
Rate Nursing care					11%	34%	55%	24
Do you experience delays in seeing a clinic provider*	56%	21%	8%	29				
Rate Physician care					7%	29%	65%	27
Experience delays in specialty care	52%	16%	32%	24				
Good follow-up to specialists	33%		67%	25				
Problems getting medication	42%	20%	39%	24				
Rate Overall Healthcare					7%	32%	61%	27

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

Medical Staffing

Auburn has authorization for two full time equivalent (FTE) doctors, one nurse practitioner (NP), and 15 registered nurses (RN). At the time of our visit, the facility had one vacant physician assistant (PA) position, which had been vacant since August 2010 and for which the facility was not authorized to fill. According to information provided by the facility after our visit, as of June 2012, the facility employed one full time (FT) and one part time (PT) clinical physician, but was employing two NPs. There were also two RN vacancies at the time of our visit, which the facility also was not authorized to fill, and according to the data provided in June 2012, the number of RN vacancies had increased to three. We were told that the failure to authorize replacing these staff members was in part due to the pending relocation of DOCCS staff following the then upcoming closure of five facilities pursuant to the state's prison downsizing plan. To temporarily accommodate for the staffing vacancies, at the time of our visit the facility was utilizing one per diem nurse and one extra service nurse about one to two days per month. The nurse-patient staffing levels at Auburn were about one nurse to every 120 patients, which is higher than the department-wide average of about one nurse to every 80 to 100 patients. We strongly encourage DOCCS Central Office administrators to grant authorization to Auburn's medical department to fill the vacant nursing items in order to decrease the nurse to patient ratio. With only three or three and a half clinic providers (two FTE doctors and one NP at the time of our visit and one FT doctor, one PT doctor, and two NPs in June 2012), Auburn had a ratio of one provider for every 575 patients at the time of our visit and one provider for every nearly 500 patients as of June 2012; either figure is significantly higher than the department-wide average of 1:400. We strongly urge the Department to grant Auburn the authorization to fill the vacant PA position and then evaluate whether additional clinical staff is needed.

Sick Call

Sick call is conducted on the housing units in very small rooms. During our visit, we inspected two of the sick call rooms on A and C Block and found them inadequate for proper medical examinations. The rooms were small with inadequate lighting, minimal furniture, no examination tables and limited medical equipment. The rooms were also very dirty and not well maintained. Although we understand that it may be difficult to ensure privacy without compromising on safety in the sick call rooms, incarcerated persons consistently raised concerns about the lack of confidentiality during sick call because often the door of the sick call room was open and security staff and other patients remained in close proximity to the area and could overhear the patients' conversations with the sick call staff. Survey participants were also concerned that security staff interfered with their access to treatment, sometimes dictating who could access sick call or who was eligible for emergency sick call. We urge the facility to consider conducting sick call in the clinic area, but if the current block sick call rooms are used, we recommend that the prison renovate the sick call rooms, re-examine the protocol of conducting sick call on the housing units and assess whether modifications can be made to ensure confidential sick call encounters.

Sick call is conducted four days a week on Monday, Tuesday, Thursday, and Friday, from 6:00am to about 7:00am or until complete. Individuals must request to be seen for sick call the night before and sick call nurses see on average about 950 patients for sick call each month.

Auburn also operates a 24-hour emergency sick call (ESC). Patients who are in need of emergency sick call notify a corrections officer and then are escorted down to the medical clinic to be seen by nursing staff. Medical staff estimated that on average, 85 patients are seen for emergency sick call per month. Medical staff estimated that about five tickets were issued in the past year for abuse of emergency sick call.

As summarized in **Table C** above, Auburn survey participants were dissatisfied with the sick call process and the care provided by the nursing staff. Over half of survey respondents reported that they experienced delays or could not access sick call when needed. This ranks Auburn the fourth worst of CA-visited facilities for incarcerated persons' access to sick call. Fifty-five percent of survey respondents also rated the sick call service they received as "poor." Patients' rating of sick call nurses ranks Auburn in the bottom third of all CA-visited facilities for adequacy of sick call care. Patients reported that there were long delays to access sick call and often they had to put in multiple sick call requests before they were seen. Some survey respondents who rated sick call poorly reported that the sick call nurses were unprofessional, rude, dismissive towards patients' medical concerns, and did not complete thorough medical examinations. We recommend that the prison medical staff administrators conduct an assessment of the care provided by sick call nurses in order to ensure that each sick call nurse is performing an adequate, thorough, and effective examination.

Clinic Call-Outs

Auburn had only three clinic providers at the time of our visit, two full-time equivalent doctors and one nurse practitioner. Clinical call-outs are conducted five days a week from 7:30am until 3:00pm and the medical staff estimated that about 340 patients are seen per month in the clinic.

Auburn survey participants had very low ratings of Auburn's clinical staff. Fifty-six percent of survey respondents reported that they frequently experienced delays in seeing a doctor, and an additional 28% reported experiencing delays at least once. This reported level of inaccessibility to clinical staff ranks Auburn as the third worst prison[1] of all CA-visited prisons for delayed clinic care. Moreover, survey participants also reported high dissatisfaction with the clinical staff. Sixty-five percent of survey respondents rated the clinical staff as poor. This is considerably higher than the average of 51% who rate medical staff as poor for all CA-visited facilities and ranks Auburn in the bottom fourth for quality of clinical care.

The long delays individuals experience in seeing clinical staff can be attributed to the unacceptably high clinical staff to patient ratio that is more than 40% higher than the system-wide average. Given these delays, it is crucial that the prison fill the vacant physician assistant position and DOCCS consider hiring additional clinical staff. Survey participants estimated that they spent a median of 30 days waiting to see a clinical provider after being referred by a sick call nurse. The median amount of delay for the 31 CA-visited facilities is 21 days. Survey participants often reported that a patient had to exhibit serious medical symptoms before he

[1] Auburn ranks 29th out of the 31 CA-visited facilities for how often inmates experience delays in seeing medical staff.

would be seen by a clinician. Other issues individuals raised regarding the medical staff were that the clinical staff did not listen to patients' concerns, displayed a lack of compassion, and were rude to patients. Several patients also reported that one doctor at Auburn often refused to touch patients during clinical exams. We urge facility administrators to investigate any pattern of complaints.

Care for Patients with Chronic Medical Problems

Auburn, like most other facilities in the DOCCS system, had a significant portion of its prison population suffering from a chronic medical condition. **Table D-Summary of Persons Confined at Auburn with Chronic Medical Conditions** details the prevalence of chronic medical conditions, number of infected patients, percentage of the prison population with the condition, and the number of patients receiving treatment at the time of our visit. Individuals at Auburn who suffer from a chronic condition are not assigned to a particular practitioner; instead, they are regularly seen at chronic care clinics which are run by nurses for each disease. There are chronic care clinics for all of the following conditions: HIV, hepatitis C (HCV), diabetes, asthma, hypertension and TB. The nurse assigned to each chronic care clinic coordinates the medical care for patients, ensuring proper patient education and medication management. Patients infected with HIV are generally seen every three months by the HIV specialist.

Table D-Summary of Persons Confined at Auburn with Chronic Medical Conditions at the Time of Our Visit

	HIV	AIDS	HCV	HIV & HCV	Asthma	Diabetes	Hypertension
Infected	**44**	**22**	**115**	**12**	**186**	**79**	**204**
% Infected	**2.5%**	**1.3%**	**6.6%**	**0.7%**	**10.8%**	**11.8%**	**4.6%**
Treated	**31**		**1**		**158**	**79**	**179**

Auburn has one doctor who is certified by DOCCS as an HIV specialist. Individuals infected with HIV may also see one of the four outside HIV specialists available for consultation. The facility estimated that the in-house HIV specialist sees about 5-10 patients each month. The four outside HIV specialists conduct an average of three infectious disease clinics each month, during which time they see about 19 individuals for infectious disease specialty appointments. The percentage of Auburn patients infected with HIV (2.5%) is significantly lower than the estimated 5% to 6% of the entire DOCCS population who are believed to be infected with HIV based upon NYS Department of Health studies.

At the time of our visit, Auburn confined 115 individuals infected with hepatitis C (HCV), representing 6.6% of the prison population. Based on information provided by the facility after our conference call, as of June 2012, the number of known HCV infected individuals dropped to 96. According to studies done by the Department of Health (DOH), 11.2% of the prison population in 2007 was infected with HCV. Although Auburn has a slightly lower percentage of the population who are infected compared to system wide data, the number of individuals in need of treatment still places a significant burden on staff. Auburn had only one individual, out of 115 HCV-infected patients, undergoing treatment at the time of our visit, which is less than 1% of the infected population and significantly lower than the system-wide treatment average of about 5% of HCV-infected patients at all DOCCS facilities. According to

information provided in June 2012, there were no patients receiving HCV treatment at that time. We urge the facility's medical staff to review the population of HCV-infected individuals in order to determine whether any of those currently not receiving treatment may be appropriate candidates for therapy.

Specialty Care

Patients who require specialty care while at Auburn are taken to the Walsh Medical Center at Mohawk Correctional Facility, seen at the facility by a specialist who comes to the facility for a periodic special care clinic, or taken to the SUNY Upstate Medical Center for specialty care. Thirty-one percent of Auburn survey participants indicated that they had seen a specialist in the past two years, which is slightly less than the 34% average of survey participants at other CA-visited facilities who reported seeing a specialist in the past two-years. Sixty-eight percent of survey participants reported experiencing delays in seeing a specialist at least sometimes, and patients estimated that the median number of days they had to wait to see a specialist was 90 days. The amount of days individuals wait to see a specialist at Auburn is significantly higher than that reported by survey participants from all CA-visited prisons, where the average median is 60 days, and ranks Auburn in the bottom 20% and equal with the five worst CA-visited facilities for the length of time it takes to see a specialist. Only 33% of survey participants reported that the medical staff at Auburn did a good job of following-up with specialists' recommendations. This ranks Auburn in the bottom third of all CA-visited facilities. The main concern according to survey participants was that specialists' recommendations were not followed through and there were long delays after a certain treatment was recommended.

Medication

Auburn operates as the regional pharmacy for individuals incarcerated at Auburn, Cayuga, and Butler Correctional Facilities. The Auburn pharmacy is staffed by one supervising pharmacist, two regular pharmacists and three pharmacist technicians. Sixty-two percent of survey participants reported that they at least sometimes experienced problems receiving their medication. This is slightly higher than the average of 57% of individuals who experience delays in receiving their medication at all CA-visited facilities. Some of the concerns expressed by survey participants were that there were long delays in receiving their medication, that medication refills were not refilled in a timely manner, and that medications prescribed by specialists were changed by the doctors at the facility without the individuals' consent.

Quality Improvement Program

Auburn's Quality Improvement (QI) Committee meets quarterly and consists of medical staff (facility health service director, and nurse administrator), security staff and additional invited guests. We were informed by the facility that some of the topics covered by the QI committee for 2011 included: HCV, men's health and diabetes. Medical staff informed us that 10 charts are reviewed during each QI meeting. We did not review the records of the QI committee, so we cannot comment on the thoroughness of these reviews.

Medical Care Recommendations

- Fill all vacant medical positions and investigate whether additional nursing and clinic provider positions should be allocated to the prison to ensure that all incarcerated persons get prompt access to sick call and clinic call-outs.
- Review the adequacy of the sick call rooms utilized in the housing areas and either (a) obtain additional furniture and equipment and make physical plant modifications to make these rooms suitable for sick call encounters, or (b) relocate sick call to the medical clinic area in the prison.
- Institute measures to improve patient confidentiality during sick call encounters.
- Review the quality of care provided by all sick call nurses and clinic providers to ensure that medical conditions are properly diagnosed and promptly treated.
- Enhance efforts to reduce the delay in getting patients seen for medical call-outs.
- Implement measures to ensure that HCV-infected patients are thoroughly evaluated to determine if they are appropriate candidates for treatment.
- Review the utilization of specialty care services to determine if all patients are getting prompt access to all needed specialty care services.

CAPE VINCENT

The Visiting Committee of the Correctional Association of New York visited Cape Vincent Correctional Facility on March 26th and 27th, 2012. Cape Vincent is a medium-security prison located in Jefferson County in Northern New York. Cape Vincent had a capacity of 882 people and confined 852 people at the time of the visit.

MEDICAL CARE

The Visiting Committee toured the medical area and met with staff about medical services. The medical area at Cape Vincent contains an infirmary, which housed two patients at the time of our visit, had between 11 and 31 admissions per month during 2012, and houses for short durations on average two to three patients, some of whom are there for post-operative recovery. Cape Vincent also operates its own pharmacy. When asked to rate overall health care, as seen in **Table E – Summary of Cape Vincent Survey Responses about Prison Medical Care**, 64% of survey respondents rated it as at least fair, ranking Cape Vincent in the top quarter of all CA-visited facilities.

Table E – Summary of Cape Vincent Survey Responses about Prison Medical Care

Medical Service	Yes	Sometimes	No	Rank	Good	Fair	Poor	Rank
Can you access sick call when needed	64%	25%	12%	12				
Rate sick call nursing care					20%	39%	41%	12
Do you experience delays in seeing a clinic provider *	28%	43%	30%	9				
Rate physician care					23%	35%	42%	9
Experience delays in specialty care	28%	21%	51%	7				
See specialist in last 2 years	26%		74%	30				
Good follow-up to specialists	37%		63%	18				
Problems getting medication	16%	10%	33%	9				
Rate dental care					30%	31%	39%	12 of 18
Rate overall healthcare					17%	47%	36%	7

* The three categories for this variable are: Yes=Frequently; Sometimes=Once or once in a while; and No=Never.
** Except where otherwise noted, CA-visited facilities are ranked from best to worst: one the best and 33 the worst.

On more specific aspects of heath care, responses from survey participants generally placed the facility in the top third or top half, with some variability, of all CA-visited facilities for the adequacy of health services on questions regarding both access to and satisfaction with care.

Medical Staffing

Cape Vincent has authorization for one full time equivalent (FTE) doctor, one physician assistant (PA), and 10 registered nurses (RN). With two clinical providers, Cape Vincent has a ratio of one provider for every 425 patients, slightly higher than the department-wide average of 1:400. Staff indicated that there is also a doctor on call used mostly for emergencies, and that in the event of staff vacations, the doctor would cover the PA and vice versa. However, during our follow-up conference call, executive staff indicated that the PA had resigned eight months prior to the call and that the facility had not yet been able to recruit anyone to fill the vacant PA item, despite having authorization to fill the position. Also, at the time of our visit and still in April 2013, the facility had two RN vacancies, which became vacant in December 2011 as a result of two retirements. There had been delays in authorization to fill the vacancies, and staff predicted that they would likely receive transfers to fill the positions. Staff indicated that the facility was operating at the time of our visit with seven actual nurses, would likely be up to nine very soon, and would reach 10 by April 2012. To temporarily accommodate for the staffing vacancies, the facility was utilizing one or two per diem nurses. With seven nurses, the nurse-patient staffing levels at Cape Vincent are about one nurse to every 120 patients, which is higher than the department wide average of one nurse to every 80 to 100 patients. If Cape Vincent returns to its previous authorized nursing staff of 10, it will return to being in line with the DOCCS average.

Sick Call

Sick call occurs at Cape Vincent Mondays through Fridays, from 6:00 a.m. to 8:00 a.m. Three nurses conduct sick call. Staff estimated sick call nurses see around 16 to 18 patients per day, and according to information provided by the facility prior to our visit, sick call nurses see an average of 258 patients per month. Routine follow-up after sick call generally takes one to two weeks. If someone had a more serious condition, such as an upper respiratory infection, he could be admitted and seen by a doctor the same day. Cape Vincent also operates an emergency sick call process, and nurses see an average of 80 patients per month for emergency sick call.

As summarized in **Table E** above, survey respondents generally expressed relative satisfaction with access to sick call, given that 64% of survey respondents reported that they could access sick call when needed, and a total of 89% could access sick call when needed at least sometimes, ranking Cape Vincent near the top third of all CA-visited facilities. Cape Vincent also ranked near the top third of all CA-visited facilities for quality of sick call care, although only 20% of survey respondents rated such care as good, indicating the perceived poor quality of sick call care across DOCCS facilities. Complaints about sick call from survey respondents included that some nurses verbally abuse patients and/or treat them rudely and disrespectfully, have poor attitudes, deny that people have actual medical needs, give ibuprofen in response to everything, deny access to clinical staff, and issue tickets to people simply seeking medical care. As one survey respondent stated about sick call, “no one cares unless you’re dying.” Some individuals also reported instances in which they attempted to use emergency sick call, but rather than being treated received misbehavior reports and disciplinary confinement.

Clinic Call-Outs

Cape Vincent had only two clinic providers at the time of our visit: one full time doctor and one physician assistant. Clinical call-outs are conducted five days a week: Monday from 6:00 to 10:00 p.m.; Tuesday and Wednesday from 9:00 a.m. to 2:00 p.m. and 6:00 to10:00 p.m.; Thursday 9:00 a.m. to 2:00 p.m.; and Friday 5:00 to 9:00 p.m. Clinical providers saw an average of 213 patients per month in 2012. For the first five months of 2012, providers saw an average of 238 patients, and that number dropped by 18% to 196 patients per month for the last seven months. Based on data provided by the facility, this drop appears to have been due in part to the fact that from April 2012 onward, the facility did not have a mid-level clinician seeing patients. As seen in **Table E** above, Cape Vincent ranked in the top third of all CA-visited facilities for both access to care and quality of care by clinical providers. Seventy-one percent of survey respondents reported experiencing delays at least once, while only 28% frequently experienced delays. The median estimate of Cape Vincent survey respondents was that they spent 14 days waiting to see a clinical provider after being referred by a sick call nurse, significantly lower than the median amount of delay for all CA-visited facilities of 21 days. Similar to survey respondents' ratings of sick call, 23% of survey respondents rated physician care as good, 35% as fair, and 42% as poor, again ranking Cape Vincent relatively high compared to other CA-visited facilities, but then also indicating the poor view of physician care across DOCCS.

Although some survey respondents expressed praise for clinical staff, numerous survey respondents alleged that clinical staff members treat almost any medical condition with basic medication such as ibuprofen, while others complained that clinical staff do not believe patients or claim that individuals with medical problems are healthy and do not have any such problems. One survey respondent, for instance, complained about receiving only ibuprofen from sick call, needing to be seen three or four times by a doctor before being taken for an X-ray, and needing to be seen another three times before being taken for an MRI and finally getting diagnosed.

Care for Patients with Chronic Medical Problems

Cape Vincent, like most other facilities in the DOCCS system, had a significant portion of its prison population suffering from a chronic medical condition. **Table F – Summary of Individuals at Cape Vincent with Chronic Medical Conditions** details the prevalence of chronic medical conditions, number of infected patients, percentage of the prison population with the condition, the number of patients receiving treatment, and the percentage of those infected who are receiving treatment at the time of our visit.

Table F – Summary of Individuals at Cape Vincent with Chronic Medical Conditions

	HIV	AIDS	HCV	HIV & HCV	Asthma	Diabetes	Hypertension
Infected	**23**	**11**	**30**	**6**	**138**	**41**	**103**
% Infected	**2.70%**	**1.29%**	**3.52%**	**0.70%**	**16.20%**	**4.81%**	**12.09%**
Treated	**14**		**5**	**1**	**71**	**41**	**98**
% Treated	**60.87%**		**16.67%**	**16.67%**	**51.45%**	**100.00%**	**95.15%**

Both the doctor and the PA at Cape Vincent are certified by DOCCS as HIV specialists. Individuals infected with HIV may also see outside HIV specialists at SUNY Upstate Medical

Center via the Walsh RMU by telemedicine, although regular clinics conducted by these outside HIV specialists are rare. The percent of Cape Vincent patients infected with HIV (2.7%) is significantly lower than the estimated 5% to 6% of the entire DOCCS population who are believed to be infected with HIV based upon NYS Department of Health (DOH) studies.

The 30 people infected with hepatitis C (HCV), representing 3.52% of the population, was significantly lower than system wide DOCCS data and one of the lowest rates of CA-visited facilities. This low percentage raises concerns about testing practices, particularly given that 11.2% of the total prison population in 2007, according to DOH studies, was infected with HCV, more than three times higher than the rate at Cape Vincent. On the other hand, Cape Vincent had five of the 30 HCV-infected patients or 16.67% undergoing treatment at the time of our visit, significantly higher than the treatment average of about 5% at all DOCCS facilities. Medical staff indicated the generally low percentage receiving treatment was due in part to transfers. Staff also indicated that the facility is awaiting protocols for offering a new HCV treatment, and had not yet begun using the new treatment at the time of our visit. Also at the time of our April 2013 follow-up call, the facility reported that there were no persons receiving the new HCV treatment.

Specialty Care

Patients who require hospitalization or specialty care while at Cape Vincent are taken to River Hospital for minor surgeries, to SUNY Upstate Medical Center for oncology cases, and the Samaritan Medical Center in Watertown for other cases. Staff indicated that scheduling surgeries can take up to three months. An optometrist comes to the facility from the outside. Some individuals with whom we had contact at the facility complained about the delays in obtaining eye glasses and the rules that prohibit individuals from obtaining their own glasses outside of the DOCCS system. More generally, survey responses raised potential concerns about the ability to be referred to any specialist when having a medical problem. As seen in **Table E** above, only 26% of survey respondents reported having seen a specialist in the past two years, significantly lower than the median 34% for all CA-visited facilities, and ranking Cape Vincent as the fourth lowest CA-visited facility for access to specialty care. As one survey respondent commented, "one should not have to wait until they are near death or about to lose a limb before they can be taken to an outside hospital." However, once referred to a specialist, patients reported relatively timely service. Specifically, 49% of survey respondents reported experiencing delays in seeing a specialist at least sometimes, ranking Cape Vincent in the top third of all CA-visited facilities, and patients estimated that the median number of days they had to wait to see a specialist was 30 days, significantly lower than the average median of 60 days for all CA-visited facilities. On the other hand once a patient has seen a specialist, only 37% of survey participants reported that the medical staff at Cape Vincent did a good job of following-up with specialists' recommendations, ranking Cape Vincent just below the middle of all CA-visited facilities.

Medication

Cape Vincent has a facility pharmacy in operation Monday through Friday, with a trained pharmacist on staff. According to data provided by the facility, Cape Vincent dispensed between 800 and 1,000 prescription medication items per month in 2012. Patients generally receive their medications through sick call. Patients wait on average five days before new medications are

dispensed, while current scripts are generally available on the same day of a request or the following day. For one-on-one medications, there are two separate stations where patients receive their medications at 8:00 a.m., 2:00 p.m., 4:30 p.m., or 8:30 p.m. After completing appropriate training, patients with diabetes may self-inject insulin under the supervision of staff. Forty-four percent of survey respondents reported that they at least sometimes experienced problems receiving their medication, significantly lower than the median 57% of all CA-visited facilities and ranking Cape Vincent in the top third. A small number of survey participants expressed concern about slight delays in receiving medication, including a patient with epilepsy.

Quality Improvement Program

Cape Vincent's Quality Improvement (QI) Committee meets quarterly. Facility staff indicated that some of the topics covered by the QI committee include HIV, Asthma, Diabetes, and HCV, and that individual charts are reviewed as part of that process. We did not review the records of the QI committee, so we cannot comment on the thoroughness of these reviews.

Medical Care Recommendations

- Fill all vacant medical positions to ensure that all incarcerated persons receive prompt access to sick call and clinic call-outs.
- Take appropriate measures to ensure that all medical staff members treat patients with respect and care.
- Review the quality of care provided by all sick call nurses and clinic providers to ensure that medical conditions are properly diagnosed and promptly treated.
- Implement measures to both ensure that HCV-infected patients are thoroughly evaluated to determine if they are appropriate candidates for new HCV treatment, and to provide the new treatment to appropriate candidates.
- Review the utilization of specialty care services, and develop mechanisms to ensure that all patients are getting prompt access to all needed specialty care services, and that medical staff at the facility are effectively following-up with specialists' recommendations.
- Review the delays dental patients experience in accessing dental care and institute measures to provide prompt access to such care.

COXSACKIE

The Visiting Committee of the Correctional Association of New York visited Coxsackie Correctional Facility on May 26th and 27th, 2010. Coxsackie is a maximum-security prison located in Greene County, approximately 120 miles north of New York City. Coxsackie had a capacity of 1,027 people and confined 1,029 people at the time of the visit. In addition to general medical care, Coxsackie also operates a Regional Medical Unit.

MEDICAL CARE

The Visiting Committee met with the Deputy Superintendent for Health Services and toured the medical facilities. We appreciated the extensive information provided by the facility prior to our visit, during our tour of the medical areas, and over the course of meetings with the executive team and medical staff. The facility has a healthcare area for the prison and a Regional Medical Unit, which is a separate unit within the prison that includes both an inpatient area similar to a skilled nursing care facility and an extensive outpatient area in which specialty care services are provided for incarcerated persons from prisons throughout the northeastern section of New York.

Although we received some complaints from persons incarcerated at Coxsackie regarding their medical treatment, the general satisfaction with the prison's healthcare system was significantly higher than at other facilities we have visited. Of the 200 persons who responded to our survey questions concerning overall medical care, 24% rated it as good, 53% said it was fair, and 23% reported it to be poor. These ratings place Coxsackie as the second highest prison for medical care satisfaction of the 26 CA-visited prisons.

Staffing

At the time of our visit, the authorized medical staff at Coxsackie for the prison medical department included 1.4 doctors, 2.5 pharmacists, one pharmacist aide, a nurse administrator, and 14 full-time nurses. One full-time nurse position had been vacant since July 2009, and the prison had the equivalent of two full-time per diem nurses. The medical staff indicated that they experienced problems filling the vacant nurse position because the salary they offered was not competitive with the rates in the community. In order to retain nurses and to encourage community nurses to apply for the vacant position, the facility was offering nurses the option of working 12 hour shifts so they would work fewer days. We also learned that the prison had two extra service positions, but that they did not often use these items. When the unit is fully staffed, the nurse-patient ratio at Coxsackie is approximately one nurse for every 70 patients, better than the state-wide average of approximately one nurse for every 85 to 100 patients. Staff informed us during our May 2011 conversation that they filled the vacant nurse position in June 2010, but expected two new vacancies due to retirement and extended illness. At the time of our conversation, staff had already requested authorization to fill these positions.

We were informed that medical staff at Coxsackie participate in continuing medical education through teleconferencing services offered through the Erie County Medical Center. Training is also offered by the prison senior medical staff.

Sick Call

Sick call is conducted five days per week, Monday through Friday, starting at 6:00 a.m. and usually ending by 8:30 a.m. Two or three nurses are assigned to sick call each day. The facility estimated that about 1,088 patients are seen in sick call per month, while 88 patients are seen for emergency sick call.

The levels of satisfaction regarding the sick call services were higher than at other prisons we have visited. Seventy-five percent of survey respondents said that they were able to access sick call when needed, 21% stated they have such access sometimes, and only 4% reported that they were unable to access sick call when needed. These figures place the prison in the top quarter for access to sick call of the 26 prisons for which we have comparable data. Coxsackie patients were also more satisfied with sick call nurses than what we have found at other prisons, with 28% of the survey participants rating them as good, 49% assessing them as fair, and 23% reporting them to be poor. These figures place the prison as the second highest rating for CA-visited prisons concerning incarcerated persons' evaluation of sick call nurses.

Many survey participants spoke positively about the nursing staff, saying that they received quality care from nurses and that for the most part the nurses exhibited a respectful and caring attitude. The primary complaint from the survey participants concerned delays in seeing a doctor following a sick call visit. Several survey participants asserted that they were only provided over-the-counter pain medications, such as ibuprofen, for a variety of aliments. Some survey respondents asserted that the care they received varied based upon the sick call nurse who examined them. Finally, a minority of respondents reported that the nurses were uncaring or exhibited a poor attitude. Overall, the comments we received in the surveys were more positive about the nursing care than at most CA-visited prisons.

Medical staff reported that the prison sees approximately 70-80 patients per month at emergency sick call, a process by which persons who are experiencing a medical emergency can be seen by the nursing staff outside the daily sick call procedure. Although the medical staff reported that some persons will, on occasion, abuse the emergency sick call system, the medical staff does not issue disciplinary actions for this misuse of the procedure. We commend them for dealing with this issue in a non-punitive manner.

Clinic Call-Outs for Doctor Visits

Incarcerated persons requiring care beyond what is provided by nurses during sick call see one of two doctors during morning or afternoon call-outs to the medical area. A few call-outs are done on Mondays; on Tuesdays and Thursdays, call-outs are performed in the afternoon, and on Wednesdays and Fridays, call-outs are conducted in the morning. The facility estimated that staff sees 236 patients for call-outs each month. Medical staff reported that it can take up to three months for a patient to see a doctor for a routine follow-up, but patients with more urgent medical needs are seen more quickly.

Coxsackie survey participants presented a mixed view concerning delays in access to prison doctors. At a rate better than at many prisons we have visited, 33% of surveyed persons at

Coxsackie reported that they never experienced a delay in seeing a doctor, compared to 23% at all prisons surveyed. Twenty-four percent of Coxsackie survey participants said they experienced frequent clinic delays, as compared to 42% of all CA-surveyed persons. In contrast to the incarcerated persons' general perceptions of physician delays, the median delay Coxsackie survey respondents reported for access to the clinic was 30 days, compared to a median 21-day delay for responses by survey participants at all CA-visited prisons, placing the prison in the bottom quarter of the 26 CA-surveyed prison for the lengthy delays in clinic access. Moreover, many survey respondents at Coxsackie raised concerns about delays in access to the prison doctors in their comment detailing concerns about medical care. We urge the prison medical staff to review the length of time it takes patients with non-urgent medical needs to see a doctor and to ensure that all patients are promptly evaluated by a doctor.

In contrast to the problems with access to the prison clinic, incarcerated persons surveyed at Coxsackie were particularly satisfied with the level of care they received from the prison physicians, with 29% rating them as good, 49% assessing them to be fair, and 23% reporting them as poor. These figures are significantly more positive than the averages we have found at the 26 prisons for which we have comparable data, and place the prison as the second highest rated facility for physician care. In particular, several patients stated that the doctors not only provided quality care, but also were receptive and respectful in their dealings with their patients. Although the assessment of the physician care was superior to the ratings at other facilities, some patients expressed concerns. In addition to delays in getting to see the clinic providers, some survey respondents stated that the quality of the interactions with the clinic providers varied according to whom they saw.

Care of Incarcerated Persons with Chronic Conditions, including HCV and HIV Care

There were 59 persons incarcerated at Coxsackie identified that were infected with hepatitis C (HCV) at the time of our visit, representing 5.7% of the population. This figure is less than the average of 9% of all DOCS incarcerated persons who have been identified as HCV-infected. It is unclear why the prison has a lower rate; nothing about the Coxsackie population would suggest it is less likely to be infected with HCV than the patients in other facilities. The facility reported that only 12 (20%) of the 59 persons were chronically infected with HCV, a rate much lower than the 75% rate in the community.[2] We question why this figure is inconsistent with community rates and urge the medical staff to review this data and its efforts to identify chronically HCV-infected patients.

According to data we received from the facility, three patients were receiving HCV treatment at the time of our visit, a treatment rate comparable to other prisons. The facility reported that the number of patients on HCV therapy ranged between one and six patients. The medical staff explained that approximately half of the HCV-infected persons whom they had identified as eligible for HCV therapy declined the difficult medication regimen once they learned about the treatment and its potential side effects. The staff said many of those refusing therapy were reluctant to start treatment that would likely cause side effects particularly when

[2] National Digestive Diseases Information Clearinghouse, *Chronic Hepatitis C: Current Disease Management*, at 1 (2010). (Available at: http://digestive.niddk.nih.gov/ddiseases/pubs/chronichepc/index.htm.)

they were currently not experiencing any adverse physical manifestations of the disease. Medical staff reported that 60% to 70% of Coxsackie patients who began HCV treatment completed the one-year regimen; the most common causes for terminating therapy early were due to side effects of the medication or lack of response to the treatment.

At the time of our visit, there were 19 incarcerated persons known to be HIV-positive, 17 of whom were on treatment. Two of the HIV-positive persons had progressed to an AIDS diagnosis. Staff reported that the number of HIV-infected persons had remained stable at about 20 patients. The percentage of the prison population (1.8%) identified as HIV-positive was lower than the department-wide average of 2.5% of the men in DOCS who are known to be infected, and substantially below the estimated 5% to 6% of all men in DOCS custody who are believed to be HIV-infected based upon Department of Health studies of HIV infection rates. It is unclear why Coxsackie has a lower HIV-infection rate, and it is important that the medical staff remain aggressive in attempting to identify its HIV-infected population. None of the patients who were co-infected with HIV and HCV were receiving HCV therapy.

The medical staff told us that most HIV-infected patients come to the prison on an HIV medication regimen and that the medical staff refers HIV-infected patients to an infectious disease (IFD) specialist for an assessment if the prison provider is considering a change in the regimen due to resistance or adverse side effects. The staff also informed us that most medically stable HIV-infected patients are seen every three months by an IFD specialist and that unstable patients are seen every month by an IFD specialist. At the time of our visit, the most recent HIV Continuous Quality Improvement (CQI) audit, conducted in May 2010, detected no unstable or end-stage HIV-infected patients during its review of ten medical charts of Coxsackie patients.

Following our conference call in May 2011, we learned from facility staff that both DOCS medical staff and NYS Department of Health (DOH) personnel provide HIV testing. Prison staff also told us that patients are encouraged to seek HIV and HCV testing during the prison orientation program. The AIDS Council of Northeast New York is a contractor of the DOH's AIDS Institute's Criminal Justice Initiative and comes to the prison weekly to provide HIV counseling services.

At the time of our visit, Coxsackie housed 154 asthmatic persons, 121 of whom were receiving treatment. Staff informed us that the prison conducted three audits of its care for asthmatic patients to ensure that it was fully compliant with the latest DOCS guidelines for the illness. In addition, the prison developed a tool for doctors and nurses at the prison to track chronically ill patients. Although we did not review the results of the asthma audits, we commend both the Department for establishing an updated mechanism to evaluate the care provided patients suffering from asthma and the prison medical staff for aggressively reviewing its care to identify any potential problems. We also learned during our visit that there were 115 persons with hypertension, 98 of whom were currently being treated. Forty-five persons were taking daily medication for diabetes out of the 50 who were diagnosed with the condition. Medical staff informed us that diabetics are provided with training to learn how to inject themselves with insulin and then are provided individual syringes at the daily call-out to self inject their medication.

The prison has assigned nurses to assist in the management of many chronic illnesses, including HIV, HCV, asthma, diabetes, and hypertension, by educating patients, coordinating laboratory tests and appointments and routinely monitoring vitals. We were told that the physicians are also involved in educating their chronically infected patients.

Specialty Care

Coxsackie persons appear to have reasonable access to specialty services. Since much of the specialty care services for incarcerated persons in this region of the state are provided for in the out-patient area of the Coxsackie Regional Medical Unit, it is understandable that access to these services is much easier for incarcerated persons at this prison. Medical staff reported that the only service they experienced difficulties accessing was rheumatology. The staff said they deal weekly with any questions about the appropriateness of a requested specialty care appointment and that most of the issues concerning approval of a consultation request were resolved by providing additional information to the specialty care scheduler so the appointments could be authorized.

The CA analyzed DOCS data on utilization of department-wide specialty care services in fiscal year 2006-07. The data for Coxsackie reveals that it used specialty care services at a rate that was 125% of the system-wide average for all prisons. During that fiscal year, the utilization rates were low for liver biopsies (73%) and orthopedics (64%), but for most other essential specialty services, Coxsackie had greater utilization rates than the system-wide averages.

The survey respondents had positive views about their access, and the facility response, to specialty care services. Sixty percent of surveyed persons stated they had not experienced a delay in seeing a specialist, compared to only 35% of all survey respondents at the 26 CA-visited prisons. This figure places the prison in the top 15% of CA-surveyed prisons for prompt access to specialists. Survey respondents estimated the median delay was about 60 days for specialty care services, similar to other prisons. Similarly, the percentage of Coxsackie survey participants who reported having been seen by specialists in the past two years (34%) was comparable to what we have found at other prisons (35%).

Coxsackie survey participants also had a more positive assessment of the prison providers' response to specialists' recommendations. Sixty-five percent of survey respondents who had seen a specialist in the last two years reported good follow-up to their specialists' recommendations, as opposed to the average of 38% favorable response from survey respondents who had comparable experiences with specialists at all CA visited prisons. This was the second highest rate for all CA-visited prisons.

Pharmacy

Coxsackie has a regional pharmacy that services this prison and other facilities in the area. Incarcerated persons are instructed to submit a slip to request medication refills three days before they run out of their current supply of pills. Seventy percent of Coxsackie survey respondents on medication reported they experienced no problems receiving their medications, a significantly higher percentage than the average of 43% of all survey respondents on medication

at all the prisons we have visited. This figure places Coxsackie as the second highest rate for satisfaction with medication access of the 26 CA-surveyed prisons. The medical department is responsible for distributing psychotropic medications because there are no NY State Office of Mental Health nurses assigned to the prison for medication distribution. This requirement places an additional burden on the medical nursing staff and is an additional justification for keeping all nursing positions filled.

Quality Improvement Activities

The prison has a quality improvement (QI) committee that meets quarterly and includes both medical and prison staff. The medical staff reported that in the two years prior to our visit the QI committee had regularly reviewed chronic care for hepatitis, HIV, hypertension, asthma and diabetes. In addition, they reviewed general medical processes, such as sick call documentation, health appraisals, specialty consultations, and emergency equipment and emergency responses. They also informed us that Regional Medical Unit staff reviews the medical records on behalf of the committee. Although we have not reviewed the documentation for these QI activities, we commend the prison for its QI efforts to address both chronic care and routine medical procedures.

Regional Medical Unit (RMU)

Coxsackie's Regional Medical Unit has a capacity to house 60 patients in its in-patient medical area and extensive out-patient facilities used for specialty care appointments for Coxsackie patients and patients from other facilities in the region. The RMU opened in 1996 and since its inception, its in-patient unit has been staffed by medical personnel employed by an outside contractor.

The medical staff in the Coxsackie RMU are employees of Correctional Medical Services (CMS). CMS has had the contract with DOCS for the in-patient unit since 1998. The contract in existence at the time of our visit was for the period from February 1, 2005, through January 31, 2011, with a total payment of $5,419,000 according to DOCS records.[3]

The Visiting Committee met with CMS and DOCS staff during our tour of the unit and was generally impressed with the medical staff's professionalism and their description of the RMU medical program. We also toured the facility, and interviewed many of the in-patient residents. We appreciated the cooperation of the medical and prison staff in providing detailed information about the unit. In addition to the tour and interviews with the patients, we received 11 written surveys from RMU residents, who sometimes also included letters and comments about the in-patient program.

The in-patient unit is similar to a skilled nursing care facility; it treats patients with serious medical conditions, such as cancer, who require significant routine nursing care, patients with long-term disabilities who require rehabilitation or long-term care, patients recovering from

[3] DOCS, Contracts Reportable Under Executive Order No. 6 (available at http://www.docs.state.ny.us/../contracts.asp

a recent hospitalization, and patients with terminal conditions who may participate in the facility's palliative care program. Most residents of the RMU are there for a long time; the average length of stay is 637 days. The medical staff estimated that only a few patients (less than 2%) are residents for under two months and that more than 60% are on the unit for more than a year, some for several years. Given the serious medical condition of most RMU patients, it is not surprising that this population is substantially older than the average age (36) of DOCS population. The median age of the residents as of October 2010 was 50 years old and approximately one-quarter of RMU patients were 65 years or older. The racial composition of the RMU is also somewhat different from the total male DOCS population with the ethnic/racial distribution of RMU residents as of October 2010 being 48.3% African American, 32.8% Caucasian and 19.0% Hispanic, compared to the Department-wide figures for incarcerated men of 51.3% African American, 21.4% Caucasian and 25.3% Hispanic.[4] It is unclear why these racial/ethnic differences exist for this population.

The RMU regularly experiences deaths of its residential patients. During the three years period prior to our visit, the RMU averaged 17 deaths per year, with 19, 15 and 16 deaths in 2007, 2008 and 2009, respectively.

RMU Programs

The in-patient unit conducts a series of programs for RMU residents who are able to participate in educational or other treatment-related programs. These include an alcohol and substance abuse treatment program, a computer-based educational program, a men's health group, a diabetics group and a "Get the Facts" group on health issues. The RMU residents who responded to our survey were asked to rate each of these programs. Almost all of the survey participants said these programs were good or fair, and 71% of respondents reported that the programs in which they were involved were good. These ratings were more favorable than the responses we receive from most general population programs we visit at other prisons.

In addition to specific educational/health programs, RMU residents also are provided essential services available to the general prison population. The majority of RMU survey participants were not satisfied with their access to materials from the general library, but most were satisfied with access to law library materials. Similarly, the majority of survey respondents were satisfied with the visiting program and commissary. However, most were dissatisfied with their access to mail and packages. RMU survey participants were also somewhat displeased with food services; more than 60% expressed overall dissatisfaction with the food. Most of their complaints focused on the quantity and nutritional value of the meals and expressed much fewer concerns about the cleanliness of the eating utensils or the time they have to eat their meals.

RMU Medical Care

RMU residents generally had favorable comments about the quality of the medical care they received. Forty percent of the survey participants rated care as good, 50% said it was fair

[4] The RMU racial breakdown was derived from DOCS computer records of its in-custody population as of October 2010. The Department-wide data was obtained from the DOCS Under Custody report for 2010. DOCS, *Under Custody Report: Profile of Inmate Population Under Custody on January 1, 2010* at 3.

and only one patient rated it as poor. These figures are substantially better than the ratings we received at Walsh Medical Center.[5] Although these figures are generally favorable, the RMU survey participants distinguished the care provided by nurse's aides, registered nurses (RNs) and physicians.

Of the 10 RMU residents who provided information about the nurse's aides, three rated their care as good, five said it was fair and two reported it as poor. Most survey respondents reported seeing an aide three to five times a day. Concerning the RNs, the survey participants were generally positive about care with some reservations; specifically, four rated nursing care as good, four assessed it as fair, and two reported it as poor. Four of the respondents said they could see the RNs promptly, four reported that they had prompt access only some of the time and two reported they did not have prompt access. In their comments, some survey participants complained that they had to repeatedly request nursing assistance and consequently had to wait for care. Several respondents expressed concern about the close relationship between the nursing staff and security personnel, asserting that security staff sometimes inappropriately initiated disciplinary actions when a patient was having a dispute with the nurses. Concerning the quality of care, several survey participants expressed the view that the level of concern varied among the nursing staff, with some being caring and attentive to their medical needs, while others were rude or uncaring.

The RMU survey participants also had primarily positive assessments of the RMU doctors and nurse practitioner. Three respondents rated these providers as good, four said they were fair and three assessed them as poor. Several patients were particularly complimentary of the nurse practitioner. Although somewhat satisfied with the quality of the care provided, 80% of RMU survey participants reported that they could not always get prompt access to their provider. Several commented that nurses sometimes acted as barriers to physician care, rigorously asking patients why they needed to see the doctor. No RMU survey respondent expressed any serious problems with access to their medications.

The RMU survey participants also were positive about access to specialty care. All but one said they did not experience delays in seeing a specialist, and seven of nine respondents said that the medical staff provided good follow-up to the specialists' recommendations. These figures are substantially better than comparable data for patients at Walsh and in other prisons.

RMU patients were generally complimentary of the quality of dental care, but raised concerns about delays in access. Two RMU survey participants said dental care was good, three reported it as fair and two assessed it as poor. Most survey respondents who had seen the dentist estimated it takes 30 days to schedule an appointment, although some reported even longer delays. When asked to explain their rating of dental services, the respondents' primary complaint was the delay in addressing their dental problems.

[5] At Walsh, 28% of CA survey participants rated overall medical care as good, 28% said it was fair and 45% reported it as poor.

Medical Care Recommendations

- Fill the vacant nursing position; if the empty position cannot be filled expeditiously, increase the salary level for this position to be competitive with community salaries for a comparable job.
- Ensure that all patients scheduled for a clinic call-out are promptly seen in accordance with their medical needs.
- Implement measures to ensure that all incarcerated persons are offered HIV and HCV tests and that HCV-infected patients are thoroughly evaluated to determine if they are chronically infected and are appropriate candidates for treatment.

Medical Care Recommendations for the RMU

- Implement a mechanism for patients to regularly report on a confidential basis the quality of the care they are receiving from nurse's aides, nurses, nurse practitioners and doctors to ensure that all patients are receiving quality care.
- Meet with RMU residents to discuss ways to reduce tension between patients and security staff and to develop better communication between staff and patients.

ELMIRA

The Visiting Committee of the Correctional Association of New York visited Elmira Correctional Facility on March 10th and 11th, 2010. Elmira is a maximum-security prison located in Chemung County in Western New York. Elmira had a capacity of 1,796 people and was filled at capacity at the time of the visit.

MEDICAL CARE

The Visiting Committee toured the medical facilities at Elmira and interviewed medical staff. We appreciated the extensive information provided by the facility staff during our tour and following our visit. The medical department at Elmira includes a 23-bed infirmary, which held 10 patients at the time of our visit.

Authorized medical staff positions included two physicians, two nurse practitioners, a nurse administrator and 19 nurses. Elmira had one nurse vacancy, for which the prison did not anticipate any difficulty in filling. The facility did not have an HIV or Infectious Disease specialist on staff, and there were no Spanish-speaking staff. Staff informed us that it had been allocated two new nursing positions about 18 months prior to our visit. Given its current staffing numbers, the prison has one clinic provider (doctor or nurse practitioner) for every 450 patients and one nurse for 100 patients, rates that are comparable to many of the other maximum security prisons we have visited. During our February 2011 conversation, we learned that the facility had filled but was again interviewing a candidate for a nurse vacancy, citing a high turnover rate. The facility had also lost one full-time physician in October 2010 and was having difficulty recruiting a replacement, however had received approval to hire two part-time physicians for the position.

Overall, persons who responded to our survey rated the prison's healthcare system as fair, a more positive assessment than the average rating at the 26 prisons the CA has visited. Eighteen-percent of Elmira survey respondents rated the overall quality of medical care as good, 48% assessed the medical care to be fair, and 34% rated it as poor. These figures place Elmira in the top 20% of CA-surveyed prisons.

Sick Call

Sick call is conducted by three nurses four days a week – Monday, Tuesday, Thursday, and Friday, from 6:00 a.m. to 7:00 a.m. Sick call is conducted every day in the SHU and the mental health units by one nurse for one hour per day. Facility staff estimated that an average of 1,273 patients per month are seen at regular sick call. An incarcerated person who experiences a medical emergency after regular sick call hours may request emergency sick call by notifying a CO who will then contact medical staff. Prison staff estimated that approximately 201 incarcerated persons attend emergency sick call per month.

Incarcerated persons rated their access to sick call at rates comparable to those at other CA-visited facilities, with slightly higher quality of care ratings once persons received care. Fifty-two percent of surveyed persons stated that they could access sick call when needed, similar to the 54% average rate at other CA-visited facilities. Forty percent reported that they

could only access sick call sometimes, while 6% stated that they could not access sick call, compared to 29% and 18% averages, respectively, at all CA-visited prisons, resulting in Elmira being in the top 40% of all surveyed facilities. Concerning the quality of care at sick call, surveyed persons were generally more satisfied than at other CA-visited prisons, with 26% rating the overall quality of sick call nurses as good, 40% rating them as fair, and 34% rating them as poor, placing the prison in the top quarter of all CA-visited facilities.[6] Incarcerated persons with whom we spoke stated that if someone submits a sick call slip after 3:00 p.m., he would not be seen for two days. Aside from delays in access, the most common complaint about sick call involved sharing medical problems with sick call nurses in the presence of correctional officers. Incarcerated persons expressed concerns about confidentiality throughout all aspects of medical care at Elmira; however, they appeared most concerned about the sick call process. We suggest that facility medical staff explore ways of ensuring patient confidentiality during medical encounters while still maintaining facility safety.

Routine Medical Care

Patients who require care beyond sick call are seen in the medical area by a nurse practitioner or physician. Clinic call-outs are held Monday through Friday, from 9:00 a.m. to 11:00 a.m. and 1:00 p.m. to 3:00 p.m. The facility estimated that they receive an average of 1,050 patients for call-outs each month. According to prison medical staff, patients with non-emergent cases wait an average of 30 to 40 days to see a provider. Survey participants were critical of the call-out system at a rate somewhat worse than the rates at all CA-visited facilities. Forty-one percent of survey respondents reported experiencing frequent delays in seeing a clinic provider, a rate that places Elmira in the lower 40% of surveyed prisons. Similarly, the median wait time to see health care providers reported by survey participants was 21 days, placing the prison in the bottom 40% of all CA-visited prisons.

Overall, incarcerated persons rated the quality of medical staff as fair, with a more positive rating than at other CA-visited facilities. Twenty-eight percent of survey respondents rated medical staff as good, 41% as fair, and 31% as poor, compared to 14%, 36%, and 50% averages, respectively, at all CA-visited facilities. Overall the rating of Elmira's clinic providers was third highest of the 26 prisons for which we have comparable data. Individuals who rated medical staff favorably said that the staff were caring, and that care provided was fair. Among reasons why individuals were dissatisfied with the quality of medical staff were that the quality of care was unpredictable, cases were sometimes misdiagnosed, and some nurses and doctors did not treat incarcerated persons in a respectful manner and did not appear to care or listen to patients' complaints.

Chronic Care

According to information provided by the facility, Elmira housed 36 HIV-infected individuals, 20 of whom were receiving therapy at the time of our visit. Of these 36 HIV-infected patients, 19 had progressed to an AIDS diagnosis. Although there were no Elmira physicians

[6] The average sick call quality rates at all CA-visited facilities are: 14% rating quality as good, 36% rating it as fair, and 51% rating it as poor.

qualified as HIV specialists under DOCS protocols, HIV-infected individuals received treatment from one outside Infectious Disease (ID) specialist. Staff informed us that the ID specialist regularly held clinics twice per month at the facility, and saw an average of four patients for ID specialty appointments per month. This appears to be a substantial increase from data we received in the past concerning incarcerated persons' access to an ID specialist. In fiscal year 2006 to 2007, there were only 19 ID appointments, representing a rate that was less than one-sixth of the department-wide utilization rate. Individuals with HIV and hepatitis C (HCV) are routinely assigned to specific providers.

Staff had identified 130 individuals with HCV, representing 7% of the prison population. This figure is lower than the average of 9% throughout the Department. Staff explained that incarcerated persons are only tested for HCV if they are part of a "high-risk" population. It appears that Elmira may not be aggressively evaluating its population to determine whether they are infected with HCV. According to facility data, only five of the 130 HCV-infected persons were receiving treatment for the disease. This represents a rate of treatment that is below the system-wide average of 5% of known HCV-infected persons receiving HCV therapy. We are concerned that of the nine persons who are co-infected with HIV and HCV, only one was receiving HCV therapy. At some prisons, HCV-infected persons are evaluated by a gastroenterologist (GI) specialist to determine if they are appropriate candidates for treatment, but this is not necessarily the case at every facility. Elmira medical staff reported that only persons who are co-infected with HIV and HCV are evaluated by a GI. While DOCS medical staff in general are not referring patients to a GI as frequently as in the past, Elmira's GI referral rate was very low, and its liver biopsy rate was 64% of the system-wide average. It would be useful to review HCV treatment records to discern whether staff are being aggressive in patient HCV evaluations and treatment.

Elmira houses many incarcerated persons with other chronic medical conditions. Staff explained that the statewide prison population has gotten older, and an aging population is afflicted with a higher number of chronic conditions. Patients are frequently newly diagnosed with diabetes, and staff estimated that they diagnose reception patients with cancer at least once a month. At the time of our visit, there were 192 persons with asthma (275 active prescriptions), 263 persons with hypertension (587 active prescriptions), and 82 persons with diabetes (120 active prescriptions). Sixty-one percent of Elmira survey respondents stated that they suffered from a chronic medical condition, including six individuals with HIV or AIDS (6%), 11 individuals with hepatitis A, B, or C (10%), 36 individuals with asthma (30%), 14 individuals with diabetes (13%), and 28 individuals with hypertension and other heart problems (24%).

Incarcerated persons with chronic medical conditions are routinely evaluated by medical staff every three to four months, and more frequently if necessary. Persons with chronic conditions are not assigned to specific providers; however medical staff told us that they try to assign persons to the same providers for every appointment.

Elmira is one of a small number of prisons that maintains a dialysis unit in the clinic to provide services for persons with kidney function loss. At the time of our visit, there were 23 individuals receiving dialysis. Persons receiving dialysis are all housed on the same block for ease of treatment. Persons on dialysis receive special discharge planning in conjunction with the

Division of Parole that includes submission of a Medicaid application and housing placement before release. Individuals with whom we spoke were satisfied with the dialysis unit, however many reported having difficulty obtaining ice chips to ease hydration balance after treatments.

Facility administrators reported 13 deaths at Elmira since 2007. Medical staff explained that one of these deaths resulted from improperly tracking patients on Coumadin, however a tracking system was later instituted. Elmira has had an unusually high rate of suicides. From 2004 through 2009, 19% of all DOCS suicides occurred at Elmira, even though it confines only 2.8% of the Department population. This rate is seven times higher than the system average. Many of these occurred while individuals were in Elmira's reception area. In an effort to lower the reception suicide rate, Elmira developed an Extended Classification Unit (ECU) in the reception area where unstable persons in reception can be constantly monitored. The utilization of this unit has succeeded in decreasing the number of suicides at the facility.

Ninety percent of reception survey respondents reported being asked about chronic problems, 83% being asked if they needed immediate medical or mental health care, and 67% reporting that staff discussed patients' medical problems with them. Thirty-four percent of survey respondents stated that an HIV test was offered to them, and three respondents (10%) received an HIV test.

Specialty Care

Patients who require specialty care services are sent to outside specialists or are seen at the prison in specialty care clinics. Specialty care clinics available at Elmira include orthopedics, urology, ophthalmology, audiology, dermatology, and general surgery. Some infectious disease specialty appointments are conducted via teleconferencing with the outside provider. According to staff, there is a significant need for orthopedic services. Staff also explained that persons requiring physical therapy must be taken to Five Points C.F. and the delay for these services is approximately two months. The CA evaluated utilization of specialty care services for all state prisons for Fiscal Year 2006 to 2007 and Elmira use was only 75% of the average rate for all prisons. Of particular concern were the low utilization rates for infectious disease (14% of department-wide average), nephrology (15%), gastroenterology (19%), dermatology (41%), and physical therapy (51%). We urge prison medical staff and DOCS Division of Health Services to review the recent utilization of specialty care at the facility to determine if all patients in need of further evaluation and care are promptly referred to and seen by a specialist.

Thirty-two percent of survey respondents reported seeing a specialist in the past two years, with 65% of these persons experiencing a delay at least sometimes. Overall, Elmira was in the bottom 40% of CA-surveyed prisons concerning specialty care delays. In contrast, 61% of the patients who had seen a specialist stated that facility medical staff provided good follow-up to the specialist's recommendations, placing the prison in the top 10% of all CA-visited facilities for responsiveness of prison medical staff to these recommendations.

Pharmacy

Elmira has its own pharmacy, which at the time of our visit was staffed by a pharmacy supervisor, a pharmacist, and two pharmacy aides. The pharmacy had recently installed a centralized computer system to track patient prescriptions, however the system was only partially in use at the time of our visit. According to staff, this new system is very useful for tracking quality of care. We commend the Department for installing this new system, and expect that it is now being fully utilized.

Staff estimated that approximately 180 patients receive medication every day. While touring the clinic, we observed a long line of patients waiting for medication. Individuals with whom we spoke reported that there are often long waits outside, even in poor weather, and that it can take as long as 30 minutes to receive one's medication. Forty-five percent of survey respondents who were on medication reported having difficulty obtaining their medications at least sometimes, a rate better than at 70% of the prisons surveyed by the CA. We remain concerned, however, that a majority of individuals on medications reports periodic problems. Difficulty obtaining medication refills was a common complaint among the surveyed individuals. Persons also complained that staff crush all distributed pain medications as a precautionary measure, which makes it difficult for patients to identify whether they are taking the correct type and dose. We understand the necessity of crushing medication for some individuals, however we suggest that medical staff reexamine this policy to determine whether it is necessary for all persons.

The facility has designated specific nurses to distribute psychotropic medications, and at the time of our visit, the prison was in the process of moving distribution of these medications to a separate area where patients could receive doses on a one-on-one basis with medical staff. Fourteen percent of survey respondents reported that they had problems receiving mental health medications at least sometimes. We commend the facility for instituting a one-on-one distribution system in order to promote patient education about their medications and to prevent prescription drug abuse.

Quality Improvement

Elmira has an eight-member Quality Improvement (QI) Committee comprising medical, administrative, and security staff that meets quarterly to review healthcare at the facility. In the case of an unexpected death of an individual, the Committee meets within the week to review the details. The Committee keeps minutes of the meetings which are provided to facility executive staff and the DOCS Division of Health Services (DHS) for review. The facility also conducts quarterly Continuous Quality Improvement (CQI) audits of its HIV care, during which staff review 10 patient charts.

Medical Care Recommendations

- Ensure that all incarcerated persons scheduled for a clinic call-out are promptly seen in accordance with their medical needs.
- Increase confidentiality between patients and medical staff during sick call encounters.

- Implement measures to ensure that all persons in reception are offered HIV and hepatitis C tests and informed that testing is voluntary and they may decline.
- Improve quality assurance protocols for treatment of patients with chronic medical conditions.
- Review the recent utilization of specialty care services at the facility to determine if all persons in need of further evaluation and care are promptly referred to and seen by a specialist.
- Streamline the medication refill process to avoid delays.
- Reassess the policy of crushing pain medications for all patients.

FISHKILL

The Correctional Association of New York visited Fishkill Correctional Facility on April 17th and 18th, 2012. Fishkill is a medium-security prison located in Beacon, NY, in Dutchess County, about 60 miles north of New York City. Fishkill had a capacity of 1,845 people and confined 1,650 people at the time of the visit. In addition to general medical care, Fishkill also operates a Regional Medical Unit and a Unit for the Cognitively Impaired.

MEDICAL CARE

The Visiting Committee toured the medical area and met with the nurse administrator and a prison physician concerning medical services at the facility. We appreciate the information provided prior to our visit and during our tour. The medical area at Fishkill has nine exam rooms, a phlebotomist room, and an emergency room with an automated external defibrillator (AED). Fishkill also has a 20-bed infirmary for patients at Fishkill, as well as a Regional Medical Unit (RMU), consisting of a 30-bed skilled nursing care unit used by patients from Fishkill and other facilities and a specialty care unit for individuals needing such services within the southern region of DOCCS. The prison infirmary houses, on average, ten patients, and the RMU long-term care unit has generally operated at capacity for most of the last two years. Fishkill also operates its own pharmacy.

For emergency hospitalization, patients are usually taken to St. Luke's Hospital by EMS as it is the nearest hospital facility. Although the prison does not control where a patient is taken by EMS, Mt. Vernon Hospital is the preferred location for care. For patients needing hospitalization who are more stable and require more advanced services, patients can be sent to Putnam, Mt. Vernon, or St. Francis Hospitals, whichever facility offers the most appropriate medical services.

Table G – Summary of Fishkill Survey Participants' Responses about Prison Health Care

Medical Service	Yes	Sometimes	No	Rank	Good	Fair	Poor	Rank*
Can you see RN when needed	55.6%	33.3%	11.1%	16				
Rate Nursing care					19.0%	37.9%	43.1%	14
Do you experience delays in seeing a clinic provider **	41.5%	38.1%	20.4%	24				
Rate Physician care					14.4%	39.2%	46.4%	15
Experience delays in specialty care	41.6%	22.4%	36.0%	19				
Good follow-up to specialists	42.7%		57.3%	12				
Problems getting medication	23.9%	10.2%	41.3%	13				
Rate Overall Healthcare					10.9%	52.7%	36.4%	13

* CA-visited facilities are ranked from 1-35, one being the best and 35 being the worst.

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

Overall, Fishkill survey participants had mixed, but somewhat favorable, view of prison healthcare, with a majority of health-related indicators ranking the prison in the top 40% of all CA-surveyed facilities. **Table G – Summary of Fishkill Survey Participants' Responses**

about Prison Health Care contains a listing of the answers to the health-related questions in the survey and details Fishkill's ranking for these responses compared to responses from individuals at the 35 prisons the CA has visited.

Staffing

Fishkill has an extensive medical staff assigned to the prison medical unit, the Regional Medical Unit and the Unit for the Cognitively Impaired (UCI). For the general prison medical department, 3.5 physicians and one nurse practitioner are authorized, but at the time of our visit, the prison had employed only three full-time equivalent (FTE) physicians and one nurse practitioner, thereby operating without a one half-time physician slot.

The Regional Medical Unit (RMU) is authorized to have two physicians, including one Clinical Physician 3 item to oversee the RMU operations and one general physician; at the time of our visit, the second doctor position was only filled with a half-time physician. There is one three-quarter time physician assigned and employed for the UCI, although a full-time doctor position is authorized for that unit.

The prison also has a large cadre of nurses. For the general prison operation, the facility is authorized to have 21 full-time permanent nurse 2 items and one temporary nurse item. At the time of our visit, one permanent nurse 2 item was vacant and had been unoccupied for two years, and the temporary item, due to expire as of June 2012, was not filled. In addition, the prison had an FTE per diem nursing item that was filled.

The RMU's long term care unit has a large contingency of medical nursing staff, including 12 registered nurses (nurse 2s), six licensed practical nurses (LPNs), and 12 nursing assistants (NAs). At the time of our visit, there was one nurse 2 vacancy, two LPN vacancies and two NA vacancies. In addition, two nurse 2s and one NA were on extended sick leave. The specialty care operation in the RMU apparently has a group of three nurse 2 and four LPN positions; at the time of our visit, two nurse 2 and one LPN vacancies existed.

Although the Fishkill medical staff is extensive, there are a significant number of vacancies which should be filled. We urge the prison to reassess its staffing needs to ensure that all persons requiring medical services are receiving care in a timely manner.

Sick Call

Sick call is conducted in the medical unit five days per week. All patients except individuals in disciplinary confinement or the RCTP are called to the medical area for sick call, including patients in the other residential mental health units (ICP and TrICP). Usually, three nurses are assigned to conduct sick call in the clinic. With 30 to 60 patients arriving for sick call each day, it takes about two to three hours for the medical staff to complete sick call duties. Sick call starts in the morning after the facility count at 7:30 am and can continue through 11:00 am. The average number of patients seen at sick call each month is approximately 900.

Fishkill also operates a 24-hour, seven days per week emergency sick call (ESC) operation. Medical staff estimated that about three or four patients are seen for emergency sick call each day. Medical staff claims they do not write disciplinary tickets for individuals who seek emergency sick call even when they are not experiencing an emergency.

Survey respondents had somewhat mixed reviews of the sick call process. More than half of the participants said they could access sick call when needed and their responses ranked the prison as average for all CA-visited prisons. With 19% of respondents rating the sick call nurses as good and 43% assessing them as poor, Fishkill was in the top 40% of CA-surveyed prisons for the quality of sick call encounters. Concerns raised by survey participants included interference with and disrespect from the security staff in the sick call area, variability in the quality of the sick call encounters based upon the nurse being seen, poor attitudes exhibited by some of the sick call nurses, failure to refer patients to the clinic providers, rushed sick call encounters, and reluctance or refusal to more aggressively respond to medical complaints of patients other than providing over-the-counter medications.

Clinic Call-Outs

Clinical call-outs at Fishkill, which are scheduled appointments for patients seen after a referral from sick call or as follow-up from a prior clinic appointment, are held five days a week, Monday through Friday, primarily from 8:00 am until 11:30 am, with fewer afternoon appointments due to limitations caused by security staff and other programming. Fishkill officials estimated that approximately 700 clinic appointments are conducted each month. Patients are assigned to specific clinic providers by the patient's name, and patients generally continue with the same provider except in cases when they need priority care and their provider is not available. Patients are not assigned to providers based upon their medical condition. Recent resignations have required patients to be reassigned to new providers, increasing the doctors' caseload.

Incarcerated persons who filled out the CA survey had mixed views about the adequacy of clinic care. Many patients expressed concerns about timely access to clinic call-outs with 80% reporting that they experience delays in such access at least some of the time, ranking Fishkill in the bottom third of all CA-visited prisons for clinic access. These survey participants estimated it takes approximately a month to see a provider. Fishkill staff admitted that for routine care it can take up to four and sometimes six weeks to see some clinic providers. The most common complaint from survey respondents was difficulties they experienced in getting timely access to their provider.

Concerning the quality of care received from the clinic providers, 14% of survey participants rated the care as good and 46% said it was poor, rates that are about average for all CA-visited prisons. Common concerns expressed by survey respondents were that the care was delayed, that some clinic providers were inattentive to patients' complaints and sometimes disrespectful and/or uncaring, and that security staff interfered with access to, and the delivery of, medical services. Some survey participants said that the quality of the care varied based upon the specific provider being seen.

Care for Patients with Chronic Medical Problems

Fishkill, like most DOCCS facilities, has a significant portion of its prison population suffering from a chronic medical condition. **Table H – Summary of Fishkill Patients with Chronic Medical Conditions** lists the data we received from the prison about those persons known to have specific chronic medical problems.

Table H – Summary of Fishkill Patients with Chronic Medical Conditions

	HIV	AIDS	HCV	HIV & HCV	Asthma	Diabetes	Hypertension
Infected	**58**	**5**	**44**	**9**	**232**	**291**	**128**
% Infected	**3.6%**	**0.3%**	**2.7%**	**0.5%**	**14.1%**	**17.6%**	**7.8%**
Treated	**51**		**1**		**232**	**291**	**120**

Chronic care clinics are run by facility nurses for all of the following conditions: HIV, hepatitis C (HCV), diabetes, asthma, hypertension and men's physicals. The nurses assigned to specific chronic conditions are required to review the records of all patients with these illnesses and are primarily responsible for completing paperwork monitoring the patients' status consistent with the DOCCS practice guidelines for each condition. The nurses also perform patient education and schedule laboratory work. The clinic providers, however, see the patients for primary care, and chronic care nurses are not generally present for these examinations, although they may prepare follow-up paperwork for medications and laboratory orders. For example, the HIV chronic care nurse schedules appointments for HIV-infected patients generally every three months, schedules blood work upon the provider's request, ensures that the scheduling of care is consistent with the DOCCS HIV practice guidelines and monitors the medical condition of the patient between visits to their primary care provider.

Fishkill has one doctor who is certified by DOCCS as an HIV specialist. The facility estimated that the in-house HIV specialist conducts four regular infectious disease clinics per month for patients at Fishkill and an average of ten infectious disease specialty appointments per month. Patients with HIV are assigned to all facility providers. In the most recent HIV quality assessment for the prison prepared by the medical staff, the facility was 100% compliant with all quality indicators for HIV. We were informed by staff that Fishkill has experienced a decline in HIV incidence: in 2005 there were around 100 known patients with HIV in contrast to the data provided at the time of our visit indicating only 58 HIV-infected patients. The facility did not have an explanation for the decline, which is more dramatic than at other facilities we have visited. Data from studies by the NYS Department of Health and CA observations from prison visits is that the population of HIV-infected persons in prisons has continued to decline throughout the last decade, although the reduction in the infection rate for men in state prisons has been much less in the last few years.[7]

At the time of our visit, Fishkill confined 44 individuals infected with hepatitis C (HCV), representing 2.7% of the prison population. According to studies done by the NYS Department

[7] NYS Department of Health Studies of HIV infection rate of newly admitted individuals to DOCCS facilities was 4% in 2005 and 3% in both 2007 and 2009. Although these figures do not represent the actual infection rate of the incarcerated population due to differences in the sampling of study subjects and the current prison population, it does suggest that the rate of HIV infections in the male population has apparently stabilized in recent years.

of Health (DOH), we estimate that 10% to 11% of the prison population in 2009 was infected with HCV. Fishkill's HCV-infected rate is well below this estimated percentage of system-wide HCV infection and is even two to three *times* below many other prisons the CA has visited. We urge the prison to enhance its efforts to identify potential HCV-infected persons in its population. Fishkill had only one individual undergoing treatment, which is less than 3% of the known HCV-infected population and lower than the system-wide treatment average of about 5% of HCV-infected patients at all DOCCS facilities. We urge the facility's medical staff to review the population of HCV-infected individuals in order to determine whether any of those currently not receiving treatment may be appropriate candidates for therapy.

Medical staff informed us that the facility was preparing for the new triple-drug treatment regimen for HCV treatment, guidelines for which were being developed by the Department as of the time of our visit. Prison medical staff told us they had ordered the new protease inhibitor drugs that will be part of the regimen, but also expressed concerns about the complexity of safely administering and monitoring patients on this treatment. Since our visit, DOCCS promulgated new practice guidelines for the new HCV treatment. We urge facility staff to re-evaluate its patients to determine if there are appropriate candidates for this more effective treatment.

Asthma is another chronic condition that requires significant medical attention at the facility. Prison staff informed us that 232 individuals, representing 14% of the prison population, are under care for this disease. Medical staff describes recent efforts to better monitor patients with asthma and told the visiting committee that the medical department has conducted several audits in the last few years to better comply with the new DOCCS protocols for monitoring asthmatic patients.

Specialty Care

Most patients who require specialty care while at Fishkill are treated at the specialty care clinics conducted at Fishkill's Regional Medical Unit. These clinics also routinely receive patients from nine other facilities, mostly from prisons in the southern region of the state, including incarcerated women, who are separated from the men.

Fishkill patients have very high utilization rates for specialty care, with 48% of survey participants stating they had seen a specialist in the past two years, ranking the prison fourth highest of all CA-visited prisons. Surprisingly, 42% of survey respondents said they experienced delays in seeing a specialist, despite their proximity to the clinics, ranking the prison in the bottom half of all CA-visited prisons. In contrast, 43% of survey participants said that they received good follow-up to the specialists' recommendations, ranking Fishkill in the top third of surveyed prisons. Comments contained in survey responses seemed to indicate that the major concern is getting the facility medical staff to refer patients to a specialist, and that this barrier varies according to the patient's designated primary care physician.

Medication

Fishkill operates an on-site pharmacy for patients at the facility and in the Regional Medical Unit. The Fishkill pharmacy operation is staffed by two teams, one for the general

prison population and the other for the RMU, with each team consisting of a pharmacy supervisor, pharmacist and pharmacy aide. At the time of our visit, it appears that one pharmacist position was filled with only a half-time person. Medical staff delivers medications to individuals in the SHU. All other patients must pick up their own medications. Patients do not receive any notice if the medications they need to be refilled have been delivered to the Fishkill pharmacy; rather, they are told to come to the pharmacy one or two days after they put in for their refill. Fishkill medical staff does not distribute psychotropic medications for mental health patients. These medications are distributed by OMH staff and the medical staff estimated that 200-300 individuals are on psychotropic medications in the prison.

Survey participants reported the highest percentage of persons on medications (75% of all respondents) compared to other prisons we have visited. Of individuals on medication, 45% said they experienced problems getting their medications at least sometimes, a rate that ranks Fishkill in the top 40% of all surveyed facilities. Many of the complaints we received from survey respondents about medications focused on whether the drugs were effective and whether their doctors had ordered medications that had been previously prescribed for their condition. Restrictions on access to pain medication were another concern raised by Fishkill patients.

Quality Improvement Program

Fishkill's Quality Improvement (QI) Committee meets quarterly and consists of representatives from all medical staff (nursing staff, nurse administrator, pharmacy, security, dental and medical records staff). The QI Committee reviews care for the entire facility, including the RMU. Medical staff informed us that there is no QI audit for the Unit for the Cognitively Impaired (UCI) or long-term care unit; however, on a quarterly basis, medical staff review patient status and programs on these units, and these reviews may generate issues on which to follow-up. For the UCI and long-term care unit in the RMU, the unit provider, psychologist, social worker, and nurse meet weekly to perform individual patient reassessments. We believe both the UCI and long-term care units could benefit from a more rigorous and better documented formal QI program.

REGIONAL MEDICAL UNIT

Long Term Care Unit

Fishkill operates a 30-bed in-patient Long Term Care Unit (LTC) in the prison's Regional Medical Unit (RMU). There are ten respiratory isolation rooms in the LTC. The LTC hosts patients from Fishkill and other prisons in the southern New York region. Nurses' assistants take vital signs and help care for incontinent patients. Patients in the LTC eat in their own rooms, and are allowed access to the day room, which has a television, at designated times. There is also a private visiting room in the LTC. The LTC does not have equipment to perform medical teleconferencing on the unit for its patients; consequently, if a provider desires such consultation, the patient must be transported to the general medical area for the telemedicine session. As detailed above on page nine, the prison has a large medical staff assigned to the unit, but vacancies exist for both doctors and nursing care that should be filled.

The demographics of patients in the LTC are generally people with serious medical conditions who are unable to function in the general population and need skilled nursing care beyond that which is available in the typical prison infirmary. This includes patients who need post-operative care, cancer patients, paraplegics, patients who have had a stroke, HIV- and/or HCV-positive patients with significant nursing care needs, and people with severe wounds. The medical staff provided us with a redacted list describing the medical conditions of each LTC patient; the most prevalent conditions were cancer; diabetes and complications from that disease; liver disease, primarily from hepatitis C; hypertension and its complications; and chronic obstructive pulmonary disease. Medical staff informed us that the average length of stay in the LTC is 172 days. While some patients have been in the LTC since 2004, there is a turnover rate for patients who die or whose health improves. In 2010, 2011 and 2012 (through April 2012) 24, 29 and 9 patients were admitted to the unit and 23, 29 and 7 patients were discharged, respectively. On the date of our visit, medical staff estimated that 50% of the patients in the LTC were terminally ill. The age of patients in the LTC ranges from 24 to 81 years old, but most patients are fifty or sixty years of age. Hospice services can be provided to LTC patients. A patient is eligible for hospice care if he has no more than six months left to live; however, the average length of time for a hospice services has been usually one month. In 2011 there were two or three hospice patients. Once a resident is designated as a hospice patient, the unit will move the person to a private room and arrange to have other incarcerated individuals who have been trained in hospice services to provide nearly constant companionship and support for the patient.

LTC patients with whom we spoke or from whom we received surveys had a mixed view of the medical services provided on the unit. Although this data is anecdotal, concerns were raised about timely access to the unit physician and the quality of care the patients received from the nurses, nurses' aides and the doctor. Some of these concerns seemed to center on the adequacy of communication between the medical staff and the patients about their condition and treatment. Overall, the survey data we received from six of the 30 patients on the unit at the time of our visit was somewhat less favorable than the information we had received from patients at the other regional medical units we have visited at Walsh Medical Center and Coxsackie.

Several patients raised concerns about the lack of confidentiality. This included the lack of privacy during bedside conversations and examinations with medical staff or when assigned to a multi-occupancy room. It is our understanding that curtains are not available to provide privacy during medical encounters at patients' beds. Moreover, several patients raised concerns that their medical information is frequently shared with unit security staff and thereafter discussed with other staff and the patient population.

Patients in the infirmary, the UCI, and the LTC have access to similar program activities. If an LTC patient is physically and mentally able, he can participate in the following programs: computer operations, ASAT, cell study, ART, and Transitional Services' Thinking for a Change. Patients enrolled in academic programs receive individual tutoring in the visiting room for ABE, pre-GED, or GED courses. At the time of our visit, staff estimated there were seven patients enrolled in an academic program. ART is taught quarterly for LTC patients. The ASAT program is held five times per week and at the time of our visit, six to eight patients were participating. At the time of our visit, the Thinking for Change program had just been completed for five LTC

residents. Patients have access to general library and law library materials upon request, and legal materials are delivered to the patients by law library clerks.

There is no patient group in the LTC to discuss residents' concerns or the operation of the program. Staff informed us that if a patient in the LTC has an individual complaint, he may write to the nurse administrator or a doctor, or request to speak to one of them personally, prior to filing a formal grievance. We were told by staff that a representative of the ILC makes rounds in the LTC and asks patients for concerns, but the ILC had not done rounds in the unit in the past quarter prior to our visit, and the ILC rounds are not regularly scheduled.

DOCCS staff has a role in discharge planning for LTC patients being released to the community. This can include identifying medical/residential programs for patients leaving prison, as well as assisting individuals in applying for public entitlements such as Medicaid. DOCCS staff assigned to assist soon-to-be-released UCI residents in identifying options for nursing homes and treatment centers in the community also help LTC patients in their discharge planning. Despite this assistance, some patients in the LTC have stayed well beyond their time when they could be released because they have had difficulties finding placements on the outside. At the time of our visit, two people residing on the unit had extended their release date because of the lack of suitable community placement, and there was one individual in 2011 who was forced to do the same because he was unable to find housing in the community.

Patients on the Office of Mental Health (OMH) caseload are seen by a psychiatrist or lower-level OMH staff in the LTC. Medical providers do most consultations at the patient's bedside. There is no current program for people convicted of sex offenses for LTC or long-term care patients, but staff indicated at the time of our visit that the facility was in the process of hiring a counselor for that program, a position that has been vacant for about a year. Patients who need the program have been transferred to another facility.

Specialty Care Clinics

Fishkill RMU also contains an area for outpatient specialty care clinics for Fishkill patients and incarcerated persons mostly from eight other prisons, including women's facilities, from the southern region of the state. There are 30 different specialty care services provided, including: audiology, cardiology, gastroenterology, infectious diseases, nephrology, occupational therapy, ophthalmology, optometry, orthopedics, pain management, physical therapy, podiatry, and urology clinics. There are five examination rooms, one of which is specifically for ophthalmology. The physical therapy clinic is a five-bed clinic with four bicycles and other equipment. Two specialists bring their own sets of staff with them: pain management staff has their own anesthesiologist, and the gastroenterologist brings their own anesthesiologist and staff to perform colonoscopies and endoscopies. Specialists in mobile trailers arrive on-site once a month or once every two weeks to perform CT scans and MRI services. There is a DOCCS nurse at the majority of the specialty clinics. As of December 2011, Fishkill started conducting nuclear stress tests in the same room as phototherapy. They also perform minor surgeries in the specialty care clinics.

Medical staff informed us that daily 50 to 60 specialty appointments are typically held, but they can see up to 100 patients in a day. The specialty care unit is staffed by two Fishkill nurses and one medical records staff person, and the clinic operation is overseen by Fishkill's Facility Health Services Director, Dr. Avanzato. On busy days, additional staff is allocated to the specialty care unit. The unit creates a medical folder for patients from other facilities who are treated in the specialty clinics, including a copy of a final report for specialty care appointments held at the clinic, but other medical records for these patients are not maintained at the clinic.

UNIT FOR THE COGNITIVELY IMPAIRED (UCI)

The Unit for the Cognitively Impaired (UCI) is a 30-bed specialized unit unique to Fishkill for patients suffering from dementia-related and other cognitive conditions.[8] The CA visited the UCI, spoke with staff, and interviewed 14 patients in the unit. The CA's interactions with people in the UCI reminded us, like with the RMU, of the tremendous need for such programs so long as the state continues to incarcerate an expanding number of elderly patients. It also reinforced the costly, cruel, and nonsensical policy of continued incarceration of people who are so physically and/or cognitively impaired that they pose no safety risk to the community and for whom there no longer remains any justifiable reason to keep them in prison. At the time of our visit, a patient board at the entrance of the UCI indicated that the patients in the unit were from the following facilities across the state: Woodbourne, Fishkill, Bare Hill, Five Points, CNYPC, Mohawk, Wende, Green Haven, Sing Sing, Elmira, Eastern, Sullivan, Clinton, Upstate, Orleans, Attica, and Clinton. While the capacity of the UCI is 30 beds, there were 26 patients at the time of our visit.

As seen in **Table I – Medical Conditions of UCI Patients**, of the 26 people in the UCI, nine patients suffered from some form of dementia (in some cases in conjunction with other conditions), two additional patients suffered from cognitive disorders, and other patients suffered from a range of other conditions. Also seen in **Table I**, and as indicated by staff, many UCI patients have coexisting medical problems, most often hypertension or vascular conditions. In fact, most patients have some significant medical issue. In addition, staff indicated that about one-quarter of UCI patients are on psychotropic drugs distributed by UCI nurses. When asked about changes in the patient population in the UCI over time, staff responded that many patients are a lot younger than they had been in the past, noting the one young individual currently with a traumatic brain injury and other veterans they have seen with brain injuries.

Table I – Medical Conditions of UCI Patients

A Fib (Atrial Fibrillation), HTN (Hypertension)
Alzheimer, Early Dementia, HTN
Cognitive Disorder-NOS (not otherwise specified), Hep C, HIV
Confusion, CAD, HTN, COPD (Chronic Obstructive Airway Disease)
COPD, BPH (Benign Prostatic Hyperplasia), Pacemaker
COPD, Depression, A Fib
COPD, HTN, Glaucoma, memory loss

[8] *See* Michael Hill, "N.Y. prison creates dementia unit," *The Associated Press*, May 29, 2007.

Dementia
Dementia, CVA, BPH
Dementia, Diabetes, HTN
Dementia, HTN, Incontinence B/B
Diabetes, HTN, Cerebral Vascular Disease
HCV, HIV Related Dementia
HIV, Dementia, Learning Disability
HTN, Chronic Renal Failure
HTN, Depression, Dementia
HTN, Hep C
Hypertension, Cognitive Disorder, +PPD (postpartum depression)
IDDM (Insulin-Dependent Diabetes Mellitus), Dementia, HTN
IDDM, Renal Failure, HTN, BPH
IDDM, Seizure Disorder, Schizophrenia
S/P CABG (status post coronary artery bypass graft, HTN, BPH, DJD
S/P CABG, HTN, BPH, DJD (degenerative joint disease)
Schizophrenia, IDDM, HTN
Schizophrenia, IDDM, HTN
Traumatic Brain Injury, Seizure D/O

As a result of the different medical conditions, according to UCI staff, patients have significant variability in skill level. A few patients are able to function fairly well, meaning that they can perform their own daily living tasks, such as washing their face or brushing their teeth. Some of these individuals need reminders to complete their meals, prompting for taking showers, and monitoring to ensure they ingest enough fluids. Part of the responsibility of UCI nurses is to ensure that patients complete these basic tasks. It is the nurses and civilians, not other incarcerated assistants, who perform these tasks. UCI staff estimated that typically about 25 out of 30 patients in the unit generally need at least prompting to complete their tasks, while 15 out of every 25 need physical help. At the time of our visit, staff estimated that there were six individuals on the unit that did not require any physical help. Staff indicated that the most common assistance needed is constant prompting and monitoring, though not necessarily physical help, for showering and feeding. Showering assistance can include prompting patients, who sit on shower chairs and have a shower hose, through the basic steps of using soap and washcloths, while feeding assistance involves talking with people while they have their meals to encourage them to eat. UCI staff expressed that the unit attempts to have patients be as independent as possible with prompting.

Medical Care Recommendations

- Fill all medical vacancies for the prison medical unit and the regional medical unit
- Reduce the time it takes for patients with routine care to see a provider for clinic call-outs
- Review the quality of care provided by all sick call nurses and clinic providers to ensure that medical conditions are properly diagnosed and promptly treated

- Enhance efforts to reduce the delay in getting patients seen for medical call-outs
- Significantly enhance efforts to identify people who may be infected with HIV and/or HCV
- Implement measures to ensure that HCV-infected patients are thoroughly evaluated to determine if they are appropriate candidates for treatment
- Review the utilization of specialty care services to determine whether all patients are getting prompt access to all needed specialty care clinics
- Create a more regular and rigorous QI program for the unit for the cognitively impaired and the long term care unit in the RMU
- Institute measures to shorten the time needed to see patients for routine dental care

Medical Care Recommendations for RMU

- Fill all medical care vacancies for staff assigned to the RMU
- Review the quality of the medical encounters with RMU nurses, nursing assistants and physicians to ensure patients have timely access to care, there is effective communication between provider and patient, and patients' needs are promptly and adequately addressed.
- Create a mechanism for patients in a group setting to discuss their observations, concerns and recommendations about the operation of the unit with unit medical and security staff
- Review procedures on the unit to ensure appropriate patient confidentiality to make certain that information is not inappropriately disclosed to other patients or to security staff
- Initiate discussion with officials from DOCCS and the NYS Department of Health concerning the lack of available and appropriate residential programs in the community for individuals being discharged from prison who have a criminal history and require extensive medical care
- Increase programming opportunities for patients in the UCI to decrease idleness and provide additional opportunities for therapeutic engagement
- Assess the current policies and practices regarding the applications for and approval of medical parole for UCI and RMU patients, make appropriate changes to ensure that all eligible patients are submitted in the proper and timely manner, and increase the number of people granted release
- Reassess current policies and practices that allow for the incarceration of people who are so physically and/or cognitively impaired that they pose no safety risk to the community and for whom there no longer remains any justifiable reason to keep them in prison
- Explore ways to expand UCI programs and services to other individuals and facilities

MOHAWK

The Visiting Committee of the Correctional Association of New York visited Mohawk Correctional Facility on July 12th and 13th, 2010. Mohawk is a medium-security prison located near Utica in the city of Rome, New York. Mohawk had a capacity of 1,184 people and confined 1,167 people at the time of the visit. In addition to general medical care, Mohawk also operates the Walsh Regional Medical Unit.

MEDICAL CARE

The Visiting Committee toured the medical area and spoke with the nurse administrator and prison physician. We appreciated the extensive information provided by the facility prior to our visit, during our tour of the medical areas, and over the course of meetings with the executive team and medical staff. The facility has a medical area for persons incarcerated at Mohawk, called the primary care unit (PCU). In addition, on the prison grounds is the Walsh Regional Medical Unit (Walsh RMU), a separate building that services individuals from prisons throughout New York state and includes both an in-patient unit similar to a skilled nursing care facility and an outpatient area in which specialty care services are provided. This section of the report evaluates the medical care provided in the primary care unit and the next section contains an evaluation of the Walsh RMU.

Persons incarcerated at Mohawk expressed mixed views of the prison's healthcare system. Of the 138 persons who responded to survey questions concerning overall medical care, 14% rated it as good, 41% said it was fair, and 34% reported it to be poor. These ratings place Mohawk slightly above the average for medical care satisfaction for the 27 CA-visited prisons, ranking it 12th in overall satisfaction. As noted below, Mohawk survey participants expressed differing views concerning several aspects of the healthcare system.

Staffing

At the time of our visit, the authorized medical staff for the PCU at Mohawk consisted of 2.5 doctors, a nurse administrator, and seven full-time nurses. There were no vacancies in the PCU medical staff at the time of our visit. In addition to the permanent staff, the PCU has two per diem nurse positions that together amount to another full-time nursing position. These per diem positions were regularly used by the medical staff to fill in for vacations and other absences by nursing staff. The prison also used overtime by nurses, but we were informed that very little of the overtime was mandatory.

Medical staff participate in medical training at the prison and at outside venues. The prison medical department has teleconferencing capabilities and regularly uses these facilities during the lunch time for non-mandatory training sessions that last for an hour to an hour and a half. Staff estimated that approximately 20% of the medical staff members participated in these sessions. According to their contracts, medical staff are also permitted three days for professional development; we were told that staff generally used these days for training outside the facility.

Sick Call

Sick call is conducted four days per week, Monday, Tuesday, Thursday, and Friday, starting at 6:00 a.m. and usually ending by 8:00 a.m. Typically, three nurses are assigned to sick call each day. The facility estimated that about 320 patients are seen in sick call per month, a utilization rate significantly less than at many of the prisons the CA has visited. Mohawk survey participants also reported less frequent use of sick call than persons at other CA-surveyed facilities. Only 15% of respondents said they frequently go to sick call, compared to 22% of all CA survey participants and ranking Mohawk in the bottom 20% of all CA-visited prisons for utilization of sick call services.

If an individual has a medical emergency on days when sick call is not conducted or after sick call has been held, he can request emergency sick call. The facility estimated that approximately 95 to 100 persons are seen monthly for emergency sick call. Although the medical staff reported that some persons will, on occasion, abuse the emergency sick call system, the medical staff said they did not issue disciplinary actions for this misuse of the procedure. We commend these staff for dealing with this issue in a non-punitive manner.

Mohawk survey participants rated sick call services similar to the average ratings for other prisons we have visited. Fifty-six percent of survey respondents said that they were able to access sick call when needed, 31% stated they had such access sometimes, and 13% reported that they were unable to access sick call when needed.[9] These figures rank the prison in the middle of the 27 prisons for which we have comparable data. Similarly, Mohawk survey respondents had average ratings for the quality of sick call nurses, with 15% of the survey participants rating them as good, 35% assessing them as fair, and 50% reporting them to be poor.[10]

The comments we received from survey participants reflected mixed views of the nursing staff. Some individuals commented that the nurses who assisted them were caring and very patient, with one individual expressing the view that the nurse providing his care was the best in his seven years of incarceration. However, the majority of comments were more negative about the nursing staff. The most critical complaints were that some nurses were uncaring, exhibited a poor attitude, and, at times, were rude or verbally abusive. Several survey participants asserted that they were only provided over-the-counter pain medications, such as ibuprofen, for a variety of ailments. Overall, the comments left the impression that the care individuals received was variable based upon the sick call nurse who examined them.

Clinic Call-Outs for Doctor Visits

Persons requiring care beyond what is provided by nurses during sick call may be scheduled by the nurse to see a doctor during morning or afternoon call-outs to the medical area. At the time of our visit, the prison had two doctors on the day shift and one half-time doctor in the afternoon. We were told by staff that each full-time doctor will typically see 10 patients in a

[9] For all CA-visited prisons, 54% of survey participants reported they could access sick call when needed, 29% said they could access it sometimes when needed, and 17% replied they could not get access as needed.
[10] For all CA-visited prisons, 14% reported the sick call nurses as good, 36% rated them as fair and 51% assessed them as poor.

day, and the medical staff estimated that there were 300 to 400 call-outs to the clinic each month. Most clinic visits occurred on Monday, Tuesday, Thursday, or Friday; Wednesday was generally used by the doctors to complete paperwork.

Mohawk survey participants presented a positive view concerning access to prison doctors. At a rate better than at many prisons we have visited, 31% of surveyed individuals at Mohawk reported that they never had a delay in seeing a doctor, compared to 23% at all prisons surveyed, and 25% of Mohawk survey participants said they experienced frequent clinic delays, as compared to 42% of all CA-survey participants. These figures rank the prison in approximately the top third of CA-visited prisons for better access to the clinic. The median delay Mohawk survey respondents reported for access to the clinic was 14 days, compared to a median 21-day delay for responses by survey participants at all CA-visited prisons. Moreover, relatively few Mohawk survey respondents who provided comments about their medical care raised concerns about delays in their care.

A majority of Mohawk survey participants rated the quality of the care they received from the physicians as poor. Seventeen percent of Mohawk respondents rated the doctors as good, 32% assessed them to be fair, and 51% said they were poor. These figures are comparable to the averages we have found at all CA-visited prisons, and place the prison in the middle of visited prisons for quality of physician care. Most of the survey comments concerned problems with the quality of the encounters with prison physicians. The most common complaints were that (1) some providers were disrespectful, rude or uncaring; (2) the physicians rushed the medical encounter and did not listen to the patient; (3) over-the-counter medications were given for conditions requiring more treatment; and (4) the patient was not given medication prescribed by a consulted specialist or the drugs the patient were receiving for his condition prior to confinement at Mohawk. Several patients expressed the view that the care varied according to provider seen. A minority of survey participants expressed positive views of physician care. Several individuals complimented Dr. Lowenstein for his care and his positive attitude with the patients. Others stated that they received prompt care and that the doctors not only provided quality care, but also were receptive and respectful in their dealings with their patients. Because of the very mixed view of physician care, we urge the Department to review the quality of physician encounters to assess whether each doctor is providing prompt and appropriate care.

Care for Persons with Chronic Conditions, including HCV and HIV Care

Ninety-nine individuals incarcerated at Mohawk identified as infected with hepatitis C (HCV) at the time of our visit, representing 8.5% of the population, similar to the average of 9% for all persons incarcerated in DOCCS who have been identified as HCV-infected. The facility reported that 74 (74%) of these persons were chronically infected with HCV, a rate similar to HCV-infected patients in the community.

According to data we received from the facility, six patients were receiving HCV treatment at the time of our visit, a treatment rate comparable to other prisons. Staff explained that if an individual agrees to start therapy, he is put on an 18-month medical hold at the prison until his HCV treatment is completed. The providers reported requesting liver biopsies for all patients they suspect to be potential candidates for treatment. Data from fiscal year 2006-07

demonstrated that the prison was aggressive in ordering this essential diagnostic test. The medical staff explained that 40% or less of the HCV-infected persons that they had assessed as eligible for HCV therapy accept the difficult medication regimen once they were explained the treatment and the potential side effects of the medication. The staff estimated that 80% or more of Mohawk persons who started HCV treatment were able to complete the one-year regimen; the most common causes for terminating therapy early were due to side effects of the medication or lack of response. Staff also estimated that a majority of patients treated for HCV respond to the medication and have no detectable virus when they complete therapy.

At the time of our visit, there were 20 individuals known to be HIV-positive, 15 of whom were on treatment. Seven of the HIV-positive persons had progressed to an AIDS diagnosis. Staff reported that in recent years, the number of HIV-infected persons had been stable at about a 20-patient level. The percentage of the prison population (1.7%) that had been identified as infected with HIV was lower than the department-wide average of 2.5% of the individuals incarcerated in the department known to be infected, and substantially below the estimated 5% to 6% of all male persons incarcerated in DOCCS who are believed to be HIV-infected based upon Department of Health studies of HIV infection rates. It is unclear why Mohawk has a lower HIV-infection rate, and it is important that the medical staff remain aggressive in attempting to identify its HIV-infected population. None of the persons who were co-infected with HIV and HCV were currently receiving HCV therapy. The Center for Community Alternatives (CCA) comes to Mohawk to provide HIV testing, HIV counseling, HIV education, and assistance in discharge planning for HIV-infected individuals.

We were pleased to learn that two of the prison doctors (Drs. Seedat and Lowenstein) have been designated by the Department as HIV specialists. Staff informed us that HIV-infected individuals are divided between these physicians. The medical staff told us that newly diagnosed HIV-infected individuals will be referred to an infectious disease (IFD) specialist for a recommendation for treatment, and patients on HIV therapy who are exhibiting treatment failure may be sent to an IFD for an assessment if the prison provider's change in treatment is not successful. Given the expertise of the prison staff, most HIV-infected individuals who are stable are monitored by the prison providers and not sent to an IFD specialist. At the time of our visit, the most recent HIV Continuous Quality Improvement (CQI) audit conducted in May 2010 detected no unstable or end-stage HIV-infected individuals during its review of ten medical charts of Mohawk patients.

At the time of our visit, Mohawk housed 165 asthmatic individuals, 110 of whom were receiving treatment. We also learned during out visit that there were 201 individuals with hypertension, 188 of whom were currently being treated. Eighty-three individuals were taking daily medication for diabetes out of the 87 who were diagnosed with the condition. Staff informed us that they welcomed the change in problem list designations for the status of asthma patients because it improved the monitoring of these patients, and the prison had little difficulty implementing the modifications because Dr. Sadat is a pulmonologist and follows these patients.

For many of the chronic illnesses experienced by persons incarcerated at Mohawk, including HIV, HCV, asthma, diabetes, and hypertension, the prison has assigned nurses to assist in the management of these diseases through patient education, coordination of laboratory tests

and appointments, and preparation and review of medical records. We were told, however, that the physicians are responsible for the examinations of these patients.

Specialty Care

Persons incarcerated at Mohawk expressed positive views concerning access to specialty care services. This result should be expected because Walsh RMU provides most of the specialty care services for persons in this region of the state, including Mohawk patients. Medical staff reported that most specialty care is provided at the Walsh RMU and that the physicians enter their specialty care requests in the DOCCS computerized system for specialty care (FHS1) themselves. Any requests that are not approved are generally resolved through telephone contact with the reviewing agency. At the time of our visit, the only service individuals experienced difficulties accessing was neurosurgery, although we learned during our August 2011 conference call that a neurosurgeon was added to the facility's consultant list.

Survey respondents estimated that it takes about 30 days to see a specialist, a response time that is shorter than 80% of the prisons we have visited. When we asked Mohawk survey participants who had been to a specialist in the past two years whether they experienced delays in access to specialists, 32% of Mohawk respondents reported their care was not delayed, a rate better than the responses from surveyed individuals at two-thirds of CA-visited prisons.

Given the inclusion of the Walsh RMU specialty care clinics within the prison, we were surprised to learn from the responses of Mohawk survey participants that the percentage of individuals reporting that they were seen by a specialist in the past two years (29% of respondents) was lower than the percentage for three-quarters of the CA-visited prisons. This may not mean, however, that Mohawk patients have less access to specialty services. The CA has reviewed DOCCS data from 2006 and 2007 that suggests that Mohawk was utilizing specialty care services at a rate similar to other prisons. Specifically, the CA analyzed DOCCS data on utilization of Department-wide specialty care services in fiscal year 2006-07, which revealed Mohawk usage of all specialty care services was at a rate slightly above the system-wide average rate for all prisons during that year. The Mohawk's utilization rates for 2006-07 were only low for gastroenterology (35%) and infectious diseases (10%), but for most other essential specialty services, Mohawk had greater utilization rates than the system-wide averages. The low utilization of infectious disease specialists may be due to the fact that two prison providers were designated HIV specialists. Data provided by the facility prior to our 2010 visit also suggests that use of infectious disease services had increased in 2010 from the 2006-07 rates. We suggest that the prison medical staff review utilization of the major specialty care services to ascertain if the prison is referring its patients to these services at a rate comparable to other prisons.

Mohawk survey respondents had mixed views of the facility's response to specialist recommendations. Fifty-six percent of Mohawk surveyed persons who had seen a specialist in the past two years stated there was not good follow-up to the specialists' recommendations, a rate comparable to the average rate for survey respondents at all CA-visited prisons.

Medication

At the time of our visit, Mohawk received its medications from the regional pharmacy at Oneida CF; however, with the October 2011 closure of Oneida, the regional pharmacy was now assigned to Mohawk for supervision. Individuals are told that they should submit medication refill requests seven days before their drugs run out and they will be called down to the clinic when their medications are available. The medical staff estimated that approximately 50 individuals are on one-to-one medications with 30 individuals being called to the clinic during the day shift for medications and 20 to 25 individuals called during the afternoon shift. For patients on chronic medications, DOCCS policy permits prescriptions to be issued for a total of six months, with a one month supply of medication provided initially and authorization for five refills. At the end of that six-month interval, the facility provider will have to reissue the prescription. We were told that individuals are not generally seen by the provider when their medications are renewed, but providers review patients' medical charts before authorizing refills. At the time of our visit, 47% of survey respondents reported that they sometimes experience problems getting their medications, a rate that is better than responses from persons at almost three-quarters of CA-visited prisons. We hope that assigning the regional pharmacy to supervision by Mohawk will further decrease delays and increase satisfaction ratings.

Quality Improvement Program

Mohawk's Facility Quality Improvement (QI) Committee meets quarterly to review medical care in the primary care unit and Walsh RMU. We reviewed the minutes from the two most recent meetings prior to our visit: October 6, 2009 and January 20, 2010. These reports indicated that audits were conducted for diabetes, which the minutes stated found eight of 10 charts in compliance, and an HIV Continuous Quality Improvement audit, which was reported in the minutes to find that all indicators were over 80% compliance. The minutes contain summaries of many elements of the prison's QI activities but provide few details about the specific activities. Overall, we were impressed by the breath of activities of the QI committee and would urge greater supporting documentation of its activities. During our August 2011 conversation, facility administrators stated that they would work to enhance their documentation.

Walsh Regional Medical Unit (RMU)

The Walsh RMU was the Department's first regional medical unit intended to provide skilled nursing care to DOCCS patients who were confined in a prison infirmary or outside hospital. Walsh opened in 1991 with 60 in-patient beds and subsequently was expanded to its current capacity of 112 beds. The unit was full at the time of our visit. The in-patient unit provides skilled nursing care, geriatric care, hospice services and post-operative care. The Walsh RMU also contains an out-patient unit where patients from Mohawk, the Walsh RMU and many of the prisons in the central and western New York region are seen for specialty care services. We met with the Walsh RMU medical staff, toured the unit and spoke with several of its patients. In addition, we obtained written surveys from 30 Walsh patients.

During our visit, we learned about plans to rehabilitate two of the three units in the Walsh RMU and to expand the entire facility. We were informed that the plans are not finalized, but the

facility hopes to include expanded program space, including a chapel and room for video teleconferencing for individuals with their families. The staff estimated that the complete project would take three years once started, but we were not provided with a time frame for the construction.

Medical Staff

The Walsh RMU is staffed by DOCCS employees and the unit has been allocated the following full-time equivalent (FTE) positions: 3.5 physicians, one nurse practitioner, five nurse administrators, one nurse III, 38.5 nurse IIs, two nurse Is, 28 licensed practical nurses (LPNs), and 49 nursing assistants. There were a few vacant positions, including a half-time physician, one nurse III, and three nursing assistants. The staff informed us that they have few vacancies and generally do not experience difficulties filling positions, although the half-time doctor position had been vacant since March 2009 and the nurse III position was vacant since June 2009. We were pleased to learn during our August 2011 conference call that the vacant Nurse III position was filled in September 2011. We were informed by the prison administration that the half-time physician position was eliminated in July 2010 due to DOCCS' workforce reduction plan.

Walsh RMU In-Patient Population

Admission to the Walsh RMU in-patient unit is determined by officials in DOCCS's Central Office. Once a patient is identified for transfer to Walsh RMU, a summary describing his medical condition is sent to the facility for review. If facility staff believe the individual is not an appropriate candidate for the unit, the staff can raise their concerns with Central Office. Very few admissions have been challenged by The Walsh RMU staff; the most recent example was an individual who had significant cognitive impairment who the staff felt would be better served at Fishkill's unit for cognitively impaired persons.

The Walsh RMU in-patient population differs substantially from the general DOCCS population in several respects. The Walsh RMU patients are significantly older; the median age of The Walsh RMU patients was almost 56 years old compared to the department-wide median age of 36. Forty-two percent of the Walsh RMU patients were 60 or more years old and less than 40% were under 50. The ethnic/racial makeup of The Walsh RMU also is substantially different. Forty-four percent of the Walsh RMU population is Caucasian, 37% are African-American and 19% are Hispanic, in comparison to department-wide figures of 23% Caucasian, 52% African-American and 23% Hispanic. Although we would anticipate the significant age difference for the Walsh RMU population, given their serious medical conditions, it is unclear why there are substantial deviations in the percentages of the ethnic/racial categories with the percentage of Caucasian persons nearly doubling the Department-wide figures. Given the older population, it is not surprising that Walsh RMU patients also have longer prison sentences. The median time to their earliest release data was 11.6 years, compared to 4.6 years for all DOCCS individuals. Similarly, the median time Walsh RMU patients had been in DOCCS was 6.1 years compared to 2.2 years for all individuals.

Walsh RMU patients generally remain on the unit for an extended period of time. The prison reported that the average length of stay in 2009 was 468 days. There were 76 and 82 admissions and 78 and 81 discharges, respectively, in 2008 and 2009. Of the discharges, 32 and 39 patients were discharged from DOCCS custody in 2008 and 2009. Twenty-seven individuals died on the unit in 2008, 17 died in 2009 and nine had died in 2010 by the time of our visit in June 2010.

Many of the Walsh RMU patients suffer from chronic medical problems. The staff estimated that there were approximately 19 patients with HCV and eight patients who were HIV-infected. Although we did not receive a precise figure, we were told many patients also suffer from diabetes. Typically, the HIV-infected population ranges from 10% to 15% of the census, down substantially from a decade or more ago when it represented 80% of the patient population. The number of patients infected with HCV has increased during the last decade, and some of these HCV-infected patients are no longer eligible for treatment. Walsh RMU staff will evaluate HCV-infected patients for a liver transplant, but no Walsh RMU patient has had a liver transplant in at least the last 15 years.

Medical Care for Walsh RMU In-Patients

Walsh RMU in-patients expressed mixed views about the medical care they received. When asked to rate the overall quality of the medical care on the unit, 28% of the Walsh RMU survey participants said it was good, 28% rated it as fair and 45% assessed it as poor. This is substantially worse than the responses we received from persons surveyed in the Coxsackie RMU, in which 40% rated medical care as good, 50% as fair and only 10% as poor. We asked Walsh RMU patients to assess several aspects of their care and their responses varied according to whom was providing the care. **Table J** summarizes the responses of Walsh RMU patients concerning several aspects of the medical care on the unit.

Table J - Walsh RMU Survey Responses Concerning Medical Care on the In-Patient Unit

Medical Service	Yes	Sometimes	No	Good	Fair	Poor
Can you seen RN promptly	60%	27%	13%			
Rate Nursing care				43%	27%	30%
Rate Nursing Assistant care				25%	39%	36%
Can you see MD promptly	17%	17%	67%			
Rate Physician care				24%	7%	69%
Experience delays in specialty care	30%	35%	35%			
Good follow-up to specialists				38%	-	63%
Problems getting medication	41%	11%	48%			

As **Table J** illustrates, Walsh RMU survey participants were more positive about nursing care, but more critical of the physician care. Generally Walsh RMU patients reported prompt access to the nurses and assessed nursing care as relatively good. The Walsh RMU patients

reported better access to such care than survey respondents from the Coxsackie RMU, but their assessment of the quality of nursing care showed greater variability in care than that reported by Coxsackie RMU patients.[11] Walsh RMU patients also had a mixed view of the nursing assistants at rates somewhat worse than Coxsackie RMU patients. The most frequent complaint about the nursing assistants dealt with poor attitude with their patients and the close relationship between nursing assistants and the security staff.

Walsh RMU survey respondents were more concerned, however, with delayed access to doctors and the quality of care they received from these providers. More than two-thirds of the survey respondents said they experienced delayed physician care and 70% reported that these delays occurred frequently. Coxsackie RMU survey participants also noted delays in care, but at rates somewhat less than at Walsh. More importantly, many Walsh RMU patients were critical of the care they received from the doctors. Sixty-nine percent of Walsh RMU survey participants said the physician care was poor in contrast to only 30% of Coxsackie RMU survey participants.

Some Walsh RMU survey respondents asserted that they were infrequently seen by their physician, that their doctor did not thoroughly examine them during these encounters and that the patients were denied timely and/or adequate care, particularly if it involved pain management. Many survey respondents referred to poor communication between physicians and their patients, including some who asserted the doctors exhibited an indifferent or disrespectful attitude toward the patients. Not all survey respondents expressed such negative views. A minority of survey participants said they received good care and felt that their doctor was providing quality care.

Approximately half of the Walsh RMU survey respondents on medication reported experiencing some problems obtaining appropriate treatment. This rate is substantially higher than the medication problems reported by Coxsackie RMU survey participants. Concerns expressed by Walsh RMU survey respondents focused on not getting the drugs the patient had been receiving prior to incarceration or at another facility, not receiving sufficient pain medication for their condition, having their medication regimen changed without consultation between the doctor and the patient and failing to prescribe medication suggested by a specialist.

Walsh RMU survey respondents also expressed mixed views on access to, and provider follow-up from, specialty care services. Approximately two-thirds of Walsh RMU survey participants reported delays in access to a specialist, substantially higher than Coxsackie RMU patients. Similarly, a majority of Walsh RMU patients said there was not adequate follow-up to the specialists' recommendations, a rate substantially worse than that reported by Coxsackie RMU patients.[12] Several Walsh RMU respondents raised concerns that they were not being sent to a specialist for significant medical problems.

[11] Only 40% of Coxsackie RMU survey participants said they could promptly access nursing care. Twenty-seven percent of Coxsackie respondents said nursing care was good, 64% reported it as fair and only 9% found it poor.
[12] Eighty-eight percent of Coxsackie RMU survey participants said they experienced no delays with access to a specialist and 13% reported experiencing delays sometimes. Seventy-eight percent of Coxsackie RMU survey respondents reported good follow-up to the recommendations by a specialist, a rate twice that of Walsh survey participants.

Medical Care Recommendations

- Review the utilization of sick call services to ensure that all persons are getting timely access to sick call.
- Review the quality of medical encounters between patients and clinic providers to ensure that patients' medical conditions are promptly diagnosed and properly treated.
- Enhance efforts to identify individuals with HIV through greater peer education efforts and more outreach by volunteer health educators and the medical staff to encourage persons at risk for the disease to be tested and seek care.
- Review the utilization of specialty care services and the adequacy of prison follow-up to specialists' recommendations.
- Enhance the minutes of the facility quality improvement committee by including more details concerning chart reviews and other QI activities.

Medical Care Recommendations for Walsh Regional Medical Unit

- Review the quality of medical encounters between patients and Walsh RMU clinical providers to ensure that patients' medical conditions are promptly diagnosed and properly treated.
- Review the quality of medical interactions between Walsh RMU patients and the RMU nurses and nursing assistant staff to identify ways to improve communication and patient satisfaction.
- Review Walsh RMU grievances and disciplinary actions against RMU patients to determine what issues and circumstances are causing conflict between RMU patients and RMU security staff, and develop with the assistance of RMU patients a plan to reduce the level of violence and verbal confrontations between security staff and patients.

MT. MCGREGOR

The Visiting Committee of the Correctional Association of New York visited Mt McGregor Correctional Facility on May 5th, 2010. Mt McGregor is a medium-security prison located in Saratoga County, about 200 miles north of New York City. Mt McGregor had a capacity of 544 people and confined 429 people at the time of the visit.

MEDICAL CARE

The Visiting Committee toured the medical facilities at Mt. McGregor and interviewed the Nurse Administrator. We appreciated the extensive information provided by the facility staff prior to and during our tour. The medical department at Mt. McGregor includes a 12-bed infirmary, the only medium-security infirmary in the Great Meadow Hub, which held three individuals at the time of our visit. Patients in need of hospitalization are sent to Albany Medical Center, and for emergencies, individuals are sent to Glens Falls Hospital. Facility staff reported no deaths in the past three years, and one suicide attempt 18 months prior to our visit.

The Visiting Committee was impressed with the medical staff's ability to ensure that all patients are seen in a timely manner, especially given the staff vacancies and financial constraints at the time of our visit. It was clear that medical staff made efforts to fulfill their duties and cover the duties of vacant positions. Patients were generally more satisfied with wait times than at other facilities, but expressed some ambivalence about the quality of services received. Overall, individuals who responded to our survey rated the prison's healthcare system as fair, though this is a more positive assessment than the average rating at all CA-visited facilities. Thirteen percent of Mt. McGregor survey respondents rated the overall quality of medical care as good, 49% as fair, and 38% as poor, placing the facility in the top third of CA-visited correctional facilities for medical services.

Staffing

Authorized medical staff positions included one physician who is an HIV specialist and seven nurse positions. At the time of our visit the facility had two nurse vacancies – one full-time vacancy and one part-time vacancy. We learned during our June 2011 conversation that these two vacancies were filled by January 2011; however, two new vacancies had opened in April and June 2011. According to staff, the facility uses approximately three overtime shifts every two-week pay period. The facility frequently uses two per diem nurses to fill the staffing vacancies. There were two incidences when staff had to work involuntary overtime between January and May 2010. Three additional outside Infectious Disease (ID) specialists provide services to persons with HIV. Given its current staffing numbers, the prison has one clinic provider (doctor) for every 432 patients and one nurse for every 86 patients, rates that are comparable, if not slightly better, than many other prisons we have visited. None of the staff speak Spanish. Staff explained that providers have access to a telephonic translation service for non-English speaking patients; however, individuals with whom we spoke complained about staff's inability to communicate with these patients and reported that staff did not know that this tool was available.

Sick Call

Sick call is conducted four times a week – Monday, Wednesday, Thursday, and Friday from 7:00 a.m. to 8:00 a.m. According to staff, two nurses are typically assigned to sick call, although sometimes only one nurse is available. Individuals must come to the clinic waiting room for sick call and are seen on a first come, first serve basis. Staff explained that they were beginning to implement a triage system where individuals in the sick call waiting area are prioritized based on the severity of their medical condition. Mt. McGregor keeps one nurse on staff at all times and emergency sick call is available 24 hours a day. Staff explained that some individuals abuse emergency sick call to be excused from programs, but staff generally do not issue tickets for this behavior, only having issued two such tickets in 2009. We oppose the use of disciplinary actions for attempting to use medical services and recommend that the prison utilize non-punitive means to address inappropriate requests for emergency sick call. Facility staff estimated that nurses see an average of 187 individuals per month at regular sick call and 40 individuals per month at emergency sick call.

Incarcerated individuals at Mt. McGregor rated their access to sick call far better than individuals at other CA-visited facilities. Seventy-one percent of survey respondents stated that they could access sick call when needed, ranking Mt. McGregor as the fourth best prison among all CA-visited facilities for access to sick call. Concerning the quality of care at sick call, surveyed persons were less satisfied than at other CA-visited prisons, with 11% rating the overall quality of sick call nurses as good, 38% rating them as fair, and 52% rating them as poor, placing the prison in the bottom third of all CA-visited facilities for quality of sick call care. When asked to explain their ratings of sick call services, several individuals described provider attitudes as uncaring or disrespectful, which sometimes deterred them from seeking health care. Persons who rated these services positively pointed out that some of the nurses were helpful and informative.

Routine Medical Care

Patients who require care beyond sick call are seen in the medical area by the physician. Clinic call-outs are held Mondays, Tuesdays, Wednesdays, and Thursdays from 9:00 a.m. to 12:00 p.m. and 12:30 p.m. to 3:00 p.m. Staff estimated that they see an average of 315 individuals per month for call-outs. Similar to the sick call process, survey participants were generally more satisfied with access to clinic call-outs than at other CA-visited facilities. At a rate lower than most CA-visited prisons, only 21% of survey respondents reported experiencing frequent delays in seeing a clinic provider, ranking Mt. McGregor fifth highest of all CA-visited facilities for provider access. Similarly, the median wait time to see health care providers reported by survey participants was 14 days, notably lower than the median wait time of 21 days at all CA-visited facilities.

Overall, survey respondents rated the quality of medical staff as fair, at a rate similar to other CA-visited facilities. Ten percent of survey respondents rated medical staff as good, 46% as fair, and 44% as poor, ranking Mt. McGregor in the middle of all CA-visited facilities for satisfaction with medical staff. Persons who rated the physician, Dr. Crook, favorably stated that he was knowledgeable and understanding, and provided better services than clinical providers at other prisons. They also expressed appreciation for his efforts at explaining medical diagnoses

and treatment in a manner that ensured their understanding. It was clear that Dr. Crook makes an effort to conduct patient education, leaving patients more informed about their care than at many other CA-visited facilities. Among reasons why patients were dissatisfied with the physician were that he was sometimes dismissive of complaints and that wait times were too long.

Chronic Care

According to information provided by the facility, Mt. McGregor housed nine HIV-infected individuals, six of whom were receiving therapy at the time of our visit. Of these nine HIV-infected patients, two had progressed to an AIDS diagnosis. The facility's full-time clinician, Dr. Crook, is a qualified HIV-specialist and sees five HIV-infected patients per month. Additionally, depending on patients' needs, HIV-infected patients are sent to nearby Albany Medical Center or seen by providers via video conferencing. Staff informed us that Dr. Crook works closely with the outside doctors to ensure continuity of HIV care once patients are released.

Staff had identified 43 individuals with hepatitis C (HCV), representing nearly 10% of the prison population, a rate that is slightly higher than the average 9% throughout the Department. Twenty-eight of these patients were chronically infected with HCV, a rate comparable to that in the community. According to facility data, only four of these HCV-infected individuals were receiving treatment for the disease; however, this rate of treatment is higher than the Department-wide average of 5%. Three individuals were co-infected with HCV and HIV, and one of these persons was receiving HCV therapy. HCV-infected patients obtain liver biopsies at Albany Medical Center, and, according to staff, there is not a lengthy wait for these appointments, although it sometimes takes several weeks to schedule the biopsy. Dr. Crook attends to gastroenterological issues himself, only sending patients to outside gastroenterologists if necessary. Staff told us that very few patients receiving HCV therapy discontinue the treatment, and the majority undergoes the full course of treatment. Staff surmised that the reason individuals incarcerated at Mt. McGregor complete the HCV treatment regimen is that Dr. Crook takes the time to fully advise patients about treatment, explaining both the side effects and difficulties they may experience.

Mt. McGregor houses many individuals with other chronic medical conditions. At the time of our visit, there were 59 individuals with asthma, 95 individuals with hypertension, and 28 individuals with diabetes. Forty-eight percent of Mt. McGregor survey respondents stated that they suffered from a chronic medical condition, a smaller percentage than at other CA-visited prisons, placing it in the bottom half of these prisons for prevalence of chronic medical conditions. According to staff, Dr. Crook sees patients with chronic conditions on a regular basis and assigns nurses to specific chronic care clinics to help facilitate continuity of care of those patients. We commend Dr. Crook for his efforts at explaining HCV treatment to patients and for ensuring that patients see nurses with special knowledge of their diseases and their particular care.

Specialty Care

Incarcerated persons who require specialty care services are sent to outside specialists or are seen at the prison in specialty care clinics. A physical therapist visits the facility twice a month, and persons who need additional care are sent to Coxsackie or Great Meadow C.F. for physical therapy appointments. According to staff, patients wait an average of eight to 10 weeks for a routine specialist appointment. Staff told the CA that there are no delays in access to any clinics.

Incarcerated individuals who had seen a specialist were generally positive about their experiences and provider follow-up to specialists' recommendations. However, the median wait time to see a specialist was 80 days, higher than the 60-day median wait at other CA-visited facilities. Thirty-seven percent of survey respondents reported seeing a specialist in the past two years, with 54% of these patients experiencing a delay at least sometimes, thereby ranking Mt. McGregor in the bottom third of CA-surveyed prisons concerning specialty care delays. In contrast, 54% of the patients who had seen a specialist stated that facility medical staff provided good follow-up with the specialists' recommendations, ranking the prison fourth among all CA-visited facilities for responsiveness of prison medical staff to these recommendations.

The CA evaluated specialty care services for fiscal year 2006-07 at all state facilities and found that Mt. McGregor utilized these services at a rate that was only 72% of the department-wide average. Services utilized substantially below the department-wide average included: cardiology (32% of department-wide rate), nephrology (52%), neurology (10%) and physical therapy (28%). We urge facility and Central Office staff to review current utilization rates to determine whether the prison is promptly referring patients to specialty care.

Pharmacy

Mt. McGregor does not have its own pharmacy. Instead, the facility receives daily deliveries from the pharmacy at nearby Washington C.F. Prescriptions for Mt. McGregor patients that are faxed to Washington by noon are delivered to the prison the same day. Staff estimated that 99% of medications come from Washington C.F. For emergency orders, DOCCS has a contract with Kinney Drugs, which has a subcontract with a local pharmacy. Staff advise incarcerated individuals to submit slips for prescription refills seven days in advance; however, individuals will not experience a delay if they submit the slip five days in advance. Medications not contained in Washington's formulary are obtained from the Central Pharmacy at Oneida C.F.

Persons incarcerated at Mt. McGregor appeared to have fewer problems obtaining medication than at other facilities. Forty-percent of survey respondents who were on medication reported having difficulty obtaining medications at least sometimes, ranking the facility in the top quarter of CA-visited prisons for ability to obtain prescription medications. Individuals with whom we spoke stated that there were some instances of medication mix-ups, but did not complain of many delays in receiving medications.

Quality Improvement

Mt. McGregor has a seven-member Quality Improvement (QI) Committee comprising medical, administrative, and security staff that meets quarterly to review facility health care. Staff explained that the QI Committee has not been able to identify any trends in care quality that require improvement, but the Committee noted that the medical staff needs to consistently update medical problem lists to ensure that all significant medical concerns are summarized in the front of patients' charts. The Committee provides meeting minutes to facility executive staff and to the DOCCS division of Health Services (DHS) for review. With the assistance of the infection control nurse, the facility nurse assigned to HIV care conducts Continuous Quality Improvement (CQI) audits of its HIV care every six months, during which they review medical charts of 10 HIV-infected individuals. We reviewed the most recent facility-based QI minutes for the October through December 2009 period and were generally impressed with the breadth of the prison's QI activities, but also concur with the recommendation contained in the minutes that they include more detail.

Medical Care Recommendations

- Fill the two vacant nurse positions.
- Ensure that incarcerated persons have timely access to all specialty care services.
- Enhance the minutes of the facility quality improvement committee.

OTISVILLE

The Visiting Committee of the Correctional Association of New York visited Otisville Correctional Facility on July 26th, 2011. Otisville is a medium-security prison located in the town of Mount Hope, Orange County, New York, approximately 90 miles northwest of New York City. Otisville had a capacity of 513 people and confined 408 people at the time of the visit.

MEDICAL CARE

The Visiting Committee toured the medical area during our visit to Otisville and was able to meet with medical staff. We appreciate the extensive information that was given to us prior to our visit and during our tour. The medical facilities at Otisville were remodeled four years prior to our visit, and the Visiting Committee was pleased to see the clean and well-kept quality of the space. The waiting room for medical services has a capacity of 28, and included two private bathroom stalls, two water fountains, and several benches. The facility also had a respiratory room, a telemedicine exam room, a phlebotomy lab, and light therapy treatment equipment. Otisville's 6-bed infirmary includes two isolation rooms. There were three patients in the infirmary at the time of our visit, which medical staff informed the Visiting Committee is the average census. The average stay in the infirmary is several days, although about once per month an individual is required to stay for an extended time, which can amount to a week or more. Doctors make rounds to the infirmary every other weekday.

Incarcerated persons at Otisville had mixed reviews of the medical care provided to them at Otisville, with about half rating overall medical care as poor and half rating medical care as fair. **Table K - Summary of Otisville Survey Participants' Response about Prison Medical Care** summarizes the medical care survey data along with the prison ranking compared to all CA-visited prisons.

Table K - Summary of Otisville Survey Participants' Response about Prison Medical Care

Medical Service	Yes	Sometimes	No	Rank	Good	Fair	Poor	Rank*
Can you see an RN when needed	68%	24%	8%	5				
Rate Nursing care					8%	43%	49%	22
Do you experience delays in seeing a clinic provider *	38%	42%	20%	18				
Rate Physician care					10%	38%	52%	24
Experience delays in specialty care	40%	16%	44%	9				
Good follow-up to specialists	35%		65%	21				
Problems getting medication	15%	18%	29%	13				
Rate Overall Healthcare					9%	44%	47%	20

* CA-visited facilities are ranked from 1-31, one being the best and 31 being the worst.
* The three categories for this variable are: Yes=Frequently; Sometimes=Once or once in a while; and No=Never.

Medical Staffing

Otisville's medical area is staffed by two part-time doctors, who are present at the facility on Monday, Tuesday, Thursday, and Friday, representing a total physician presence equal to one full-time doctor. Otisville also has seven full-time equivalent (FTE) nursing items, consisting of six full-time and two part-time nurses. At the time of our visit, two of the full-time nurses were out on medical leave and one was retiring, but the facility had authorization from Central Office to fill the latter position. The nurse-to-patient ratio at the facility, when all items are operational, is about one nurse to every 50 to 60 patients, much lower than the system-wide average of about one nurse to every 80 to 100 patients. When the facility expands the population to 600 persons the nurse-to-patient ratio, with all staff operational, will be about one nurse to every 80 to 90 patients, which is equal to the system-wide average. The CA is concerned with the reported number of nursing vacancies at the time of our visit, which leaves the facility inadequately staffed to serve its current population and will only worsen when the population expands.

The ratio of clinical staff, one FTE doctor, to patients is about one doctor to every 400-410 patients, which is similar to the system wide average of 1:400. However, when Otisville expands and opens the two additional dorms, increasing the population to 600 persons, the ratio of doctors to patients will be about one to 600, which is significantly higher than the system-wide average. We strongly recommend that the Department evaluate whether additional clinical and nursing staff is needed with the expansion of Otisville's population. Medical staff did inform the Visiting Committee that both FTE doctors spoke Spanish, as well as one of the nurses, and patients were permitted to bring an incarcerated person translator with them if they wanted, though medical staff never encouraged them to do so.

During our follow-up call with facility administrators, the CA requested an update on medical staffing items allocated to the prison. We were informed that since our visit, one of the two part-time physicians had retired in September 2011, leaving the facility with one part-time physician, who was at the facility Monday, Tuesday, Thursday, and Friday, during which time he conducts clinical call-outs from 6:00am to 8:00am. Otisville administration informed the CA that they have authorization to fill the second vacant part-time physician's position and are interviewing candidates, but there was no plan to increase the overall number of clinical staff at the facility despite the increase in the patient population. We are concerned about the current shortage in physician staffing and urge to prison to quickly fill the vacant position.

The CA was pleased to learn that the Nurse Administrator position was filled in May 2012, but the facility seemed to be struggling with the number of medical staffing turnovers in the past year. Administrators noted that although there was significant turnover in the medical staffing, they were not having problems findings suitable candidates to fill vacant positions. Since July 2011, one nurse position had been terminated, one had retired and one part-time nurse had been transferred. The facility had also hired one full-time nurse in addition to the Nurse Administrator, and had received authorization to replace the half-time nurse. The CA is still concerned that the number of medical staff, both clinical and nursing, may not be sufficient to adequately address the needs of the population. We continue to encourage Central Office to review the number of medical staff to determine whether Otisville could benefit from additional staff.

Sick Call

Sick call is conducted on Mondays, Tuesdays, Thursdays and Fridays and starts at 6:00 am for those patients housed in the South Compound and at 7:30 am for patients in the North Compound. Sick call is usually completed by 8:30 am. Medical staff estimated that between 145-180 patients are seen each month for regular sick call and about 35 patients are seen per month for emergency sick call. Medical staff informed the Visiting Committee that they do not issue tickets for abuse of emergency sick call.

As indicated in **Table K** above, over half of all survey respondents reported that they could access sick call when they needed, which ranks Otisville at the top of all CA-visited facilities. However, survey participants had mixed reviews of the quality of the sick call encounters with about half reporting that the sick call nurses were poor and most of the other respondents reporting that the nurses were fair.[13] According to survey comments, some sick call nurses did a good job and cared about the patients they were treating, while other nurses did a less favorable job. Survey participants were most concerned by the instructions to drink water and take ibuprofen for most ailments. Some survey participants also reported that some sick call nurses were unprofessional and rude. Due to the inconsistencies in the nursing services patients reported they were receiving, we suggest that the facility medical administration review the quality of the sick call encounters to ensure that each nurse is providing timely and appropriate care.

Clinic Call-Outs

Clinical call-outs by the doctors are conducted five days a week and the physicians see between 140-160 patients per month. Medical staff estimated that it takes about two weeks to see a doctor; though patients may be seen by a physician right away if the sick call nurse deems it is necessary. Over 50% of survey participants reported experiencing delays in seeing the doctors, and survey participants estimated that it takes a median of 18 days to see a physician, which is actually less than the estimated 21 day median average at all CA-visited facilities. As with the sick call nurses, patients had mixed reviews of the quality of their clinical encounters with about half rating them as good or fair and half rating them as poor. The biggest concern expressed by survey participants was that the doctors often seemed like they were in a rush and therefore patients felt that they were not being provided with adequate time to communicate their concerns and be thoroughly examined. The CA is very concerned that with the increase in the population and vacant physicians positions, there will be further delays and a greater likelihood that patients will not receive appropriate care. We strongly urge the Department to hire additional clinical providers for Otisville as part of the expansion of the prison's capacity.

Care for Patients with Chronic Medical Problems

Otisville, like most other facilities in the DOCCS system, has a significant portion of its prison population who suffer from a chronic medical condition. **Table L - Summary of Persons Confined at Otisville with Chronic Medical Conditions** details the chronic medical conditions,

[13] Eight percent rated the sick call nurses as good; 42% rated them as fair and 49% rated them as poor.

number infected, percent of the prison population, and number treated for several illnesses as of the time of our visit. Patients at Otisville who suffer from a chronic condition are not assigned to a particular practitioner; instead, specific nurses are responsible for monitoring a group of patients suffering from the same chronic medical condition. These chronic care nurses primarily perform administrative/paperwork duties and scheduling of laboratory tests associated with these patients' care. The physicians regularly examine these patients to monitor their medical condition and conduct much of the patient education. One chronic care nurse is assigned to all HIV-infected patients; one nurse is responsible for all the patients with diabetes and hypertension, and a third nurse monitors hepatitis C and B, and asthma patients. Patients with a chronic condition receive a clinic call out at least once every three months. Patients, who suffer from diabetes, self-inject insulin in the medical area from 7:15 to 8:00 am under the supervision of the nursing staff.

Table L - Summary of Persons Confined at Otisville with Chronic Medical Conditions

	HIV	AIDS	HCV	HIV & HCV	Asthma	Diabetes	Hypertension
Infected	**10**	**3**	**50**	**5**	**37**	**37**	**117**
% Infected	**2.5%**	**0.7%**	**12.25%**	**1.2%**	**9%**	**6.6%**	**28.6%**
Treated	**10**		**1**	**0**	**22**	**9**	**105**

Both of the doctors at Otisville were certified as HIV specialists by DOCCS. Otisville medical staff informed the Visiting Committee that there has been a relatively low number of individuals infected with HIV housed at the facility in the past 2-3 years. HIV-infected patients are not assigned to a particular doctor; instead, they see whoever is available at the time. Otisville's doctors conducted one infectious disease clinic for patients in the past month and see about two to three patients for specialty appointments each month. The percent of individuals at Otisville infected with HIV is significantly lower than the estimated 5% to 6% of the entire DOCCS population who are currently believed to be infected with HIV based upon NY Department of Health studies. However, we are extremely pleased to see that all HIV-infected patients are currently receiving treatment.

Otisville had 46 individuals infected with hepatitis C (HCV) at the time of our visit, representing 11.3% of the incarcerated population. Otisville had only one patient currently undergoing treatment, which is 2% of the HCV-infected population, significantly lower than the system-wide average of about 5% of the infected population being treated. We urge the facility's medical staff to review the population of HCV-infected individuals in order to determine whether any of those currently not receiving treatment may be appropriate candidates for therapy.

Specialty Care

Patients in need of care outside the limits of the Otisville clinic's capabilities are generally sent to Fishkill's Regional Medical Unit (RMU). Medical staff estimated that on average about 30 patients are sent to the Fishkill RMU each month. Planned hospital visits are done at Mt. Vernon Hospital, and patients in need of emergency attention are sent to Horton Hospital. Medical staff informed the Visiting Committee that a total of 100 medical trips are

made from Otisville each month. Liver biopsies are conducted at the Fishkill RMU or Horton Hospital. The medical staff informed the Visiting Committee that an optometrist and podiatrist come to Otisville to conduct treatment and that X-rays are also done on site. The medical staff expressed some concern that it was often difficult to get an orthopedist at the facility. Thirty-nine percent of survey respondents reported having seen a specialist in the past two years, and 56% reported experiencing delays at least sometimes in seeing a specialist, which ranks Otisville in the top third of CA-visited prisons for fewer patients reporting specialty delays. Patients reported an estimated average wait of 31 days to see a specialist, which is half the estimated average number of days survey respondents at all CA-visited facilities reported waiting to see a specialist.[14] Otisville survey participants rated the medical staff's follow-up to specialist recommendations slightly lower than average, with 35% saying follow-up care was good, as compared to an overall average of 38% for all CA survey respondents. There were also reports by survey participants of Otisville doctors changing the specialists prescribed medication without their previous knowledge.

Medication

Otisville does not have a pharmacy and for most medications, patients' prescriptions are sent to a local pharmacy to be filled. Prescription refills are submitted similarly to sick call requests, although the doctor does not have to see the patient prior to refilling his medication. Patients are instructed to submit refills for medication five days prior to running out to ensure that they do not miss doses. Medication arrives at the prison at approximate 2:30 pm each weekday. Since the medical staff does not notify a patient when their medication has arrived, patients must continuously check the medical area for their prescriptions.

Twenty-nine percent of survey participants reported they experienced no problems in receiving their medication, 15% reported experiencing problems and 18% reported sometimes experiencing problems getting their medication. This is compared to the average of 23% of survey participants at all CA-visited facilities who reported experiencing problems getting their medication and ranks Otisville in the top half of all CA-visited prisons for the least amount of problems patients have receiving their medication.

Quality Improvement

The Quality Improvement Committee at Otisville meets quarterly and is made up of the superintendent, one clinical provider and two nursing staff. Medical staff informed the Visiting Committee that this year HIV and asthma were the two treatment conditions reviewed. At the time of our visit, the last QI audit of HIV care had been conducted on May 18, 2011, during which all medical charts of HIV-infected persons were reviewed. The staff informed us that during this review, the prison was found to be compliant in the standard of care provided to HIV-infected patients.

[14] Persons at all CA-visited facilities estimate that they wait an average of 60 days to see a specialist.

Medical Care Recommendations

- Promptly fill all nursing and physician vacancies.
- Consider hiring additional clinical staff to decrease the clinical provider to patient ratio with the increase of the population.
- Review the quality of care provided during both sick call and clinical call outs to ensure that patients are receiving adequate medical attention and care from all providers.

QUEENSBORO

The Visiting Committee of the Correctional Association of New York visited Queensboro Correctional Facility on March 16th, 2011. Queensboro is a minimum-security prison located in Long Island City, Queens. Queensboro had a capacity of 424 people and confined 408 people at the time of the visit.

MEDICAL CARE

The CA Visiting Committee toured the medical area and met with the Nurse Administrator (NA) about the medical services at the facility. We appreciate the detailed information provided prior to our visit and during our tour. The medical staff at Queensboro is comprised of one full-time physician, one Nurse Administrator, and three full-time equivalent nurses. Queensboro also utilizes one agency nurse for 32 hours per month to cover a part-time nurse vacancy, which the facility has authorization to fill, but had not found someone suitable for the position at the time of our visit. Both the Nurse Administrator and the doctor are bilingual, and therefore, they do not need a peer translator for monolingual patients. The medical staff conducts sick call everyday starting at 10:00 am in the morning and sees about 410 patients per month. Clinical call-outs are conducted Monday-Friday starting at 8:00 am and the physician sees about 210 patients per month. Medical staff also makes rounds to 2S, the restricted housing unit, every day. The Nurse Administrator reported that they do not issue tickets for emergency sick-call encounters and see about 44 such encounters per month.

The Nurse Administrator informed us that the medical staff at Queensboro is required to conduct a chart review for every person that arrives at the facility, which is about 50 to 60 patients per week. The medical staff conducts five to ten minute interviews with all new arrivals and utilizes an inter-facility screening form. Upon their arrival to the facility, all persons who present with a chronic illness are referred to the facility doctor. According to the surveys we received, 25% of respondents reported suffering from a chronic illness. If persons are in need of 24-hour medical care, they are transferred to Sing Sing C.F.; otherwise, they are taken to a local hospital.

The Nurse Administrator felt that the most common chronic illness was asthma and that the elevator being broken hindered individuals' movement about the facility. The CA learned that the elevator was being renovated between December 2010 and April 2011 and was completely operational as of January 2012. There have been no deaths at Queensboro since 1999 and no reported acts of self-harm during the last several years. The medical staff expressed concern that some persons transferred to the facility are more ill, or have more medical needs, than the facility can accommodate, and the prison frequently has to send such individuals back to upstate facilities because their medical needs cannot be met at Queensboro. The CA Visiting Committee heard some of the same concerns from ILC members, that incarcerated persons are often transferred to Queensboro who need more medical attention or more specific accommodations than can be addressed at the facility. We commend the facility for performing a thorough medical assessment of newly admitted persons and for recognizing that an incarcerated person may need more care than the facility can provide, and we urge the medical staff to continue to recommend the transfer of patients the facility staff believe cannot be adequately

cared for at the prison. We suggest, however, that DOCCS screen incarcerated persons more thoroughly before transferring an individual with significant medical problems to the prison, and thereby avoiding unnecessary dislocation of incarcerated persons and added expense to the Department for multiple transfers.

During our follow-up call, Queensboro administrators expressed the view that the number of times incarcerated persons had to be transferred due to persistent medical issues that the facility could not address were infrequent and that additional screening was not necessary.

Overall, surveyed persons were generally satisfied with their access to sick call and the doctor. Ninety-six percent reported having access to sick call when needed, 63% rated the sick call nurses as "good" or "fair," 63% reported never experiencing delays in receiving medical care and 72% reported their overall satisfaction with medical care as "fair." These figures place Queensboro in the top third of all CA visited prisons for quality of medical care services.

(a) Discharge Planning and Treatment for Patients with HIV and HCV

Many incarcerated persons at Queensboro who are known to be infected with Hepatitis C (HCV) or HIV are seen by Osborne Association staff, who assists these patients in getting appointments with health providers in their communities so that they can promptly receive medical attention once released. The Nurse Administrator estimated that about 50% of HIV-infected patients and 25% of HCV-infected patients, respectively, elect to continue to see this community-based medical provider once released. We urge Queensboro medical staff to encourage the reinforcement of those connections between infected persons and community provides while persons are at Queensboro in order to ensure better continuity of care. The Nurse Administrator informed the CA Visiting Committee that all HIV lab work is done at the facility by a phlebotomist who comes once a week and completes the HIV testing promptly to inform patients of their results. The NA also told us that the number of individuals seeking HCV testing has increased, due to incarcerated persons being asked to be tested by their loved ones before returning home. The medical staff at Queensboro participates in four to five hours of mandatory training for HIV per year, which is conducted via DVDs and video conferences.

All medical charts for persons released from Queensboro are stored in Long Island City. The medical staff creates a Comprehensive Medical Summary (CMS) for each incarcerated person, which is available to them at the time of their release. The Nurse Administrator estimated that about 75% of persons request their CMS upon release. We commend the facility for providing medical information to soon-to-be-released individuals who will need such documentation to improve continuity of care in the community.

Medical Care Recommendations

- Fill all medical staff vacancies.
- Screen inmates recommended to the program more thoroughly to ascertain whether the facility can meet their medical needs.

WALLKILL

The Visiting Committee of the Correctional Association of New York visited Wallkill Correctional Facility on August 2nd, 2010. Wallkill is a medium-security prison located 60 miles north of New York City in Ulster County. Wallkill had a capacity of 606 people and confined 553 people at the time of the visit.

MEDICAL CARE

The Visiting Committee toured the medical facilities at Wallkill and met with the Nurse Administrator. We appreciated the extensive information provided by the facility staff during our tour and following our visit. The medical facilities include two examination rooms, an emergency room that also houses a telemedicine unit, and an optometry exam room. The waiting room was brightly lit and contained several benches for waiting patients. There are 13 automated external defibrillators (AEDs) located in Wallkill, some of which are located in the medical facilities. The facility does not have an on-site infirmary and individuals requiring this environment are sent to the Shawangunk infirmary. Staff explained that since housing areas never close, individuals who are feeling ill may use "medical no duty" excuses and stay in their housing area during program hours. Persons experiencing medical emergencies are taken by ambulance to nearby St. Luke's Cornwall Hospital or to Albany Medical Center, depending on the severity of the condition.

Medical care is a primary area of concern of incarcerated persons at Wallkill, given that the majority of grievances are about medical care as compared to any other issue. Despite complaints of long wait times for routine appointments and poor quality of care when seeing the doctor, individuals rated Wallkill higher than most other CA-visited facilities for timeliness of sick call and quality of sick call staff, wait time for specialty care appointments, and access to medication. Eight percent of Wallkill survey respondents rated the overall quality of medical care as good, 65% as fair, and 28% as poor, placing the facility in the top quarter of all CA-visited prisons for quality of medical care.

Staffing

Authorized medical staff positions included a physician, a nurse administrator, four full time equivalent (FTE) permanent nursing items and one FTE per diem nursing item. At the time of our visit, the permanent nurse positions were filled by one full-time nurse and three half-time nurses; the per diem nurse item was being filled by nurse who worked two to three days a week. The facility had one part-time nurse position which had become vacant approximately one month prior to our visit. The full-time nurse was hired a week prior to our visit, filling a position that was vacant from January through July 2010. Staff mentioned having difficulty filling the vacant nurse positions due to the nature of working in a prison, low wages, and the lack of people looking for part-time positions. In addition to the physician, there had previously been a part-time nurse practitioner and then a part-time physician's assistant until April 2009, but authorization for these positions were terminated. The nurse practitioner used to take histories, provide physicals and work with patients with asthma, back pain, skin rashes, and other minor issues, but now this work is included in the physician's duties. The facility did have

authorization for an additional clinical provider who could work up to 10 hours per week to cover vacations.

Training and continuing medical education is available to the medical staff through Albany Medical Center via telemedicine and on site. Infection control nurses occasionally come to the facility to provide training, and hepatitis training is also available.

Given its current staffing numbers, Wallkill has one clinic provider (doctor) for every 595 patients and one nurse for every 149 patients, rates that are significantly higher than other CA-visited prisons. Also, none of the medical staff speak Spanish. We are concerned about these staffing loads and encourage the Department to allocate more medical staffing to the facility.

Sick Call

Sick call is conducted by one nurse four days per week on Mondays, Wednesdays, Thursdays and Fridays from 7:40 a.m. until 10:00 a.m. In order to attend sick call, an incarcerated individual must fill out a sick call request slip by 3:00 a.m. The individuals requesting sick call are told to come to sick call at 7:30 a.m., but no call-out list is prepared. Instead of seeing patients first come, first serve, as was done in the past, the sick call nurse now sorts patients by severity, and see patients in the order of priority. Staff explained that the new sorting procedure has led to a decline in sick call numbers. Staff estimated that approximately 200 patients per month are seen at regular sick call and 80 patients per month at emergency sick call.

Seventy-two percent of surveyed individuals stated that they could access sick call when needed, ranking Wallkill as the fourth best prison among all CA-visited facilities for access to sick call. Concerning the quality of care at sick call, surveyed individuals were generally far more satisfied than at other CA-visited prisons, with 25% rating sick call nurses as good, 48% rating them as fair, and 28% rating them as poor, ranking the prison as the fourth highest of all CA-visited facilities for quality of sick call care. When asked to explain their ratings of sick call services, despite their positive ratings of sick call services, individuals stated that certain nurses are nice and try to be helpful, but some of the nurses are rude and threatening, and did not treat incarcerated individuals humanely.

Routine Medical Care

Individuals who require care beyond sick call are seen in the medical area by the physician for a medical clinic call-out. The facility estimated that they see an average of 100 patients a month for call-outs. The physician prioritizes call-outs based on need. According to staff, incarcerated individuals may wait between two weeks to two months for routine appointments; however, persons with urgent needs may be seen the same day. Staff explained that delays have increased significantly since losing the nurse practitioner. At a rate similar to responses from persons at all CA-visited prisons, 36% of Wallkill survey respondents reported experiencing frequent delays in seeing the physician. The median wait time to see the physician was 30 days, longer than the average 21-day wait at all CA-prisons.

Overall, individuals rated the quality of medical staff as fair at a rate only slightly higher than the average rate at all CA-visited facilities, with 20% of survey respondents rating them as good, 29% as fair, and 51% as poor.[15] When asked to explain their rating of the physician, Wallkill survey participants' comments included that she was unprofessional, and showed little care towards patients. Patients also complained that the doctor did not continue medications, treatments, and recommendations from previous facilities. Several patients also complained of long wait times, asserting that they did not get to see the doctor even when they had serious medical concern.

Chronic Care

According to information provided by the facility, Wallkill housed 14 HIV-infected individuals, 13 of whom were receiving therapy at the time of our visit. Of these persons, four had progressed to an AIDS diagnosis. Wallkill does not have an HIV specialist on staff; instead, approximately two to four HIV-infected individuals are sent to infectious disease specialists per month. According to staff, each of these individuals is seen approximately every three months. Destabilized patients may have an appointment every month. Staff explained that persons co-infected with HIV and hepatitis C (HCV) used to visit a gastroenterologist; however, this protocol was discontinued. Only patients experiencing serious problems would be sent to the gastroenterologist.

Staff had identified 48 persons with HCV, representing 9% of the prison population and equal to the average rate throughout the Department. Thirty-eight of these patients were chronically infected with HCV (79%), a rate comparable to the 75% rate in the community.[16] According to facility data, none of these HCV-infected individuals were receiving treatment for the disease, far lower than the Department-wide average of 5%. The facility health services director told us that the prison offers liver biopsies to all chronically HCV-infected individuals, but more than half have refused this procedure. Two to three patients were receiving treatment but were paroled shortly before our visit, and two patients may start treatment, pending a liver biopsy. The medical staff reported that zero to six patients have been on treatment for HCV at one time. Medical staff cited the high turnover rate at the facility as the reason for low numbers of HCV treatment, and expressed concern that this turnover rate negatively affects continuity of care. We are concerned that Wallkill patients are not being treated for this disease, and despite the high turnover rate, urge the medical staff to review the caseload to determine if anyone is eligible for treatment. Five patients were co-infected with HIV and HCV, but none were on treatment for HCV.

Wallkill houses many individuals with other chronic medical conditions. At the time of our visit, there were 88 individuals with asthmas, 95 individuals with hypertension, and 46 individuals with diabetes. Thirty-nine percent of survey respondents stated that they suffered from a chronic medical condition, a smaller percentage than survey respondents at all CA-visited prisons and placing it in the bottom fifth of these prisons for prevalence of chronic medical conditions.

[15] Compared to average medical staff ratings of 14% as good, 36% as fair, and 50% as poor.
[16] National Digestive Diseases Information Clearinghouse, *Chronic Hepatitis C: Current Disease Management*, at 1 (2010). (Available at http://digestive.niddk.nih.gov/ddiseases/pubs/chronicheps/index/htm.)

Specialty Care

Patients who require specialty care services are seen in the facility at specialty care clinics or taken to outside specialists at the Coxsackie CF Regional Medical Unit (RMU), Shawangunk CF, or Albany Medical Center. Specialty clinics held at Wallkill include optometry, audiology and appointments to obtain prescription footwear. Patients requiring physical therapy are taken to Shawangunk. Staff reported no delays in specialty care appointments; however, according to survey respondents, the median wait time was 60 days, equal to the median delay at all CA-visited prisons.

Wallkill survey respondents who had seen a specialist were generally more satisfied with the care than at other CA-visited prisons. Twenty-seven percent of survey respondents reported seeing a specialist in the past two years, with 33% of these persons experiencing a delay at least sometimes, ranking Wallkill third best of all CA-visited prisons for frequency of experiencing specialty care delays. Fifty-eight percent of those who had seen a specialist stated that Wallkill medical staff provided good follow-up with the specialists' recommendations, ranking the prison in the top third for responsiveness of medical staff to these recommendations.

Pharmacy

Wallkill does not have its own pharmacy. Staff explained that medication requests are faxed to a pharmacy in New Paltz and medications are delivered to the facility the next day. Deliveries are made Tuesdays through Saturday. Individuals must submit refill requests five days in advance but generally receive their medications the next day. Wallkill does not have computerized pharmacy records. Individuals incarcerated at Wallkill appeared to have fewer problems obtaining medications than at other facilities, with 21% of survey respondents reporting having difficulty obtaining medications at least sometimes, ranking the facility fourth of all CA-visited prisons for ease of obtaining medications.

Wallkill's administration informed the CA that as of November 2011, the facility was now receiving it's medication from the Ulster Regional Pharmacy and had been using the DOCCS computerized pharmacy system for recording patients' medications.

Quality Improvement

Wallkill has a five-member Quality Improvement (QI) Committee that meets quarterly. The Committee reviews a set of charts for a particular condition during each QI meeting and the nurses review 10 randomly selected medical records of patients with this condition. Staff explained that during the most recent meeting prior to our visit, in July 2010, the QI committee reviewed treatment for asthma, and staff found some codes to be confusing and that some documentation needed to be fine-tuned. A facility nurse conducts Continuous Quality Improvement (CQI) audits of its HIV care and the last HIV audit determined that the facility was 100% compliant with the quality indicators. This nurse also conducts HIV tests, reviews HIV charts and consults with an infection control nurse when necessary.

Medical Care Recommendations

- Review the quality of medical encounters between patients and clinic providers to ensure that patients' medical conditions are promptly diagnosed and properly treated.
- Consider allocating two additional full-time providers to the facility's medical team to decrease delays in accessing routine medical care.
- Review the utilization of specialty care services.

WOODBOURNE

The Visiting Committee of the Correctional Association of New York visited Woodbourne Correctional Facility on February 15th, 2012. Woodbourne is a medium-security prison located in the town of Woodbourne, in Sullivan County, approximately 90 miles northwest of New York City. Woodbourne had a capacity of 1,106 people and confined 849 people at the time of the visit.

MEDICAL CARE

During our prison visit, we met with staff from the medical department at the prison and toured the medical area. We also received extensive information both prior to and after the visit about the healthcare operations. We appreciate the cooperation of the prison staff in providing this information and explaining the health services at the facility.

Woodbourne survey participants had mixed reviews of the medical care provided to them at the prison, with half rating overall medical care as fair, about one-third rating medical care as poor and 13% stating it is good. Overall this places Woodbourne in the top third of CA-visited prisons for patient assessment of their treatment. **Table M- Summary of Woodbourne Survey Participants' Response about Prison Medical Care** summarizes the data on several aspects of the medical care system, along with the prison ranking for each indicator.

Table M- Summary of Woodbourne Survey Participants' Response about Medical Care

Medical Service	Yes	Sometimes	No	Rank	Good	Fair	Poor	Rank*
Can you see an RN when needed	72.8%	18.3%	8.9%	3				
Rate Nursing care					13.3%	42.5%	44.2%	16
Do you experience delays in seeing a clinic provider *	28.9%	46.2%	25.0%	15				
Rate Physician care					18%	41.6%	40.4%	11
Experience delays in specialty care	45.2%	14%	40.9%	16				
Good follow-up to specialists	41.8%		58.2%	13				
Problems getting medication	20.1%	21.5%	58.3%	8				
Rate Overall Healthcare					13.3%	51.1%	35.6%	10

CA-visited facilities are ranked from 1-33, one being the best and 33 being the worst.
* The three categories for this variable are: Yes=Frequently; Sometimes=Once or once in a while; and No=Never.

Medical Staffing

At the time of our visit, Woodbourne's medical operation was staffed by a nurse administrator, one full-time physician and one half-time physician, seven full-time equivalent (FTE) permanent nurses, and two FTE per diem nurses. In addition, a physician's assistant (PA) worked extra service at the prison 10 to 15 hours per week seeing patients in the clinic. During our follow-up phone call with the facility in May 2013, we learned that the half-time physician position was replaced with a full time nurse practitioner. At the time of our visit, 2.5 FTE nursing items were vacant, two of which had been unfilled for eight months, and the facility was still not authorized to fill these vacant items. Since our visit, however, one half-time nursing item was filled, bringing down the vacant FTE nursing items to two. In order to operate the medical unit, the prison was regularly using overtime for permanent staff and the per diem items. The ratio of nurses to patients was one for every 90 patients, a figure somewhat worse than at many other facilities. The ratio for physician staff at the time of our visit was one doctor for every 550 patients, which is much worse than the system-wide average of 1:400. Although there was a PA temporarily working at the prison, even with this addition, the clinic staff to patient ratio was still one provider for every 450 patients. We are concerned about the limited physician and nursing staff, particularly given the older age of the prison population. We are pleased that at least Woodbourne was able to replace a half-time clinical provider with a full-time nurse practitioner, bringing the patient to clinic staff ratio closer to the system-wide average.

Medical Facilities

We toured the medical area, which consisted of two examination rooms for the clinic providers, a treatment room, and an additional room that is sometimes used for examining patients. There is an issue about the ability to keep conversations private in the examination rooms as some medical staff keep the exam door open during medical encounters, which can allow security staff in the area to hear conversations occurring in these rooms.

The prison does not have an infirmary for patients requiring 24-hour nursing care and therefore, individuals needing these services must be transferred to Sullivan C.F. The staff estimated that five to 10 patients are sent to Sullivan each month for infirmary care. Staff informed us that on average about one person per week is sent to Sullivan for inpatient care. Persons returning from an outside hospital also go to the infirmary at Sullivan before returning to Woodbourne. Given the large number of older patients and individuals with chronic illnesses, we are concerned about the prison's lack of an infirmary, specifically, whether there is prompt intervention when a patient needs infirmary care and whether the prison can maintain adequate continuity of care for individuals sent to Sullivan for care. Woodbourne medical staff noted that the physician's assistant (PA) currently performing extra services at Woodbourne is assigned to Sullivan and suggested that this provider can facilitate the coordination of care for these patients. We remain concerned about this situation, however, as this is only a temporary assignment for the Sullivan PA and should not be the mechanism to ensure continuity of care. We urge the prison to consider reopening the infirmary for its patient population.

Sick Call

Sick call is conducted four days per week on Monday, Tuesday, Thursday and Friday starting at 6:00 am until 10:00 am. Medical staff estimated that 355 patients are seen each month for regular sick call and about 65 patients are seen monthly for emergency sick call. Medical staff informed the CA visiting committee that they rarely issue tickets for abuse of emergency sick call.

73% of survey respondents reported that they could access sick call when they needed, which ranks Woodbourne near the top of all CA-visited facilities for access to care. However, survey participants had mixed reviews of the quality of the encounters with sick-call nurses with 44% reporting that they were poor and 43% reporting that they were fair; this places Woodbourne at about average for all CA-visited prisons. Although some survey participants thought some sick call nurses did a good job and cared about the patients they were treating, many respondents said some sick call nurses exhibited a negative and uncaring attitude towards their patients. One sick call nurse was repeatedly cited as rude and disrespectful to her patients. Due to the reported inconsistencies in the service patients are receiving, we suggest that the facility review best practices of care with all medical staff to ensure that all patients are receiving the very best of care.

Clinic Call-Outs

Clinical call-outs are conducted five days a week at various times during the day depending upon who is working that day. The one full-time physician sees approximately eight patients per day, four days per week; the part-time doctor sees 12 patients per day when he is at the facility. A physician's assistant works extra service at the prison two to three hours in the morning five days per week and sees five to seven patients for chronic care, physicals and emergencies. Overall, the prison estimated they see about 220 call-out patients per month.

Woodbourne survey participants expressed some concerns about their ability to access a doctor when needed. Only one-quarter of survey participants reported never experiencing delays in seeing their clinical provider and nearly 30% said they frequently were delayed in getting clinic care. The responses on access to the clinic for Woodbourne were about average for CA-visited prisons. Some of the delays were attributed to the refusal of sick call nurses to refer the patient, and several individuals said they had to repeatedly go to sick call before they were permitted to see a doctor. We remain concerned about the adequacy of clinic staff, particularly since a significant portion of the clinic appointments are performed by an extra service provider who is not permanently assigned to the facility.

Patients had mixed reviews of the clinic providers, although the overall response of the survey participants placed the prison in the top third of CA-visited facilities for the rating of clinic staff. Forty percent of survey participants assessed the providers as poor, but 18% thought they were good. As with the sick call nurses, there were several reports that the quality of care depended upon the clinic provider seeing the patient. Other concerns raised in the surveys were that the care was delayed, that some recommendations of the specialists were not implemented by the prison medical staff, and that some providers were reluctant to aggressively address the

patients' medical problems, preferring to prescribe less expensive treatment that did not adequately treat the patient's condition.

Care for Patients with Chronic Medical Problems

Chronic Care

Woodbourne has as significant number of patients with chronic illnesses as illustrated in **Table N** below. Woodbourne survey participants reported the highest percentage (62%) of patients suffering from a serious or chronic medical condition of all CA-visited prisons. We attribute this in part to the older age of the prison population and the longer time these individuals have been incarcerated. Although all patients with a specific chronic condition are not assigned to specific provider, the facility has designated specific nurses to monitor patients with certain illnesses; including HIV, hepatitis C (HCV), diabetes, asthma and hypertension. These nurses are responsible for patient education, paper work, coordination of laboratory testing and medical appointments; however, they do not participate in the appointments with the patient and the clinic provider.

Table N – Summary of Woodbourne Patients with Chronic Medical Conditions

	HIV	AIDS	HCV	HIV & HCV	Asthma	Diabetes	Hypertension
Infected	**23**	**17**	**92**	**11**	**117**	**78**	**117**
% Infected	**2.8%**	**2.1%**	**11.2%**	**1.3%**	**14.2%**	**9.5%**	**14.2%**
Treated	**22**	**N/A**	**1**	**0**	**115**	**76**	**115**

Hepatitis C (HCV)

We were concerned to learn that although the prison had identified 92 individuals infected with HCV, at the time of our visit no patient had been receiving treatment, and none had been on therapy during 2012 since the time of our visit. In May 2013, staff informed us that one person was being treated for HCV and three others were being prepared for potential treatment. The prison medical staff had no explanation for the lack of eligible candidates for therapy, but asserted that they believed all HCV-infected patients had either been through treatment or appropriately evaluated for therapy. With a new treatment regimen about to be approved by DOCCS for HCV care that has the potential for substantially improving the outcomes of antiretroviral therapy, we urge the prison medical staff to carefully review all current patients to determine whether they will benefit from the new triple-drug therapy. We urge the prison to undertake this effort promptly because we were informed that several individuals have filed grievances about denial of HCV therapy, and we received some complaints from HCV-infected survey respondents who objected to their inability to get access to the new HCV therapy.

HIV and AIDS

With an estimated 5.2% of men incarcerated in DOCCS facilities infected with HIV,[17] Woodbourne has apparently identified a little more than half (2.8%) of the estimated HIV-infected population in the prison, if the department-wide figure is relevant to its patient population. Given the older age of the Woodbourne population, we suspect that an even greater percentage of its patient population may be HIV infected than the department-wide estimate. Of the 23 known HIV-infected patients, nearly all were on treatment, according to information provided by the facility. Although no Woodbourne prison provider is an HIV specialist, the medical staff reported that its HIV-infected patients are regularly seen by an infectious disease specialist every three to four months, and more frequently if unstable. We were also told that when an HIV-infected patient is transferred to the facility, he is seen by the nurse coordinating HIV care.

Woodbourne reported that they have an aggressive HIV testing program conducted both by the facility and the outside contractor funded by the AIDS Institute to perform HIV support services, including an HIV testing program. The staff informed us that they knew the HIV status of 530 patients, representing a little less than two-thirds of its patient population. Despite these efforts, we were disappointed to learn from the staff that they were aware of only one individual being identified as HIV-infected by the outside contractor in the last six years and only two HIV-infected patients identified by the prison testing program during the same time period. On a positive note, Woodbourne is utilizing members from its Prisoners for AIDS Counseling and Education (PACE) program during its orientation as a way to inform its incoming population about AIDS and Hepatitis C. However, given the likelihood that during this time it is possible that 80 or more undetected HIV-infected patients had been at the prison, we believe additional efforts must be made to encourage at-risk individuals to seek testing.

Medication

Woodbourne does not have a pharmacy at the prison, but medications for its patient population are supplied by the hub pharmacy at Ulster C.F. The medical staff reported that during the last several years, the number of monthly prescriptions has increased from 500 to 600 per month to 2,000, the highest rate of any prison in the Sullivan hub. Prescriptions are faxed from the prison to the Ulster pharmacy each weekday, and medications are delivered the next day Monday through Friday. The medications are sent in an individual bag for each patient, which the patient must then pick up and sign for. Patients are told that for refills, they should submit their request for their medications five business days before they will run out of their supply of drugs.

Forty-two percent of survey participants reported that they sometimes have difficulties getting their medications. Although this figure suggests that some problems exist in timely delivery of medications, the response from Woodbourne patients was better than three-quarters of the CA-visited facilities concerning access to prescription medication.

[17] Maruschak, L. *HIV in Prisons, 2001-2010,* at Table 2 (2012).

Specialty Care

People incarcerated at Woodbourne in need of specialty services are generally sent to the out-patient specialty care clinics at Coxsackie Regional Medical Unit or Albany Medical Center. The prison conducts very few specialty clinics at the facility; only prosthetics, audiology and optometry clinics are held in the prison. The medical staff reported that the facility experiences the most difficulties in scheduling neurology consultations. In addition to Albany Medical Center, hospitalization occurs at Mt. Vernon Hospital and Westchester County Medical Center. Survey participants had mixed reviews of specialty care services. Fifty-nine percent of respondents said they sometimes experience delays in access to specialty care, a rate that is average for all CA-visited prisons; the median estimate by these individuals for the delay in specialty care was 60 days, the same figures as the median delay for all surveyed prisons. Individuals who went to specialty care appointments outside the facility raised concerns about being shackled for many hours while they were transported to the medical facility, during the time they waited for the appointment, and during the return trip to the prison; they felt this process discouraged some patients from seeking specialty care. Similarly, 58% of survey participants reported that there was inadequate follow-up to the specialist's recommendations, a response that was comparable to the average response from other surveyed prisons.

Continuous Quality Improvement Committee

The Quality Improvement Committee at Woodbourne holds quarterly meetings to review healthcare at the prison, including regular review of medical charts, monitoring healthcare indicators, and reviewing deaths and other important healthcare events. We reviewed the minutes of the quarterly QI meetings and were generally impressed with the level of reporting and actions taken to address identified issues. We commend the facility for performing regular chart reviews of patients with chronic conditions and the staff's efforts to address any noted deficiencies. We also note the regular attendance of the Regional Medical Director Dr. Whalen, which is an important addition to the QI committee.

Medical Care Recommendations

- Review nursing procedures and best practices of care with all medical staff in order to eliminate inconsistencies in patient treatment provided during sick call encounters and protect confidentiality during examination room medical conversations.
- Consider reopening an infirmary in order to more adequately care for a mostly older patient population presenting unique challenges in terms of chronic illnesses and illnesses associated with aging.
- Address the limitations incurred by a shortage of physician and nursing staff, particularly given the older age of the prison population.
- In light of several grievances regarding the denial of HCV therapy and objections arising from the lack of access to new therapy, prison medical staff should carefully review all current patients to determine whether they will benefit from the new triple-drug therapy.
- Given the likelihood that Woodbourne may be undercounting its HIV-infected population, additional efforts must be made to encourage at-risk individuals to seek testing.