



**New York State Health/Medicaid Budget Hearing:
Testimony of Jack Beck for
The Correctional Association of New York
Regarding the New York State Executive Budget Proposals
State Fiscal Year 2018-2019
February 12, 2018**

I am Jack Beck and work for the Correctional Association of New York (“the CA”), which is an independent, non-profit organization founded by concerned citizens in 1844 and granted unique authority by the New York State Legislature to inspect prisons and report its findings and recommendations to the legislature, the public and the press. Through monitoring, research, public education and policy recommendations, the CA strives to make the administration of justice in NYS more fair, efficient and humane. Our unique access to prisons run by NYS Department of Corrections and Community Supervision (DOCCS) and the information garnered from incarcerated persons and prison staff, combined with our policy and legislative expertise, informs our perspective today. We have detailed information about healthcare in our state prison system and how prison healthcare is connected to public health. Moreover, as nearly everyone in our prisons and jails returns to his/her community, we are also concerned about continuity of care for those released from incarceration to improve the health outcomes for these returning citizens and enhance the public health in the communities to which they return.

This testimony will focus on the following issues: (1) the need to improve medical services in our state prisons and how NYS Department of Health (DOH) can assist in efforts to enhance both access to healthcare services and the quality of care in state prisons; (2) an analysis of current DOH efforts to improve services in state prisons through the AIDS Institute’s Criminal Justice Initiative, DOH Oversight Law and Ending the HIV/AIDS Epidemic as articulated in the Governor’s *2015 Blueprint to End AIDS*; (3) efforts by DOCCS and DOH to improve continuity of care for persons returning home from prison; (4) the need for greater oversight of healthcare in DOCCS; (5) expanding the number of soon-to-be-released persons who have been approved for Medicaid prior to their discharge; (6) restoration of funding for DOH’s efforts to link patients with chronic conditions being discharged from prisons and jails to Health Homes in the community; (7) the Governor’s proposal to expand parole for older persons in prison and the need to improve community resources to provide immediate and effective care for these patients entering community-based medical services upon their release; and (8) the negative health impacts of solitary confinement and the need for the HALT Solitary Confinement Act, A.3080A / S.4784.

Overview of Healthcare in DOCCS

As the CA has documented for decades, NYS prisons have a population that has significant health needs that are more challenging than those existing in the general outside community. With greater chronic illnesses than the general public, the well-documented syndrome that incarcerated persons exhibit medical conditions that reflect a person 10-15 years older than the incarcerated person's actual age, and the increase in the percentage of the prison population who are 50 years or older, the demand for medical services in prison is significant and increasing. Unfortunately, DOCCS has struggled to meet this need both because of challenges in maintaining adequate staffing and in hiring staff that are empathetic and engaged with their patients. As a result, incarcerated persons consistently report great dissatisfaction with medical care inside in survey responses provided to the CA and as reflected in the large number of grievances submitted to DOCCS. During the past five years, mid-2012 through mid-2017, the CA has processed more than 4,500 survey responses from persons at 25 prisons. Overall, only 11% of the respondents rated medical care as good, 42% assessed it as fair, and 47% found it to be poor. These assessments are much worse than comparable ratings for other prison services, including mental health care and educational and vocational programs. Healthcare has been consistently one of the two highest numbers of grievances filed throughout DOCCS, with the other being misconduct by prison staff. Evaluating the reasons for this dissatisfaction generally focuses on two problems. First, in many prisons, there is insufficient medical staff, often due to the inability of DOCCS to hire people to fill existing vacancies. As a result, patients experience significant delays in getting to a medical provider. Second, even when a medical encounter occurs, many patients report that their medical issues are not appropriately addressed in a timely manner and/or that some providers are disrespectful, inattentive, or fail to exhibit a caring attitude. The assessment of healthcare varies among the prisons, and this variability raises concerns about the adequacy of meaningful oversight of healthcare throughout DOCCS.

Although we have documented some serious concerns about the DOCCS healthcare system, we have also observed progress in some areas of care and initiatives that appear to improve some outcomes for the patient population inside prisons and for those who have been recently released. In particular, as a result of the long-standing relationship between DOCCS and DOH focused on HIV and HCV care, which, in part, is codified in the DOH Oversight Law, it appears that DOCCS has significantly improved the identification and treatment of HIV- and HCV-infected patients. As is more fully discussed in section B (1), the HIV-infected prison population has declined, and a much greater percentage of DOCCS HIV-infected patients have revealed and/or been identified as HIV-positive and are engaged in care. DOCCS has become the national leader in the treatment of HCV-infected patients; during 2016, about 500 individuals received the highly effective new HCV therapies, a rate that is more than 10 times the rate existing in most other state correctional systems.

Following successful DOCCS-DOH programs to foster better continuity of care for HIV- and HCV-infected patients returning home, DOH is undertaking measures to enhance the continuity of care for HIV-infected patients returning to their communities through peer care coordinators. For the past few years, DOCCS has expanded its efforts to get its soon-to-be-released patients enrolled in Medicaid by employing DOCCS staff to assist incarcerated patients preparing for release to submit their Medicaid application prior to discharge. In addition, DOCCS and DOH have been working on mechanisms to facilitate the enrollment of patients with significant health

issues in the Medicaid Health Homes program in the community; this has been facilitated by several pilot programs throughout the state with community providers who have been connected to soon-to-be-released patients to assist them in getting prompt care in their community upon release. Finally, this year DOCCS has hired discharge-planning staff to assist patients with chronic illnesses other than HIV and HCV in making connections with community providers so that there can be improved continuity of care upon release.

Despite these encouraging developments, much more is needed to ensure that all DOCCS patients receive appropriate care inside DOCCS facilities and that all returning citizens are given the necessary assistance prior to release to get enrolled promptly in health insurance programs and to be connected to appropriate community-based programs to ensure continuity of care.

A. Inadequate Staffing of DOCCS Medical Services and the Need for DOH Assistance

The CA has documented for several years the inadequate staffing of the DOCCS healthcare system, often resulting in delayed services at many prisons and poor quality of care provided many patients. As the CA reported in its testimony before the Assembly’s Correction and Health Committees in October, 2017,¹ the Department has exceptionally high vacancy rates for prison providers (doctors, physician assistants, and nurse practitioners), nurses, pharmacists and dentists. Although the CA submitted a Freedom of Information request in September 2017 for documentation concerning medical staff, DOCCS has still not provided any information about its staffing levels. Fortunately, the CA regularly visits DOCCS prisons so it can assess the adequacy of healthcare in the Department. As indicated in **Table 1 – DOCCS Medical Staff at CA-Visited Prisons 2012-17**, we found that at the 25 facilities we visited in the past five years, 24% of the clinician positions were vacant, 16% of the nurse items were vacant, and the vacancy rate for pharmacists and dentists was 14% and 16%, respectively.

Table 1 - DOCCS Medical Staff at CA-Visited Prisons 2012-2017			
POSITION	# of Staff Items	# of Vacancies	Percent Vacant
Physician	55	14.25	25.9%
Phys. Assist/ Nurse Practitioner	26	5	19.2%
<i>Total Clinicians</i>	81	19.25	23.8%
RN/ Nurse 2s	354.5	55	15.5%
LPN	18.5	4.5	24.3%
<i>Total Nurses</i>	373	59.5	16.0%
Nurse Administrator	26	4	15.4%
Pharmacist	18	2.5	13.9%
Pharmacy Aides	16	0	0.0%
Dentist	44	7	15.9%
Dental Assistant/Hygienist	43	3	7.0%

¹ Testimony of Jack Beck before the NYS Assembly Committees on Correction and Health: Healthcare in NY State Prisons, October 30, 2017, available at: <http://www.correctionalassociation.org/wp-content/uploads/2017/10/CA-Testimony-10-30-17-re-Prison-Healthcare-Text-Only1.pdf>.

This situation has been a chronic problem for the Department, and the vacancy rates have not improved and may well have deteriorated during the past two years. Moreover, during the seven-year period from FY 2012 to FY 2019, the **authorized** staffing levels for health services has also been reduced by 18% while the DOCCS population has only declined by 12%. This is particularly disturbing because during the same seven-year period, the number of security staff positions only declined by 2.6%, a rate **seven times less** than the rate for health services. We believe that many of these reductions in authorized medical staff have been imposed because the prisons were unable to fill long-standing vacancies, and the reductions do not represent any diminution in medical staff needs. Taken together, the reduction in authorized positions and the vacancies that exist in DOCCS medical staff translate into significant deficiencies in healthcare.

During our prison visits, we have found that with current medical staffing there were unacceptably high rates of staff to patient ratios at many prisons. With an average clinician-patient ratio of 450 persons for each clinician at the 25 prisons we visited in 2012-17, it was extremely difficult for clinicians to properly monitor and promptly treat each patient. Of even greater concern, there were six prisons with a ratio of one clinician for more than 600 patients, and three facilities had ratios over 800 patients. These ratios make it nearly impossible for the prisons to provide effective and timely care, and patients regularly experience extensive delays for even routine services. Overall, we obtained surveys from 4,500 patients at 23 prisons from 2012 through 2017 and only 11% of residents in the general prison population rated healthcare as good and 47% assessed it as poor; for those in some form of solitary confinement, only 9% found medical care good and 54% reported it as poor.

We have a crisis in medical staffing in our prisons, and the Governor, legislature, DOCCS and DOH must take action to remedy the situation. The information we have obtained from the prisons suggests that the medical salaries within the Department often are not competitive with those in the community for comparable positions. Moreover, the high staffing ratios and the challenges medical staff encounter in providing care in a correctional setting add to the reluctance some medical professionals have in deciding to work in DOCCS. We urge the legislature to require the Governor, DOCCS and DOH to undertake a comprehensive review of its medical staffing needs in the prisons and determine why the DOCCS has chronically experienced challenges in filling essential medical positions. In order to address the current crisis, however, alternative strategies must be undertaken to address critical shortages. One proposal is to authorize prisons to employ clinicians from outside private agencies to fill existing vacancies. This has been done for nurse vacancies to some degree, but has not generally been utilized for prison clinicians. Moreover, efforts should be made by the Governor, legislature, DOCCS and DOH to determine if other mechanisms are available to increase compensation for DOCCS medical staff and whether other incentives can be provided to encourage medical professionals to work for DOCCS. We also urge the Governor and DOCCS to consult with DOH concerning ways to recruit and retain quality medical staff.

We commend the Governor for including funds for the development of electronic medical records for DOCCS. This initiative has been needed for more than a decade and will hopefully permit better coordination of care among the prisons and particularly when patients are returning home from prison. It is crucial that any electronic medical record be designed to facilitate communication among both DOCCS and community providers, and therefore urge DOH to be

engaged in the development and implementation of any DOCCS-based electronic medical records system.

B. Criminal Justice Initiative, DOH Oversight Law, DOCCS HIV and HCV Care, and Cooperation between DOCCS and DOH

The Department of Health has been involved with assisting DOCCS in HIV and HCV care for more than two decades, and this partnership has yielded significant results in improved care inside the prisons and enhanced discharge planning and continuity of care for HIV-infected persons coming home from DOCCS. Several efforts by DOH have been made to improve the care of HIV- and HCV-infected DOCCS patients.

The CA has been closely monitoring the care provided HIV- and HCV-infected patients for more than two decades. During that time, we have issued a number of reports about medical care at specific prisons and more comprehensive documents analyzing system-wide prison healthcare and HIV- and HCV-specific treatment issues.² Throughout these reports and comments to DOCCS and DOH, we have been concerned about (1) encouraging persons in DOCCS to learn their HIV and HCV status by being tested, (2) providing infected and non-infected patients with information about HIV and HCV so they can make informed decisions about whether and how to get tested and obtain effective care, (3) ensuring that DOCCS identifies HIV- and HCV-infected patients, and engages and retains them in DOCCS care, (4) ensuring that HIV and HCV information is kept confidential and that encounters with these patients are private; and (5) providing treatment to these patients with the most effective therapies available in the community and ensuring appropriate continuity of care for these patients as they are transferred among DOCCS facilities, and, more importantly, when they are released and return to their communities. Much improvement has occurred during these two decades in each of these categories, but some additional measures are needed to ensure that all patients are receiving community standards of care and are given the best opportunity to address these illnesses and have productive and healthy lives.

We believe much of the gains that have been achieved in the treatment of DOCCS patients with HIV and HCV are due to the long-standing cooperation between DOCCS and the AIDS Institute (AI) of NYS DOH. This relationship was encouraged in the late 1990s and in the early 2000s due to activities of the AIDS Advisory Council, which issued an extensive report about HIV care in the prisons, and the Assembly's Health and Correction Committees, which held a public hearing in 2004 about healthcare in our prisons. We commend both DOCCS and AI for these efforts.

² CA, *HIV Services for Women in New York State Prisons* (2015) available at <http://www.correctionalassociation.org/wp-content/uploads/2015/10/WIPP-WOMEN-HIV-REPORT-FINAL-08-19-15-1.pdf>; CA, *2013 Comments Concerning DOH Oversight of HIV/HCV Care in New York State Prisons* (2013) available at available at: <http://www.correctionalassociation.org/wp-content/uploads/2013/10/CA-Memo-2013-Comments-DOH-Oversight-Law-Final-Draft.pdf>; CA, Memorandum to NYS Department of Health Implementation of Public Health Law § 206(26) (June 30, 2011), CA, *Healthcare in New York State Prisons 2004-2007* (2009) available at <http://www.correctionalassociation.org/resource/healthcare-in-new-york-prisons-2004-2007>; CA, *Health Care in New York State Prisons* (2000) available at http://www.correctionalassociation.org/wp-content/uploads/2012/05/healthcare_report.pdf.

1. HIV and HCV Prevalence and Treatment in DOCCS Facilities

In the CA's 2013 Comments on the DOH Oversight Law, we explained in great detail the processes of identifying and treating HIV- and HCV-infected patients and will only briefly summarize this process and highlight more recent developments. In 2013, based upon available data from DOCCS and OMH, we estimated that there were between 2,700 to 3,000 HIV-infected persons in the Department, but acknowledged that this was a questionable estimate due to the fact that DOCCS did not test all of its patients for HIV. Similarly, we estimated that there were 6,000 to 6,600 DOCCS patients infected with HCV.

As we reported then, NYS DOH, Bureau of HIV/AIDS Epidemiology (BHAЕ), had been performing studies of newly admitted persons to DOCCS approximately every two years from 1988 and had continued this process through 2015. The HIV-infected rate has consistently declined from 1988 to 2012 for both men (18% to 2.4%) and women (20% to 3.7%), and the latest figures for 2015 fell to 1.9% for men and 2.8% for women. Given the advocates' repeated concern that there were many unidentified HIV-infected patients in DOCCS, in 2015 DOH and DOCCS agreed to share information about the DOCCS patient population to compare these individuals to DOH's HIV surveillance data to match patients to determine if any HIV-infected persons were in DOCCS but their status was unknown to DOCCS' medical department. As a result of this study, DOH identified 1,108 HIV-infected persons in state prisons, of which 10%, approximately 110 patients, was not known to DOCCS. DOH then undertook an initiative to meet with these patients to encourage them to reveal their HIV status to DOCCS. It is our understanding that this process has been relatively successful and that many of these patients decided to disclose their status to DOCCS and engage in care. We further understand that this process has continued with matching of DOCCS and DOH records to identify patients not in DOCCS care and DOH outreach to encourage unidentified HIV-infected incarcerated persons to engage in HIV care in the prisons. We applaud these efforts and commend both DOCCS and DOH for undertaking this process.

It should be noted, however, that HIV-infected DOCCS patients are sometimes reluctant to disclose their status because of concerns about the lack of confidentiality in our prisons and concerns about the quality of care they will receive. Both of these issues are real, and although DOCCS is prescribing the current therapies and HIV-infected patients are doing well in prison, the general concerns of incarcerated persons about their access to care deter some patients from engaging in care when they are unsure about how they will be treated. For this reason, as we explain later, we strongly urge expanding the use of peer educators inside DOCCS.

Concerning identification of HCV-infected patients, there are some new developments that increase the likelihood of engaging this patient population in care. In 2013, we estimated that there were 6,000 to 6,600 HCV-infected persons in DOCCS. At that time, DOCCS was not testing all of its population for HCV. It is our understanding that starting in 2017, DOCCS initiated uniform HCV screening. We applaud this initiative. The DOH seroprevalence studies demonstrate that these efforts are needed, as the DOH data indicated that there may be an increase in HCV-infected patients in DOCCS. Specifically, in 2015, DOH found that 10.3% of newly admitted men and a shocking 24.2% of women were HCV-infected. Both groups recorded increases from prior years, but the increase for women was dramatic. For men, the HCV infection rate in 2009 and 2012 was 9.5% and 9.6%; for women it was 14.6% for both

years. An increase to 24% reflects a 66% increase from prior years. Given the limited sample size for newly admitted women, typically in the range of 800-900 tests, one must be cautious in projecting long-term trends, but clearly DOCCS and OMH must closely monitor the situation to respond to any increase in the HCV-infected population to ensure that adequate resources and procedures are employed to treat this population. Concerning the increase for the men, there is some suggestion in the community that HCV infection rates are increasing with the increased use of opioids. If this means that there may be an increase in the percentage of younger patients who are HCV-infected, DOCCS policies and procedures, with the advice of DOH, may need to be adjusted to reach and treat this younger patient population.

DOCCS provides treatment to the vast majority of individuals who identify as HIV-infected and who are willing to take medications. The data we obtained from the prisons during the past five years confirms this trend. It also appears that this therapy is mostly effective. As part of the DOH Oversight Law, DOH has been monitoring care through chart reviews of patients in a limited number of facilities each year. During that time, DOH reported that viral load suppression of HIV, signifying that the medications are effectively reducing HIV in the patients' blood, ranged from 90% to 98%. These rates are comparable or even better than some community studies. We believe that additional resources are needed to expand DOH monitoring beyond the four to six prisons investigated each year, but these limited results suggest that effective HIV care is probably being provided at most DOCCS prisons.

Hepatitis C treatment has dramatically changed in the four years since the CA 2013 report. At that time, few DOCCS patients were on treatment. Since then, two major developments have occurred. First, much more effective and shorter term therapies have been developed. These treatments are very expensive but result in 90% or more of treated patients being cured. Second, DOCCS in FY 2015-16 increased its medication budget by \$23M so that it could provide HCV therapy to more patients. In 2016, DOCCS treated nearly 500 patients with the new therapies. Through September 2017, DOCCS has already treated 513 patients. The treatment protocols in DOCCS are also more aggressive than in many other corrections departments. Specifically, DOCCS will consider providing therapy to patients who are chronically infected and have a fibrosis level of 1 on a 0 to 4 scale. Many other jurisdictions will only consider patients for therapy if they have more advanced fibrosis, levels 3 or 4. We believe the treatment rates in DOCCS are the highest in the country for prison-based HCV care; in many jurisdictions, fewer than 50 patients are being treated annually. We commend this effort.

We are concerned, however, that initiation of therapy requires facility-based providers to evaluate HCV-infected patients to determine if they are appropriate candidates for therapy and to then submit a request to DOCCS Chief Medical Officer to get approval for care. Anecdotally, we have received complaints from some patients that they have not been evaluated for potential therapy, despite being HCV-infected for an extended time and therefore at risk for the development of fibrosis. Unfortunately, the evaluations of HCV care by DOH are inadequate to assess whether this screening is occurring and whether appropriate candidates for treatment are being offered therapy and approved for the new medications. In addition, the FY 2019 DOCCS health services budget also contains reductions in non-personal health services expenditures. The \$4.5M decrease is explained as arising from savings related to hepatitis C (HCV) therapy. We hope that reduction in per-patient costs will account for all the decrease in the proposed budget; it would be a tragedy to reduce the number of patients getting this extremely effective

care. We urge DOH to closely monitor the number of DOCCS patients receiving HCV treatment to ensure that this reduction in funding does not impede the aggressive HCV treatment program implemented during the past two years.

2. Cooperation between DOCCS and DOH

The AIDS Institute (AI) has been involved with prison healthcare for more than two decades, and we believe the agency's engagement with DOCCS has had positive effects on the ability of the DOCCS to provide care to HIV- and HCV-infected patients. Three aspects of DOH/AI activities with DOCCS have had a significant impact on the care being provided to incarcerated persons in the state prisons: (1) the support services provided by community providers contracted with AI to perform duties under the Criminal Justice Initiative (CJI); (2) the Ending the Epidemic initiative, including the Governor's *2015 Blueprint to End AIDS* and efforts to implement the *Blueprint* recommendations, including follow-up to the progress made with AI's Project START and the federally funded pilot program Positive Pathways Project, which were conducted to encourage incarcerated individuals to disclose their HIV status and/or to enter care; and (3) the HCV continuity of care program.

a) AIDS Institute Criminal Justice Initiative

The DOH Criminal Justice Initiative (CJI), coordinated by the AIDS Institute, has been in operation for several decades and entails the use of community-based organizations that come into the prisons to provide prevention and service needs of incarcerated HIV-infected persons, incarcerated individuals who engage in high-risk behavior, and formerly incarcerated HIV-infected persons who have returned to their communities with the objective of decreasing the spread of HIV/STD/HCV. Specifically, the CJI interventions and services are designed to (1) increase early detection of HIV in the prisons through an anonymous HIV testing program; (2) provide support services to HIV-infected patients in DOCCS to encourage them seek care and remain in treatment; (3) provide HIV/STD/HCV information to the general prison population; (4) train incarcerated persons to become peer educators capable of delivering HIV/STD/HCV information to the DOCCS population; and (5) provide discharge planning for HIV-infected patients returning home and additional assistance to them for several month following their release from prison.

The CA has supported the CJI program throughout its existence for the services it has provided and its efforts to expand the knowledge of the entire DOCCS population about these illnesses. We have also repeatedly expressed the need to expand the resources for CJI so that each of the aforementioned services will be available at each prison in DOCCS. To date, adequate resources have not been provided to ensure comprehensive services for all HIV-infected patients at every prison. Although recent information about the coverage of CJI services is not available, it is clear that not all HIV-infected patients receive CJI support services, discharge planning and community-based aftercare. We have also documented that DOCCS has failed to utilize fully the services of the CJI peer training graduates to educate the prison population about these conditions and support those at risk in the prisons to get tested, enroll in care and remain engaged in their treatment program.

Another issue we raised in 2013 and still observe is that the peer education program is not realizing its full potential. Specifically, individuals who complete the training are not necessarily assigned to peer education projects in the prisons. Currently, this valuable resource is not being used by most DOCCS facilities. There is no consistent DOCCS policy of which we are aware that specifies how graduates of the CJI peer program will be incorporated into the prisons' HIV education programs, nor is there system-wide funding to pay these trained individuals to perform education and support services for the prison population. Although many peers attempt informally to educate others inside, we believe DOCCS is not fully utilizing the knowledge and skill of these peers, since most prisons do not assign these individuals to paying jobs and other programs in which they can consistently and regularly engage the prison population in formal and informal presentations on HIV/HCV education, prevention, and risk reduction. Conducting health education programs that are only HIV-specific is not the best method in which to get this information widely disseminated in the prison population because non-infected individuals are often reluctant to attend such an event, since their mere attendance can lead to an inference that they are HIV-positive. Therefore, HIV/HCV education must be regularly inserted into non-medical education and other support programs to reach a much wider audience. It is not feasible to do this throughout DOCCS with outside professionals or the prison medical staff. Peer educators could perform this function for limited additional funding so that the entire DOCCS population can repeatedly learn important facts about HIV and HCV, and understand the benefits of learning one's status and entering care. We urge AI to initiate discussions with DOCCS on measures that can be taken to expand the role of its peer educators in all DOCCS programs.

Another proposal we believe DOCCS and OMH/AI should explore is the potential for enhancing the peer education program to prepare its participants to become community health care workers after they are discharged. This would not only help these returning citizens find meaningful employment, but also would help community-based programs engage and retain recently released patients by having care coordinators who can relate and assist these new patients navigate the difficult transition from prison care to community healthcare.

We recommend that adequate funding be provided to expand the comprehensive CJI program to every prison, and that enhanced resources be made available to provide assistance to recently released DOCCS patients returning to community-based care

b) Ending the HIV Epidemic

The Ending the HIV/AIDS Epidemic Taskforce efforts resulted in the Governor's *2015 Blueprint to End AIDS*, which provides specific recommendations concerning improving HIV and HCV care for all criminally involved persons in our state. The essential components of the *Blueprint* were to enhance services for patients within correctional institutions and to patients returning home from prison so that all persons at risk for HIV are encouraged to get tested, those infected are urged to engage in care, those in care are given assistance to stay engaged in treatment and patients returning to community care are linked to community services and provided assistance to stay engaged in community care and obtain viral load suppression.

To realize these objectives, DOH/AIDS Institute must be more engaged in improving the quality of HIV care for all HIV-infected incarcerated persons in both prison and jail facilities. To encourage incarcerated persons to get tested and start care, efforts are needed to educate the

prison population and staff about HIV/HCV, to improve the quality of such care in the prisons, and to ensure that barriers to care enrollment, such as lack of confidentiality and stigma, are minimized.

As previously discussed, peer educators within DOCCS should be better utilized in educating the prison population and encouraging those at risk to seek testing and those infected to engage in care. We also urge DOH/AI to explore the possibility of expanding the CJI training of peer educators to prepare them to be community health care workers after they are released from prison. This would improve the peer educators' effectiveness within DOCCS, enhance their ability to be successful when they return home, and most importantly, improve the ability of community-based health agencies to engage and retain HIV-infected patients who are returning to community-based care. We repeatedly have heard from recently released HIV-infected patients that they have experienced difficulties in engaging healthcare staff at community clinics because the staff lack the knowledge and skill needed to relate to someone who has been inside and who has understandable skepticism about the commitment and intentions of the people providing them care. Formerly incarcerated community healthcare workers are ideally suited to bridge the transition from prison care to community care for these vulnerable patients returning home.

The AIDS Institute and its CJI partners have also been engaged in efforts to identify HIV-infected persons in DOCCS who have not revealed their HIV status to DOCCS and have consequently not been engaged to appropriate treatment while incarcerated. The Project START and the Positive Pathways Programs, which attempted to identify this population and to reduce barriers to patients engaging in HIV care, have ended, but now the AIDS Institute has undertaken similar activities of identifying potential HIV-infected patients in DOCCS, attempting to engage them in care while they are incarcerated, and providing support services to formerly incarcerated patients when they return home. It is our understanding that these efforts are being developed pursuant to the Ending the Epidemic initiative following the approval of the Governor's *2015 Blueprint to End AIDS*. For example, recently DOH issued a request for community agencies to submit proposals for funding to provide support services to HIV-infected patients returning home from DOCCS in Queens. These efforts will require adequate funding and we urge DOH to expand these efforts in more communities throughout the state.

c) Discharge Planning and Support for HCV-Infected Patients Returning Home

For more than a decade, DOH has been providing support for HCV-infected patients who are released from DOCCS while they are still receiving HCV treatment. Given the new shorter term treatment regimens now being used, we suspect there is less demand for this specific continuity of care, but we urge DOH to expand its effort for HCV-infected patients who have not started treatment, but are in need of evaluation for treatment and appropriate monitoring of their HCV condition. We urge DOH to explore mechanisms by which potential candidates for HCV therapy who have not been treated while incarcerated and who are returning home can be connected to community-based providers who can evaluate these patients for treatment, and for those who are not eligible for treatment, engage them in care to ensure that their HCV status is properly monitored.

3. DOH Oversight Law Monitoring

Section 206 (26) of the Public Health Law (DOH Oversight Law), enacted in 2009, requires DOH to annually review the policies and practices of DOCCS concerning HIV and HCV care, including prevention of these diseases, and to determine whether such policies and practices are "consistent with current, generally accepted medical standards and procedures used to prevent the transmission of HIV and HCV and to treat AIDS, HIV and HCV among the general public." Upon completion of each review, the law mandates DOH to, in writing, either approve DOCCS policies and practices or direct DOCCS to "implement a corrective plan to address deficiencies." The DOH Oversight Law authorizes DOH to visit prisons, interview staff and incarcerated persons, inspect policy and procedure manuals and medical protocols, review medical grievances, and inspect a representative sample of patients' medical records. Finally, the DOH Oversight Law requires DOH prior to initiating its review to notify the public of the scheduled review and invite them to provide relevant information.

During the first few years of implementation, DOH primarily reviewed protocols and DOCCS data, but did not assess the care provided to HIV- and HCV-infected patients. The CA was very critical of this limited review and raised these concerns in its 2010 and 2013 comments to DOCCS and DOH. As reflected in the 2016 *DOH Review of Corrections HIV and HCV Policy and Procedures - 2015 Status Report*, the review of DOCCS prisons now entails a chart review of patients in one of the nine hubs of DOCCS prisons. Unfortunately, no new report about DOH review of prison HIV care has been made public since this 2015 review. Starting in 2013, it appears that this process has assessed care at 19 prisons.³ The reviews to date have found that for HIV care, greater than 90% of the treated patients have suppressed viral load, suggesting that they are receiving effective care. We commend DOCCS on this accomplishment and urge DOH to expand its monitoring efforts to reach a much wider group of prisons.

The DOH Oversight Law also mandates assessment of HCV care. For this disease, we are much less satisfied with the review process. Particularly in the last two years, it is clear that the vast majority of HCV-infected patients can be cured if they are prescribed the new HCV medications. The metrics DOH is using to assess HCV care do not address the evaluation of patients for potential therapy, whether therapy was provided, or the results of such treatment. We strongly urge DOH to modify its protocol to include these measures in next year's review. Overall, we believe DOH will need additional resources to perform its legislative duties under the DOH Oversight Law, thereby visiting more prisons each year and enhancing the scope of review for HCV care. We urge the legislature to appropriate what is needed so that at least every four years all prisons could be evaluated. Given the evolution of HCV care, it is important that DOH ensure that care at each prison is consistent with current community standards of care.

The CA strongly recommends that the DOH Oversight Law be expanded to include healthcare issues in our prison and jails beyond HIV and HCV. We strongly support the recently introduced Assembly bills A 9675 and A 9676, sponsored by Assembly Health Committee chair Richard Gottfried. Bill A 9675 would expand Health Law Article 28 to include all healthcare services in DOCCS. As a more limited reform, A 9676 would mandate that in addition to HIV and HCV,

³ NYSDOH, AIDS Institute, *DOH Review of Corrections HIV and HCV Policy and Procedures - 2015 Status Report* (September 2016) available at

https://www.health.ny.gov/diseases/aids/providers/reports/docs/corrections_policy.pdf

DOH would be required to assess care in state prisons and local jail concerning (1) women's and transgender health, (2) chronic health conditions, such as asthma, diabetes and heart disease, (3) health services for incarcerated persons 50 years and older, and (4) discharge planning for soon-to-be-released persons requiring residential placement or long-term care services in the community. Bill A 9676 would also require DOH, in consultation with DOCCS, to conduct a study of health care staffing in our state prisons and jails to assess the adequacy of staffing, challenges these agencies experience in hiring and retain staff due to salary limits or geographical factors, and the impact of staffing levels on the availability of medical services.

The experiences of physical and sexual abuse that the overwhelming majority of incarcerated women have endured exacerbate their medical and mental health problems; per capita health costs for women in custody are approximately double the costs for men.⁴ Having DOH oversight focus on women's health will make a difference for these women and for the children and families they return to upon their release. The cultural tendency to dismiss women's medical and mental health complaints due to gender bias is dramatically worse for women in prison, leading to delay of necessary medical care, disrespect and dismissiveness by DOCCS medical personnel, and poor quality of care. This is exacerbated at present by the lack of oversight of prison medical care, the failure to consistently provide care that is trauma-informed, and an ineffective grievance process that does not address problems. Inadequate medical care is consistently one of the most highly grieved areas for women in DOCCS custody. DOH oversight could draw attention to the women's population, which is often ignored by the overwhelming focus on men in the DOCCS system.

These bills would require DOH to address many of the healthcare concerns we have raised about medical care in the state prisons. Equally important, these bills would increase transparency and accountability for healthcare in both prisons and jails, thereby permitting the legislature, advocates and the public to better understand the quality of medical care in correctional facilities and to permit more focused and effective interventions to improve services for those inside and public health generally.

C. DOCCS and DOH Efforts to Improve Discharge Planning

Persons leaving DOCCS to return home face numerous obstacles in making this transition, with health concerns only one of many needs they must address. For most DOCCS patients with chronic medical conditions, the Department provides them with a two-week supply of medication and a prescription for their drugs that they could use once they are home. DOCCS has a comprehensive medical summary form in which a patient's medical condition and needs are described, but it is unclear what percentage of patients are actually given this documentation prior to release. Until recently, very few patients prior to release had an appointment with a community provider or had contact with a community provider who is prepared to continue their treatment. Moreover, few soon-to-be-released individuals have had the means to pay for community healthcare. New York wisely passed a law requiring the state to suspend, rather than

⁴ As of 2014, DOCCS reported that the per capita health care cost for men in custody was just under \$6,000, and the per capita cost for women was just over \$12,000. This figure includes personnel, non-personnel and medication costs. Letter from NYS DOCCS received on September 4, 2014 in response to Correctional Association of New York's information request sent on July 29, 2014.

terminate, Medicaid for individuals entering DOCCS who are currently enrolled in Medicaid when incarcerated. Unfortunately, that law impacted only a minority of patients.

In the past two years, the situation has improved. There are now about 18 DOCCS staff hired to assist DOCCS patients prepare a Medicaid application while they are still incarcerated and then submit this documentation to the appropriate offices for processing so that the patients can promptly get their Medicaid insurance when they return home. This effort is being conducted throughout the state prison system. We are unaware of any published data on the number of individuals who have filled Medicaid applications before their release, but believe several thousand applications have been submitted.

For the past few years, DOCCS and DOH have been meeting and developing pilot programs to enhance services for patients going home through New York's Medicaid Redesign Program. The primary focus has been in the development of pilot programs to enroll recently discharged patients in the Medicaid Health Home programs around the state. These pilots have been successful in ensuring that patients discharged from DOCCS have appropriate continuity of care by getting connected to comprehensive community care programs funded through the Health Home program. As discussed in section F, we urge the state to reinstate the funds initially proposed two years ago to continue to finance this pilot program. Moreover, we urge that these efforts be expanded and that the evaluation of the effectiveness of the program be continued to identify barriers to enrollment and best practices to ensure that returning citizens with serious medical conditions are promptly enrolled in appropriate community-based care.

Finally, DOCCS Division of Health Services (DHS) created a new initiative this year to provide enhanced medical discharge planning for patients with chronic medical problems other than HIV and HCV. Because the CJI discharge planning program only assisted patients with HIV/HCV, patients with other serious medical conditions generally were not receiving comparable services to help them in obtaining appropriate care in the community. DOCCS DHS initiated a program through the Medical Department in DOCCS' Central Office to provide discharge planning for patients who should be promptly enrolled in care once they are released. Without having any designated funding, DHS managed to identify a program coordinator and five staff members to facilitate the collection of medical information and to contact community providers who could provide services to these patients. It is our understanding that 2,500 patients have been served so far this year and these efforts are expanding. We believe this is an important initiative that requires dedicated funding with increased staffing beyond the current staffing levels. We commend DOCCS for starting this program, and we urge DOCCS, the Governor, and the legislature to enhance funding for this project. For this program to be successful, however, it is also crucial that DOCCS discharge planning be coordinated with DOH efforts to expand opportunities for placement of recently released patients in community-based care. In addition, to the extent that DOCCS develops electronic medical records, continuity of care will be improved if the DOCCS electronic records can be easily shared with community providers serving returning citizens; DOH must play a role in facilitating the exchange of information between DOCCS and community providers.

D. Need for Greater Oversight of DOCCS Healthcare

Two years ago, the CA and many other advocates testified before the Assembly's Correction Committee urging greater oversight of DOCCS operations.⁵ The CA provided extensive testimony about the inadequacies of internal DOCCS oversight mechanisms and the limitations of existing external oversight. In our testimony we emphasized the need for transforming the agency-level investigations and accountability, including revamping the defective grievance system and limitations on investigations conducted by DOCCS' Office of Special Investigations. Concerning medical care, we described the limitations generally of the State Commission of Correction (SCOC), and detailed its power through its Forensic Medical Unit (Review Board) to review any death occurring in DOCCS facilities. We noted that in 2014, there were six full Review Board assessments of DOCCS deaths and abridged reviews of seven additional cases. It must be noted, however, that there were 122 deaths that year, so only a small portion of deaths received any close scrutiny. More importantly, we found no evidence that the Review Board was exercising its broader authority to report on systems for delivery of medical care. We are unaware of any examples of SCOC or its Forensic Medical Unit investigating medical care systems in the state prisons outside of a specific investigation of a death. Moreover, there are no reports by the SCOC indicating that it is performing these investigations or has made any recommendations to DOCCS on how to improve general medical delivery systems.

Based upon our assessment of the inadequacies of current oversight of DOCCS medical operation, we believe several measures are needed to ensure appropriate care of DOCCS patients. Given the evidence that the current DOCCS-DOH relationship is producing positive results for HIV and HCV care, we believe it is essential that DOH jurisdiction be expanded to all medical services conducted by DOCCS including services provided by outside providers treating DOCCS patients. As noted above, Assembly bill A 9675 would apply DOH Article 28 jurisdiction to the prisons and consequently accomplish this purpose. Assembly Bill A 9676, although more limited, would significantly expand the review of DOCCS medical services and staffing deficiencies, and therefore, has the potential to identify significant care issues that require remediation. It will be important to ensure that DOH has full access to all relevant health records, including those prepared by outside providers serving this population. This authorization should also permit DOH to promulgate prison-specific regulations to the extent that community-based standards may not be appropriate in limited cases due to the unique conditions inside correctional institutions.

We also believe there must be greater transparency and accountability concerning the care and treatment of incarcerated persons. Besides reforming the defective grievance system, we support the legislation proposed in the Assembly to create a Correctional Ombudsman (A.1904), which would establish an independent public oversight agency to monitor conditions in the prisons, to investigate complaints raised by incarcerated persons or others in the community about treatment of DOCCS residents, and to report to the Governor, Legislature, DOCCS and the public about what it has learned and what remedial measures are needed to correct noted deficiencies. The

⁵ Correctional Association Testimony before the NYS Assembly Committee on Correction re Oversight and Investigations of the Department of Corrections and Community Supervision (December 2, 2015). An Executive Summary of this testimony is available at <http://www.correctionalassociation.org/wp-content/uploads/2015/12/CA-Testimony-Executive-Summary-and-Recommendations-Dec-2-2015.pdf>.

Ombudsman would have authority to investigate medical issues both systemically and based upon individual complaints.

We also believe there needs to be greater public oversight and transparency that would expand media access to the prisons and require mandatory public reporting by DOCCS and other state agencies, including DOH, about the conditions within the prisons and the results of any investigations conducted by these entities.

Finally, we urged the legislature to support independent oversight by those outside state government. This could include federal investigations by the Department of Justice and access by the UN Special Rapporteur against Torture and other national and international investigative bodies. We also urged the augmentation of the authority of the Correctional Association by requiring DOCCS to respond to the CA's findings in writing and develop corrective action where necessary, as well as authorizing the CA to utilize unannounced visits, access to all relevant documents, confidential communications with incarcerated people during monitoring visits, and unencumbered access to speak with staff.

We believe with greater oversight DOCCS could improve healthcare through collaboration with outside monitors, expand its information about barriers that exist to providing quality care, and gain the support it needs to enhance its resources to provide effective care.

E. Expand Enrollment of Soon-To-Be-Released Incarcerated Persons in Medicaid and Ensure Receipt of Medicaid Cards Prior to Discharge

Since 2007 the state ended its practice of terminating Medicaid when a person was incarcerated but rather suspended their benefits and began a program to reinstate their Medicaid eligibility upon release. This program has been successful in restoring Medicaid for some patients being discharged from DOCCS, but the vast majority of DOCCS residents is not enrolled in Medicaid at the time of their incarceration and therefore is not eligible for Medicaid restoration. Starting in 2012, the State began a process of attempting to enroll all soon-to-be-released persons in Medicaid. It is our understanding that recently several thousand persons a year have been enrolled of the 24,000 persons annually released from DOCCS. We commend DOCCS for hiring staff to assist in enrollment and for the counties that timely process these applications.

It is our understanding, however, that many counties in the state are not enrolling incarcerated persons onto benefits and often require personal interviews after their release before processing their application. The failure to have benefits immediately upon release can have serious negative medical consequences for those patients returning home. It is well documented that there are high rates of self-harm and suicide immediately after discharge; it is crucial that persons have access to emergency rooms, detoxification and substance abuse treatment facilities, and other essential health services. It is also essential that persons with chronic health needs get connected to community-based health services promptly upon release to maintain continuity of care, improve their likelihood of successful reentry and to foster public health and public safety. Having Medicaid is often a requisite before a patient can receive many health services in the community.

Consequently, we urge that the State and particularly DOH take all necessary steps to maximize enrollment of all persons being discharged from incarceration onto Medicaid and to ensure that such benefits are immediately reactivated upon release so that patients can seek immediate linkage to essential care.

F. Restore and Increase the \$2.5 million in Funding to Link Patients in the Criminal Justice System to Healthcare Services in the Community

In 2015, the Governor requested and the Legislature allocated \$5 million in Medicaid funding over two years to support efforts to connect those in the criminal justice system who have chronic health conditions to health home services in the community. The first allocation of \$2.5 million was distributed in December 2016. We were very pleased that DOH instructed eligible health home applicants to delineate how they would coordinate services to best reach individuals at two of the following three criminal justice intercept points: release from prison, release from jail, and participation in an alternative to incarceration (ATI) program.

We urge the Legislature to ensure that the second half of this funding is included in this FY 2019 budget. Doing so will support key linkage efforts that will result in reduced institutionalization, both in the criminal justice system, through reduced recidivism, and in the health care system, through the reduced use of emergency rooms and addition detoxification facilities, allowing the State to realize significant financial savings.

We also encourage the Legislature to increase this funding. Seven health homes were eligible for the first \$2.5 million, meaning that each provider received approximately \$357,000, a tiny amount of funding to meet such a huge need.

G. Geriatric Parole and Need for Appropriate Community-Based Services for Discharged Elderly Patients with Significant Health Needs

It is positive that Governor Cuomo is focusing on the crisis of elderly people in prison, and that his proposed budget initiatives seek to expand geriatric parole; however, there are substantial flaws in the geriatric release proposal that need to be revised and at the same time much more is needed to address the ongoing and worsening crisis of people aging in prison and repeated and inappropriate parole denials regardless of age. Moreover, efforts need to be taken by DOH to end the apparent discrimination against elderly criminal justice involved patients seeking residential care in the community and to expand appropriate placements for those with skilled nursing care needs.

With regard to the specific geriatric parole initiative proposed, it is positive that the proposal attempts to expand release of people who are aged 55 or older in prison who have a debilitating medical condition. New York's medical parole release has for years and decades been extremely under-utilized, with hardly anyone being released and people languishing or dying in prison because of the failure to release people with serious medical conditions. As an example, only 13 people in 2016 and eight people in 2017 were released on medical parole (after changes had previously been made to the law to expand release), despite there being hundreds of elderly patients recognized by DOCCS to have such serious medical needs as to require placement in

one of the state's Regional Medical Units. In 2016, 110 persons died of natural causes in DOCCS, most of them from health conditions that were known by DOCCS to be life threatening.

The portion of DOCCS population who are older is sizable and expanding. Recent data indicates that 10,337 persons 50 years or older were in our state prisons, representing 21% of the entire DOCCS population. Since 2000, the number of older people has more than doubled while the total prison population has decreased by nearly 30%. Many of these elderly individuals suffer from significant medical problems. As of January 2016, 64% of the patients (183 individuals) in the five DOCCS Regional Medical Units, which are skilled nursing care facilities in the system, were aged 50 or older and 47% (135 patients) was 65 or older. Many of the elderly population in DOCCS remain in prison years after they are eligible to be released. Moreover, many of those who are discharged to community supervision end up being sent to shelters or other housing options, such as halfway houses, hotels, motels, housing placements or are undomiciled, that do not provide necessary services. In 2015 and 2016, 1,025 and 1,198 persons 50 or older, respectively, were sent to a shelter upon release and 540 and 501 were discharge to non-shelter facilities. Many of these locations are not suitable to meet the health needs of this population and consequently, undermine the ability of these persons to receive care and be successful in their reentry.

Although we support the concept of geriatric parole, the Governor's proposal should be revised and expanded. First, although the eligibility criteria in the new proposal for medical parole were expanded from the current law, they still are very restrictive and should be expanded further. The proposal would allow for "geriatric parole" if a person has a "chronic or serious condition . . . exacerbated by age, that has rendered the person so physically or cognitively debilitated or incapacitated that the ability to provide self-care within prison is substantially diminished." We question why the phrase "exacerbated by age" is included since (1) it might be difficult to assess whether a condition that substantially diminishes an elderly patient's self-care status has been exacerbated by age, and (2) the degree of diminution in self-care is the relevant factor in deciding eligibility. We strongly support the narrowing of DOCCS review to the medical status of the patient and leaving any assessment of risk of recidivism to the parole authorities. We would also suggest that the language contained in section 2(a) requiring the medical provider to evaluate whether the patient is "severely restricted in his or her ability to self-ambulate" should not be included since the ambulation limitation has been used in the past under medical parole and has resulted in very few patients being qualified for release. Ambulation is only one of many factors to be considered in a patient's ability to maintain self-care and should not be elevated to some higher priority. We were particularly disturbed to learn during the Public Protection Hearing on the budget that DOCCS' Commissioner apparently will still require a patient to demonstrate restrictions on ambulation to be eligible for geriatric parole even though the proposal does not make that a requisite to be approved for release.

In addition, it is deeply problematic that the law excludes people based exclusively on their crime of conviction. Evidence demonstrates that people convicted of murder and the most serious crimes are the least likely to commit a crime upon release. Moreover, any person – regardless of their crime of conviction – who is suffering such a debilitating condition or who is dying in prison – should have the opportunity for release. The proposal should eliminate the exclusion and all people should be eligible for consideration on a case-by-case basis. Similarly, the proposal should be revised to remove the following language that has been abused by the

Parole Board in other contexts to repeatedly and inappropriately deny people release: “release is not incompatible with the welfare of society and will not so deprecate the seriousness of the crime as to undermine respect for the law.”

Furthermore, the proposal should be revised to speed up the process by which medical parole release decisions are made rather than slow them down. The proposal provides for a 30-day comment period – for the sentencing court, district attorney, defense attorney, and crime victim – before geriatric parole can be granted. This expansion of time on the existing 15-day comment period for medical parole is problematic and should be reversed, particularly given the often time-sensitive nature of these procedures given applicants’ serious and potentially life-threatening conditions. For example, DOCCS’ most recently available data indicates that between 1992 and 2014, 108 of the 525 certified medical parole applicants died prior to receiving medical parole. We would urge including time limitations on each of the several steps in the review process, including deadlines on the initial medical review, the review and decision-making process in determining medical eligibility by the Commissioner or his/her designee, and the parole board processes in rendering a final parole decision.

In addition to these changes, we strongly support adding metrics to be reported by DOCCS and the Parole Board to enhance transparency and accountability in this review process. The public needs much more information about who is being granted or denied release, the basis for these determinations, and whether the review process is fair and effective in getting elderly persons with significant health problems released from prison.

Moreover, the Governor and the legislature must take bolder and more expansive steps to address the inhumane, abusive, and costly parole system as a whole – to release more elderly people (regardless of whether they have a debilitating medical condition) and to release more parole-ready people in general regardless of age.⁶ Two current priorities for this budget and legislative session are: presumptive release and “second look” parole consideration. For presumptive release, proposed bill A.7546, requires the board to focus on a person’s current public safety risk at all appearances and creates a presumption of release at parole reappearances (following an initial denial), unless there is evidence that a person poses a current serious public safety risk. For “second look” parole consideration, New York should provide all older people (aged 50 or 55 and older) – regardless of their sentence – the opportunity to appear before the parole board for release consideration after they have spent 15 years in prison. Given the extreme sentence lengths in New York State, the ability of people to grow and change over this period of time, and the extremely low risk to public safety posed by older people and people convicted of the most serious crimes, allowing people who meet these criteria to at least appear before the Board is a much more humane and cost-effective policy.

To expand release of DOCCS elderly patients with significantly diminished ability to provide self-care, it is crucial that facilities exist in the community to which these patients can be discharged. For years, DOCCS and parole officials have struggled to locate community-based skilled nursing care facilities and other residential settings that are willing to serve the needs of

⁶ For more information regarding the failures of the Parole Board and the need for fundamental reform, *see* Correctional Association Testimony before the NYS Assembly Corrections Committee re Board of Parole, Dec. 4, 2013, *available at*: <http://www.correctionalassociation.org/wp-content/uploads/2013/12/CA-Parole-Testimony-12-4-13-Hearing-FINAL.pdf>.

DOCCS patients with serious medical needs or challenges with self-care. From anecdotal accounts the CA has received, it appears that many nursing homes and other similar residences consistently refuse to admit debilitated persons being released from prison based upon their criminal history, without any serious or fair consideration of the likelihood that the patient poses any risk to the safety of other patients or future recidivism. Because of this resistance, frequently DOCCS has been forced to keep patients beyond their conditional release date or even their maximum sentence because no appropriate safe residence has been identified for the patient.

The CA urges that DOH review this situation and take action to ensure that these patients are not being inappropriately discriminated against because of their criminal history. Regulations may be needed to require objective evaluation of the risks posed by any recently released patient to the safe operation of a community-based health facility. In addition, we urge that DOH develop incentives to encourage community-based agencies to accept these patients, an action that will ultimately save the state money and provide appropriate care to elderly patients in need of essential services.

H. The Negative Health Impacts of Solitary Confinement and the Need for the HALT Solitary Confinement Act, A.3080A / S.4784

Solitary confinement has devastating health impacts on people, and Governor Cuomo and the New York Legislature must do much more than what is proposed in the Governor's budget in order to end the torture of solitary confinement in New York's prisons and jails and implement more humane, effective, and health-promoting alternatives. Solitary has long been known to cause devastating mental health impacts on people. More research is now also developing about the broader medical harm caused by solitary confinement, including related to hypertension, vitamin D deficiencies, stress hormones, bone vulnerabilities, and alterations to brain activity.⁷ In addition, people in solitary have much more restricted access to healthcare, with CA survey respondents reporting on difficulties of access to care – with very brief cell-side medical encounters, delays in seeing providers, very limited confidentiality; and quality of care – with only 9% of survey respondents rating both physician care and overall health care as good while 60% and 54% rating physician care and overall care, respectively, as poor. Incarcerated women face additional special issues related to solitary confinement and its impact on emotional and physical health,⁸ including issues related to exacerbated impacts on survivors of domestic violence and abuse, triggering of Post-Traumatic Stress Disorder (PTSD), limitations on access to children and loved ones, and infringements on reproductive health care (including limitations on access to sanitary pads, toilet paper, obstetrical services, exercise and movement).

⁷ See, e.g., Lucius Couloute, *Aging Alone: Uncovering the Risk of Solitary Confinement for People Over 45*, May 2, 2017, available at: https://www.prisonpolicy.org/blog/2017/05/02/aging_alone/; Alexis Agathocleous, *Unprecedented Conference Sets the Tone for Abolishing Solitary Confinement*, April 18, 2016, available at: <https://ccrjustice.org/home/blog/2016/04/18/unprecedented-conference-sets-course-abolishing-solitary-confinement#>; Shruti Ravindran, *Twilight in the Box*, Aeon, Feb. 27, 2014, available at: <https://aeon.co/essays/this-is-what-solitary-confinement-does-to-the-brain>; Dr. Brie Williams, *The Health Risks of Solitary Confinement: Advancing evidence for policy reform*, an ongoing Global Health Sciences: Global Research Project, 7/1/15-6/30/19, project description available at: <http://globalprojects.ucsf.edu/project/health-risks-and-costs-solitary-confinement-advancing-evidence-policy-reform>.

⁸ See *Reproductive Injustice: The State of Reproductive Health Care for Women in New York State Prisons*, A Report of the Women in Prison Project of the Correctional Association of NY, p. 145-158, Feb. 11, 2015, available at: <http://www.correctionalassociation.org/wp-content/uploads/2015/03/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf>.

Despite the terrible health impacts of solitary, on any given day there are more than 2,900 people in Special Housing Units (SHU) in the state prisons alone, and an additional estimated 1,000 people in keeplock – another form of solitary. While Governor Cuomo has touted the reductions in the use of SHU mandated through settlement of the *Peoples* litigation, 5.9% of people incarcerated remain in SHU and that number has remained relatively stable over the last five months – still worse than the national average (of roughly 4.4%) and much worse than many states around the country with less than 1-2% in solitary. Black people, and other people of color, are specifically targeted and sent to solitary confinement in what the *New York Times* referred to as a “scourge of racial bias.” While the entire United Nations has prohibited the use of solitary beyond 15 days for all people, because longer periods amount to torture, there is no total time limit on solitary in New York, and people continue to be held for months, years, and decades. Moreover, people are still sent to solitary for petty or minor, non-violent rule violations or even as a way to cover-up officer misconduct or as a tool for officer oppression of people who are incarcerated.

The HALT Solitary Confinement Act, A.3080A/S.4784 would ensure that *no* person is subjected to the torture of solitary confinement beyond 15 days and would create more humane and effective alternatives. The use of solitary confinement has negative health impacts for the individual being isolated and the corrections staff assigned to monitor them. It negatively impacts the prison and community health and safety and has led our state into an urgent human rights crisis. The Governor and legislature must HALT solitary confinement in New York State and end this torture.

Recommendations

- 1. Enhance DOCCS Medical Staff** - Efforts should be made by the Governor, legislature, DOCCS and DOH to end the crisis in medical staffing in the prisons by evaluating what medical positions are needed to provide appropriate care and why DOCCS is unable to recruit and retain health providers and developing mechanisms to recruit and retain staff who receive appropriate compensation.
- 2. Enhance Funding for DOH’s Criminal Justice Initiative** – Ensure these is adequate funding so that all the elements of the CJ program are provided at each DOCCS facility.
- 3. Increase Funding for Implementation of the DOH Oversight Law** – Expand the resources for the DOH Oversight Law so that more facilities can be reviewed each year and that more rigorous reviews can occur for HCV treatment.
- 4. Enhance the Use of CJI-trained Peer Educators and Initiate a Program to Qualify them to be Community Health Care Workers when they are released** – Expand the opportunities of peers trained by CJI contractors to assist persons inside the prison to learn about HIV and HCV and engage in appropriate care. Explore the possibility of creating a program in prison to train these peer educators to be eligible to become Community Health Care Workers upon release.

5. Expand the Program Helping DOCCS Patients Apply for Medicaid Prior to Release – Evaluate the effectiveness of the DOCCS program to help currently incarcerated persons to submit applications for Medicaid prior to their discharge and provide additional resources to ensure all soon-to-be-released persons are given an opportunity to prepare a Medicaid application and receive their Medicaid card prior to discharge.

6. Expand the Pilot Programs to Connect Incarcerated Patients with Significant Medical Needs to a Health Home Program prior to Discharge – Increase the efforts to encourage other Health Home providers in the community to connect with DOCCS patients prior to release who will need such services when they come home. Reinstate the \$2.5M Medicaid funds authorized two years ago to support the pilot program.

7. Enhance Resources for the DOCCS Discharge Planning Initiative for Patients Leaving Prison who will need Healthcare in the Community - Expand the new DOCCS initiative to provide meaningful discharge planning for all patients who will need health services in the community. Ensure coordination between DOCCS and DOH to facilitate the prompt enrollment of patients in community-based care and the exchange of essential medical information between DOCCS and community providers.

8. Ensure Comprehensive Discharge Planning and Post-release Assistance to HIV- and HCV-infected Patient returning Home – Adequately fund Ending the Epidemic initiatives to provide assistance to HIV- and HCV-infected patients prior to discharge and to continue such assistance for at least six months after they are released.

9. Expand DOH Oversight of DOCCS Prisons by Applying Article 28 Jurisdiction to all Correctional Facilities and to Patients receiving Medical Care while Incarcerated or Enacting A 9676 to Expand the Medical Conditions Reviewed by DOH Pursuant to the DOH Oversight Law – Make DOH Article 28 apply to all DOCCS prisons and ensure that DOH has full access to all relevant health records, including those prepared by outside providers serving this population. This authorization should also permit DOH to promulgate prison-specific regulations to the extent that community-based standards may not be appropriate in limited cases due to the unique conditions inside correctional institutions. If Article 28 jurisdiction is not expanded, enact Assembly Bill A 9676, which would extend DOH review of DOCCS care to women's and transgender health, patients with chronic conditions, treatment of the elderly population, and discharge planning efforts for soon-to-be-released patients requiring residential placements or long-term care.

10. Pass the Correctional Ombudsman Bill (A.1904) – Create an Office of Correctional Ombudsman that would be an independent public oversight agency to monitor conditions in the prisons, to investigate complaints raised by incarcerated persons or others in the community about treatment of DOCCS residents and to report to the Governor, Legislature, DOCCS and the public about what it has learned and what remedial measures are needed to correct noted deficiencies.

11. Expand Independent Outside Monitoring and Enhance Media and Public Access to the Prisons – The legislature should permit independent oversight by entities outside state government, including federal investigations by the Department of Justice and access by the UN

Special Rapporteur against Torture and other national and international investigative bodies. The authority of the Correctional Association should be expanded by requiring DOCCS to respond to the CA's findings in writing and to develop corrective action where necessary, as well as authorizing the CA to utilize unannounced visits, access to all relevant documents, confidential communications with incarcerated people during monitoring visits, and unencumbered access to speak with staff. The media should have better access to the incarcerated population, and DOCCS and other state agencies should be required to publish information about medical care inside and the results of any investigations about deficiencies in the prisons.

12. Enact an Expanded Geriatric Parole Law and Ensure that Adequate Resources are Available in the Community to Provide Appropriate Care to Discharged Patients with Diminished Ability to Self-Care - The Governor's proposal for geriatric parole should be applications. DOH should ensure that the patients released under this law will not be discriminated against in the community due to their criminal history and that adequate resources are available in the community to meet their health needs once home.

13. Pass the HALT Solitary Confinement Act, A.3080A/S.4784 – New York must pass HALT in order to end the torture of solitary for thousands of New Yorkers and create more humane, effective enacted with appropriate modifications to the criteria for eligibility, elimination of the restrictions on eligibility based upon crime of conviction and with strict time limits for the processing of these, and health-promoting alternatives.