

CITY COUNCIL  
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

of the

JOINT COMMITTEE ON HEALTH, FIRE & CRIMINAL JUSTICE  
SERVICES

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October 28, 2008  
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HELD AT: Council Chambers  
City Hall

B E F O R E:  
  
JOEL RIVERA  
MIGUEL MARTINEZ  
Chairperson

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Helen Sears  
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## A P P E A R A N C E S

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CHAIRPERSON JOEL RIVERA: Good

afternoon, ladies and gentlemen. My name is Joel Rivera. I'm the Chair of the Health Committee. I want to thank my colleague, to my right, Council Member Miguel Martinez, the Chair of the Fire and Criminal Justice Services Committee, for holding this joint hearing today. We are here to discuss physical health services in New York City's correctional facilities.

In our City's criminal justice system, the Department of Correction is responsible for all correctional facilities, including the care of incarcerated individuals. The Board of Corrections is responsible for establishing care and treatment standards. The Department of Health and Mental Hygiene's duty is to promote medical and health services for inmates of all correctional facilities maintained by the City. Within the DOHMH, there is a Correctional Health Service Bureau that is responsible for the medical and dental services in the City's correctional facilities. In New York City, correctional health services are provided through a contract between the Department of Health and

2 Mental Hygiene and a for-profit corporation,  
3 Prison Health Services. PHS is a national  
4 corporation which administers health services in  
5 numerous prisons throughout our country.

6 For the record, I would like to  
7 note that PHS was invited to this hearing today  
8 and responded that they would be attending. Yet,  
9 less than 24 hours before this hearing, Committee  
10 staff was informed that PHS would not be in  
11 attendance and would be represented by the  
12 Department of Health and Mental Hygiene staff.  
13 Needless to say, the Committee's extremely  
14 disappointed. We were looking forward to hearing  
15 from PHS directly on the services that their staff  
16 provide day-in and day-out in our City's  
17 correctional facilities. PHS could give the most  
18 accurate account of care. In addition, the  
19 Committee had hoped to hear PHS's view on its  
20 failure to meet standards in its contract,  
21 resulting in substantial fines over the last few  
22 years. In the wake of these fines, PHS was  
23 awarded an additional three-year contract.

24 Although, we won't hear from PHS,  
25 we expect to hear from the Department of Health

1  
2 and Mental Hygiene on the services provided to  
3 incarcerated individuals. These services include  
4 intake screening, HIV and AIDS testing, sexually-  
5 transmitted disease testing and treatment for  
6 asthma and other conditions. Both DOC and DOHMH  
7 have taken steps to improve the quality of care  
8 provided to incarcerated individuals, including  
9 establishing electronic health records and  
10 automating case management and discharge planning  
11 systems. It is imperative to ensure that  
12 individuals continue receiving care after they are  
13 released.

14 Today, we will explore the services  
15 provided to inmates and the interaction between  
16 the government and private agencies in providing  
17 this care.

18 I would like to thank the staff of  
19 both Committees for their hard work. And, I want  
20 to welcome the members who are here with us today.  
21 We have, to our far left, not on the political  
22 spectrum, but on a dais over here, we have Council  
23 Member Tony Avella. We have Councilwoman Helen  
24 Sears. And, of course, we have, you know, our  
25 Chair, Co-Chair, Council Member Miguel Martinez,

1  
2 who will say a few words.

3 CHAIRPERSON MARTINEZ: Thank you,  
4 Chairman Rivera. As you stated, my name is  
5 Council Member Miguel Martinez. I am the Chair of  
6 the Fire and Criminal Justice Committee. I want  
7 to thank Chair Rivera and our staff for putting  
8 together this important hearing on physical health  
9 services in our City jails. As you know, there  
10 are a variety of health services provided in our  
11 City jail, including mental health services.  
12 Mental health services has been a subject of  
13 previous hearing of this Committee and the Mental  
14 Health Committee and will be subject of future  
15 hearing, but will not be the subject of today's  
16 hearing, which will focus on the physical health  
17 services.

18 I think we all agree that providing  
19 health services to detainees and sentenced inmate  
20 in the City's jails is a monumental task.  
21 However, I also believe that it is the City and  
22 its contractors' obligation to provide those  
23 services in a professional and timely manner. In  
24 fiscal year '08, the Department of Correction had  
25 108,000 admission and manage an average daily

1  
2 inmate population of 13,850 individual. The  
3 average length of stay was 48 days. However, 28%  
4 of the inmate are released within two or three  
5 days and 52% leave within seven day, making this  
6 assessing need and providing care all more  
7 difficult.

8 From my perspective, while the  
9 Department of Health and Mental Health Services  
10 has the primary obligation of ensuring adequate  
11 health services in the City's jail, and for  
12 overseeing entities which the City contract with  
13 to provide these services, at the end of the day,  
14 the Department of Corrections has the ultimate  
15 responsibility for the care, custody and control  
16 of all people within City jail and an obligation  
17 to act if those obligations are not being met.

18 I am looking forward to today's  
19 hearing and to the testimony we're about to hear.  
20 I want to acknowledge and thank those who are here  
21 to testify and to answer question. And, if Chair  
22 Rivera has no more remarks, I would ask that our  
23 first panel identify themself for the record and  
24 begin their testimony.

25 JASON HERSHBERGER: Thank you.

1  
2 Good morning, Chairpersons Rivera and Martinez and  
3 the members of the Health and Fire and Criminal  
4 Justice Committees. My name is Dr. Jason  
5 Hershberger and I am the Assistant Commissioner of  
6 the Bureau of Correctional Health Services. It's a  
7 Bureau of the Department of Health and Mental  
8 Hygiene. With me is my boss, Louise Cohen, Deputy  
9 Commissioner of the Division of Health Care Access  
10 and Improvement.

11 CHAIRPERSON RIVERA: On your best  
12 behavior then.

13 JASON HERSHBERGER: I will be. I  
14 will be. And, with me is my partner, Deputy  
15 Commissioner Roger Parris from the Department of  
16 Correction. We, collectively, thank you for this  
17 opportunity to update you on the healthcare system  
18 for people incarcerated in the New York City jail  
19 system.

20 Let me begin by providing an  
21 overview of how correctional healthcare is  
22 provided in New York City. Under City Charter, the  
23 Department of Health and Mental Hygiene is  
24 responsible for providing healthcare to the 14,000  
25 New Yorkers in the custody of the Department of

1  
2 Correction every day. About 100,000 people come  
3 into our jails every year, of whom approximately  
4 60% are coming for a single incarceration and the  
5 remaining group are returning to jail for a second  
6 or third time that year. Ninety percent of our  
7 inmates are male; most are African-American or  
8 Latino, and many come from the poorest  
9 neighborhoods in the City. Education levels are  
10 low and unemployment levels are high.

11 The mission of my Bureau,  
12 Correctional Health Services, is to provide the  
13 best possible medical assessment and treatment  
14 during an inmate's incarceration and provide  
15 appropriate discharge planning services to promote  
16 health once a person leaves jail. We strongly  
17 believe that the quality of correctional health  
18 services are critical to patient safety and health  
19 while they're in jail and to safeguard the health  
20 of the communities to which discharged inmates  
21 return. To this end, DOHMH's Correctional Health  
22 Services Bureau directly employs physicians,  
23 nurses, pharmacists, psychiatrists, psychologists,  
24 social workers, health educators, discharge  
25 planners and contract managers.

2 CHS also oversees a large medical  
3 services contract with Prison Health Services,  
4 which has approximately 1,000 medical and allied  
5 health personnel working 24 hours a day, seven days  
6 a week in New York City jails. Following a  
7 competitive process, the Health and Hospitals  
8 Corporation, which ran Correctional Health Services  
9 at that time, signed a three-year contract with PHS  
10 effective 2001. This was extended for one year  
11 beyond that period. In 2003, DOHMH reassumed  
12 direct supervision of Correctional Health Services.  
13 The Department issued an RFP. PHS was selected and  
14 they began a new three-year contract in 2005.  
15 DOHMH exercised that contract's three-year option  
16 to renew, in 2008. This contract will expire in  
17 December 2010.

18 PHS provides over one million  
19 medical, dental and mental health encounters each  
20 year at 10 out of the 11 City Department of  
21 Correction facilities. One facility, the Vernon C.  
22 Bain Center, a barge in the Bronx, is staffed by  
23 the Health and Hospitals Corporation under direct  
24 supervision of the DOHMH. CHS closely monitors the  
25 PHS contract by tracking progress against

1 performance indicators and quality control  
2 measures, reviewing individual cases, directing  
3 quality improvement projects, assessing and  
4 credentialing professional staff, and ensuring  
5 compliance with CHS policy and procedures.  
6

7 Let me now turn to the key health  
8 services provided in New York City jails. These  
9 include initial medical intake, chronic care  
10 management, sick call, urgent care, mental health  
11 services and discharge planning. Each month there  
12 are more than 8,000 intake visits, approximately  
13 70,000 medical visits, 2,500 specialty clinic  
14 visits and 18,000 mental health visits. While  
15 many of our patients are young and healthy, a  
16 significant proportion of our patients suffer from  
17 serious health problems including chronic diseases,  
18 substance abuse and mental illness.

19 An inmate's first encounter with  
20 health services in New York City jails occurs on  
21 day one of incarceration. All inmates receive a  
22 full medical intake examination within the first  
23 24 hours of entering the custody of DOC. New York  
24 City is among national leaders in this regard, as  
25 it takes most jurisdictions between one and two

1 weeks after admission to custody to complete such  
2 exams.  
3

4 Using this higher standard allows  
5 for three positive outcomes in our system. First,  
6 from the first day of custody, jailed New Yorkers  
7 have access to a physician who can detect and treat  
8 health conditions ranging from acute issues  
9 requiring emergent care to chronic illness.  
10 Second, the Department of Health and Mental Hygiene  
11 has an opportunity to screen and treat every jailed  
12 New Yorker for health conditions that present a  
13 risk to the public health of the City. And,  
14 third, we can begin to provide discharge planning,  
15 particularly important for patients with HIV and  
16 other chronic disease, as soon as possible.

17 While an inmate is incarcerated,  
18 CHS provides medical care and treatment, including  
19 regular follow up for chronic conditions such as  
20 diabetes, hypertension, asthma and HIV. Sick call  
21 is provided on a daily basis to anyone who  
22 requests it and urgent care is provided by  
23 emergency room physicians. Preventive care is  
24 provided to all and includes immunizations against  
25 flu, hepatitis and pneumonia. The Department also

1 provides appropriate discharge planning for people  
2 leaving jail, focusing on those with chronic  
3 disease, particularly HIV, but also, for example,  
4 women who have had pap smears but left without  
5 receiving their results, or those with mental  
6 illness or substance abuse problems.  
7

8 Over the last few years, we've had  
9 great success in redesigning our HIV discharge  
10 planning program so that it reaches more people  
11 more effectively. Of the people with HIV who are  
12 released to the community, approximately 70% are  
13 successfully connected with either community  
14 medical or substance abuse providers.

15 The Department's correctional  
16 health and public health missions are closely  
17 aligned and CHS takes every opportunity to realize  
18 the Department's public health goals as part of its  
19 work in City jail. For example, a major  
20 Department public health goal is for every New  
21 Yorker to know his or her HIV status so that proper  
22 treatment can be obtained and further transmission  
23 be curtailed. We know that the rate of HIV among  
24 New York City inmates is many times higher than  
25 the rate found in the rest of the City and inmates

1  
2 suffer from compound risk factors for HIV illness,  
3 including high risk sexual behavior and unsafe  
4 injection drug use. For these reasons, all  
5 inmates are offered voluntary rapid HIV testing on  
6 admission to jail and at subsequent medical  
7 encounters. Under this voluntary testing program,  
8 Correctional Health provides over 25,000 HIV tests  
9 per year, an increase from approximately 6,000 in  
10 2003.

11 Similarly, in 2005, Correctional  
12 Health Services established a testing program for  
13 young men with asymptomatic Gonorrhea and  
14 Chlamydia infections. Women, at the time, were  
15 already universally screened. To date, over  
16 155,000 individuals have been screened, and over  
17 14,000, or about 9%, have been found positive. Of  
18 these, 70% are treated before release with a single  
19 course of an antibiotic. These inmates came into  
20 custody with an infection illness that they didn't  
21 know about. They didn't have any symptoms and,  
22 left not infectious with improved health.

23 The public health mission of  
24 Correctional Health can also be seen in additional  
25 initiatives, including universal mental health

1  
2 screening and mental health discharge planning,  
3 universal screening and control of tuberculosis,  
4 and increasing number of inmates receiving flu,  
5 pneumonia and Hepatitis B vaccinations.

6           It's important to note that almost  
7 40% of inmates tell us they are active substance  
8 abuse users. And, 16% say they regularly drink  
9 alcohol. And, we believe that the actual  
10 prevalence of substance abuse is significantly  
11 higher than inmates report. To this end, the  
12 Department actively seeks to identify and assist  
13 individuals with substance abuse in order to  
14 provide them with appropriate care while detained  
15 and so that they may return to communities linked  
16 to continued assistance.

17           CHS is a national and international  
18 leader in the treatment of substance abuse.  
19 Patients are assessed at intake for their need for  
20 detoxification or maintenance treatment and New  
21 York City jails are among the few in the country  
22 accredited by the Substance Abuse and Mental  
23 Health Services Administration to provide methadone  
24 maintenance treatment. Since 1987, we have  
25 provided detoxification and methadone maintenance

1  
2 services to patients addicted to opiates, and we  
3 detoxify almost 20,000 people each year. Upon  
4 reentry, inmates are connected to community-based  
5 methadone programs to continue and support their  
6 recovery.

7 Correctional health care is  
8 delivered in a highly restrictive and secure  
9 environment. And, this presents significant  
10 challenges not seen in other health care settings.  
11 So, it is only through our collaborative  
12 relationship with our sister agencies and  
13 community partners that CHS is able to  
14 successfully provide care in the secure custody  
15 environment. The partnership between DOC and  
16 DOHMH, made possible by the strong commitment of  
17 Commissioner Horn and his senior staff to the  
18 health and well being of inmates, enables us to be  
19 successful in spite of the many hurdles to  
20 providing health care in City jails. In medical  
21 emergencies, stabilization and emergency  
22 transportation is provided by the excellent work  
23 of the Fire Department of New York's Emergency  
24 Medical Services unit. And, the Health and  
25 Hospitals Corporation provides emergency room care,

2 hospitalization and some specialty services in  
3 secure prison wards at Bellevue and Elmhurst  
4 Hospitals. The City's Human Resources  
5 Administration and Department of Homeless Services  
6 are helping CHS link patients to needed public  
7 benefits and shelter. And finally, the hundreds  
8 of community medical and mental health providers  
9 who care for inmates after they leave the system  
10 are among our most important partners.

11 Thank you again for this opportunity  
12 to testify. We are happy to answer any questions  
13 you may have.

14 CHAIRPERSON RIVERA: Thank you very  
15 much. We've, before I begin my line of  
16 questioning, we've been joined by Council Member  
17 Eric Gioia, Council Member Alan Gerson,  
18 Councilwoman Helen Diane Foster and Council Member  
19 Kendall Stewart. Now--

20 CHAIRPERSON MARTINEZ: Mr. Chair--

21 CHAIRPERSON RIVERA: Yes.

22 CHAIRPERSON MARTINEZ: I just want  
23 to state, for the record, before you open your  
24 line of questioning, that, from our perspective,  
25 we did ask the Board of Correction to be

1  
2 represented here. And, unfortunately, there is no  
3 representation of the Board of Corrections.

4 CHAIRPERSON RIVERA: Got you.  
5 Thank you. One of my questions that I have is  
6 which healthcare functions are provided by PHS and  
7 which are provided by the Department of Health and  
8 Mental Hygiene?

9 JASON HERSHBERGER: Okay. The PHS  
10 provides the direct medical care for the men and  
11 women in the custody of the Department of  
12 Correction on Rikers Island and in the Manhattan  
13 House of Detention. As I mentioned in my  
14 testimony, they provide over a million clinical  
15 encounters a year. The role of the Department of  
16 Health and Mental Hygiene is in oversight and  
17 management of that contract.

18 CHAIRPERSON RIVERA: Okay. Now,  
19 does the Department investigate inmate complaints  
20 if it's, you know, against PHS staff not, you  
21 know, granting access to medical care for the  
22 inmates? And, if so, what's the follow-up from  
23 the Department of Health and Mental Hygiene?

24 JASON HERSHBERGER: Okay. One of  
25 the offices within CHS is the Bureau of

1  
2 Performance Improvement and Risk Management. And,  
3 that Bureau fields and accepts complaints from  
4 inmates and from the community that we do an  
5 investigation of all complaints, including access  
6 complaints. And, if we have substantive findings,  
7 we refer that to the Department of Correction for  
8 their investigation. Or, we ask corrective  
9 actions of our CHS vendor.

10 CHAIRPERSON RIVERA: Have you seen  
11 an uptick in complaint over the past couple of  
12 years with PHS? Or, has there been a standard  
13 complaint level year-in and year-out?

14 JASON HERSHBERGER: The number of  
15 complaints, in general, has been stable over the  
16 course of the PHS contract. We track complaints  
17 by the number, but also in category. Are they  
18 complaints about healthcare? Are they complaints  
19 about access? Are the complaints about, you know,  
20 getting what medication they want? That sort of  
21 thing. So, not only has the global number of  
22 complaints more or less stayed the same, the  
23 categories of complaints have also been stable.

24 CHAIRPERSON RIVERA: Okay. Now, in  
25 reference to the RFP, the DOH recently released a

1  
2 concept paper and the RFP seeking providers to  
3 provide care in three correctional facilities with  
4 an emphasis on continuity of care when an inmate  
5 leaves the system. No providers have responded to  
6 the RFP. A) does the Department of Health intend  
7 to reissue the RFP at the end of PHS' current  
8 contract? And, is DOH exploring other models of  
9 correctional healthcare provision?

10 LOUISE COHEN: Hi. I'm Louise  
11 Cohen, Deputy Commissioner--

12 CHAIRPERSON RIVERA: How are you?

13 LOUISE COHEN: --for the Department  
14 of Health and Mental Hygiene. Thank you for  
15 inviting us here today. In terms of the concept  
16 paper and the RFP that was released in, I believe  
17 in May of 2007, we did not get the community  
18 response that we had hoped for. We have broken  
19 that RFP down into individual jails, hoping that a  
20 community provider, who might find the entire  
21 system very daunting, to try to hire up a thousand  
22 people and to begin a whole new 24/7 delivery of  
23 care system, might be able to do in a smaller jail  
24 system. And, I, personally, called many of the  
25 community health centers in New York City, their

1  
2 Medical Directors and CEOs, to try to find people-  
3 - encourage people to apply. In spite of that, we  
4 did not have significant local response.

5 In any case, the PHS contract ends  
6 in December of 2010 and we have to reissue an RFP  
7 and do a new competitive process, which we will  
8 do. And, we are hoping, yes, to try to come up  
9 with ways in which we can promote local community  
10 providers of care's interest in providing care to  
11 people who are incarcerated in New York City  
12 jails. It's our perspective that they're the same  
13 people who receive community healthcare in the  
14 community. And, we'd like to see some vendors try  
15 to step forward to be able to do this. We're  
16 trying to think about ways in which we can see  
17 what we can do to try to make this possible.

18 But, in talking to folks, it's a  
19 very daunting task to deliver healthcare, first of  
20 all, 24/7, which most, as you know, community  
21 providers do not. And, second of all, in a secure  
22 custody environment, which I think is a difficulty  
23 for people. So, we took people on tours. We  
24 invited them into the jails to try to see if we  
25 could encourage them to apply. And, we welcome

1  
2 your assistance in encouraging local community  
3 [pause] to apply at the next RFP round.

4 CHAIRPERSON RIVERA: In reference  
5 to PHS, how often does the Department of Health  
6 meet with PHS to discuss their performance issues?

7 JASON HERSHBERGER: I was a little  
8 distracted. Did you ask me how often we meet with  
9 PHS?

10 CHAIRPERSON RIVERA: Yes, to  
11 discuss the performance issues that they've had in  
12 the past.

13 JASON HERSHBERGER: Well, there's a  
14 formal and an informal structure. There is a  
15 quarterly meetings that occur with, you know, on  
16 the top level with the Commissioner and PHS that  
17 happen once a quarter. There are monthly meetings  
18 with my Bureau and the PHS leadership. And then,  
19 on a daily basis, we meet on special projects and  
20 special issues with PHS.

21 CHAIRPERSON RIVERA: Okay. Now,  
22 back towards-- you mentioned something with the  
23 medication, if there's an issue with medication.  
24 Now, if a prisoner arrives at a facility and  
25 states that he or she is on a particular type of

1 medication for a particular condition, is that  
2 individual provided with that medication  
3 automatically? If not, then why?  
4

5 JASON HERSHBERGER: They're not.  
6 What we ask of our physicians when they're  
7 assessing patients that come in through intake to  
8 do a medical assessment. And, that includes  
9 taking a history, doing a physical exam and making  
10 a treatment recommendation. And, often, often,  
11 the treatment recommendation is to continue  
12 community treatment. But, by no means do we  
13 accept, without review, community treatment and  
14 just continue. But, there are occasionally people  
15 show up in intake and claim to be receiving  
16 treatment they're not receiving or have been  
17 receiving treatment that we don't think is  
18 appropriate. And, we give our intake physicians a  
19 lot of discretion about what they want to  
20 continue.

21 CHAIRPERSON RIVERA: Now, this is  
22 always a topic of discussion. You just said that,  
23 you know, you'll verify the necessary treatment.  
24 If you don't agree with the treatment that the  
25 person's been administered, then you'll reference

another type of treatment. Is cost an issue? Is cost a factor when determining whether or not--

JASON HERSHBERGER: No.

CHAIRPERSON RIVERA: --treatment should be continued?

JASON HERSHBERGER: We don't have an incentive program for physicians to prescribe one medication versus another medication based on cost. We do have a pharmacy and therapeutic community that reviews all medications to see whether they're safe and effective. But, cost isn't a determinate in the decision.

CHAIRPERSON RIVERA: But, if a person's deemed to need treatment, then obviously, the Department of Health or PHS--

JASON HERSHBERGER: Yeah.

CHAIRPERSON RIVERA: -- will administer--

JASON HERSHBERGER: Yeah.

CHAIRPERSON RIVERA: -- that treatment.

JASON HERSHBERGER: Comes out of our budget.

CHAIRPERSON RIVERA: Okay. Then,

I--

LOUISE COHEN: If I might--

CHAIRPERSON RIVERA: Yes.

LOUISE COHEN: -- Council Member,  
just to let you know also that the Department of  
Health purchases all pharmaceuticals so that there  
is no incentive in the contract for over-treatment  
or under-treatment. It's not that anyone gets any  
extra money if they save on pharmaceuticals. We  
purchase them all. So, we also do review-- there  
are medication exception programs and we review  
them on a regular basis. And, I think that it  
also depends on the type of medication that  
someone comes in on whether or not we feel that  
it's more important to give them a dose where they  
may not miss a dose for medical reasons. But,  
then, we're going to verify their dosage from  
their community physician. So, I think that  
there's a whole series of things that are put into  
place to safeguard.

Having said that, we're also not--  
that we also are concerned about the cost of  
pharmaceuticals, which is high. So, we do have a  
formulary process. And, we do try to use generics

1  
2 whenever possible. We're always glad when  
3 something goes off patent onto generic. It  
4 actually saves us a lot of money. In the reverse,  
5 it costs us money if we can't do that. So, we are  
6 aware of the cost issues. But, it is not an  
7 issue--

8 CHAIRPERSON RIVERA: [Interposing}  
9 A primary factor.

10 LOUISE COHEN: --in any  
11 individual's treatment.

12 CHAIRPERSON RIVERA: Okay. And  
13 now, when a person's released from being  
14 incarcerated, do you share your medical findings  
15 with his or her primary care physician so that way  
16 they can continue your type of treatment? Or, is  
17 that not taking place?

18 JASON HERSHBERGER: So--

19 CHAIRPERSON RIVERA: If it seemed  
20 to be more cost-effective, but have no impact on  
21 their health or if it'd seem to be a better  
22 treatment.

23 JASON HERSHBERGER: What the  
24 medical services provides what's called an  
25 aftercare letter to inmates. So, at their

1  
2 request, if they'd like us to, we'll write a  
3 letter listing their diagnoses and listing the  
4 medications prescribed to them while they're with  
5 us at Rikers Island. And then, they can take that  
6 and present that as their medical care when they  
7 go back to the community.

8 LOUISE COHEN: We also will provide  
9 medical records upon request. And, we do that  
10 often so that people know where they can get their  
11 medical records. We do supply them to their  
12 physicians.

13 CHAIRPERSON RIVERA: Okay. Now,  
14 how does the Department of Health ensure that  
15 patients' medical privacy is protected?

16 JASON HERSHBERGER: Well, you know,  
17 we take medical privacy very seriously. And, we  
18 take medical confidentiality very seriously. We  
19 have a separate chart that's reviewable only by  
20 medical and accessible only by medical personnel.  
21 We don't share information without inmate consent.  
22 We follow the Board of Correction's minimum  
23 standards about what's a legitimate disclosure.  
24 And, that's how we manage it.

25 CHAIRPERSON RIVERA: Okay. At this

point, I'll turn it over to my Co-Chair, Council Member Miguel Martinez.

CHAIRPERSON MARTINEZ: Thank you. What expertise, what do you look for when selecting a provider? I mean, what makes you decide this is the provider to provide services at our correctional facilities?

LOUISE COHEN: I assume you mean through an RFP process.

CHAIRPERSON MARTINEZ: Correct.

LOUISE COHEN: Right. Well, I think that we look for providers who have significant experience and ability to provide care in a secure custody environment. We look for those who are willing to work 24/7, who have providers who are licensed appropriately and who are interested in developing quality improvement programs that will get care faster to patients, high-quality care to the right patient at the right time. So, there is an element of experience. But, we're looking also for both correctional experience as well as community experience or a willingness to work in a correctional environment.

2 CHAIRPERSON MARTINEZ: So, it is  
3 the Department of Health that's responsible for  
4 overseeing the entire operation of the provider.

5 JASON HERSHBERGER: Yes.

6 CHAIRPERSON MARTINEZ: And, you  
7 know, from looking at our briefing documents,  
8 right, the current provider had some issues in  
9 other states in terms of the quality of services  
10 and even some violations of policies. And, my  
11 understanding also that including New York State  
12 Commission of Correction had also repeatedly  
13 recommended discipline. Were there any issues  
14 found in New York City with PHS?

15 JASON HERSHBERGER: Well, New York  
16 City's quite different than most other  
17 jurisdictions. Principally because we have  
18 Correctional Health Services, a Bureau of the  
19 Department of Health, managing and monitoring both  
20 the fiscal integrity, but also the quality of care  
21 delivered by PHS. In most other jurisdictions,  
22 healthcare services are contracted directly, you  
23 know, between a Department of Correction, who  
24 doesn't generally don't have a lot of healthcare  
25 expertise, and a medical provider. In New York

1  
2 City, because CHS employs doctors and physicians  
3 and psychiatrists and social workers, we're really  
4 attune and able to better monitor quality issues.  
5 And, here in New York City, we've been pleased  
6 with their performance and their ability to  
7 improve their performance over time.

8 LOUISE COHEN: In addition, Council  
9 Member, the PHS, as a vendor's part of the RFP  
10 process, is required to submit a Vendex  
11 [phonetic]. All the Vendex has to disclose any  
12 actions--

13 CHAIRPERSON MARTINEZ: Um, hm.

14 LOUISE COHEN: --that Vendex and  
15 the contract was approved by the City's  
16 oversights, the Mayor's Office Contract, the  
17 Department of Investigation and so forth; the  
18 Comptroller signed off on this. So, there are a  
19 number of people who reviewed any-- who do review,  
20 as you know, for any contact all the outstanding  
21 issues that might be...

22 CHAIRPERSON MARTINEZ: Let me just  
23 read this statement. Despite your Department  
24 renewal of the PHS contract report had documented  
25 that it failed to meet performance indicators

1  
2 required by the contract. In the first quarter of  
3 2005, failed 12 of 39 performance measure in its  
4 evaluation conducted by the Department, Health  
5 Department. These included problems such as  
6 incomplete medical records and diabetes therapy.  
7 Similarly, in two years leading to its 2008  
8 contract renewal, PHS failed to meet at least 15%  
9 of its contract standards. I'm just wondering,  
10 you know, what has happened in terms of, you know,  
11 when we have a provider, and I want to make the  
12 correlation with the Department of Correction,  
13 where we have a provider who obviously has a  
14 history, not only in New York State or New York  
15 City, of inefficiency, how good is the quality of  
16 services they're providing to the inmate in the  
17 City of New York?

18 JASON HERSHBERGER: Okay. Well,  
19 the performance indicators are created by the  
20 Department of Health and Mental Hygiene. And, we  
21 have very high standards. We set performance  
22 targets--

23 CHAIRPERSON MARTINEZ:

24 [Interposing] I'm sorry, can I interrupt you  
25 there--

2 JASON HERSHBERGER: Of course.

3 CHAIRPERSON MARTINEZ: -- 'cause I  
4 wanted to get there. Does the Board of Correction  
5 have any input into those standards?

6 JASON HERSHBERGER: No, it's  
7 directly determined by the Department of Health  
8 and Mental Hygiene through our contract.

9 CHAIRPERSON MARTINEZ: Um, hm.

10 JASON HERSHBERGER: The Board of  
11 Correction determines the minimum standards--

12 CHAIRPERSON MARTINEZ: Um, hm.

13 JASON HERSHBERGER: -- of healthcare  
14 delivery on Rikers Island, but not the contractual  
15 standards.

16 CHAIRPERSON MARTINEZ: Um, hm.

17 JASON HERSHBERGER: You know, the  
18 Department of Health believes that there's--  
19 there's a lot that we're proud of in PHS'  
20 performance over the life of the contract. But,  
21 we do think, there's still room to improve and  
22 work to be done. We set high standards and high  
23 performance indicators. And, of course, we'd love  
24 it if they passed all of them. But, they do pass  
25 most of them most of the time. And, the ones that

1  
2 they have not passed, they are, in general,  
3 steadily improving over time.

4 CHAIRPERSON MARTINEZ: I have the  
5 most respect for the Department of Health, the  
6 City. But, with all due respect, everything  
7 you're saying is not meeting those standards  
8 because even the Comptroller, in 2007, found that  
9 this contractor is not meeting its requirement and  
10 its contract obligations. And, you know, it's  
11 hard for me to believe that, or let you continue  
12 to say about the high standards and, with all due  
13 respect, and looking at all the documentation,  
14 even from the Comptroller's office, the New York  
15 State Comptroller in 2007, he says that the audit  
16 found that it had not met any of the performance  
17 indicator for the - - quarter. According to the  
18 audit, in many instance, the Department of  
19 Correction contract monitoring and following up  
20 effort had not provided adequate assurance that  
21 the healthcare services are delivered in  
22 compliance with its contract. So, I don't know,  
23 you know, when you talk about the standards and  
24 the high standard, and I'm very proud of this  
25 Department. But, on this issue and the service

1  
2 delivery by this vendor, by this contractor, there  
3 are obvious problems that need to be addressed.

4 And, speaking of, can I ask a  
5 question in terms of reimbursement? I mean, what  
6 do you have to say about that? The Comptroller in  
7 2007, again, stated that this contractor had not  
8 met its due obligation and compliance. And,  
9 you're saying that you're setting high standards,  
10 but the high standard you're setting are not being  
11 met by this vendor. So, what do we do about that?

12 LOUISE COHEN: Let me just try to  
13 explain a little bit about what these particular  
14 performance indicators are, because--

15 CHAIRPERSON MARTINEZ: Uh, huh.

16 LOUISE COHEN: -- they are actually  
17 only one component of our contract monitoring.  
18 The performance indicators are of three different  
19 types. One of them are process indicators,  
20 timeliness, how soon something happened. So,  
21 while we expect a 95% compliance, some of the  
22 things that happened to knock them out of the 95%  
23 compliance may have been a day late; might have  
24 been a documentation issue. So, we're actually  
25 very strict in how we review charts. So, we are

1  
2 very careful and we review charts, I think,  
3 there's something like 7,000--

4 CHAIRPERSON MARTINEZ:

5 [Interposing] So, it's not like--

6 LOUISE COHEN: -- a quarter.

7 CHAIRPERSON MARTINEZ: In all  
8 fairness, it's not like we have an inmate that--

9 LOUISE COHEN: That's correct.

10 CHAIRPERSON MARTINEZ: -- has  
11 health issues and that he's not being--

12 LOUISE COHEN: That's correct.

13 CHAIRPERSON MARTINEZ: -- attended  
14 to. You're telling me that more of an issue of  
15 paperwork and--

16 LOUISE COHEN: In one regard,  
17 absolutely in these. So, I think that we review  
18 7,000 charts a quarter. And, every time we review  
19 a chart, we do these on a weekly basis, we  
20 actually give the information back to PHS so that  
21 if there is any health issue, they can take care  
22 of it right away. But, we still ding them if they  
23 didn't document it correctly, if they did  
24 something a day late or two days late or even a  
25 couple days late. What we worry about is making

1  
2 sure that--

3 CHAIRPERSON MARTINEZ:

4 [Interposing] Can you be explicit about that?  
5 When you say they do it a day or two day late are  
6 not treatment?

7 LOUISE COHEN: That's correct. If  
8 they may have not documented or they may not have  
9 called down someone. What we worry about is if  
10 someone didn't treatment that they needed. And,  
11 that's why we send our nurses, Department of  
12 Health nurses--

13 CHAIRPERSON MARTINEZ: Um, hm.

14 LOUISE COHEN: -- a core of them  
15 out every day in the jails to review charts. And,  
16 they're reviewing them continuously during the  
17 quarter. So, that it's not at the end of the  
18 quarter, we say to them, and this was actually a  
19 fundamental misunderstanding of the State  
20 Comptroller, we tried to explain this and we were  
21 unsuccessful. We don't do this--

22 CHAIRPERSON MARTINEZ:

23 [Interposing] Well, that helps a lot.

24 LOUISE COHEN: We don't do this at  
25 the end of the quarter. We actually do it all the

1 way through. And, we give them the feedback  
2 immediately and say this patient and they do go  
3 and find patients that might need additional help.  
4 The second type of indicator is a performance  
5 improvement indicator. So, we thought that why  
6 should we have indicators all the time that  
7 they're performing at 95%. Let's pick something  
8 that they're performing at 30% and try to get them  
9 up. So, there was one that I believe your  
10 Council, your Committee Council, looked at, that  
11 was newly being measured. It was something-- it  
12 was a community standard, which is every three  
13 months to get someone's CD4 and viral load count  
14 taken if they're HIV positive. And, that was  
15 newly-- it had not been measured before. It's a  
16 community standard. But, if you look at the  
17 standards by which hospitals are required to--  
18 they report this information as well in the  
19 community, they're not doing 95% on this either.  
20 And, what you will see in our performance  
21 indicators is it went-- it doubled from the first  
22 quarter we measured it to the fourth quarter we  
23 measured it. So, what we believe is what gets  
24 measured gets done. And, we think that that's one  
25

1  
2 of the reasons to start with something that's  
3 actually low and get them to improve it.

4 Now, most of the time, quality  
5 improvement indicators like this are really not  
6 contractual. They're really part of a process in  
7 any medical facility were you figure out what's  
8 not working and then, you try to improve it. So,  
9 this is a little bit of an unusual thing to have  
10 those kinds of indicators in a contract.

11 CHAIRPERSON MARTINEZ: Um, hm.

12 LOUISE COHEN: And then, finally,  
13 there's some outcome indicators that, you know, a  
14 diabetes A1-C level less than nine. Now, that's  
15 something that, in the community, it's not, you  
16 know, certainly not at a 95% and we expect that to  
17 grow--

18 CHAIRPERSON MARTINEZ: Um, hm.

19 LOUISE COHEN: -- and develop over  
20 time. So, these particular indicators are really  
21 mainly a medical and quality improvement kind of  
22 guidelines. There are other things that we look  
23 at when we do the Vendex reviews, certainly, but  
24 every month, we look at staffing issues. We look  
25 at a whole host of issues by which we judge this

1  
2 contractor. And, we try very hard to address  
3 things as quickly as we can with them so that it  
4 doesn't become a chronic problem and that issues  
5 are resolved in a timely fashion so the treatment  
6 is not an issue.

7 CHAIRPERSON MARTINEZ: But, the  
8 paramount issue is that when we read this report  
9 from the-- and I'm going to just ask if some of  
10 the recommendation-- but, when we read the report  
11 that-- how do you compare, if any relevance, the  
12 State Comptroller's report and the report, if you  
13 have it available to you, the report in New York  
14 Time in 2005 that spoke about the nationwide  
15 operation of this particular vendor and among the  
16 thing they found was the, in the investigation,  
17 was flaws medical care in Florida, Pennsylvania  
18 and it included New York State and the fine that  
19 they got that they had to pay for that? But,  
20 before that, I think the paramount issue that you  
21 make in terms of the Comptroller's report is the  
22 fact that no inmate in New York State, when we  
23 look about it, when we hear about a day late,  
24 we're not talking about a day late for medical  
25 care or two days late for medical care. It's more

1  
2 in terms of paperwork that needs to be submitted  
3 and anecdotal that need to be submitted and  
4 reviewed by the Department of Health. Is that  
5 correct?

6                   LOUISE COHEN: Let me not give the  
7 false impression. There are times when someone  
8 may not get treatment that day. But, it wasn't  
9 consequential to their treatment. For example,  
10 the community standard of a viral load and CD4  
11 count three months after their last one, if they  
12 got it a day before, a day after, three days  
13 later, it's really not consequential to their  
14 care. But, we do work very hard to make sure--

15                   CHAIRPERSON MARTINEZ: Um, hm.

16                   LOUISE COHEN: -- that inmates are  
17 getting all the care that they deserve. I think  
18 that Dr. Hershberger basically pointed out the  
19 significant difference between us and any other  
20 jurisdiction. You know, PHS has 1,000 people in  
21 our jails every day. I have 250. I'm monitoring  
22 them every day in every jail. We talk about  
23 cases. We talk about individuals. I have people  
24 who go to the housing areas to talk to people. I  
25 have people who do discharge planning. We know

1  
2 when there are things that are falling through the  
3 cracks, if there are, and we get them fixed  
4 immediately. So, the differences, in some of  
5 those instances in New York State, you know,  
6 there's a Sheriff's office where they didn't have  
7 anybody on call. Well, okay. Now, the Sheriff's  
8 office wasn't going to pay for it. So, it may be  
9 PHS' fault. But the fact of the matter is that we  
10 have a huge staff in the jails that assist in the  
11 work. So, we see this as collaborative effort  
12 between both ourselves, PHS and, frankly, the  
13 Department of Correction. And, we think that's  
14 the only way to run a jail system like that.

15 CHAIRPERSON MARTINEZ: Um, hm.

16 And, in terms of the recommendations made, in  
17 terms of if they haven't developed electronic  
18 medical records--

19 LOUISE COHEN: Okay. We--

20 CHAIRPERSON MARTINEZ: -- of the 11  
21 recommendation made, how many of these were  
22 adopted, addressed or already implemented?

23 LOUISE COHEN: By and large, we  
24 have already implementing most of the  
25 recommendations. So, let me just also say, with

2 all due respect to the State Comptroller, they  
3 didn't have appropriate personnel doing this.  
4 They had no nurses going in to do chart review.  
5 So, they had lay people doing chart reviews, which  
6 I really think is probably-- we suggested  
7 strongly, at many different times, that they  
8 should hire nurses in order to do this chart  
9 review. And, they chose not to. So, having said  
10 that, first of all, we are in the process of  
11 putting in a electronic medical record. We have  
12 other medical electronic systems. For example, we  
13 now get electronic lab reports from our lab  
14 vendor. We have an electronic system for  
15 medications so that we can make sure that people  
16 get their medications in the right housing area.  
17 As you know, people get transferred between  
18 housing areas. We need to make sure that they get  
19 the right pills in the right place at the right  
20 time. So, we do that.

21 And, there were other  
22 recommendations, like we should validate our  
23 nurses' assessments from a supervisor. So, we go  
24 ahead and we do that. We now do spot checks of  
25 some of what our nurses are showing. But,

1  
2 interestingly enough, the Comptroller also agreed  
3 that not one error was made by our nurses in  
4 actually doing the reports that led to the  
5 indicators that you saw. So, our nurses are not  
6 favoring PHS. They're favoring the patients.

7 CHAIRPERSON MARTINEZ: Um, hm.

8 LOUISE COHEN: And, that's really  
9 what they-- that's what I've told them to do.  
10 That's what Dr. Hershberger has told them to do.  
11 They are not out there to make friends with  
12 anybody, but to make sure that our patients get  
13 appropriate care.

14 So, we have, and had at the time,  
15 been developing alternative ways to think about  
16 chronic care, particularly making sure that the  
17 right people come back in the right periodicity.  
18 And, in terms of some of the corrective action  
19 plans, again, I think they misunderstood some of  
20 our current system and really, we do deliver this  
21 information to our vendors on a weekly basis.

22 So, we feel that, you know, we are  
23 implementing the recommendations that we think  
24 made a lot of sense. And, we reserve the right  
25 to, you know, think otherwise in a couple cases.

But, for the most part--

CHAIRPERSON MARTINEZ:

[Interposing] Which leads me to the next question in terms of the expertise, according to the Department of Corrections, the Board of Correction minimum standards, and when it deals with healthcare services, one of the issues that they highlight is the fact, and they shouldn't be, is the fact that an officer should not be treating, prescribing any medical condition. However, how does an officer know when to call in the experts? In other words, from Correction, what type of training? How many hours of training do the officers get on this particular issue?

ROGER PARRIS: Sure. We have a large system. We have a system that's fluid. We have a system that has thousands of inmates moving; hundreds of inmates working. We have injuries sometimes. We have a very sick population that's coming in. So, what we do in our training academy for all recruit officers is we provide a course for them on how to respond to medical emergencies. And, in responding to those medical emergencies, in that course, they also

1  
2 receive certification in CPR and in first aid.

3           They learn, once they've identified  
4 that it's an emergency, they call the clinic.  
5 They actually talk to the medical staff in the  
6 clinic and determine whether the inmate patient  
7 can go down to the clinic or does the clinic have  
8 to, the healthcare staff, have to come to that  
9 location to treat the inmates.

10           So, we have a really good system.  
11 We have what we call Man Down drills, where, in  
12 conjunction with DOH and PHS, on a weekly basis,  
13 we go out and we call emergencies unknown to the  
14 staff just to check the responses from the clinic.  
15 The clinic will respond with medical staff to that  
16 area.

17           So, I mean, we are doing what we  
18 have to do on an ongoing basis. And, we encourage  
19 our staff, even on routine basis, if an inmate  
20 presents in the housing area and says that they're  
21 sick, that inmate is allowed to go down to the  
22 clinic. So, both on a routine and an emergent  
23 basis, and I think you heard in the testimony from  
24 the Department of Health, we also have an Urgi-  
25 Care Center on Rikers, where we have emergency

2 medicine doctors who can respond to any location  
3 on the Island and we also bring patients to them,  
4 as well.

5 CHAIRPERSON MARTINEZ: I'm sorry,  
6 can you just identify yourself for the record.

7 ROGER PARRIS: Yes, I'm Roger  
8 Parris. I'm the Deputy Commissioner for New York  
9 City Department of Correction.

10 CHAIRPERSON MARTINEZ:  
11 Commissioner, let me ask you, how often do  
12 correction officers go for training, other than  
13 when they, at the academy--

14 ROGER PARRIS: Sure.

15 CHAIRPERSON MARTINEZ: --how often  
16 does that happen?

17 ROGER PARRIS: For example, our CPR  
18 training, they go for recertification so that they  
19 are recertified. We have in-service training for  
20 our officers, annual in-service training for all  
21 of our officers. So, they go back to the academy  
22 to receive in-service training in the various  
23 subjects.

24 CHAIRPERSON MARTINEZ: And, the  
25 drill, how often does the drill happen?

2 ROGER PARRIS: We're doing weekly  
3 Man Down drills in conjunction with the Department  
4 of Health and PHS. And, we go from building to  
5 building. We'll call an emergency on different  
6 tours and different locations. And, the medical  
7 staff and our staff have to respond to the  
8 location. So--

9 CHAIRPERSON MARTINEZ: I'm sorry.

10 ROGER PARRIS: Sure. No, I mean,  
11 I'm just, you know, I think between what we do in  
12 the academy, what we do in-service with them and  
13 the fact that we're working on a weekly basis with  
14 the field staff, you know, it's a priority for us  
15 to make sure that adequate and appropriate  
16 responses are taking place in the jails.

17 CHAIRPERSON MARTINEZ: I'm going to  
18 come back to that question before I bring you back  
19 to my colleague. But, with the concept of borough  
20 jails, how difficult would it be for the  
21 Department of Health to have borough, sort of like  
22 a concept of borough health services, rather than  
23 one main provider?

24 LOUISE COHEN: Well, as you know,  
25 right now, sometimes it gets confusing. But, at

2 VCBC, the barge in the Bronx, that is directly  
3 staffed by Health and Hospitals Corporation  
4 physicians and the Department of the Health also  
5 has some staff there as well. So, we, on a number  
6 of occasions, have had, throughout the history of  
7 correctional services, have had some of the  
8 borough jails, in particular, be staffed by other  
9 than the main contractor at the time [pause] the  
10 Department of Health did some direct services.  
11 HHC did some direct services. I believe, St.  
12 Vincent's at one time did some.

13 ROGER PARRIS: Yeah, St. Vincent's.

14 LOUISE COHEN: Ran one of the  
15 jails. So, we thought that that would be  
16 appealing more to, say, a local community health  
17 center or a diagnostic and treatment center to say  
18 I'll take care of the jail in the Bronx, for  
19 example--

20 CHAIRPERSON MARTINEZ: Uh, uh.

21 LOUISE COHEN: -- because that's,  
22 you know, 'cause that's where my patients are, you  
23 know, really they come from there and they go back  
24 into the community. We did not find the community  
25 providers enthusiastic about this option. So, we

1  
2 need to think more about what would make it  
3 appealing for that. But, it's a good idea. We'd  
4 like to try to do it.

5 CHAIRPERSON MARTINEZ: Mr. Chair,  
6 before I turn it over, you mentioned that this  
7 contract is due next year, it's over next year.  
8 Is that...

9 LOUISE COHEN: December of 2010.  
10 So, we're going to start writing the RFP in the  
11 next six months.

12 CHAIRPERSON MARTINEZ: So, I think  
13 this goes along with what the planning, strategic  
14 planning, of the borough jails and I think that  
15 now is an excellent opportunity, particularly in  
16 the City of New York, where we have a friendly  
17 minority women-owned effort to contract with the  
18 City. I think this effort goes along what we're  
19 trying to do with the borough jails in terms of  
20 having borough wide health services. So, I would  
21 love to have further discussion with you on how we  
22 could get the word out--

23 LOUISE COHEN: [Interposing] Yeah,  
24 we'd be pleased to--

25 CHAIRPERSON MARTINEZ: -- about

1  
2 letting people know that these are opportunities.  
3 In many communities, in many boroughs, there are  
4 facilities that I'm sure we could be knocking on  
5 their doors. Thank you, Mr. Chair.

6 CHAIRPERSON RIVERA: Thank you.  
7 Does any of the Committee members have any  
8 questions? Okay. We've been joined by Council  
9 Member Mathieu Eugene and Council Member Mendez.  
10 And, the first question goes to Council Member  
11 Gerson. And then, Council Member Stewart.

12 COUNCIL MEMBER GERSON: Thank you,  
13 Mr. Chair, Mr. Chair. Good afternoon. Just want  
14 to follow up on the issue of substance abuse.  
15 Substance abuse programs, not only the  
16 detoxification and the rehabilitation, is that  
17 part of PHS' contracted responsibility?

18 JASON HERSHBERGER: Yes, it  
19 certainly is.

20 COUNCIL MEMBER GERSON: Are they  
21 required, under the contract, to provide a  
22 treatment program for every inmate who is  
23 identified to have a substance abuse addiction  
24 problem?

25 JASON HERSHBERGER: Well, they're,

1  
2 you know, we develop, CHS develops programs over  
3 time. And, we have some programs for inmates with  
4 addiction problems. Do we have programs for  
5 everyone who's been identified with an addiction  
6 problem? No. But, we have done a lot of work in  
7 that area, particularly on people with--

8 COUNCIL MEMBER GERSON:

9 [Interposing] Now, we, you're talking about CHS?

10 JASON HERSHBERGER: CHS, yeah.

11 Particularly with inmates who are addicted to  
12 opiates. Universally, PH does provide a substance  
13 abuse screen for everyone who walks into a New  
14 York City jail.

15 COUNCIL MEMBER GERSON: PHS?

16 JASON HERSHBERGER: PHS does. And  
17 so, that includes-- it's part of a general history  
18 and physical, including a history of substance use  
19 including the risk for withdrawal, including a  
20 history of alcohol use. So, that's all part of  
21 PHS' work. Now, we're trying--

22 COUNCIL MEMBER GERSON: The  
23 screening part.

24 JASON HERSHBERGER: The screening  
25 part. And, we're--

2 COUNCIL MEMBER GERSON:

3 [Interposing] Now, what is their responsibility  
4 for treatment?

5 JASON HERSHBERGER: Well, the--

6 COUNCIL MEMBER GERSON: Under their  
7 contract.

8 JASON HERSHBERGER: The treatment  
9 for drug addiction in jail is not defined in the  
10 contract. There are particular things--

11 COUNCIL MEMBER GERSON:

12 [Interposing] Why would something-- so, in your  
13 testimony, you highlighted the significance of  
14 substance abuse issues. I think we all know the  
15 linkage between substance abuse and crime and  
16 recidivism. Why would that not be part of a  
17 contract?

18 JASON HERSHBERGER: PHS is required  
19 to comply with the CHS programs including a very  
20 large methadone maintenance and detoxification  
21 program that serves, you know, over 1000 inmates  
22 per month. They also staff--

23 COUNCIL MEMBER GERSON:

24 [Interposing] The methadone maintenance serves a  
25 thousand inmates a month?

JASON HERSHBERGER: Yes.

COUNCIL MEMBER GERSON: And, that's operated by PHS.

JASON HERSHBERGER: PHS. We've also, in the last year, developed some new programming to serve male detainees in one of our jails, AMKC, which allows for inmates identified as having a substance abuse program to get residential-level substance abuse programming treatment and discharge planning while they're in Rikers Island. So, programs in this area are growing. We're still way, light years, ahead of most of the world, but more development needs to happen in this area.

COUNCIL MEMBER GERSON: I mean, it sounds like we have a universal screening program and we have a universal discharge program. But, we have very little in between, aside from, you know, a partial methadone maintenance. Let me ask you this, in terms of responsibility. I just want to get at if PHS' contractual responsibilities, if the Department of Health comes up with a treatment program, which you believe is state-of-the-art treatment for this population, do you have the

2 contractual responsibility to tell PHS to  
3 implement that? Do they have to implement what  
4 you come up with? Or, is it--

5 JASON HERSHBERGER: Yes.

6 COUNCIL MEMBER GERSON: -- without  
7 cost restriction?

8 LOUISE COHEN: No, let me speak to  
9 that issue, because I think that it is-- there are  
10 not insignificant cost. So, there is information  
11 in the contract about their obligations. We do  
12 have some grants that are pass-throughs from the  
13 State AWASAS [phonetic] to fund some programs,  
14 particularly for adolescents as well as for--

15 COUNCIL MEMBER GERSON:

16 [Interposing] Well, I was going to get to the  
17 adolescent--

18 LOUISE COHEN: --some of the  
19 methadone--

20 COUNCIL MEMBER GERSON: --  
21 population particular.

22 LOUISE COHEN: --maintenance. But,  
23 to the extent that we develop new programs, then  
24 we need to find funding for it.

25 COUNCIL MEMBER GERSON: So, they're

not obligated unless you provide funding or find funding.

LOUISE COHEN: We need to-- right.

JASON HERSHBERGER: Yes.

LOUISE COHEN: That's correct.

COUNCIL MEMBER GERSON: So, let me just-- is there any treatment that they are, that PHS currently is contractually obligated to provide; not screening, not discharge planning, treatment, (a) for adolescents, (b) for adults?

JASON HERSHBERGER: Yes, there is a program called MADE, which is--

COUNCIL MEMBER GERSON: Called who?

JASON HERSHBERGER: Called M-A-D-E, MADE, which focuses on adolescents with alcohol problems in our adolescent jail. That's OASIS funded. There is a program in the women's jail called WINGS, which also is OASIS funded to treat women with addiction problems. But, the bulk of our treatment programs falls under what we call our KEY program, which is an OASIS-funded methadone maintenance program, which is the one I've been referring to that serves over a thousand inmates a month.

1  
2 COUNCIL MEMBER GERSON: You add up  
3 MADE, WINGS, and KEY, if I got the acronyms  
4 correctly, what percentage of the 40% of the  
5 population that you estimated, you indicated that  
6 it's probably higher, I believe, but, what  
7 percentage of the population that you estimate has  
8 a substance addiction problem is enrolled in one  
9 of these three programs at any one time? You said  
10 it's not 100%. Is it 90%? Is it 50%? Ten  
11 percent?

12 JASON HERSHBERGER: Well, you know,  
13 substance problems really range-- there are some  
14 substance abuse problems that require immediate  
15 treatment. And, some substance abuse problems  
16 that are not so amenable to jail treatment. For  
17 example, many of our intakes involve people that  
18 are addicted and dependent on opiates. And,  
19 without those opiates, they're going to go through  
20 a painful and uncomfortable withdrawal. We  
21 believe that any inmate who comes in dependent on  
22 an opiate will receive detoxification and be able  
23 to come off drugs with some level of comfort. The  
24 same is true for people that are dependent on  
25 alcohol.

1                   HEALTH, FIRE & CRIMINAL JUSTICE SERVICES 57  
2                   The ongoing, you know, the ongoing  
3 treatment of the underlying addiction happens  
4 through our mental health programs and happens  
5 through some of these focused substance abuse  
6 programs that I've mentioned. I'd say roughly,  
7 you know, there're 8,000 people that come every  
8 month. And, about a thousand of them are  
9 receiving opiate treatment through our KEY  
10 program. So, a large percentage of that group are  
11 people that are addicted to some other substance,  
12 like stimulants, mostly they don't, you know, we  
13 detoxify them because they're incarcerated. But,  
14 there's not enough treatment.

15                   COUNCIL MEMBER GERSON: Do you have  
16 any idea what percentage of the inmate population  
17 is there for a drug-related offense, either  
18 directly or indirectly?

19                   JASON HERSHBERGER: I think about  
20 30%.

21                   COUNCIL MEMBER GERSON: Thirty, I  
22 bet it's a little higher than that one. Directly  
23 meaning for a violation of a law pertaining to  
24 drugs and indirectly meaning for a non-drug-  
25 related crime resulting from a drug issue. I'm

1  
2 willing to bet that, you know, it's much higher  
3 than 30%. But, why don't we leave it at this. I  
4 think it's clear, Mr. Chair, Mr. Chair, I think  
5 it's clear from the testimony presented that we  
6 certainly don't have a universal drug treatment  
7 program for the incarcerated population. We  
8 certainly don't have a detailed contractual set of  
9 obligations by the chief provider for drug  
10 treatment. And, I would go a step further, that  
11 even for the adolescent population, which is  
12 particularly sensitive, we not only don't have a  
13 universal treatment program, but, we don't have a  
14 satisfactory one. So, I'm going to make a  
15 recommendation and a request. And, that is when  
16 you put together the next RFP, that you factor in  
17 whether it's part of the contract or whether it's  
18 going to be an ancillary service provided outside  
19 of the contract directly by government, but one  
20 way or the other, we should have a plan, starting  
21 at the adolescent level, then expanding to the  
22 entire population for not just maintenance to, you  
23 know, avoid incidents or health problems when in  
24 jail, but for real treatment. For all of the  
25 obvious reasons, we have, you know, sadly we have

1  
2 an opportunity to get at a population  
3 disproportionately who are in jail because of  
4 substance abuse issues, rather than just, you  
5 know, let the problem lie. We would serve them.  
6 And, we would serve the communities better if we  
7 take the fact that we have a captive population  
8 and let's get, you know, real treatment at least  
9 started there, which can continue into the  
10 community. From the testimony I'm hearing today,  
11 we don't have that. And, I think, I urge that we  
12 make that a goal. And, I'd like to have a follow-  
13 up, you know, feedback from you as to what you're  
14 doing on that goal. And, Mr. Chair, Mr. Chair,  
15 maybe a follow-up hearing. Thank you very much.

16 JASON HERSHBERGER: Thank you.

17 CHAIRPERSON RIVERA: Thank you.

18 Next, we have Council Member Stewart.

19 COUNCIL MEMBER STEWART: Thank you,  
20 Mr. Chair. I basically got the understanding that  
21 you're stating that at intake, we get a full  
22 medical examination. Is that a comprehensive  
23 medical examination? Or, just the basic?

24 JASON HERSHBERGER: Well, it's a  
25 complete physical and history.

2 COUNCIL MEMBER STEWART: It says  
3 full. But, I'm not too sure it's a comprehensive  
4 medical examination.

5 JASON HERSHBERGER: Well, it--

6 COUNCIL MEMBER STEWART: And,  
7 that's what I'm trying to get a clarity with you.

8 JASON HERSHBERGER: Maybe a point  
9 of comparison would be helpful. There are many  
10 correctional settings where inmates who come in on  
11 the day of admission are screened by a  
12 correctional officer or even a, you know, in some  
13 places, an Allied health professional for just,  
14 you know, just a checklist--

15 COUNCIL MEMBER STEWART: Right.

16 JASON HERSHBERGER: -- of general  
17 health conditions. New York City does much more  
18 than that. New York City provides access to a  
19 physician, who does a history, you know, a full  
20 history, just like you were, you know, going to  
21 your first visit in a primary care doctor's  
22 office, reviewing, you know, any medical  
23 conditions, any acute medical conditions, any  
24 treatment needs. And, we do that day one, which  
25 is one of the reasons why our system is so much

1  
2 different than other jurisdictions.

3 COUNCIL MEMBER STEWART: Right.

4 And, after the examination and testing, what kind  
5 of program do you have to educate folks about  
6 signs and symptoms that they may have, you know,  
7 in terms of preventative care? What do you follow  
8 up with?

9 JASON HERSHBERGER: Okay. Well,  
10 anyone who's identified at intake as having a  
11 chronic illness, for example, is sent or is  
12 scheduled for a follow-up visit in one of our  
13 chronic care clinics. So, if you have an inmate  
14 with hypertension, someone with high blood  
15 pressure comes in. It's identified at intake,  
16 treatment is started then. And, a follow-up  
17 appointment within the next month is arranged with  
18 another doctor to assess that person's, the status  
19 of that person's blood pressure. Usually, at  
20 these chronic care visits, where we do a lot of  
21 our patient education about how to manage these  
22 sort of chronic illness, whether it's HIV, whether  
23 it's hypertension, whether it's asthma, diabetes.

24 COUNCIL MEMBER STEWART: So, you're  
25 saying that, at that time, they tell them about

1  
2 what to look for and things like that, and how to  
3 take-- at that time?

4 JASON HERSHBERGER: Yeah.

5 COUNCIL MEMBER STEWART: So, is  
6 that followed at the same time at discharge? If  
7 someone is being discharged and they had a  
8 problem, are they given information about-- so  
9 that they don't go back and repeat the same thing  
10 and they may have--

11 JASON HERSHBERGER: Well--

12 COUNCIL MEMBER STEWART: --sign and  
13 symptoms that they're not--

14 JASON HERSHBERGER: Okay.

15 COUNCIL MEMBER STEWART: --  
16 symptomatic?

17 JASON HERSHBERGER: Well, treatment  
18 at discharge is tricky in jail, particularly  
19 because discharge is unpredictable. People will  
20 often go to court and be released from court. So,  
21 there's not an opportunity to see a medical  
22 professional on sort of the back door of the  
23 system. What we do do at intake is provide  
24 everyone with a general patient information  
25 brochure, which tells them how to deal, you know,

1  
2 access services while they're in jail. But, also  
3 provides the Department's support, you know,  
4 referrals to community agencies after release.  
5 So, people will have, you know, get some  
6 information to point them in the right direction  
7 to either continue care or initiate care once  
8 they're back in the world.

9 COUNCIL MEMBER STEWART: Do you  
10 have a number of specialties that you refer to  
11 these folks to, the patients, to any specialty  
12 that you...

13 JASON HERSHBERGER: Yeah, there are  
14 two levels of specialty services. Some of the  
15 more common specialty services are the ones that  
16 don't require procedures or operating rooms are  
17 handled right on the Island. So, we have inmates  
18 go and see neurologists or podiatrists or  
19 optometrists and general routine specialty care  
20 right on the Island. And, people that need higher  
21 level subspecialty care will go and get treated at  
22 one of our HHC facilities, usually Bellevue.

23 COUNCIL MEMBER STEWART: And, my  
24 last question, you mentioned awhile ago about  
25 reviewing of charts. And, you know, there's a big

1  
2 difference in writing of the charts and the  
3 reviewing of the charts. You can write a very  
4 good chart, which will pass muster by the nurse  
5 that you may send there to review those charts.  
6 However, in terms of providing the service in a  
7 timely fashion and the appropriate service, it may  
8 not be even linked. How do you check that? How  
9 do you really get to the point whereby all that is  
10 being done and being done in the manner that it's  
11 said, is written up in the chart?

12 JASON HERSHBERGER: Okay. Well,  
13 there's lots of ways that we, you know, track the  
14 sort of care delivery and document to the chart.  
15 One is, of course, many patients have multiple  
16 visits. So, if something was missed at one visit,  
17 we can compare it to prior notes or subsequent  
18 notes. So, we can see whether the chart hangs  
19 together. We also directly talk to inmates. We  
20 go to the housing areas. We receive complaints  
21 from inmates who are unsatisfied with their care.  
22 We receive, through their advocates or the  
23 attorneys or the families, requesting assistance.  
24 And so, we hear about the satisfaction or things  
25 that, you know, that might occur in the course of

1  
2 medical care in that way. And, we investigate  
3 those and review them.

4 COUNCIL MEMBER STEWART: All right.  
5 Thank you.

6 CHAIRPERSON RIVERA: Thank you.  
7 We've been joined by Councilwoman Inez Dickens and  
8 Council Member Vincent Gentile. And next, we have  
9 Council Member Mathieu Eugene with a line of  
10 questioning.

11 COUNCIL MEMBER EUGENE: Thank you  
12 very much, Mr. Chair. Thank you. Thank you very  
13 much members of the panel for your presentation.  
14 Thank you so much in what you are trying to do  
15 also for our inmate. And, in your testimony, you  
16 mentioned that you have a discharge plan. Can you  
17 elaborate a little bit for me on the discharge  
18 plan? What I'm looking for is how do you address  
19 the situation of the inmate who don't have medical  
20 insurance. And, those, also, who's English is not  
21 the first language, who don't speak it. How do  
22 you address the issue?

23 LOUISE COHEN: Well, there are a  
24 number of different kinds of discharge planning  
25 programs that exist in jails. Some of them are

1  
2 run by the Department of Correction and, in fact,  
3 they have a program for sentenced inmates that is  
4 run, called the RIDE program. And, they do a lot  
5 of benefits so that people get health insurance,  
6 either it's reactivated if they had it before.  
7 Or, they get new applications or they do public  
8 assistance applications and food stamps  
9 applications there, as well. As well as trying to  
10 connect people to other services in the community,  
11 such as employment and education. From the  
12 medical point of view, we are focusing on the most  
13 high need people. And, right now, we're fully  
14 committed to 100% of the people who come in with  
15 HIV are provided with a significant discharge  
16 planning. And, that includes benefits, as well.  
17 We make sure that people who have HIV are  
18 connected to care in the community and about 70%  
19 of the people who are released from jail actually  
20 go to their first appointment in the community,  
21 which we think is extraordinarily high and we're  
22 very pleased with that. We'd like to see it  
23 higher. But, that's, we think that's great. And,  
24 all of those people are assisted with health  
25 insurance, including ADAP [phonetic], which is a

1  
2 State program, as you may know, to provide  
3 additional services for those people who might  
4 qualify.

5 So, those are things that we do  
6 routinely. We also work with some folks who might  
7 have chronic diseases that need specific follow  
8 up; someone who we want to make sure has a  
9 provider in the community. We'll make sure that  
10 they have a provider that is culturally  
11 appropriate, culturally competent in their  
12 community, as much as possible. And, that they  
13 have health insurance, either when they walk out  
14 the door or they at least have an application for  
15 health insurance.

16 So, we'd like to do more. But, we  
17 think we do a great deal. We also do a great deal  
18 of discharge planning for people who are mentally  
19 ill and that includes health insurance, in  
20 particular, as well. And, as you know, that there  
21 is a new state law that requires that those people  
22 who had Medicaid when they came into jail, that  
23 Medicaid should be suspended. We're obviously  
24 working closely with the State Health Department,  
25 the Department of Corrections and others to make

1  
2 sure that that is activated appropriately.

3 COUNCIL MEMBER EUGENE: Thank you  
4 very much. But, in term of treatment, and also  
5 providing services to patient, we know that the  
6 communication between the doctors and the patient,  
7 you know, is very, very important. I'm going back  
8 again, for those who don't speak English properly,  
9 what do you have in place inside the jail to make  
10 sure that the patient, you know, understand the  
11 doctor and the doctor understand the patient?  
12 And, the patient can receive the proper medical  
13 care.

14 JASON HERSHBERGER: I think there's  
15 three major resources that we use. For the most  
16 part, you know, we're fortunate to have a high  
17 level of bilingual medical staff. Many  
18 correctional health professionals speak Spanish,  
19 come from other parts of the globe. So, there's  
20 often the staff, themself, or we can find staff  
21 that match with the patient to have a direct  
22 conversation. Barring that, we have, you know, we  
23 contact with professional interpreter services.  
24 And, in a pinch, we'll use telephone language  
25 support.

2 CHAIRPERSON RIVERA: Is it one of  
3 the requirements of the contract?

4 JASON HERSHBERGER: Yes.

5 CHAIRPERSON RIVERA: To provide  
6 bilingual services?

7 JASON HERSHBERGER: Yes, it's a  
8 requirement of the contract to be able to  
9 communicate with non-English speakers.

10 COUNCIL MEMBER EUGENE: You said  
11 that bi-language, and you mentioned Spanish. But,  
12 we know that New York is a very diverse city.

13 CHAIRPERSON MARTINEZ: He didn't  
14 say Spanish. He said bi-lingual, you know.

15 CHAIRPERSON RIVERA: He said both.

16 COUNCIL MEMBER EUGENE: Miguel, you  
17 know, I think, you know, I'm talking to him--

18 JASON HERSHBERGER: I said both.

19 COUNCIL MEMBER EUGENE: Thank you.  
20 Yeah, you said Spanish. But, what about the  
21 people who speaks Chinese or Russian, Creole and--

22 JASON HERSHBERGER: There's many  
23 Creole speakers.

24 COUNCIL MEMBER EUGENE: The Chinese  
25 also, and other languages, you know. How do you--

I know that it would impossible to have all the languages. But, what do you have in place to make sure that more people get access to quality of care in term of, you know, language barriers?

JASON HERSHBERGER: Well, when we don't have a staff member that can directly speak, we use contracted translators or we use a telephone language support.

COUNCIL MEMBER EUGENE: Okay.

JASON HERSHBERGER: Call the language bank.

COUNCIL MEMBER EUGENE: We know that infectious disease, like HIV, STD, you know, can be transmitted very easily. But, while they're inside the jail, what do you have in term of prevention or the way to minimize the transmission of the disease in term of counseling, workshop, to let them understand the need they have to protect themself not to spread the disease? I know that you have treatment assistance to treat them, get them medicine and stuff like that. But, in term of helping them understand they have to make an effort also not to transmit the disease, especially infectious

1  
2 disease. Do you have workshop, you know,  
3 counseling, let them know, you know, you have  
4 this, you know. You can give it to that person  
5 who doesn't have it. What technique, what measure  
6 they should, you know, observe inside the jail?

7 JASON HERSHBERGER: The Department  
8 does a lot of harm reduction activities. We focus  
9 on safe sex practices, safe drug use practices.  
10 Of course, we always want people to achieve  
11 sobriety. But, we understand that many of our  
12 patients won't. So, when we talk about clean  
13 needle exchange, for example, as a way of helping  
14 curtailing the transmission and spread of disease  
15 after someone returns to the community.

16 LOUISE COHEN: We also received  
17 some funding from the CDC HIV prevention grant.  
18 And, I have prevention counselors, who go into  
19 housing areas and talk to people about HIV  
20 prevention. And, one of the main things that we  
21 try to do, of course, is talk to people and try to  
22 get them, if they don't know their HIV status, to  
23 try to get them tested as one of the ways in which  
24 we can open up the conversation about HIV and so  
25 that it's not just a one-time conversation, but,

1  
2 we're saying why don't you go get tested. Then,  
3 you go get another conversation with a medical  
4 professional. There's a whole series of things  
5 that we do to try to help people understand the  
6 ways in which they can prevent themselves from  
7 getting, in particular, HIV.

8 COUNCIL MEMBER EUGENE: But, in  
9 term of substance abuser or users, in the  
10 testimony it seemed that some of them, you know,  
11 come back the first and the second time. You see  
12 what I mean? But, it seem that there's a  
13 correlation between the substance abuser job  
14 situation. But, do you have anything in place to  
15 try to prevent them to come back in term of  
16 substance abuse, you know, to get--

17 JASON HERSHBERGER: Yes.

18 COUNCIL MEMBER EUGENE: -- the - -  
19 out of the jail and follow this one, you know, in  
20 order to prevent [crosstalk]?

21 JASON HERSHBERGER: One of the  
22 programs that we're most proud of that we've  
23 developed in the last year is called-- a program  
24 that we call A Road Not Taken, ARNT. The program  
25 I mentioned that happens in AMKC, one of our jails

1  
2 for male detainees. And, it's a program that  
3 focuses on people who have demonstrated a  
4 willingness to address their substance abuse  
5 problems and, are at least, making the first steps  
6 towards a commitment to avoid substances. We take  
7 referrals from health providers, mental health  
8 providers. We take referrals from the Department  
9 of Correction. And, one of the things I'm very  
10 pleased with is we're getting more and more  
11 referrals directly from the City's drug courts of  
12 people that are looking to break the cycle of  
13 addiction and recidivism by coming through our  
14 program.

15 It's growing. Right now, we have  
16 three units, each with 50 people in it. And,  
17 we're looking to expand it. And, we're looking  
18 for funding sources to allow us to do that.

19 COUNCIL MEMBER EUGENE: Thank you  
20 very much. And, I hope that the City Council  
21 Members will increase the funding in order for you  
22 to be able to provide more services like that.  
23 Thank you very much. And, Mr. Chair, thank you  
24 very much.

25 CHAIRPERSON RIVERA: You touch on

1  
2 a-- we've been joined by Council Member Jimmy  
3 Vacca from the Bronx. You spoke about the  
4 Medicaid. The Committee has data indicating that  
5 in a given month in 2006, 38% of the people or  
6 inmate in our jail had health insurance. What  
7 effort, if any, has the City made to seek  
8 reimbursement from the insurance company that will  
9 cover these inmates? And, do you know of any  
10 other jurisdiction that pursued reimbursement from  
11 inmates that have health coverage?

12 LOUISE COHEN: My best guess is  
13 that the vast majority of those 38% had public  
14 insurance, Medicaid or Medicare, which we can't  
15 get reimbursement for people who are incarcerated.  
16 I think it's a very small percentage of anybody  
17 who might have private insurance. And, I don't  
18 know that it would be cost effective to spend a  
19 lot of time going after that health insurance,  
20 when, in fact, it's unlikely that we would get  
21 that reimbursement. So, I don't know about other  
22 jurisdictions. But, I think for private health  
23 insurance, it's actually-- it would be a fraction  
24 of that 38%.

25 CHAIRPERSON RIVERA: You know, we

used to have the light off, the mic was on--

LOUISE COHEN: Very confusing.

CHAIRPERSON RIVERA: -- now the light is on. Has there been any studies done by the Department to see how many of the inmates actually--

LOUISE COHEN: Have private insurance?

CHAIRPERSON RIVERA: Private, yeah.

LOUISE COHEN: Not that I'm aware of. We think it's fractional and probably wouldn't yield a large amount of dollars for a fairly large amount of work to go after that. We would certainly look into it. But, I think it'll yield us very little.

CHAIRPERSON RIVERA: Right. I think we have a question from Council Member Dickens. I'm sorry, we've been joined by Council Member Rosie Mendez.

COUNCIL MEMBER DICKENS: Thank you. We apologize.

CHAIRPERSON RIVERA: No, I like Rosie. I mentioned her again.

COUNCIL MEMBER DICKENS: Thank you

1  
2 so much, Chairs. And, thank you Commissioner for  
3 the testimony. And, I apologize for my lateness.  
4 But, I have just two quick questions. One is on  
5 preventive testing; in other words, regular  
6 testing. I've noticed in your testimony on page  
7 2, you said from the first day of custody, jailed  
8 New Yorkers have access to a physician who can  
9 detect and treat health conditions. I'm talking  
10 about regular testing that the health industry has  
11 determined is necessary. For instance, for  
12 prostate cancer, the PSI's are running high;  
13 cervical cancer, mammogram, pap smears, are they  
14 done regularly because the health industry has  
15 determined that these are tests that should be  
16 done annually or maybe every five years, if it's  
17 colon cancer. Are these tests conducted  
18 regularly? Or, do you wait until something  
19 manifests itself?

20 JASON HERSHBERGER: Well, for the  
21 most part, we do a lot of work to screen for  
22 public health conditions like cervical cancer,  
23 breast cancer. So we do refer women who come into  
24 Rikers Island to our gynecologist for routine  
25 primary care screening. Some of the other

testing, like PSA testing--

COUNCIL MEMBER DICKENS: Um, hm.

JASON HERSHBERGER: -- or colonoscopy, we don't routinely do. Again, part of that is because we are treating people in a very quick turnover. So, it's unlikely that someone's going to be with us on Rikers Island or in our care for a long period of time. So, we try to focus on conditions that we can screen pretty quickly. Long term routine primary care, like colonoscopy, PSAs, usually we defer to the outpatient world. However, any physician can order those tests while they're with us when those needs arise.

COUNCIL MEMBER DICKENS: All right. The reason I questioned because, particularly in men, if the PSAs are running high, that can be a determining factor in whether prostate cancer is close at hand or they already have it. And, I think that that is something that is very important, particularly because I'm getting quite a few men who are coming out of jail and now they're having trouble. I've got, just in the last year, I've gotten approximately 15 men who

2 have come back into the community. Their PSAs are  
3 running high. And, they're either at the onset of  
4 a problem because, as you know, the PSAs reflect,  
5 or could reflect, prostate cancer. So, I'm very  
6 concerned about that now that I'm, you know,  
7 seeing this on the rise. So, I just wanted to  
8 bring that to your attention because I am now  
9 being faced with that in my community.

10 The other part of this is, in your  
11 testimony, you, on page 3 of your testimony, you  
12 refer to methadone treatment while incarcerated.  
13 What about those that are incarcerated, they have  
14 substance abuse, they become free and clean and  
15 they go back into the communities free and clean.  
16 But, they don't need to be referred to a methadone  
17 program, instead they need to be referred to a  
18 treatment program where they can continue to be  
19 free of drugs.

20 JASON HERSHBERGER: Well, an  
21 example of such a program is the ARNT program that  
22 I described a little bit earlier, which is a  
23 residential-type therapeutic community that  
24 occurs, you know, on Rikers Island for male  
25 detainees. For the most part, the goal is

1  
2 sobriety and free and clean living. And, as part  
3 of that program, there's discharge planning that  
4 helps people connect to community resources.

5 COUNCIL MEMBER DICKENS: Thank you.  
6 And, one last question because you do have a  
7 program where you're releasing the incarcerated  
8 that come for treatment. They're still  
9 incarcerated over on the Island and they come  
10 over-- they're brought over on a bus and they're  
11 released at 125th Street and Lexington Avenue to  
12 go to a treatment program and then, the late  
13 afternoon, they get back on the bus to go back  
14 over. Are you familiar with what I'm talking  
15 about? They're not incarcerated in jails, but  
16 they are over-- are you familiar? No?

17 JASON HERSHBERGER: I'm not  
18 familiar with that.

19 COUNCIL MEMBER DICKENS: All right.  
20 Because that's becoming a real problem in my  
21 community where they're being released right at--  
22 there's at least 70 that's released right at one  
23 location between 126th and 125th on Lexington  
24 Avenue. They're referred to a program that's in  
25 the area and--

2 JASON HERSHBERGER: Councilwoman,  
3 could that be the State Department of Correction?

4 COUNCIL MEMBER DICKENS: Yeah, it  
5 is the State Department of Corrections.

6 JASON HERSHBERGER: Yeah.

7 COUNCIL MEMBER DICKENS: But, I  
8 just wanted this because I want my Chairs to be  
9 focused on it because my community is becoming  
10 very alarmed about what's occurring. So, I just  
11 wanted my Chairs to be aware, both my Chairs,  
12 Chair Martinez, the ones that are here. Thank  
13 you. All right. But, thank you for your answers.  
14 But, you know, I wish you'd look at the PSA  
15 testing and the pap smear on a regular basis.  
16 Thank you.

17 CHAIRPERSON RIVERA: Thank you very  
18 much, Council Member. And, we concur with Council  
19 Member Dickens as well. Council Member Stewart  
20 has a follow-up question.

21 COUNCIL MEMBER STEWART: I just  
22 want to be clear. You said there were 38% of the  
23 inmates with insurance. And, what type of-- if  
24 you're not filing for any of the private insurance  
25 when you treat someone, and the State is taking

1  
2 away the Medicaid part of it, of the insurance, so  
3 you were saying that you're not doing anything as  
4 far as insurance and treatment is concerned.

5           LOUISE COHEN: I believe the 38%  
6 number comes from, at least it matches what  
7 inmates, our patients, tell us when they come in  
8 that they have insurance. We don't bill for  
9 insurance while someone is in jail. We are not  
10 allowed to bill for Medicaid or Medicare when  
11 someone is incarcerated. That is considered a  
12 local obligation. So, primarily our funding comes  
13 from City tax levy and a State match for public  
14 health purposes. So, there's probably a very,  
15 very small proportion of those people who might  
16 have private insurance. We have not asked that  
17 question. And, we do not, at this time, bill for  
18 private insurance.

19           COUNCIL MEMBER STEWART: So, what  
20 you're saying, you're guessing it's a small  
21 portion of that.

22           LOUISE COHEN: We think it's  
23 probably a very small proportion of people.

24           COUNCIL MEMBER STEWART: You don't  
25 think it's wise for us to get those stats to know

1  
2 what percentage of the folks that may have  
3 insurance that, for services, that you provide  
4 that should be reimbursed?

5 LOUISE COHEN: We can certainly  
6 look into it by doing some kind of a spot check.  
7 But, I think we will find that it will be not  
8 enough to even pay for the staff who would have to  
9 do the billing.

10 COUNCIL MEMBER STEWART: No, you  
11 don't have to pay for the staff. You can get a  
12 private company to do that. And, they get a  
13 percentage of it. A lot of the medical people do  
14 that. What they do is contract with someone who  
15 will do the billing and they get a percentage of  
16 the billing. So, you know, to me, this is monies  
17 that are going down the drain for services that we  
18 have provided, even if it's 10% of the folks that  
19 may have private insurance. Whatever service you  
20 provide, if they have insurance, you should be  
21 filing for that. And, the others, you know, we  
22 can then deal with the State later on. But, the  
23 fact is if you do have private insurance, I think  
24 we should be seeking to get that. And, you don't  
25 need to do it. You get a company to, as long as

1  
2 you do the treatment, a company can come in and  
3 seek to get that reimbursement.

4 LOUISE COHEN: We'll look into it.  
5 Thank you.

6 COUNCIL MEMBER STEWART: Thank you.

7 CHAIRPERSON RIVERA: Thank you very  
8 much, Council Member. And, thank you to all my  
9 colleagues. Thank you for attending with us here  
10 today. We are now going to move on to the last  
11 panel. So, I think we're concluded with this  
12 panel.

13 JASON HERSHBERGER: Thank you.

14 CHAIRPERSON RIVERA: The next panel  
15 will consist of Corinne Carey from the New York  
16 Civil Liberties Union, as John Boston from the  
17 Legal Aid Society, as well as Dale A--

18 FEMALE VOICE: Wilker.

19 CHAIRPERSON RIVERA: --Wilker from  
20 the Legal Aid Society. If we have any written  
21 testimony, you can just provide it to the Sergeant  
22 of Arms and he'll make sure to distribute it to us  
23 here on the dais. Okay. So, you can just proceed  
24 by stating your name for the record, your  
25 affiliation and proceed with your testimony.

2 CORINNE CAREY: My name is Corinne  
3 Carey. I'm Public Policy Counsel to the New York  
4 Civil Liberties Union. The NYCLU, the state  
5 affiliate of the American Civil Liberties Union,  
6 has approximately 48,000 members. The NYCLU is  
7 devoted to the protection and enhancement of  
8 those fundamental rights and constitutional  
9 values embodied in the Bill of Rights of the U.S.  
10 Constitution and the Constitution of the State of  
11 New York.

12 I' like to thank the Committee on  
13 Health for inviting the NYCLU here today to  
14 provide testimony relating to physical health  
15 services in New York City's correctional  
16 facilities.

17 I'm here today to speak on the  
18 narrow issue of access to reproductive health care  
19 for women in jail in New York City. For the  
20 record, the NYCLU is deeply concerned about the  
21 privatization of healthcare services in jails and  
22 PHS, in particular. We're well aware of problems  
23 associated with this vendor throughout the state.  
24 But, I'm here today to talk about an investigation  
25 that we did into what policies and procedures

1  
2 exist to ensure access to reproductive healthcare  
3 services. The work that we did was not about  
4 access to such services. But, I can tell you that  
5 we spoke with advocates who work with women in  
6 prison and did not hear of any significant  
7 problems with access to reproductive healthcare.  
8 So, let me turn to the work that we've done to  
9 assess the quality of the City's policies.

10 Sparked by cases where women in  
11 county jail facilities outside of New York City  
12 were denied access to reproductive healthcare  
13 while incarcerated, the NYCLU last year launched an  
14 investigation of policies for provision of  
15 healthcare specific to female inmates. The NYCLU  
16 sent Freedom of Information Law requests to 58  
17 counties, seeking information about access to a  
18 variety of reproductive healthcare services,  
19 including abortion, prenatal care, routine  
20 gynecological exams, contraception and testing  
21 and treatment for HIV and sexually transmitted  
22 infections.

23 We published a report of our  
24 findings in March of this year entitled Access to  
25 Reproductive Health Care in New York State Jails.

1  
2 Our report exposed an uneven patchwork of  
3 healthcare policies in the 52 county jails in New  
4 York that house women. Those policies often fail  
5 to address the most basic reproductive health  
6 services, such as pregnancy testing, prenatal  
7 care, screening and treatment for sexually  
8 transmitted infections or access to abortion  
9 services. Women who are incarcerated in New York  
10 State are legally entitled to such care, but few  
11 county jails have policies ensuring comprehensive  
12 access. Without uniform policies, the quality of  
13 healthcare a woman receives in a county jail  
14 depends on where she's incarcerated.

15           Fortunately for women incarcerated  
16 here in New York City, we found that access to  
17 reproductive healthcare in City facilities is  
18 quite good. In fact, we have suggested that New  
19 York's policies and practices regarding healthcare  
20 for female inmates serve as a model to other  
21 counties across the state. There's still work to  
22 be done, however, to improve the breadth of  
23 services that should be offered to women in our  
24 city jails. In addition, some of the services  
25 that are in place for women now are not provided

1  
2 pursuant to any official policy, but simply  
3 because the current administration believes  
4 they're necessary. We've found that good  
5 practices must be memorialized in written policies  
6 and procedures, or else they risk being eliminated  
7 as personnel and administrations change.

8           Let me begin by telling you what we  
9 found that made New York's policies outstanding.  
10 New York City's policy on emergency contraception  
11 is exemplary. It recognizes that women may enter  
12 the system having had unprotected or inadequately  
13 protected sex up to 120 hours prior to being in  
14 custody. It ensures that emergency contraception  
15 is made available to women who may be at risk of  
16 pregnancy, and it provides guidance to jail staff  
17 about how to determine whether a woman may need EC  
18 and how to administer it. The city's policies  
19 also recognize that women may need to continue  
20 birth control during their incarceration, and  
21 allows them to do so. The policies provide that EC  
22 is provided as a routine part of post-sexual  
23 assault treatment, as well as post-exposure  
24 prophylaxis to prevent HIV infection.

25           Access to abortion services is also

1  
2 guaranteed by New York City's policies, as well as  
3 basic prenatal care for women who choose to  
4 continue their pregnancies while incarcerated.  
5 The City's policy on the use of restraints for  
6 pregnant inmates is commendable. It proscribes  
7 the use of restraints on pregnant women who are  
8 being transported to a hospital in order to  
9 deliver, and that at all other times, pregnant  
10 inmates can be handcuffed in the front of their  
11 bodies, but not with their arms behind their  
12 backs, and never at the ankles.

13 In conversations we had following up  
14 on the documents that we received from our FOIL  
15 request, we found that women are routinely offered  
16 gynecological examinations, and we heard this in  
17 the testimony that we just heard, including STI  
18 testing at admission. However, this offer of  
19 routine gynecological care is not part of the  
20 policies and procedures that govern healthcare in  
21 the facility.

22 In our report, we offered a series  
23 of recommendations for ensuring access to  
24 comprehensive reproductive healthcare for women  
25 in jail. We based our recommendations on

2 guidelines from the American College of  
3 Obstetrics and Gynecology's Health and Health  
4 Care of Incarcerated Adult and Adolescent Females,  
5 and the American Public Health Association's  
6 Standards for Health Services in Correctional  
7 Institutions. Our recommendations were adopted by  
8 the State Commission of Correction, which issued a  
9 memorandum to all county jail facilities  
10 encouraging them to adopt written policies and  
11 procedures addressing access to reproductive  
12 health care.

13 While New York City's policies and  
14 practices are by far the best in the state, we  
15 offer three recommendations from our report that  
16 would improve them. First, we urge the City to  
17 strengthen the commitment it has already  
18 demonstrated to ensuring access to comprehensive  
19 reproductive healthcare to women in jail by  
20 memorializing current practices and procedures in  
21 written policies, so that such practices are more  
22 likely to remain in place regardless of shifts in  
23 personnel or administration. Second, although we  
24 just heard from CHS that breast cancer screening  
25 is available, we did not find that in our study.

1  
2 And so, we recommend that the City provide women  
3 with access to age-appropriate mammography  
4 services. And, finally, the City should establish  
5 procedures to guide jail officials in preparing for  
6 the timely transport of pregnant women to  
7 appropriate facilities for labor and delivery.

8 Jail officials are required by law  
9 to provide inmates with access to necessary  
10 medical care. But, there is also significant  
11 public health benefit to doing so. Incarcerated  
12 women suffer disproportionately from lack of access  
13 to primary care and resulting poor health  
14 outcomes. Jail administrators have a unique  
15 opportunity to provide not only necessary  
16 treatment, but also preventive healthcare services  
17 and screening for medical problems that often go  
18 undetected at home. Offering such services  
19 ensures that women return to their communities  
20 healthier and in less need of public health  
21 resources.

22 We believe that if the changes that  
23 we have proposed were to be implemented, New York  
24 City's provision of healthcare to incarcerated  
25 women could become a model not only to the rest of

1  
2 New York State, but also to the nation. Thank  
3 you.

4 DALE WILKER: Chairman Rivera,  
5 Chairman Martinez, members of the Committee, my  
6 name is Dale Wilker. I am a staff attorney at the  
7 Legal Aid Society's Prisoner's Rights Project. I  
8 am joined here today by John Boston, who is the  
9 Project Director.

10 Thank you for the invitation to  
11 appear at this hearing. And, thank you to the  
12 Chairmen, Mr. Martinez and Mr. Rivera, for their  
13 leadership in calling this hearing about these  
14 important public health issues. The Legal Aid  
15 Society's Prisoners' Rights Project has been  
16 dealing with the jail healthcare system for about  
17 35 years. The Legal Aid Society is intensely  
18 interested in improving the quality of care for  
19 City prisoners to the extent that we've actually  
20 had to bring cases in court, Federal Court and  
21 State Court, about healthcare issues. And, we  
22 advocate on a daily basis for individual prisoners  
23 who call us with complaints. We are also  
24 concerned with the City's plans for the future of  
25 healthcare services to constituents who are held

2 in the City jails.

3 Virtually every day, our office is  
4 contacted by prisoners or their families or  
5 attorneys with complaints about jail medical care  
6 issues. We regularly contact the medical  
7 provider, Prison Health Services, Incorporated,  
8 and the Department of Health staff, both in the  
9 central offices and on Rikers Island and the Board  
10 of Correction on behalf of these prisoners. We  
11 usually communicate instantaneously via an e-mail  
12 system, where we transmit the inmate's complaints  
13 to the responsible officials as fast as the send  
14 button will forward it. While we do not have the  
15 resources at the Legal Aid Society's Project to  
16 compile statistics or issue reports on the medical  
17 care system's performance, there are clear patterns  
18 of complaints that we have noticed and which we  
19 believe reflect ongoing deficiencies in the jail  
20 medical care system.

21 To save time, I will limit my oral  
22 presentation to a few of the patterns of problems  
23 that inmates tell us about. I have provided the  
24 Committees with a fuller version of the Society's  
25 testimony in written form, which I ask be inserted

1  
2 into the record.

3           The significant problems in jail  
4 medical care that we have noticed include  
5 inadequate response to the risk of suicides; lack  
6 of access to sick call, both regular daily sick  
7 call, as well as emergency sick call; significant  
8 delays in dental treatment, even for patients who  
9 complain they are in pain; unexplained failures to  
10 continue treatments that prisoners were receiving  
11 before incarceration or treatments ordered by  
12 specialists at the City's hospitals or hospital  
13 clinics that serve the prisoners; a failure to  
14 carry out medical diet orders, or to continue  
15 medical diet orders that have been made by jail  
16 doctors when prisoners are transferred from one  
17 jail to another; a lack of a systemic approach to  
18 the accommodation of disabled prisoners who have  
19 mobility problems and other disabilities. We  
20 receive repeated complaints of confiscation by  
21 corrections staff of prescribed mobility aids,  
22 that is wheelchairs, canes, crutches, braces,  
23 orthopedic shoes and the like that the jail  
24 doctors give permission slips to the inmates to  
25 have, but which correction officers during

1 security searches seize, confiscate without  
2 checking first with the jail medical provider to  
3 see if the inmate had permission to have those  
4 devices.  
5

6 We receive repeated complaints of  
7 retaliation or threats of retaliation and other  
8 abusive treatment by some prison health services  
9 staff. These patterns of problems that we see day  
10 after day, month after month, year-in and year-  
11 out, suggest to us that there is a basic problem  
12 of accountability and oversight. Problems with  
13 the City Council may be able to help with.

14 The Board of Correction is, as this  
15 Council's noted, has oversight authority and  
16 promulgates minimum healthcare standards, which  
17 are very good standards. The problem is is the  
18 Board does not enforce them. They do not appear  
19 to investigate most of the medical complaints  
20 which we forward to them or respond to us with a  
21 result of their investigation. They do not  
22 discuss medical problems in their monthly public  
23 meetings except in very general terms. And, they  
24 seemed to have ceased their former practice and,  
25 we think, duty of conducting thorough independent

1  
2 medical reviews of prison deaths. Frankly, the  
3 Board admits that they do not have the staff  
4 resources to follow up on more than a fraction of  
5 the problems.

6           There's also a problem under the  
7 present leadership at the Board. We think that  
8 they have grown a little too close to the  
9 agencies, Health and Corrections, that they are  
10 supposed to regulate. Some things that we think  
11 the Council could do, as a legislative matter, to  
12 address these types of patterns are as follows.  
13 And, we have six recommendations.

14           The first with respect to the Board  
15 of Correction is to fully fund it, so it has  
16 adequate staff in the jails, in its home office to  
17 do the monitoring, enforcement, investigation of  
18 its minimum standards that the standards  
19 themselves call for. That would go a long way, we  
20 think, to reducing the number of complaints that  
21 we receive and also clearly improving the  
22 healthcare system itself.

23           Second, this Committee could help  
24 reestablish a death review system, which the Board  
25 formerly engaged in, that would be independent,

1 public and transparent. There is a state death  
2 review system that is conducted by the State  
3 Commission on Correction. But, their reports tend  
4 to be long delayed and do not seem to have much  
5 follow up in terms of the recommendations they  
6 have for improved healthcare. And, by that I mean  
7 because of the delay, such long time has passed  
8 between the inmate's death and the recommendations  
9 for practice changes that we question the  
10 usefulness of those recommendations in current  
11 time. Perhaps the Committees could, at the next  
12 hearing, ask the Department of Health if any of  
13 the recommendations from the State Commission on  
14 Corrections death reviews have been implemented,  
15 either by the Department or by PHS.

17 Third, the Council could enact  
18 legislation that would explicitly make the Board  
19 of Correction minimum standards enforceable in  
20 local courts; not Federal courts, local courts.

21 Third, the Council can require that  
22 jail medical services seek and obtain  
23 accreditation from the national body, the Joint  
24 Commission on Accreditation of Healthcare  
25 Organizations. We think that this, as a peer

1  
2 review mechanism, would provide the type of  
3 professional insight into the workings of the jail  
4 healthcare system that would also be independent,  
5 transparent and extremely useful.

6 Fourth, the Council can enact  
7 legislation with respect to contracting that would  
8 create a preference for local, non-profit teaching  
9 hospitals for the provision of jail healthcare.

10 When jail medical services were provided by  
11 Montefiore Hospital and, for a time, by St.  
12 Vincent's Hospital at the Manhattan Detention  
13 Center and on Rikers Island, the level of  
14 complaints that we received was not only lower,  
15 much lower, but it seemed to us that the  
16 responsiveness of the medical care practitioners  
17 in the system was greater than it has been under  
18 the for-profit providers of the last ten years.

19 And, sixth, finally, there is a  
20 medical infirmary on Rikers Island that was  
21 supposed to be temporary. It is somewhat  
22 decrepit. It has had problems with leaks and  
23 falling ceilings. It was constructed out of an  
24 old garage and industrial shop building. The City  
25 had had a plan, some years ago, to build a modern

1  
2 properly equipped jail infirmary on Rikers Island  
3 to serve all of the jails. Now, that was known as  
4 the C-133 Project. That Project was defunded  
5 during the Giuliani Administration. We think that  
6 the Council can restore funding for the  
7 construction of a new medical infirmary to replace  
8 the present outmoded and truly decrepit facility  
9 on Rikers Island.

10 In conclusion, thank you for the  
11 opportunity to testify before the Committee.

12 Mr. Boston and I would be happy to answer any  
13 questions that members of the Committee may have.

14 CHAIRPERSON RIVERA: Thank you very  
15 much. Do any Committee members have any  
16 questions? Yes.

17 CHAIRPERSON MARTINEZ: Well, with  
18 the whole concept of the borough jail, would there  
19 be a need to fix up the infirmary over at Rikers  
20 Island, since you're going to have less inmates?

21 DALE WILKER: Yes, because the  
22 borough jails, there is only two borough jails  
23 that are operating now. There's the VCB jail in  
24 the Bronx and there's the Manhattan House of  
25 Detention.

CHAIRPERSON MARTINEZ: There'll be a Brooklyn one.

DALE WILKER: There will be, and we're not sure when that's going to open. But, the vast majority of prisoners are, and will remain for the foreseeable future, on Rikers Island. And, they have daily current medical needs, many of which require infirmary care. So, that it behooves us to provide that care we think in an atmosphere that is properly equipped, that is not a risk to patients' health just by the nature of the building itself and, which will attract, frankly, quality staff to work there, should another contract provider come on the scene.

CHAIRPERSON MARTINEZ: Your preference is to have the teaching medical facilities, but not every borough has the luxury of having a teaching medical facility hospital, a teaching hospital as a preference to provide the healthcare or to contract to provide the healthcare. Doesn't that present a challenge?

DALE WILKER: I think that most of the boroughs, and I'm just running through my

1 head, do have teaching medical hospitals.  
2  
3 Certainly, the Bronx does; Manhattan certainly  
4 does. I believe Brooklyn does and I'm not  
5 terribly sure about Queens. But, I don't that the  
6 teaching hospital or the contracts necessarily  
7 need to be subdivided by borough or geographic  
8 area. I would think that that model could be  
9 applied across borderlines. And, in our  
10 experience, frankly, it has provided not only the  
11 leadership committed to quality patient care, but  
12 also amongst the staff themselves, it tends to  
13 attract people who are truly committed to  
14 providing good medical care to inmates, despite  
15 the fact that they are inmates and perhaps  
16 disfavored otherwise in the community. So, that  
17 you do tend to get both administrators and doctors  
18 who see their position as not just a job, but  
19 something that they want to do and want to do  
20 well.

21 CHAIRPERSON MARTINEZ: And, you  
22 mentioned that, you made several recommendations  
23 in terms of the Board of Corrections, is there a  
24 doctor member of the Board?

25 DALE WILKER: There is. Most

1  
2 recently, there is a doctor, or at least a  
3 healthcare administrator, by the name of Pam Bryer  
4 [phonetic], who was formerly the Executive  
5 Director, I believe, of Bellevue Hospital. Prior  
6 to her tenure on the Board, there was a medical  
7 doctor by the name of Gwen Zornberg [phonetic] and  
8 before her, there was another medical doctor, who  
9 sat on the Board. But, as far as I know, Pam  
10 Bryer's not a medical doctor. So, there's no MD  
11 now. And, there are no healthcare trained staff  
12 members.

13 CHAIRPERSON MARTINEZ: Does the  
14 Board has a subcommittee that review all the  
15 incidents of complaints in terms of health in the  
16 jails and the death in the jail? Or, is it just  
17 the entire Board that goes through the process?

18 DALE WILKER: Well, frankly, (a) I  
19 don't know that there is a committee of members  
20 that review complaints, as members go. Staff  
21 receive complaints. And then, what happens to  
22 those complaints and how they investigate them and  
23 how they are reviewed and what communication they  
24 may or may not have with the Departments, we're  
25 just not privy to. There is, I believe, a

subcommittee on health that is composed of some--

CHAIRPERSON MARTINEZ: From a  
complaint--

DALE WILKER: -- some members.  
But, I don't know what they do.

CHAIRPERSON MARTINEZ: Can you  
provide an example of a complaint that you  
mentioned you have made several complaints on  
behalf of clients. Can you give an example of a  
complaint that you registered with the Board that  
you got a response to?

DALE WILKER: That I got a response  
to?

CHAIRPERSON MARTINEZ: Yeah.

DALE WILKER: No.

CHAIRPERSON MARTINEZ: None?

DALE WILKER: Virtually none. I  
mean, I think we may have received one. We'll  
send someone to check into it. But, we don't--

CHAIRPERSON MARTINEZ: How many  
complaints--

DALE WILKER: -- get a substantive  
response from the Board as to what their findings  
were or any corrective action that was taken.

1  
2 CHAIRPERSON MARTINEZ: How many  
3 complaints do you submit to the Board?

4 DALE WILKER: Oh, hundreds and  
5 hundreds a year.

6 CHAIRPERSON MARTINEZ: And, no  
7 response--

8 DALE WILKER: No.

9 CHAIRPERSON MARTINEZ: -- in terms  
10 of--

11 DALE WILKER: Apparently, it's  
12 their practice not to respond to us, even though  
13 we seek responses.

14 CHAIRPERSON MARTINEZ: Can you go  
15 back and to the recommendation you made in terms  
16 of legislatively to the Council in terms of making  
17 it more of a local court and not a--

18 DALE WILKER: Federal.

19 CHAIRPERSON MARTINEZ: -- Federal  
20 Court? Can you go talk to me about that?

21 DALE WILKER: Well, the Board  
22 standards we think are enforceable in court  
23 because they create, in an explicit way,  
24 particular rights of inmates' access to care and  
25 treatment. But, to make that absolutely clear,

1  
2 and as a check and balance mechanism, when the  
3 Board itself cannot enforce the standards or  
4 chooses not to or the Departments do not follow  
5 the standards, to provide both the Board and the  
6 aggrieved individuals, the inmates, the  
7 opportunity to enforce the standards in court and  
8 say that explicitly through the legislation would  
9 erase any doubts there might be and, certainly,  
10 defense challenges that there might be to whether  
11 an inmate can even come into court and assert his  
12 rights under the Board standards or the Board can  
13 go into court and assert their right over the  
14 Departments to compliance with the standards.

15 CHAIRPERSON MARTINEZ: Okay. I  
16 will definitely follow up with you, with Counsel  
17 of the Fire and Criminal Justice Committee to  
18 discuss some of those recommendations that you put  
19 forward. Thank you, Mr. Chair.

20 CHAIRPERSON RIVERA: Thank you.  
21 Seeing no other questions, thank you very much for  
22 your time. Appreciate it.

23 DALE WILKER: Thank you. Before I  
24 leave, I know you had wanted to talk to Prison  
25 Health Services. I'm just going to leave with the

1  
2 Sergeant at Arms, perhaps for the Committee  
3 library, a compendium of newspaper articles that  
4 we discovered on the internet from across the  
5 country about Prison Health Services,  
6 Incorporated; what reports have been made in the  
7 various states including New York.

8 CHAIRPERSON RIVERA: Perfect.

9 Thank you very much.

10 DALE WILKER: You're welcome.

11 CHAIRPERSON MARTINEZ: I want to  
12 make a correction for the record. I earlier  
13 mentioned that there was no one here from the  
14 Board of Correction. I want to, for the record,  
15 make that correction that there is representation  
16 from the Board of Correction at this hearing,  
17 however no testimony from the Board of Correction.  
18 Thank you.

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C E R T I F I C A T E

I, DeeDee E. Tataseo certify that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

Signature

A handwritten signature in cursive script that reads "DeeDee E. Tataseo". The signature is written in black ink and is positioned above a horizontal line.

Date November 16, 2008