CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS JOINTLY WITH COMMITTEE ON CRIMINAL JUSTICE AND COMMITTEE ON MENTAL HEALTH, DISABILITIES AND ADDICTION

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November 15, 2018
Start: 1:37 p.m.
Recess: 4:54 p.m.

HELD AT: 250 Broadway – Committee Rm. 14th Fl.

B E F O R E: CARLINA RIVERA
Chairperson

KEITH POWERS
Chairperson

DIANA AYALA
Chairperson

COUNCIL MEMBERS: Mathieu Eugene
Mark Levine
Alan N. Maisel
Francisco P. Moya
Antonio Reynoso
Alicka Ampry-Samuel
Robert F. Holden
Rory I. Lancman
Fernando Cabrera
James G. Van Bramer

A P P E A R A N C E S (CONTINUED)

Patsy Yang, Senior Vice President for Correctional Health Services, NYC Health & Hospitals

Basil Youssef, Assistant Commissioner for Health Affairs, New York City Department of Correction

Patrick Alberts, Assistant Vice President for Policy and Planning, NYC Health & Hospitals

Ross McDonald, Chief Medical Officer
NYC Health & Hospitals

Veronica Lewin, Director for Communications and Public Affairs, NYC Health & Hospitals

Carlos Castellanos, Chief Operating Officer
NYC Health & Hospitals

Martha King, Executive Director, NYC Board of Correction

Emily Turner, Deputy Executive Director of Research, New York City Board of Corrections

Dr. Robert Cohen, Board Member Appointed by the City Council and Correctional Health Expert, and former Director of the Rikers Island Correctional Health Service

Mik Kinkead, Sylvia Rivera Law Project
Director of Prisoner Justice Project and Staff Attorney

Dionna King, Drug Policy Alliance

Jennifer Parish, Director of Criminal Justice Advocacy, Urban Justice Center Mental Health Project

Brooke Menschel, Civil Rights Counsel, Brooklyn Defender Services

Meghan McCarthy, Prisoner's Rights Project of the Legal Aid Society

Julia Solomon, Social Worker, Criminal Defense Practice, Bronx Defenders

Jordyn Rosenthal, College and Community Fellowship

Sade Dixon, Corrections Accountability Project, Urban Justice Center

[sound check] [gavel]

CHAIRPERSON POWERS: Good afternoon, noon it is. (sic) We're waiting for the TV again. Good. Alright. [gavel] Thank you. Good afternoon and thank you everybody for your patience, and your travel over to the 250. It's a busy day here at City Council with the number of votes, and so we are—we're going to get started, and as we—we'll note that we've just been joined by Council Member and Chair of the Hospitals Committee Carlina Rivera and Council Member and Chair of the Mental Health Committee Diana Ayala is on her way. Oh, oh. She's here? Oh, my God. [background comments] I will never, ever pay—I will be paying for that forever. We're also joined by Council Member Cabrera, Council Member Alan Maisel, Council Member Bob Holden and we'll be joined by many more. We were earlier joined by Council Member Van Bramer as well. Thank you all for being here. I thank the Administration for being here. I'll keep my—my opening statement short just because we are already running behind time. Just two years ago Health and Hospitals was a little too—HMH took over the operation of Correctional Health Services in the city's jail system. The hope is that that would help

change and improve the condition of services and quality of care delivered to the incarcerated individuals with the support of the Department of Corrections. Progress has been made, we believe, but continue to hear about ongoing issues and problems that we want to help resolve. We have heard from the Board of Corrections that over a fifth of all medical services for incarcerated individuals scheduled in the latter half of 2017 were not completed. We've also heard that certain months where those numbers have been higher. Those are factors contributing to that, can be sometimes difficult to solve like lockdowns and housing units for safety reasons, but we still believe that you're not going to hinder the department for making improvements where it can, and where it must. We know that many incarcerated individuals enter the Correctional system with behavior and mental health conditions including mental illness and substance abuse, which often times are rooted in trauma, but we must ensure that this system supports the needs of those who are incarcerated rather than adding to their trauma. Today, this hearing with the other committees that are here is an opportunity to hear more information

about how the Department of Health has improved over—over prior operators, what progress has been made, what issues related to access delivering quality? Can we work together to improve, and how the Council can build on that work to ensure better healthcare. We'll hear a bill today that's my bill along with Council Member Carlina Rivera, which aims to ensure that any healthcare provider contracting with the Department of Health and Mental Health provide healthcare services—health services to incarcerated individuals, and that they—that they collect and report data on sick calls. This bill inspired by the Board of Correction's recommendation will ensure that correctional health staff not just correction staff are doing triage, and making sure medical appointments are kept. We will also be hearing my resolution 581 calling on the New York State Legislature to pass and the Governor to sign Senate Bill 8673 and Assembly Bill 8774 to require that State Correctional facilities provide incarcerated individuals with access to Method—to Methadone, Naltrexone, and—and others for the duration of their incarceration. The city has done work in this area of addressing drug addiction, and we want to make

sure the state also does the same. I want to thank my staff and the committee here for helping to put this hearing together. I want to thank the Administration for being here and their ongoing work in this area and all the agencies represented. With that being said, I will now hand it over to the Chair of the Hospitals Committee and my colleague to the west and the south Carlina Rivera.

CHAIRPERSON RIVERA: Thank you, Chair Powers. [coughs] Good afternoon everyone. I'm Council Member Carlina Rivera, the Chair of the New York City Council Committee on Hospitals, and I would just like to start off by thanking my colleagues Council Member Powers who is the Chair of the Committee on Criminal Justice and, of course, Diana Ayala, Chair of the Committee on Mental Health, Disabilities and Addiction for this joint hearing today and, of course, to all of you for being here. I want to welcome members of the committee who are here including Council Member Maisel. Thank you for being here. Today we'll be hearing testimony from the agencies charged with providing correctional health services in our city's jails. As my colleague Council Member Powers noted, our committees are

concerned by the level of access to health services available in our correctional facilities, and we want answers as to why according to a recent report by the Board of Corrections only 67% of scheduled medical appointments actually result in patients being seen by a physician or a healthcare provider. We also want to better understand how the Department of Corrections and Correctional Health Services identify and track requests for health services to ensure that incarcerated individuals requesting medical services outside of the context of intake procedures are able to schedule appointments with Correctional Health Services, and are able to make those appointments. Ensuring that incarcerated individuals have access to health services is critical, but we must also ensure that the health services they receive are of high quality and address their needs. This is why the Council passed Local Law 58 in 2015. Local Law 58 requires the Department of Health and Mental Hygiene, which under the city's Charter is responsible for Correctional Health Services to issue a quarterly report that includes any physical or mental health performance indicators reported to them by any healthcare provider in city jails and covers five

area indicators or health services: Intake, follow-up care, patient safety, preventable hospitalizations and preventable errors in medical care. H&H currently submits these reports to the Mayor and Council on a quarterly basis. However, while the first report issued under this legislation provided details regarding the metrics used to assess each indicator and totaled 22 pages, these reports now provide very few details and are only 1 to 2 pages long. This continues a troubling pattern with regards to the difficulty of obtaining relevant information from H&H and various contacts including during the budget process. The committees look forward to examining this and other correctional health reporting requirements and would also like to explore the continuity of care individuals receive when they are released from incarceration—incarceration. The city has a responsibility to ensure that individuals in its care including those in correctional facilities receive quality healthcare services. Thank you, Mr. Chair.

CHAIRPERSON POWERS: Thank you. Now we will hear from the fantastic Chair and Council Member Diana Ayala.

CHAIRPERSON AYALA: [off mic] That kind makes it a— Bear with me. [on mic] I have new glasses and I can barely see. So, I have to adjust to the light. Some of you will understand. Thank you, Chair Powers—Powers and Chair Rivera and good afternoon everyone. I'm Council Member Diana Ayala, Chair of the Committee on Mental Health, Disabilities and Addiction, and I would like to thank all of you for being here today. In 2015, it was announced that healthcare management and administration of healthcare services for incarcerated individuals at the Department of Corrections would be transferred from a private contractor to the public benefit corporation Health and Hospitals. While this transfer was enacted to create better continuity of care, as well as the integration of Physical and Behavioral Health Services, there still remain gaps in service provisions that we hope to today. We know that over 21% of the incarcerated individuals in New York City jails have been diagnosed with a mental health disorder, and out of 21%, 11% of those individuals were found to have serious mental illness such as Schizophrenia, Bipolar Disorder or Post-Traumatic Stress Disorder. In fact, according to the

DOC, city jails including Rikers Island now house more mental health patients than all hospitals in New York City. It is our responsibility to make sure that incarcerated individuals who need behavioral healthcare are able to access it in a timely manner. While we recognize that this a challenge—a challenging population to serve, we must ensure that all individuals including those with behavioral healthcare needs and disability are provided with the appropriate healthcare treatment that they need by a well trained trauma informed staff in accordance with the law. We look forward to hearing from all of the stakeholders here today in order to work towards building a better system for incarcerated individuals and the people who work with them. I would like to thank committee staff, Counsel Zara Alia (sic); Policy Analyst Christie Dwyer; Finance Analyst Jeanette Merrill; and Chief of Staff Mili Bonilla; and Legislative Director Bianca Almedina for making this hearing possible. Finally, I would like to recognize committee members that have joined us, Fernando Cabrera, did you recognize everybody?

COUNCIL MEMBER CABRERA: Uh-hm.

CHAIRPERSON AYALA: Bob Holden. Okay, I am willing to do that. We look forward to hearing from you all today.

CHAIRPERSON POWERS: Great. Thank you, and so with that we will administer the oath and by Committee Counsel.

LEGAL COUNSEL: [off mic] Do you affirm to—Oh, if everyone could wait and let me-- Thank you. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this Committee and to respond honestly to Council Member questions?

DR. PATSY YANG: [off mic] I do.

ROSS MCDONALD: [off mic] I do

LEGAL COUNSEL: Thank you.

CHAIRPERSON POWERS: Great. Thank you. Do you want to begin testimony? If you can introduce yourself before you start.

DR. PATSY YANG: Alright. Good afternoon Chairpersons Ayala, Powers and Rivera, and members of the Committees on Mental Health, Disabilities and Addition, on Criminal Justice and on Hospitals. I'm Patsy Yang. I'm the Senior Vice President of Health and Hospitals in charge of Correctional Health

Services. I am joined here by a lot of our team. To my right is Patrick Alberts. He's Our Assistant Vice President for Policy and Planning, Ross McDonald. He's our Chief Medical Officer. Veronica Lewin who is our Director for Communications and Public Affairs, and Carlos Castellanos who's our Chief Operating Officer. The Department of Correction, our partner is also here represented by a number of people, and I know that we're going to pull them up to the table after—after this testimony, and I want to say on behalf of Dr. Mitchell Katz, our President and CEO, we all appreciate your inviting us to speak with you today about this, and—and your support of our work. We share with our—your concerns about accessing quality of care, and they are the reason we exist. Just as an overview New York City Health and Hospitals Correctional Health Services we call ourselves CHS for short. We operate one of the largest correctional health systems in the country with over 43,000 admissions per year and an average daily population of about, 8,900 people across 11 jails in the city. We provide healthcare services from pre-arraignment through discharge including medical and mental health services, substance use

treatment, dental care, social work services, discharge planning and reentry services. CHS is an essential partner in New York City's Criminal Justice reform efforts. We believe that we have the unique opportunity to cushion the impact of incarceration, and that we have the responsibility to address the healthcare needs of our patients to better prepare them to leave jail and not come back. It's through this lens that we pursue or work in increasing access to quality medical care for people while they're in custody in the, and as they rejoin their communities. Since we moved over to New York City Health and Hospitals in August of 2015, we have rebuilt a framework of our systems, and we changed the culture and the way we deliver services. We've reduced our alliance by 80% on private contractors. We've replaced private contractors with CHS staff, and with service arrangements with Health and Hospitals facilities. This is a resulted in higher quality, greater accountability, and greater efficiency. Our move to Health and Hospitals also really greatly boosted our ability to attract highly qualified staff, clinicians, administrators, everybody who share our commitment to high quality care as a human

right. In becoming the direct provider of healthcare, we underwent a major reorganization to improve supervision and supportive staff at every level in every capacity within our division. This restructuring was implemented in every clinical and administrative department whether it was creating an Independent Office of Quality Management that reports directly to me or consolidating all our substance use treatment services and programs under the leadership of Mental Health and Dr. McDonald. We have also implemented new ways of delivering care to make sure that our patients get the healthcare that they need when they need it. In collaboration with the Department of Corrections, we've increased access to healthcare in jails by cohorting patients with similar medical diagnose into discrete housing area often with a matched satellite clinic. This could be mental health patients, people with substance use disorders of certain chronic medical conditions. This model brings our services closer to where the patients actually are, and it reduces the need for escorts to clinic. Given the comprehensiveness of our intake assessments and the high quality of our clinical work, we know who needs to be seen and when,

and we work daily with DOC to ensure that our patients get the care and the medications that they need. At the same time we continue to see a high volume of sick call encounters in part due to the higher standard heled by the New York City Board of Correction compared to other large city systems. We also follow through and investigate to conclusion every single patient complaint or concern that we receive from our patients or their representatives. As part of the Health and Hospitals system, we successfully leveraged the resources of this large—this largest and oldest public healthcare delivery system in the nation, and that's all towards including healthcare or patients under our care both before, during and after incarceration. We became the sole and direct correctional health service provider, and since doing that in 2016, we asked for and were approved and funded for a 5-year plan to improve our services, expand things at work and—and try—try new—new approaches. I'm just going to go through a snapshot of some of the milestones that we reached in less than three years, and about the two or so years that we've been here. We have more than quadrupled the number of patients initiated with

Hepatitis C treatment in jail. In Fiscal Year 2018, so far we've gotten almost 160 patients who were initiated on this cure compared to 28 in Fiscal Year 16. While we run the nation's oldest and largest jail based opioid treatment program, we nearly doubled the number patients in our program since just last year, tripled the number of patients in our program since just last year. Last month we had over 1,000 patients either on Methadone or Buprenorphine on any given day. Since December of 16 when we've reached our—recently reached our 4,000 target of group sessions that are part of the Creative Arts Therapy Program, which is one of the largest programs of its kind in the nation, and just last month we celebrated the opening of yet another—our Annual Art Show in Chelsea in coordination with the School for Visual Arts. We have distributed almost 11,000 Naloxone kits to members of the public who come to Rikers to visit members of their family and loved ones and in the borough jails since the launch of Healing NYC in March of 2017. We've expanded to a total of six specialized housing units for patients with serious mental illness. This program for accelerating clinical effectiveness of Pace is

something that I think every—everyone in the Council has heard about and—and visited, and it's demonstrated its efficacy in increasing medication adherence, reducing incidents of injury and self-harm and lowering uses of force. We were the first in the Health and Hospitals system to establish a Telehealth program for patient-provider encounters. This is really to enhance access to special services both on and off Island. It now includes multiple specialty services at Bellevue and it's an honor for our male and female patients respectively. We also use Telehealth to do assessments for post-acute placements of our patients at Kohler Long-Term Care post acute care facility of Health and Hospitals, and we do consultations at an increasing pace among our jail facilities. Following the success in Manhattan, where we—we have extended our enhanced pre-arraignment screening in our ePassu (sp?) into Brooklyn. We just did that recently. ePassu allows us to better identify and respond to acute medical and mental health issues. We avoid preventable runs to the ED, which disrupts case processing in the courts, and we've been able to get with patient consent provide defense attorneys in the courts with

clinical summaries that can help support alternatives to incarceration. Of the 82,000 screenings since the Manhattan operation went 24/7 emergency room—emergency room lines were avoided by 27% and almost 3,000 clinical summaries were provided to defense counsel. In an effort to improve the quality and timeliness of court ordered psychiatric competency evaluations, we at CHS volunteered to consolidate the citywide clinics that were previously operated by Bellevue and Kings County. We believe that it is closer aligned with our mission and that we can bring that closer to the city's large criminal justice reform efforts. In partnership with the Mayor's Office of Criminal Justice, the courts prosecution and defense bar we launched a pilot program at the Queens facility of the—of the Psychiatric Evaluation Clinic, and the goal here of the pilot was to complete court ordered evaluations for defendants from an average of 43 days citywide to 7--to within 7 and 14 business days for misdemeanors and felonies respectively. In the five months, almost five months since we went live in Queens we have met or exceeded our goal in most of those cases with an average completion time of misdemeanor and felony reports

completed with 9 and 11 business days respectively. As part of New York City, First Lady Shirley McCray's Women in Rikers Initiative, we established The Healthy Lifestyle Therapies Program. It's a wellness initiative that promotes healthy coping skills for stress, and trauma through different modalities including exercise, cognitive therapy, and acupuncture and guided meditation. We also launched a program for our Counseling Safety Planning and referrals to community resources upon discharge for women who have experienced intimate partner violence before being incarcerated. To address the need—the unique needs of young people, we began conducting high quality screenings of every young person entering the jail regardless of his or her medical health history. This has allowed us to identify people with whom we can connect with services both in jail and upon reentry for planning. We also created the Geriatric and Complex Care Service. This is the first and only jail base program of its type in the country. The service provides integrated clinical care, court advocacy and reentry planning to the oldest and most vulnerable of our patients. Thanks to Thrive NYC, we received successive funding to

implement a series of initiatives to address mental health and substance use issues among youth who are incarcerated. We've enhanced our programming—for mental health programming for youth by offering comprehensive services including psychiatric assessments, creative arts programming, harm reduction and substance use engagement and discharge planning. These enhancements allow us to better serve a population with intellectual disability, new onset of mental illness and substance use are regularly—are over-represented, and exposure to trauma is ubiquitous. We currently also screen patients for neurodevelopmental impairments during intake. This year we started asking every individual who enters jail whether they ever had involvement with the Office of Persons with Development Disabilities, the State OPDD Office. With this new question, we've been able to identify-the rate of identifying people with neurodevelopmental disorders or disabilities from about two-thirds of one percent or three percent, and this—we expect to refine and continue to hone—hone this process through screening. This allows us to connect people with services while they're in jail as well as for reentry, and we

actually dedicated a PACE unit, one of the PACE units that I talked about a little bit earlier to individuals who are suspected or confirmed with neurodevelopmental disorders. Reentry and planning discharge services are as important or in terms of the service that we provide in jail to have people to be released to the community, back to their communities and not return to jail. To prepare our patients, we've revamped our discharge planning service throughout the system to maximize every tough and to optimize every impact that we have with our patients while they're in custody. We define a core set of services of every discharge planning service and discipline would include ,and we're coordinating all of that so we're not doing multiple visits, but actually extending our reach with the—with the resources that we have. We are making sure that all our patients have health insurance upon release. We were focusing initially on the 55% of patients who come into jail with active Medicaid to make sure that their—their Medicaid is reactivated when they get released, and we've more recently focused on the 45% who don't and we—last year—well, earlier this year initiated a pilot at AMKC our largest intake male

jail, and this summer extended—extended to the women's jail a pilot that we are undertaking to offer Medicaid application assistance within the first 24 hours of intake. We're monitoring that to see what—what we can do with—with our resources. They continue to do that and expand it to all the jails. As of September of 2018 a total of 603 patients received an application at intake. That was an average of about 65 patients a month. In addition—in addition to a Medicaid application, we've been growing the reach of our discharge planning services to more patients with medical needs. So, whether our patient has HIV-AIDS, is an older person with complex medical needs or somebody who is needing to complete his or her treatment, and to for Hepatitis C in the community, we're working to link the patient—the patient to a care provider in the community and notably leveraging all the service capacity in the Health and Hospitals system. We offer discharge plans to all patients in the mental health service. Every patient with a mental health diagnosis is counseled on what is included in his or her discharge plan, and in partnership with Empower Assist Care of EAC, we've created the Community Reentry Assistance

Network. A unified provider system that has increased efficiency, allows for increased oversight of service delivery and allows us to be more responsive to patients' changing needs before and after release. In addition, as part of our programming under Thrive NYC, we offer discharge planning for young patients, which includes care coordination across city agencies providing referrals to court advocacy and transitional planning for youth 18 to 21 years of age. We've also expanded our comprehensive Discharge Planning Services to the Substance Use Reentry Enhancement Program, that's SURE, but which involves every—to include—make sure that any patient who has a substance use disorder, who is not already receiving this service does get court services, harm reduction counseling, Medicaid screening and application assistance and reentry planning. We also began prescribing e-Prescribing Naloxone so that patients who are discharged are trained before discharge and when they—they enter—reenter the community they can pick up Naloxone and use that and that on their person. Additionally, we—our patients, I think there was bout 8 or 900 patients in the-each month since we've don SURE who have been discharged, and tested.

So, as the city embarks on it's ambitious plan to create a smaller, safer and more fair correctional system over the next decade, CHS continues to be a critical partner in planning the—in planning what that future system will look like, and how the delivery of quality of healthcare can be improved. We are committed to uphold our ethical obligation to improve the health of our patients and prepare them to live a healthy life when they rejoin their communities. We're grateful the for the unwavering support of the Mayor de Blasio, the New York City Health and Hospitals Board, New York City Health and Hospitals Presidency of Mitch Katz, and we again thank you for your support and your interest in our work.

CHAIRPERSON POWERS: Thank you. Thanks for our testimony. Is DOC test—DOC is testifying, too? Not? You're here answer questions, too. Okay. Thank you for that. So, we—but we may—we'll ask you to come up and take the oath as well if there's—if there's questions for it. I'm going to do a couple of questions and then I'll—I'll hand it to the chairs and we'll—we'll go from there. I know we have a lot of members coming and going. So, just—just generally

on the—as you guys have taken over, you've been there for two years. You have—you outlined a pretty—pretty robust list of new pilot programs, new programs put in place. One of the things I was looking for was or would ask is generally how you're measuring yourself not just in sort of in terms of new programs, but totally recognize the importance of that especially around the drug treatment and things like reentry services, and connection to care because we're going to— I haven't talked a lot about that, but even just in terms of metrics around delivering care while in custody. Can you talk to us about how you measure yourself in terms of that regards and how we would as a city and a City Council measure performance relative to somebody who has been there, you know, prior, you know, H&H essentially replaced, and how w would measure in terms of the delivery of care to people because, you know, we even cited some stats here around people missing appointments, and for some reasonable reasons some others. So, can you just talk to us about generally how you would measure yourself in terms of performance, and how we would be viewing the last two years in terms of performance to the—those who are incarcerated?

DR. PATSY YANG: Sure. I think I can start if I can. As related to Health and Hospitals, we have actually grown and made more robust our quality assurance and improvement processes. Health and Hospitals as the largest and oldest healthcare delivery system highly regulated has an extremely robust structure for quality assurance as it reports directly to the Board. There's a committee to whom we report on a regular basis. There's a ton of metrics and—and we report to the Board. There's also a number of reports that this a external thing that reports to the Board of Correction, in addition to—to—to Council. Internally, where I think the real change occurs is not only what we've done in terms of supervisory structure and support, everything from the performance setting individual clinician, everything from chart reviews, errors, complaints, education and training to including the frontline providers in every aspect of our Quality Assurance Program. So, we also have within Health and Hospitals—within Health and Hospitals a quality improvement structure and within CHS we've had a parallel one. It all reports directly to me. It's a complex committee structure covering every

discipline, and not just the clinical disciplines because we think that operational aspects are critical to—to the work that we do. There are a number of I don't even know how many hundreds of—of metrics that we—we keep, but they cross all aspects of performance whether it's quality time and, you know, time and attendance, supervision, state of arts, and CLE, CME.

CHAIRPERSON POWERS: And can you—do you mind sharing with us just—just generally because I think those are some key metrics you said would be things you kind of—just in terms of performance how two years later we doing it in terms of any of those time and attendance, quality of care, outcomes. Any, any—any data you can show us in terms of where—where we are today versus a few years ago?

DR. PATSY YANG: Yeah, I-you know, the—the—it's been a real shift. The chairperson that I had referenced earlier to—to what L-58 looked like the first time when it was under DOHMH and Corizon. There were numerous metrics that were more adversarial, more—more—it was an external contractor whose performance was being very microscopically examined to—to see where something would go wrong

rather than a more supportive, open and opaque. You know, we don't want mistakes to be hidden. We want them to be reported so that we can correct them, we can understand them, we can see if it's systemic or whether we can see it's an individual and either way we'll correct those. So, that the—the feel and the culture of that is a significant change.

CHAIRPERSON POWERS: And I appreciate that, and—and thanks—and thanks for that, and the—and I understand the structural changes within a contract or an agency have—have benefits. And the—and can you talk you about any ways you guys are using like sort of data to—to measure outcomes and how you're doing that?

DR. PATSY YANG: Yeah, I think both Dr. McDonald who is our C&O and Mr. Albert who actually manages all of the data and reporting, which we—which we centralized so that we have better—better consistency standard reporting and more in-depth analysis is under Mr. Alberts watch in there.

PATRICK ALBERTS: Sure so, we have a very robust system of—of quality improvement and really what we've sought to do since the transition to Health and Hospitals is to engage the frontline staff

around choosing metrics that are meaningful and being part of the process of quality improvement. So, they're often around specific clinical issues that our clinical staff along with our clinical leadership and the facilities have identified, and we'll do performance improvement projects to address a particular indicator. I think, you know, one of the challenges and one of the things that we thought very deeply about is the importance of measuring care, but also a balance there. If you recall, many of the indicators under the previous contract often worked good, and with the appropriate systems in place, any metric within medicine can—can creep its way up. I think much of what we've attended to since the transition is a little more nuanced. It's about caring about the patients. It's about doing the right thing for the patient in front of you. A lot of this is captured in our morbid-morbidity and mortality review process, which we spend a lot of effort on to really think deeply about our systems of care delivery, how people communicate, and how they work together. So, there's a—there's robust program and it's—it's really more from the ground up than it ever was before as Dr. Yang mentioned, but I think

it's also important to recognize that many of the things that were so critical for us to change are—are not easy to—to put a metric on, and we've acknowledged that as well.

CHAIRPERSON POWERS: Got it. I'll come back to some of that, and thanks—thanks for the insight. I went to intake. So when somebody comes into custody with you, just give us a sort of—a walk through of the process from sort of initial custody to receiving the initial screening, what intake looks like for somebody who comes into custody with that process that's both in the DOC and from this—the H&H standpoint?

PATRICK ALBERTS: So, you know, I'll pick it up at the H&H level. So, well, I should probably start in pre-arraignment. So, increasingly in two boroughs we have now CHS staff in pre-arraignment. So that means when patients are still in NYPD custody, they'll be evaluated by nursing staff who have access to our Correctional Health record. So, if anyone has been in the jails before, we will have information about their medical history and background, and we have the screening that more effectively decides who should go to the hospital,

and also it gives us a heads up for any who's coming to the jails. So, we can kind of pre-alert the jail intake staff that this person is coming with this particular problem. Inside the jails, DOC has an intake process that they do, which occurs in different locations in each facility and every intake facility has a clinic that operates 24/7. One of the things that's unique about the New York City jail system is that we do a full history and physical on— on intake upfront, and that's done by a physician assistant, a doctor or a nurse practitioner. That's a much more robust level of intake screening and most jails around the country do historically, and it allows us to really start off on the right foot in identifying chronic disease, in identifying undiagnosed disease. So, that's where we do universal HIV rapid screening. It's where we're moving towards universal Hepatitis C rapid screening. It's where we do testing like QuantiFERON testing, which allows us to protect our patients and our staff against the transmission of Tuberculosis. We screen for Ghoneria, and Chlamydia for all women and all men under 35, and we screen for a litany of chronic diseases that we know to be common in out patient

population including critically acute withdrawal and we know that about 18% of our patients are in acute opioid withdrawal at the point admission, and we have clinical staff there to begin their treatment right at the point intake. So, we can treat withdrawal upfront, and alleviate the suffering associated with that condition for our patients. Whereas, in most jail systems there's no possibility to do that at that point. Those clinicians will also set the trajectory for future care so they make referrals to specialty services. They have a triage that refers people to mental health, and it may—it may warrant a stat mental health encounter at that time, and they also arrange for follow-up visits. So, they'll schedule follow encounters in the electronic health record so that we can track those patients moving forward.

CHAIRPERSON POWERS: Okay, thank you, and I just want you to know we were joined by Council Member Lancman and Council Member Moya as well. I think it's—who else? So, what—just when that screening happens that initial screening you're describing with the number of well, a long list of things that you're looking for and—and trying to

provide services for, what is it—how long before somebody—I know Brooklyn and Manhattan asked for the pre-screening process. How long before somebody—how long when somebody is in custody do they receive that screening? Like what is the time period between again average between sort of coming into the custody of DOC and then seeing somebody from your H&H staff?

PATRICK ALBERTS: So, that screening always happens prior to a person being housed in the jail system, and the standard is 24 hours as I understand it from the point of DOC custody to housing a person.

CHAIRPERSON POWERS: That's the rule, right? What's the average? I'm just curious. I think the rule is they have to see them with 24 hours. Are there—is there a population that's not receiving—getting to them within 24 hours? Does somebody give you any information then?

DR. PATSY YANG: Yes. I think that's for Ms. Josef.

CHAIRPERSON POWERS: Okay, so we'll just have to ask you to take the oath as well, and then introduce yourself, please.

LEGAL COUNSEL: [off mic] If you could raise your— [on mic] Please raise your right hand, please. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this Committee and to respond honestly to Council Member questions?

BASIL YOUSSEF: Yes.

CHAIRPERSON POWERS: Thank you. Introduce yourself—

BASIL YOUSSEF: Sure.

CHAIRPERSON POWERS: --and—

BASIL YOUSSEF I'm the Assistant Commissioner for Health Affairs, New York City Department of Corrections

CHAIRPERSON POWERS: Great. Thank you. Welcome. Thanks for joining us.

BASIL YOUSSEF: Thank you, sir.

CHAIRPERSON POWERS: So, I think the question is some data on I think it's important Correction's role around 24 hours to see—to receive an initial screening from—from—from CHS. Is—can you give us any data on average time between when somebody comes in t and gets an initial screening? How often perhaps when he doesn't receive it within

24 hours or maybe the answer onto that. Any—any information you can share with us on—on-on meeting that 24-hour--

BASIL YOUSSEF: So, first of all--

CHAIRPERSON POWERS: --meeting.

BASIL YOUSSEF: --I would say that we—in most cases, patients are seen within the 24 hours. They're very unusual, very, very unusual. I don't have the data off hand as to the exact time on the average that someone gets to see Medical, but I can tell you that it's all done within the 24-hour timeframe, yes.

CHAIRPERSON POWERS: So, you—so 100% within 24 hours. I know you're under oath, and so--

BASIL YOUSSEF: [interposing] Yes.

CHAIRPERSON POWERS: --obviously you can't play this out, but you're saying high—high compliance with the 24-hour regulation. You can share with us maybe data after the hearing on what the average time is?

BASIL YOUSSEF: We can, yes.

CHAIRPERSON POWERS: is that fair—is that a fair to come with this?

BASIL YOUSSEF: We'll try, yes.

CHAIRPERSON POWERS: But that-but the high compliance part of 24 hours.

BASIL YOUSSEF: Yes.

CHAIRPERSON POWERS: And that's from the second day. That's before they're housed they get the initial screening, and that is when they are within DOC custody, is that correct?

BASIL YOUSSEF: Well, every patient may before they're housed must be seen by medical first--

CHAIRPERSON POWERS: [interposing] Right.

BASIL YOUSSEF: --and then the housing is determined after.

CHAIRPERSON POWERS: And on the prescreening were Manhattan—Manhattan siting was first, Brooklyn was second. Any information those were the first choices?

DR. PATSY YANG: It's really logistics. It's the readiness of the facilities and the capacity of the facilities.

CHAIRPERSON POWERS: Okay. So, and then these are plans to expand that to other--?

DR. PATSY YANG: Yes, yes.

CHAIRPERSON POWERS: The boroughs (sic) are seen. Any time—any information on timeline, though.

DR. PATSY YANG: Queens will be next and then the Bronx.

CHAIRPERSON POWERS: Queens and Bronx. Any timeline? Do you know?

DR. PATSY YANG: Queens we're hoping this year, later this year, at the end of this year, and Bronx we're—we're—there some space and facility issues we've got to iron out. So that will be some time next year.

CHAIRPERSON POWERS: Okay, thank you and the—what happens if before they're housed and having been screened if there are a need for medication, treatment services? What happens in that period of time? If there is something sort of eminent or, I know, pre-screening might help to determine that. In places where there isn't prescreening, what happens in that sort of gap period? Especially if it's upwards toward 24 hours.

BASIL YOUSSEF: So, it's important to remember that in all of the New York City jails, our staff are ready to respond to emergencies 24/7. So,

and—and it is not unusual to respond to emergencies in the—in the intake area. So, really anyone who has an acute complaint that was of concern, the DOC staff in that area could activate an emergency response and our staff would actually report to the intake to evaluate the person at that moment.

CHAIRPERSON POWERS: And drug treatment? Like if somebody needs--

BASIL YOUSSEF: So, drug treatment is available through—at—at the—at the intake point. Our clinical staff have learned over the years that that should be the first question we ask. So, when we observe that somebody is in acute withdrawal, we'll often address that with them, get everything set up for them to get a dose of Methadone or Buprenorphine, and then we find that we can get to the rest of the conversation more comfortably from that point. So, we try to frontload that as much as possible.

CHAIRPERSON POWERS: Okay, I had several questions but for the sake of time, I'm just going to go through one more category, and then I'll it to the other chairs. We have the bill on sick call. I know it's a new bill we won't ask you to comment on it. We will await feedback on some of it. I just wanted

to ask general questions, though. Can you just give us information on the process today if you are—are incarcerated and want to do a sick call, can you walk us through that process for how that happens, how—how somebody—I think it's a foreign (sic) paper, and then what the process of is for getting to you.

BASIL YOUSSEF: Yes, so normally sick call is offered Monday through Friday except for weekends and holidays. So, the general process is that there is a list of Foreign--

CHAIRPERSON POWERS: [interposing] Okay, you said it's offered Monday to Friday except weekends and holidays?

BASIL YOUSSEF: Right, and I'll get—and I'll differentiate what happens in those days for you. So, really that's routine sick call I'm talking about. So, every day a list is posted in each housing area. Any inmate that wants to go to sick call the next day, signs up on that list. At the end of the evening tour, that list is removed by the outgoing officer and is actually taken to our control room where it—they actually make copies of that list and actually gives copies to our clinical staff, uniform staff. The next morning, that-the officer

will end up using that list to call each housing areas for those inmates that sign up for sick call. However, you have inmates that sign up for sick call that don't necessarily show up for sick call, and that's a choice of their own. You have a second section—a sector of inmates who never signed up, but still come to sick call. So, the list does not really—is not the bottom line for any—everyone for sick call. You sign up and go, and if you don't sign up you could still also go to sick call on a daily basis. Okay, so what about evenings and weekends, et cetera. So, you're in a housing area, you're not feeling well. You still have access to come to the clinic on those off tours. So, the officer will call the clinic, and they will notify the clinic the inmate will be either escorted or sent in a zone depending to the clinic for sick call. So, the bottom line is that inmates have access to the clinic 24/7.

CHAIRPERSON POWERS: But there still seems to be a difference because you are—I mean you even noted in your comment the difference between Monday and Friday, weekends and holidays. So, what is—so I'm still unclear what hat difference is.

BASIL YOUSSEF: So, the—so we classify those ae emergency sick calls on the days when routine sick calls are not being offered as I said for evenings, weekend, et cetera. Those are termed emergency sick calls, which they come to the clinic.

CHAIRPERSON POWERS: Why not offer seven days a week and holidays, everything else? I don't get to choose when I get sick. It's a holiday. I'm sick on the weekend. I mean why not have it available all the time in the same way?

BASIL YOUSSEF: So, as we—part of the answer is the Board standards of that. We—except for weekends and holidays, but I think from a clinical standpoint, the key is that we need to be able to address urgent clinical issues 24/7, and we are able to do that through Emergency Response. Sick call really should be for more mundane run-of-the-mill type complaints that really we're best staffed. Just like a regular outpatient clinic, we're best staffed to—to handle during the—during the normal work week.

CHAIRPERSON POWERS: And what would qualify as a run of the mill?

BASIL YOUSSEF: So, dry skin is a very common, low back pain is one of the most common. When

we look at the sorts of complaints around sick call those tend to be at the top of the list.

CHAIRPERSON POWERS: Okay, and—and—and you—when—I mean you're at the Department of Corrections correct?

BASIL YOUSSEF: Yes.

CHAIRPERSON POWERS: So you're—you're managing this process. So, you're in charge of the healthcare, is that correct?

BASIL YOUSSEF: Yes.

CHAIRPERSON POWERS: So, why is—why is that? Why does DOC manage this list when you're the healthcare? I mean it seems like you—shouldn't the healthcare provider be in charge of managing the list and appointments?

BASIL YOUSSEF: So, I think it's a reflection of the—of the Board standard, which is I think it's important to say really the—the most robust mandate for access to care that I'm aware of in the country and really what the Board standard says, the way we interpret it is that anyone who wants to come to sick call on the days that it's offered is allowed to come to sick call. So, there really is no triage process to decide who can come to

the clinic. Most systems across the country do a written process where someone will sing up, request a sick call, and that piece of paper will usually go direction to the Clinical Service. The Clinical Service typically has 24 hours to process that, and to decide if the person is going to be seen, and when they're going to be seen. So, in contract to most systems, we as the Health Service don't decide who comes to the clinic. The standard is that everyone can come to the clinic, and for that reason, it's not useful to us to have a list of people who may have indicated that they wanted sick call, but aren't presented to the clinic because our only response to that would be bring them to the clinic if they still want to come.

CHAIRPERSON POWERS: To be sure that sounds like it—it sounds like a system problem. Like you don't need a list. If anybody can come, so you have a list that people sign up, and could still come, which is different than other places. Not, not to answer the question, but why one agency now uses verse the other. I mean unless I I'm missing—unless I'm missing something.

DR. PATSY YANG: So, my-my interpretation of that is—is that in New York City unlike other large city correction health systems, that sick—the request for a sick call is not clinically triaged. There's no clinical eyes on it that says yes you should, yes you're urgent, not you're not urgent or we could fix this at something—some other way. The requirement in the city is if you want sick call, DOC brings you. So, it's—it's not who's managing. It's—it's not—nobody is suppose to be triaging here. If you want sick call, and you ask for it, DOC brings you to us.

CHAIRPERSON POWERS: And so, a good segue. Thank you. We are—can you tell us what percentage of people under your numbers that request sick call are seen? We had some data that I—I made in my opening statement, but we're happy to hear if you have different numbers.

BASIL YOUSSEF: So, I don't have the data to tell you exactly what numbers after you sign up because as I said before, everyone that requested sick call, you know, whether you sign up or not, are allowed to come to sick call.

CHAIRPERSON POWERS: I understand that, but there is no information on how many requests versus how many people are seen? You know nothing? I think even the—the DOC reports have some of that, and do we have some data to share with us?

BASIL YOUSSEF: For sick call, yes, we do have some data, which I could probably share with you at a later time, which I don't have with me right now that I do track in my division, but that it is separate from scheduled visits.

CHAIRPERSON POWERS: We had—the number I think we had cited was about a fifth—I'm sorry, sorry about fifth of that 20% had—had—oh, I'm sorry, it had not—well, let me move to non-completion and—and, which is—so, reasons for non completion from the stats we have is for the six months of this year, rescheduled 16%. Less people were seen, 2.1%; non-produced by Department of Corrections 63.8% and out deployed 17.8%. Do those numbers sound correct to you?

BASIL YOUSSEF: Okay. So, you're talking about something completely different.

CHAIRPERSON POWERS: Yeah, I'm moving down towards the general.

BASIL YOUSSEF: So, that is actually scheduled visits you're referring to?

CHAIRPERSON POWERS: Yes.

BASIL YOUSSEF: Which is different from sick call.

CHAIRPERSON POWERS: Scheduled visits, right. Okay, right.

BASIL YOUSSEF: Yes.

CHAIRPERSON POWERS: Okay, right.

BASIL YOUSSEF: Yes.

CHAIRPERSON POWERS: Well, let's actually let's go back to sick call and I would—we would appreciate data on the request versus seen.

BASIL YOUSSEF: Okay.

CHAIRPERSON POWERS: Do you think you could share that after the hearing?

BASIL YOUSSEF: I could get that data for you.

CHAIRPERSON POWERS: Okay.

ROSS MCDONALD: So, I'll just mention also if I may, so we've looked at the utilization, and we know that sick call is used and we provide a lot of sick call visits. So, some ballpark numbers. Of the people who stay for more than month, about 78%

of them access sick call at least once. Of those people who choose to access sick call, about a quarter of them access it five or more times during their stay, and when we look at the people who use sick call the most we have very high utilizers. So, there are people who come to sick call more than the number of weekdays in the month. So, we do have those ways of knowing that we're providing a lot of sick call encounters. Also, when we talk to our colleagues around the country, other large urban jail systems about the pros and cons of—of their system versus ours, we do find that we have more encounters than they do, and importantly since our encounters are not triaged, our encounters are with physician assistants or doctors whereas most of this work is done by nurses in other settings. So, we think it's fairly safe.

CHAIRPERSON POWERS: And I understand I think to your point was that people can show up or sign up. So, saying how many are seen and relative to that is hard to say because people just show up, but any data you can share with us in terms of how many people are signing up, and—and being seen would be helpful to non-completion of scheduled visits, which

is and I'll—I'll hand it off after this. Non-produced by DOC is an extremely high category. I think we could talk about all that at once, court and conflicts with court dates, rescheduled and reasons for that and we understand, but can you share with us. Not produced by DOC seems incredibly vague to me.

BASIL YOUSSEF: Well--

CHAIRPERSON POWERS: Can you share with us in data that fall under that category and why one would fall into that 66 or 64% depending on the time period?

BASIL YOUSSEF: Sure. So, first and foremost, we work everyday with H&H to ensure that all those inmates are produced for the requirements. Out of all folks I think I have a very good appreciation of the importance of getting the patients for their scheduled appointments. On a daily basis, when we get that list from my colleagues and on H&H, those lists are reviewed continuously throughout the day by our uniform staff that works in the clinic along with the clinical staff to make sure that those patients produced and in most cases to try to prioritize those most important patients that needs to come to the clinic. In most of our

facilities in the Island, you know, there are different clinics, different facilities, all those clinics I would say to you have their own unique issues and problems. So, on a day-to-day basis, we will be there. When I say we, the Health Affairs Division staff will meet with our H&H colleagues in addressing those issues. The production issues, and if there are frontline issues that needs to be addressed, we do it in a very timely manner, and I will tell you, and I could say this very confidently at this point, the production rate has gotten much, much better. I don't have the data to support that at this point, here, but based on my interactions and their dealings with H&H, we do a very good—we are doing much better in terms of producing patients for their scheduled appointments.

CHAIRPERSON POWERS: Maybe—maybe more bluntly can you share any data that would be, you know, maybe more specific data on them not scheduled by—not produced by DOC and then again that seems like a vague—a vague categorization of—of non-completion, and I'm hoping maybe we could get a clearer sense of what are the reasons or causes why somebody wouldn't be produced?

BASIL YOUSSEF: I will check and see if we have that data, and if we do have that data I'll be more than happy to share that with you.

CHAIRPERSON POWERS: I would appreciate that. I mean I would hope that you guys would have come with some—some reflection that because it's—it's an extremely generic category, it could result into anything. It could be a lockdown or it could be something worry—you know something that would cause some more concern and we would—we would certainly like to see that. We will—we will follow up with you on that. Can you just describe discrepancies between different jails in terms of why there are different completion rates at different jails? It seems like some have large gaps between each other and completion rates.

BASIL YOUSSEF: So, glad you're asking that question. So, you take a facility such as AMKC, which is our largest facility on the island. It has the most and the first number of services that must be—that are delivered in that facility. Initially, we had one clinic where that most of the services were expected to—all of the patients were expected to be produced. That is when I saw the physical plant

limitation was—was an issue and it still was an issue—is an issue. So, within the last couple of months we've worked very closely with Health and Hospitals to where we opened a—what we term South Side Mini Clinic where—which is a clinic that is in close proximity to where the inmates are housed. So, now inmates could be seen it very quickly and returned to their housing area. So, that by itself improved the access to care by just opening that one mini clinic in AMKC. We're in the process right now of looking, of opening an additional min clinic, which we termed the North Side Mini Clinic, and again the concept is the same just to take the service closer to where the inmates are housed, and we feel by doing that we will actually improve the production and access. We looked at other facilities, and I'll give you GMVC and—not GMVC, GRVC and MBC where we felt that we needed to extend the hours of operation beyond the day tour in terms of providing certain services. We've worked very, very closely with Health and Hospitals where we both added additional staffing on the off tour to actually continue services to those patients. In some facilities in the evening tour where we did not have adequate

supervision, the department has added clinic captains that they could supervise the clinic officers, coordinate the delivery of services and coordinate deep introduction of patients to the clinic. So, those are just a few things that we've done that have actually made a significant different in terms of producing patients for their services.

CHAIRPERSON POWERS: So, and on the plant limitations is that mostly a security and staffing issue.

BASIL YOUSSEF: What?

CHAIRPERSON POWERS: Well, you said the plant limitations of the plant, the physical plant.

BASIL YOUSSEF: [interposing] Yes, that's right.

CHAIRPERSON POWERS: Okay, I'm sorry. Is that—is that around safety and security? Is that around staffing or what is the—what are the limitations in terms of the big jail?

BASIL YOUSSEF: The size of the clinic, the whole—let's use--the AMKC is a good example where the holding area where our patients coming into the clinic for their services only could hold about 15 or 20 patients tops in the clinic. Taking it into

consideration a large number or inmates housed in AMKC, that requires services, that is simply not adequate. So that is what I meant by physical plant limitations.

CHAIRPERSON POWERS: Okay, and I'm going to ask one last question, and then I'll hand it off. Just in terms of 19% of mental health services not completed because of rescheduling, CHS I think reschedules the appointment if I'm correct. Can you try—can you tell us what the need is. Something you guys answered, is something that you talked about the need to reschedule that. Also, I think it's 17% is the number I have that are not completed because patients are at the court, and just wondering why plaintiffs would be—be scheduled to conflict with this court case. I mean is there a way that we can improve that?

BASIL YOUSSEF: So, as I said previously, we—this is a work in progress. We have been working very closely with H&H to ensure delivery of patients to the mental health on a daily basis. I want to say to you that, you know, just as we did for sick—for scheduled follow-ups, the same is true for mental health where the clinical staff and the uniform staff

we view those lists on a daily basis just to make sure that the priority patients are being seen and making sure hat the one that they really want to get seen are produced, and to work through issues that they may have in terms of production on those days.

CHAIRPERSON POWERS: Okay. Sorry.

DR. PATSY YANG: So, I can—not the court issue but the question about mental—mental health, one of the main reasons why we at CHS would reschedule more on mental health is because the—to establish and maintain--the provider-patient relationship is paramount. It—less so medical, but where you could see that the available provider but to see your psychiatrist and your psychologist.

CHAIRPERSON POWERS: So the specific staff are--

DR. PATSY YANG: [interposing] It's continuity.

CHAIRPERSON POWERS: --versus the availability.

DR. PATSY YANG: It's continuity and quality.

CHAIRPERSON POWERS: And on the court dates, do you have—does CHS have access to the

management system, which would have—I think we would have their information of their court dates, and if—if that—if that is the case, is there a reason why court dates and appointments would be scheduled over each other?

BASIL YOUSSEF: So, for many of our patients that are detainees, sometimes we do not know the court date in advance when CHS makes that appointment. So that's a typical example then of the appointment—if the inmate has a court date that we don't know in advance where you may find a conflict.

CHAIRPERSON POWERS: And is there ever an attempt to reschedule it? Is that—is there a way to flag that it's been mis-scheduled and to reschedule immediately?

PATRICK ALBERTS: Yes. So that part of the process is critical, and I just want to point out that, you know, this is a constant effort to try to get the right people into the clinic in the right time frames, and so on any given day when we don't them readily, you know, that's a feature of any clinic I've ever worked in. There's a certain no show rate, and the key to good healthcare delivery is having good systems to make sure that those people

are getting the care that they need. So, if you didn't see them today, you have to respond to that, and try to see them tomorrow. With regard to court in particular, some types of court visits are more knowable to us than others, and I would also point out that a lot of times we're able to catch people after they come back from court. So, I would caution against scheduling practices that might make those numbers look a little bit better, but if there's 10% chance we can catch somebody after court, then I still would like our staff to go ahead and schedule that encounter and give it a shot.

CHAIRPERSON POWERS: I appreciate it. I understand the need to—for quality, and the numbers don't always—it's, you know, probably the numbers do—do help us understand stuff that's happening. So, I—I appreciate that. Thank you for the answers. I'm going hand it over to the Chair Rivera.

CHAIRPERSON RIVERA: Thank you, Chair Powers. So, you mentioned that for the sick call process if you did sign up you can still show up. What is that process like in terms of being able to go and seek medical attention?

BASIL YOUSSEF: Okay, so let's use a good—a week day, for example, where they sign up for sick call. So, the officer goes to the housing area, and they announce sick call. So, everyone on that list who knew to assign up, some may—not decide—decide not to go. So, those who decide to go, they'll sign. Will go to the clinic for a sick call. If an inmate did not sign up, and didn't go, and they all said I want to go to sick call, even though he or she did not sign up, that officer would also escort that and bring that inmate to the clinic for sick call.

CHAIRPERSON RIVERA: I just wanted to make sure that whether it was in theory or in practice. So, if—if you show up, can you be turned away? Will everyone be seen?

BASIL YOUSSEF: You're not turned away once you get—once you go to the officer.

CHAIRPERSON RIVERA: And CHS mentioned that they—they don't triage. So, is it the Department of Corrections that—that does the triage?

BASIL YOUSSEF: We do not triage

CHAIRPERSON RIVERA: Sow what are some of the reasons again and Chair Powers alluded to this.

What are some of the reasons that DOC would not be able to present and individual to CHS for a scheduled medical appointment? Now, we have our own data, and our own reasons, but I'd like to hear from you. I know you don't have the data per se, which again is a consistent issue that I have whenever I sit across the table from H&H, but do you track these events?

BASIL YOUSSEF: Of the reasons why they are not produced?

CHAIRPERSON RIVERA: Yes.

BASIL YOUSSEF: I will go back. I think we do have some. I can't see that offhand.

CHAIRPERSON RIVERA: Okay. So, I want to talk a little bit about structure and reporting, which I mentioned in my opening testimony. Can you describe the contractual relationship between H&H, DOHMH and the Physician Affiliate Group of New York PAGNY in terms of the correctional healthcare services?

DR. PATSY YANG: Sure. Also, if I could just go back to that other question where you had indicated that you have an issue getting data from Health and Hospitals. We have so much data and I'm not aware that we were withholding it from you, but—

CHAIRPERSON RIVERA: I—I didn't say that withholding. I think the transparency--

DR. PATSY YANG: [interposing] Okay.

CHAIRPERSON RIVERA: --is sometimes an issue with H&H, and I've said that in every hearing, and I—and I think that you all come to the table, and you're honest, and you care about what you do, and I have tremendous respect. However, and I'm going to ask you about reporting in a minute. When you initially—you see a report from 2015 that's 22 pages long that is detailed and itemized and allows us to be better Council Members, and oversee an agency like H&H, and then you get a one-page report like this, very, very recently, you start asking questions about how mutually respectful their relationship is, and I want the next few years to be a partnership.

DR. PATSY YANG: Yes, Council Member.

CHAIRPERSON RIVERA: And so—so that's why I'm bringing it up, and so why this hearing is so important to us is because of healthcare services for incarcerated individuals, and I know there are multiple partners involved. So, if you could just kind of describe that relationship.

DR. PATSY YANG: Yes, sorry. I'll got to ask you about you—your question.

CHAIRPERSON RIVERA: No, no. that's okay. I appreciate you asking.

DR. PATSY YANG: The—in the City Charter, we have responsibility for Correctional Health Services with DOHMH. When the decision was made in 2015 to transfer to CHS, Correctional Health Services from DOHMH to Health and Hospitals, there was an agreement that was written and signed by multiple city agencies including the City Law Department, Correction, Health and Mental Hygiene, Health and Hospitals that transferred that responsibility from DOHMH to Health and Hospitals. So, that's—that's the two at that level, and so we do not report to DOHMH for--for Correctional Health Services. We have that responsibility delegated to us. Our relationship with PAGNY is—is as a medical affiliate for hiring the frontline staff, clinical staff whom we determine we want as part of our service. This was a decision that was made as part of the 2015 negotiations and discussions that enabled Health and Hospitals to maintain continuity of care and disruption of service during this transition first of

all from DOHMH to Health and Hospitals with the known imminent transition of Corizon out of the picture. So, some of this—the—the core levels of staffing who were Corizon that sort of staffing model we did select people. Some selected. We did not select all. Those are the people who are hired onto PAGNY's payroll. PAGNY as an independent medical affiliate gives us a little bit more flexibility in terms of salary, and-and both terms and conditions of hiring and employment.

CHAIRPERSON RIVERA: So, who is ultimately responsible for overseeing, monitoring supervising the—the Correctional Healthcare process, and what kind of safeguards are in place to ensure efficient oversight?

DR. PATSY YANG: So, we are and Health and Hospitals' Board, and Health and Hospitals' President and CEO, through me—I'm—I am accountable to them, and we—that—that includes what—what happens with PAGNY. One of the—the things that we've made sure to build into the PAGNY contract, which is a—is a little different from the other affiliation agreements with Health and Hospitals is that all leadership, all management is with us. There are no

chiefs of service that are in PAGNY. There are—with Health and Hospitals. We make the clinical decisions. We make the hiring decisions. We make the firing decisions. We had—we insisted on a higher—on a very high level of fiscal accountability. We get biweekly payroll runs from PAGNY, which we review and monthly reconcile so that we know who's working, what their hours are. We actually manage their time and attendance in HR and labor so we know that we're actually getting the service that we are paying for.

CHAIRPERSON RIVERA: So, I'm looking at the report. There—the current reporting that's under Local Laws 58, as we mentioned, includes indicators, but there is no real information in what I show you very, very briefly, and I know you're very aware of that report Does the report currently provide enough information to ascertain the general health of patients in your correctional facilities?

DR. PATSY YANG: I—there's-there's more that we can report to you. There's for example, as I mentioned earlier, we had numerous reports that—that are public that go to the—the Board of Correction.

It's a—it's specifically called various—various cuts of access reports after access reports.

CHAIRPERSON RIVERA: Do you—there's additional data that you have that's not shared in these reports? Do you thin that some additional measures could be taken?

PATRICK ALBERTS: No, I—you're just talking about some of the—the data that we share right now. So, we have electronic health records. We're one of the first jail to put that in place. It gives us access to this incredible amount of information about our patients, and I think it's probably served kind of the basis for a lot of the changes that we've made in the service with—with data sharing, and Correctional Health, my division was essentially put together to ensure that there is continuity with the way that we talked about, the services we were delivering—that we were delivering, that our partners understood the type of services we were delivering, and one of the—kind of the culmination of that in partnership with DSC and the Board of Correction, is the Access Report, which provides this unprecedented book our service delivery, which is encounter base in the New York

City jail system. It's 26 pages. It goes every month, and it's sent to the Council as well as the Board of Corrections and it's—it's posted on their website. So, this was done in partnership with them really kind of to serve as really transparent view in how we deliver services in the jail. I'll kind of highlight some of the issues that we need to work on and the successes. There aren't a lot of healthcare providers like us and none that I know of like us that-that provide this level of detail. So benchmarking what we do is a little difficult but we—we provided this data for long enough now so that I think the public has a good understanding of—of kind of what's going on in the jail. We—we certainly can provide more information. So, going back to your question and the Local Law, the—the report that Corizon was producing, and that DOHMH was passing along to the Council was a contractually based report. It's kind of a kit—kind of a sticks and carrot way to manage an outside provider with monetary penalties and it was not a quality based approach to healthcare like we have now. So—so in terms of systems, I think the systems are much better. I doesn't call for that type or report any

more, but we have information we could talk to you about—about the report that we share now.

CHAIRPERSON RIVERA: I know that H&H you said in your testimony, the—the report was a microscopic view of where something would go wrong, but, you know, I think that more details are—are better than not, and so I—I ask in terms of people with chronic conditions for example, someone with diabetes or issues that you know they'll need repeated cared, do you have information on the number of individuals, incarcerated individuals with chronic illnesses.

DR. PATSY YANG: Yes? No.

CHAIRPERSON RIVERA: And you have what kind of treatment they receive through the year?

PATRICK ALBERTS: Yes, absolutely. That type of quality of care information reports up to the Health and Hospitals Board under the same kind of reporting structure that hospitals have, and much of it is in the realm of—of clinical quality assurance, and there's a structure for us to report that to the Health and Hospitals Board and ultimately to our CEO Mitch Katz.

CHAIRPERSON RIVERA: In terms or pregnant women and—and mothers who are incarcerated, what sort—what sort of support is provided for them?

PATRICK ALBERTS: So, we have robust services for prenatal care. We have a full-time obstetrician as well as dedicated support staff who work issues of transitional care, and also clinical education about motherhood in preparation for the process in motherhood.

CHAIRPERSON RIVERA: So, when—if someone is a new mother, and they are breast feeding or specifically I'm concerned about pumping. So, we heard of an example where an incarcerated individual was not given access to a breast pump when she needed it, and so it ultimately resulted in surgery to remove cysts that formed in her breasts. For women like this who need to pump, what is the process for requesting access to pumps both pre-arraignment and while incarcerated?

PATRICK ALBERTS: So, we have extensive equipment in the—in the Rose M. Singer Center in the Women's facility. We have a number of breast pumps available, and our process in place and policy that promotes breast pumping and—and breast feeding. I

could get, you know, more details on that. I'm not familiar with the case leader siting.

CHAIRPERSON RIVERA: We'll be sure to send you some info. What about the process for gaining access to the nursery? What are some of the pitfalls in that process?

BASIL YOUSSEF: So any—anyone that comes into the system that needs to go into the nursery, there is an outpatient process that—that an inmate has to complete, which is then reviewed internally within the facility, and then the determination is made based on the findings and criteria that is outlined for that admission.

CHAIRPERSON RIVERA: How do the mothers or the women get to know about the process?

BASIL YOUSSEF: At intake there is notification of nursery services available and, of course, H&H has services in the clinic that will actually educate that inmate of the different services that are available to them in the facility.

CHAIRPERSON RIVERA: And what about the—the breast pump, what exactly is the process if you need one?

PATRICK ALBERTS: So, they're available in the infirmary.

CHAIRPERSON RIVERA: Okay.

PATRICK ALBERTS: I'm sorry, in the nursery and they would be available to nursing mothers as well who did not have a child in the nursery, and that would be through the clinic.

CHAIRPERSON RIVERA: So, I want to ask just one last question before I turn it over to Council Member Ayala, and it's about when— unfortunately when things do go wrong and there are deaths on Rikers Island specifically. So February 2018 the State Commissioner of Correction they released a report entitled *The Worst Offenders*. It's probably where the most problematic local correction facilities of New York State, and they included a review of inmate mortality cases, and some of those instance were attributed to deficient medical care. The deficient medical care substandard mental health services or inadequate custody and supervision by security staff. So, how specifically has CHS addressed the issues of deficient medical care and substandard mental health services?

DR. PATSY YANG: I—I have to familiarize myself again with that report. It's been a while, but I believe I recall that most, if not all of those cases were under Corizon when it was failing (sic) the program was still at DOHMH. That along with other issues and concerns and considerations led to the Mayor's decision that Correctional Health Services should be moved from DOHMH to Health and Hospitals, and that Corizon contract should be allowed to expire.

CHAIRPERSON RIVERA: Well, there's two that I want to bring up, and I'm going to say their names because they at least deserve that, but—and also to tell you what they died from. So Wayne Anderson died in 2017 from untreated seizures. That was in the New York Post and then just recently this month Cheeky McClain, this was in the Daily News died after collapsing while playing basketball and complaining of pain. Are you familiar with those cases? Is there a lack of personnel at the Department of Correction at CHS? Do you think you're delivering the most top quality care to the people in your facilities?

ROSS MCDONALD: Yes, absolutely. I, you know, I—I am not able to speak about specific cases. As a physician there are--

CHAIRPERSON RIVERA: [interposing] He died. I understand.

ROSS MCDONALD: --rules, both laws and—and ethical reasons that I can't get into any details of specific cases. What I can say is that we have-we have an excellent clinical staff, and since the transition we have recruited and retained amazing staff who are absolutely devoted to health fair for vulnerable populations to this work of healthcare in the jails, and to minimizing bad outcomes in any way that we can, and I think that we have had both success that we can point to in making the systems of care delivery much safer over those years, as well as a process in place to—to look at every bad outcome and make sure that we learn everything we possibly can from it, and use anything that goes wrong to continue to improve. Some of—some bad outcomes in jail are not preventable, but we hold ourselves to a very high standard, and we look for any areas where we cold have done something differently in every case.

CHAIRPERSON RIVERA: And—and I'm going to turn it over to my colleague. I understand those to be—those two cases sounded preventable, and I know that you also mentioned in your testimony you are held to a very high standard, held by the New York City Board of Corrections compared to other large city systems, and so, you know, you touted a number of accomplishments, and—and we appreciate the—the update, and so we ask that to reflect that in some of the things that do go wrong, which are bound to happen that you just try to provide us with—with the data and the information that we're requesting respectfully. So, I—I thank you for your testimony and for the answers, and with that, I turn it over to my colleague.

CHAIRPERSON POWERS: Thank you. I just wanted to ask one more question on—on a sort of related topic, and then sorry, I'll take—I'll have the other Chair take it up. (sic) On staffing, are you guys feeling like you're properly staffed today? You know that it's—and do you—can you just talk about any challenges you have in terms of recruiting staff to work in any of the jails, challenges you face, and that happens, and also any issues or comment you hear

with regard to safety and security of staff there? Just would be curious to hear more on the actual challenges of or—or—or how you're overcoming any challenges related to staffing?

ROSS MCDONALD: Okay, so I think on the clinical side, you know, this has really been one of the critical successes of this transition. It's that it's—it's changed the landscape for recruiting really mission driven people, clinicians across the spectrum from nursing, social work, doctors, both on the medical and the mental health side down to the pharmacists, pharmacy techs, really across the board recruiting people who want to be part of fixing a problem, who want to be part of a mission driven organization, and we have a litany of really amazing physicians in particular who have come to work with us, in the last few years, and that recruiting is way more successful than it ever could have been under the old model. People feel like they're part of something, and people who are informed by mass incarceration as a social issue, and came to this work because of that, worked for us and find the work rewarding, and find that they're part of something that's meaningful and important. So, that's a

critical change. Recruiting is a constant effort. We've built systems to have relationships with training program across the spectrum of clinical services so that we get trainees into the jails to show them what we do, to show them the importance of our work, and to recruit them to be the next generation of clinicians to help us.

CHAIRPERSON POWERS: Anything you can say around it. I mean we've heard some concerns around, you know, potentials. I mean in potential new jails would—would take some of these issues, but just safety issues, security issues related to staff up there.

DR. PATSY YANG: Yeah, I mean just, to tag onto what Ross said, the—our ability to attract and retain people and just change the culture and lift up everybody's—not just as I say do the work, but improve the work has really been boosted by—by this—this move to—to out the current model, which is not to say that recruitment particularly on off hours and weekends isn't difficult and challenging particularly in—in an environment that challenging. It's—we acknowledge it and—and our staff deserve the highest respect and thanks for taking those on every

single day, and putting the health and wellbeing of our patients above theirs. So, recognizing that the jails are a tough place, we have been working within CHS, and in close partnership with DOC to raise the bar on staff safety and security. When we came over to Health and Hospitals, which has a very robust workplace violence program, we benefitted greatly from that in terms of training materials, structure, reporting and support. So, there's been a lot more training of our staff specifically, and joint training with DOC in—in techniques like deescalation, right that reduces stress. (sic) We have daily kind of—they're called huddles, but in all the jails with DOC and CHS where potentially behaviorally challenging patients are identified. We talk about what precautions could be taken beforehand, how we might differently manage our situation. So, I think it's a range of everything from training support to physical plant reorganization as you—as you mentioned—that's a note—when-when I think we were in one of the design conversations about the borough jails that the lines of sight and daily, you know, everything in lines of sight for safety to natural light right, which changes the entire mood of a

place. We are really excited about, and-and are really hoping that that allows us to do what we know works well, and better more.

CHAIRPERSON POWERS: Thank you.

DR. PATSY YANG: Yes.

CHAIRPERSON RIVERA: Also, I just want to recognize two of my colleagues that were here Council Member Moya and Council Member Eugene. So, thank you.

CHAIRPERSON RIVERA: Ready?

CHAIRPERSON AYALA: Thank you. Does the electronic record system allow you to feed services that were rendered through the network or just services that have been rendered at Rikers?

DR. PATSY YANG: It's—it's within the—our system is—is the care that we provide within the jail system, the Correctional Health System or pre-arraignment, the entire justice involved system, but as we are part of Health and Hospitals we have interfaces with—particularly with Bellevue and Elmhurst, which are where the outpatient specialty and all in-patient care is provided. So, we get to see theirs, they get to see ours, and there is that exchange that—that is supportive of both.

CHAIRPERSON AYALA: But it only follows two hospitals.

DR. PATSY YANG: Those are the—really the two hospitals that we use--

CHAIRPERSON AYALA: Yeah.

DR. PATSY YANG: --that we—where referrals are made either on an outpatient basis or inpatient basis. Ultimately, there will be some movement towards better integration that Health and Hospitals itself is undergoing as you well know on migration to a new system. Definitely to be part of the Enterprise and interface with the Enterprise is a goal.

CHAIRPERSON AYALA: I mean because Metropolitan Hospital wouldn't be considered part of that processing yet. We have a Psychiatric Department there. So if an individual was treated there for psychiatric, you know, illness and then went to Rikers, you wouldn't be able to gauge that right now, is that correct?

DR. PATSY YANG: Not on a—on an electronic systems basis.

CHAIRPERSON AYALA: Okay, the--

DR. PATSY YANG: [interposing] Not right now, but that is the plan.

CHAIRPERSON AYALA: Yes, yes. How does the—can you explain how the—the intake process that's for—for someone who has a developmental disability, and they have, you know, trouble articulating their own history.

DR. PATSY YANG: [background comments]

ROSS MCDONALD: So, again I think that's the critical function of having those high level staff doing that evaluation so physician assistance, nurse practitioners and physicians who are trained to recognize the signs of developmental delay--

CHAIRPERSON AYALA: [interposing] Yes.

ROSS MCDONALD: --and now have additional screening questions that they have to complete to look for those conditions as well as changes in our mental health service to better treat that patient population and understand their needs once we identify them up front.

CHAIRPERSON AYALA: Do you have a number of individuals with developmental disabilities at Rikers right now? Do you know?

DR. PATSY YANG: [off mic] About three percent.

CHAIRPERSON AYALA: What is the percentage?

DR. PATSY YANG: About three percent.

CHAIRPERSON AYALA: About three percent, and what type of disabilities more or less?

ROSS MCDONALD: So, they—they run the gamut. I think, you know, there is a system OPWDD which should take dare of developmental disabilities that are known to that system, but sometimes people will come to jail who have not yet become enrolled in that system, and so—or patients will be at a sort of borderline level where they have some degree of developmental delay, but they would not necessarily meet the—the strict criteria for entry into OPWDD. So, it—in that process, you know, takes some time sort out, and we've improved our processes and our communication with those partners to—to do that work as quickly as possible, but when you--

CHAIRPERSON AYALA: [interposing] When you say plan, how much time—what—what are you talking about? They wait a week, a month, a year? I mean most people don't spend much time at Rikers, but--

ROSS MCDONALD: Well, so I think—I—I can't. It happens on a case-by-case basis, but I think the key that we've recognized is we can't defer that work to other systems and other entities because at that moment that patient with us, right. So, that's where we've built up specialized expertise and—and housing options for that particular population, and done that intake screening more robust—in a more robust way to try to get those people linked into care and to treat them appropriately for whatever time they're there.

DR. PATSY YANG: Just in the two years that we've been--during us--

CHAIRPERSON AYALA: [interposing] Yes.

DR. PATSY YANG: --we've recognized that the neurodevelopmental population is some—somebody who has been largely hidden, and been lost somewhere in the system previously. So, we've done a number of things acknowledging fully that there's a long way to go, and that's ranged from developing a better screening tool, which has increased again, you know, who we can identify from about two-thirds of one percent to three percent. It's probably more, but we keep refining our tool and doing that. We've

actually dedicated a PACE unit for—for people with—with neuro developmental disorders and disease and disabilities so that they—we can provide better treatment on site, better engagement, better linkages, better care while they're with us and linkages outside. We are currently recruiting for a social worker who will be dedicating an expert in this population and the community resources so that we can both provide better care focused and get guidance while people are with us, and then when they're leaving. So, these are—these are nascent. We—we acknowledge that, but we—we recognized last year that we needed to do something. We have been convening regular meetings with community partners and state partners to create linkages. The—the network out there for this population overall needs—needs to grow.

CHAIRPERSON AYALA: Are special accommodations made in the living quarters of individuals let's say a person that may be quadriplegic and, you know, a wheelchair user? They require special, you know, accommodations be made, but need to be able to, you know, move. Doors need to be able to open inward. What accommodations are

made considering that the facility is pretty aged and pretty deficient at this point?

ROSS MCDONALD: Yeah, so another important function of the intake screening process is to screen for disabilities, and patients with the requirements that you're describing will be transferred to infirmary settings, which are ADA compliant, and we work very closely with the Department of Correction on-on that issue.

CHAIRPERSON AYALA: Okay. Can you—I know that we've been asking this, but we're really trying to get a response. So, could you explain like some of the reasons that DOC would be unable to present an incarcerated individual for a medical appointment would be—is it—is—has it ever been, you know, has the failure to produce an inmate ever been due to staffing issues?

BASIL YOUSSEF: No. You know, as I said earlier, we work very closely with Health and Hospitals, and then we are given the list of patients to be produced for appointments. Our staff—frontline uniform staff, officers, captains who meet with the clinical staff to review those lists to make sure that, you know, the priority patients that they need

to be seen are brought, and if someone has not produced advise them accordingly. They work collectively as a team to make sure that those patients are produced.

CHAIRPERSON AYALA: So, who follows up with a patient that did not show up to find out why they didn't show up to an appointment?

BASIL YOUSSEF: Well, as I said before, the officers and the clinic captain will work with the—with the clinical staff there. If for example if the officer goes to a housing area, and the inmate says I'm not going for my appointment, you know, we will come back. We will communicate that to H&H. They will make a determination, you know, in terms of whether we need to talk to the person a little bit more, to get them to the clinic. We've done that frequently where we get not only a captain involved, well get a door commander. We will try to go to the highest level within the department.

CHAIRPERSON AYALA: Do you do that for every inmate--

BASIL YOUSSEF: [interposing] No, no

CHAIRPERSON AYALA: --or do you do that for cases where there's an extreme need for--

BASIL YOUSSEF: Cases that are—that we work together that have been identified as someone that must be seen that they need to see that person, they can't miss that appointment. We try to escalate it the highest level to make sure we get that person to for--

CHAIRPERSON AYALA: [interposing] And we document the reason why in the person's record, the reason they're explaining, the reason they didn't come to the appointment? Is like is that something that you track?

BASIL YOUSSEF: We will just note very briefly in the list here that the person refused, but--

CHAIRPERSON AYALA: [interposing] But not why? Because I mean there's a difference if you're no longer presenting symptoms than you couldn't go because you had to go to court or because you had--

BASIL YOUSSEF: [interposing] Well, if it's for the court, yes.

CHAIRPERSON AYALA: --like the call center (sic)

BASIL YOUSSEF: [interposing] If it's of the court or something like that yes. We will –the

person had court. Yes we will document that in the list. We will let the medical staff know or the clinical staff know this person is out to court or the person went to rec or doesn't—you know, whatever the situation is.

CHAIRPERSON AYALA: So, assuming that there's a case scenario where an inmate was supposed to show up for court—court and did not show, and then the DOC officer, you know, approaches the individual and says, Hey, you know, why didn't you show up, and they say well because I had, you know, I had to choose between going to see the doctor, and making, you know, and calling my family, but this is person that—a person that's been presenting, you know, serous symptoms. Is there a follow up, you know, to that and in a case scenario like that?

ROSS MCDONALD: So, I would just say on the clinical side we're tracking all of those cases of non-production. So, it never ends with we just didn't see somebody. We would then have a process in place to reschedule that person. So that isolated number of non-production is for a given day, but a big part of the work of the Clinical Service using the Electronic Healthcare Code is to make sure that

we're tracking those cases and continuing to get in contact with those people to manage their clinical condition.

CHAIRPERSON AYALA: Now, how many of the people that don't show up are—are—have been diagnosed with a mental illness? [background comments]

ROSS MCDONALD: I don't think we have the particular non-production broken out by that, but I—I think that, you know, it's a struggle across the clinical services to get people to care, but the key point remains that we keep trying until we see people. So, we will never discharge somebody from the clinical service for a reason of non—production. We have to actually reach down and talk to them and understand what's going on there.

CHAIRPERSON AYALA: So, move on. So, the—the DOC and H&H track incarcerated individual 311 calls related to medical complaints? Does 311 report these call to DOC or H&H?

PATRICK ALBERTS: Yes. So, I think DOC would probably want to answer for themselves, but we—we definitely do. So, when 311 became free in the jail, it has kind overtaken all sources of kind of inmate—patient communication to us in terms of

medical or mental health condition I mean requests and so I think last year we had about 2,100 maybe of these communications and 56% of them were 311. So, it's—it's an active part. I think we're trying, you know, trying to figure out how to deal with it, but I think the important thing is that we see or we dispose of every single case that comes our way through this process. So, it's—it's an active part. I think we're trying to, you know, trying to figure out how to deal with it, but I think the important thing is that we see, or we dispose of every single case that comes our way though this process.

CHAIRPERSON AYALA: But that's—that's why I'm a little confused because if I have access to—if I have adequate access to the medical provider that is up to par, why—I—I don't understand the rationale. Why a person would choose then to have to call 311.

PATRICK ALBERTS: I think DOC could probably talk about some of the benefits.

BASIL YOUSSEF: Well, you know, a very common reason is as I spoke about earlier about coming on for sick call and sick call is called to the housing area, but then you come to the clinic. Of course, you're not coming into the clinic and get

called in immediately. You would probably wait a half hour or whatever time there is in the clinic to wait. Status tell you that sometimes patients don't want to come to the clinic for that waiting time. So, their bypass is to call 311, to put a call in, and when they come to--

CHAIRPERSON AYALA: [interposing] But they're planning it voluntarily so I don't understand why they--

BASIL YOUSSEF: [interposing] Pardon me?

CHAIRPERSON AYALA: They're already planning it—planning it voluntarily.

BASIL YOUSSEF: No, no, you're talking two different things now. You were talking there's scheduled follow-ups, which we talked about separate before, and we talked about sick call where they're signing up, but sometimes even when they sign up and you call their housing area, they don't want to come to the clinic and wait, and I'm not saying that's for everyone. It is a percentage of those were it happens. So, if you call 311, the call comes into my office through the Constituent Services. Now we assign a staff. We called H&H. We said to them, there is—and there are two calls and needs to see a

doctor, whatever the reason or case might be. We will then call our facility to the tour commander and say go the housing area. I have someone go to the housing area, pick this inmate up and bring them to the clinic. That's like getting an expedited service to the clinic to get seen bypassing everything else. I'm not saying that's the case for everything but those situations do happen. It does happen.

CHAIRPERSON AYALA: I mean with 2,100 inmates, that's 2,100 calls. That's a significant number of calls.

BASIL YOUSSEF: Well, they're not all medical calls. You know, there are different reasons why those calls come to us.

CHAIRPERSON AYALA: People will 311? What—what is another reason that an inmate will call 311?

BASIL YOUSSEF: It could be for a visit issue.

CHAIRPERSON AYALA: Okay.

BASIL YOUSSEF: It could be, you know, it could be a multitude of different issues, yes.

CHAIRPERSON AYALA: Okay. When mental health appointments are missed does DOC notice a

spike in behavioral issues among incarcerated individuals? For example, if a person with a mental health diagnosis misses an appointment with a mental health provider, how does the impact—how does that impact any one incarcerated?

BASIL YOUSSEF: Again, you know, as I said before we work very closely with H&H to make sure that all the patients at their request are brought down. Of course, we have officers who are mental health first aid trained. If they notice something unusual with a patient, they would make that referral. They—you know, they will—they have that communication with respect to clinical staff in that facility where they would refer that patient to the clinic on their own, but as I said before, if that person is scheduled, we try our best and as Dr. McDonald pointed before, if that person is not seen in that day, that person would be rescheduled very shortly.

CHAIRPERSON AYALA: Do most mental health patients self disclose that they have a mental illness when they come or is that something that I—is identified through all the intake processes.

DR. PATSY YANG: That's something that we identify, Correctional Health Services identifies during intake, if they—they can also tell us on intake.

CHAIRPERSON AYALA: But the intake process is on day one, right.

DR. PATSY YANG: Within 20, the standard is within 24 hours of incarceration.

CHAIRPERSON AYALA: And some are—

DR. PATSY YANG: [interposing] They're taken into custody.

CHAIRPERSON AYALA: And some of the onus is that you require some level of personal observation and--

DR. PATSY YANG: Yes. So-so there can be a referral immediately at intake to Mental Health, and I-it's-it's important to note that for—to talk about reduction that is about 90% of those intake referrals to mental health are accomplished by CHS. It's been set for 72 hours that required. I—I just wondered if I could go back to the--

CHAIRPERSON AYALA: [interposing] Yes,

DR. PATSY YANG: --the question about mental health. Again, you know, one of the—the

differences in the way we-we run our mental health services is that—that—that connection between the patient and the provider is paramount.

CHAIRPERSON AYALA: Yes.

DR. PATSY YANG: So, we want to maintain that continuity of care and the relationship that accounts for some of the rescheduling that you see that's higher that we do, recognizing that reduction has improved, but could always get better, and how critical mental health services are and medication is that CHS has done not only worked with DOC to improve production, but we've also come up with our own initiatives and ways to reduce the demand on DOC to escort people, but yet maintain or increase access to care, and that's everything from the PACE Units and the CAPS Units, but also in our MOs, the ones that aren't designated as PACE and CAPS and don have that environment or that level of staffing that we are there and present more often in the Mental Health Units so that we are engaging patients, communicating with them, watching, interacting and providing care and counseling ono site.

ROSS MCDONALD: I just wanted to mention—

CHAIRPERSON AYALA: Yes.

ROSS MCDONALD: So and DOC makes referrals to the Mental Health Service as well. So, there is a process by which DOC officers if they're observing something in the housing area that they can make a referral directly to Mental Health and we will evaluate that person. The other thing I wanted to point out is that specialized mental health, mental observation units as well as the CAPS and PACE units. All of the mental health encounters in those areas occur on the unit. So, there is no issue of production with that type cohorted housing, and that's the highest level of mental health service that we provide, and generally the highest level of need is concentrated in those—those units.

CHAIRPERSON AYALA: Do you track the number of referrals that are made by DOC related to mental illness to mental health issues? So, let's say an inmate comes in and he does, you know, your process is done. You know, you go through the regular intake process and, you know, no one-there's nothing that would indicated that this individual has a mental health issue until a few days later. Like how—and I'm assuming that's when DOC refers. Do you track the number of referrals?

ROSS MCDONALD: I think we'll have to check on that. It's a paper form that we get from DOC that initiates that process. So, I think we'll have to get back to you if we have data on that.

DR. PATSY YANG: [off mic] Let me just say as far as we know (sic) it's probably text in my—in my electronic program, we want to give it a sample or something you write out, too. (sic)

CHAIRPERSON AYALA: Yeah, I—I—I mentioned it because I—I often speak to this. I had a little—my brother and my younger brother was incarcerated from the time that he was 11 until he was 33 years old in and out of different, you know, he was in Rikers, he was Stafford, he was in a state and he was never diagnosed with mental illness until he came out and it was pretty evident toward the end that his behavior was pretty erratic yet he never received treatment, you know, in any of these institutions. I mean it wasn't until we got home that we were able to realize that he had a serious mental health issue, but it wasn't easy to diagnose either initially because they have already adapted, right, and they've learned to kind of, you know, blend in and-- And so, it takes a specific, you know, kind of attention to

realize. I mean in his case he was pretty severe. He was very manic. So, I, you know, it's always pretty alarming, you know, to me and again, this has been many, many, many years, and I'm sure that the, you know, the system has gotten significantly better. At least, I would hope, but, you know, the—it's important to not like if something like that happened, we missed it, a lot of people miss it, right on day 1 What happens on day 10? Does somebody pick it up and say, you know, what? I was training for a self mental—you know, health, and I—I recognize that this person is exhibiting, you know, symptoms of, you know, bipolar or whatever. That would be important to know at least for me. And my final question is the—so the city's fiscal budget advocated $1.8 million to CHS in Fiscal Year 2017 through Healing NYC. The Administration's plan to combat the opioid epidemic. The funding, which increased to $5 million in Fiscal Year 2018 was intended to expand access to Naloxone, Methadone and Buprenorphine and to improve the searching planning outpatient referral services. What are the outcomes of this funding? Specifically, how many individuals, additional individuals received Naloxone, Methadone,

Buprenorphine this this $5 million investment?

[background comments, pause]

ROSS MCDONALD: I can speak to generalities while look for the specific numbers, but this has really been a tremendous success story of—of the transition. We've just about been able to triple the number of daily people on Methadone and Buprenorphine, which is a critical need for our system. We historically—eligibility for these life saving medications was based on charges, and it was because of a prediction of a person going to the state prison system where these medications were not available. With this additional funding, we were able—and improved data systems—we were able to throw any eligibility criteria out the window and we only use clinical determinations to decide who is eligible for Methadone and Buprenorphine today. This will absolutely save lives based on what we know of the effect of these medications for people with Opioid use disorder, and it's a tremendous achievement that we're very proud of. I think I the coming months hopefully we'll have data from post-release outcome to show even a mortality benefit of this expansion.

DR. PATSY YANG: So, just—sorry, I'm doing a quick round of arithmetic in my head, but since last year-last year on Methadone we had 709 patients. We're close to 3,000, 120 for Bup and the chart there is 450, and we're not done with Fiscal Year 18 yet.

CHAIRPERSON AYALA: Okay and what is the discharge plan because assuming that a person comes and they're in there for maybe two or three days, I'm assuming that an individual that has a chemical dependency is going to be, you know, is going to say that immediately because they don't want to get sick. So, they want medication, but is there a conversation with them about--?

ROSS MCDONALD: Yes.

CHAIRPERSON AYALA: --aftercare because we know that, you know, the numbers, the mortality rate, you know, where it had been pretty—significantly high, right because people don't understand and now they detox and they come out and they get high--

ROSS MCDONALD: [interposing] Yes, right.

CHAIRPERSON AYALA: --their body doesn't absorb--

ROSS MCDONALD: [interposing] Yeah.

CHAIRPERSON AYALA: --the chemicals.

DR. PATSY YANG: So, that's everything from counseling, risk reduction, harm reduction and making this a connection to community providers, and we just started re-prescribing the Naloxone program so that we can train people on how to use Naloxone and then when they're discharged they can pick that up in that front—in the front so along with everything else. So, they have that in case.

CHAIRPERSON AYALA: Okay, thank you. Thank you so much.

CHAIRPERSON POWERS: Okay, I had a couple more questions and I'm sorry then I'll turn it over. I'm sorry. This is really bothers me, and I'm sorry if I have to ask this question for the fourth time, but I just did the quick math. 50,000 appointments were amassed in the last six months because of DOC's failure to report the person. We don't have any--- we've not been given any single explanation for that today, but you—there were some I think that rescheduled. It was a fair answer and I appreciate that. What's the number one reason? Can you share with us a singular reason that may be a high reason

why in that number—I'm just talking about the last six months of last year, and I think there's more data this year. There's plenty of staff, different DOC. Why failure or is it staffing? Is it lockdowns, is it--?

BASIL YOUSSEF: First, that number seems very high. You know, I'll have to go back and look at that to be very honest with you, but if I had to give you one single example of what may contribute to that number, it's the undocumented refusals where I said earlier that an inmate might be scheduled for an appointment. The officer goes up to the housing area. The inmate says I'm not going. I don't want to go any more, you know, but that is the only time that that is considered--

CHAIRPERSON POWERS: Uh-hm.

BASIL YOUSSEF: --acceptable. Than inmate must come down to the H&H staff and sign that refusal in the presence of a clinical staff. Where that staff will be educated by the clinical staff. So, it's—I had thing of signing offhand. That's one of the things that sticks out in my head because I see that very often that happens in the system.

CHAIRPERSON POWERS: So, right, there's a-there's a document of the refusal and then there's an undocumented refusal--

BASIL YOUSSEF: Correct.

CHAIRPERSON POWERS: --and you're saying undocumented refusal means the person won't sign a form?

BASIL YOUSSEF: He would not come to the—that person had to refuse in the presence of a clinical staff. That's called a documented refusal.

CHAIRPERSON POWERS: Okay and that's at 90 or 80% or something like that by the numbers in the DOC report I think, and you're saying and do we have an idea of how—what percentage of that number—total number of the-of the DOC failure to bring the person, number that is?

BASIL YOUSSEF: No, I don't.

CHAIRPERSON POWERS: but you say it's the highest one you think. Do you have any idea of what that would represent?

BASIL YOUSSEF: If I tell you off hand, I'd be really misinforming you.

CHAIRPERSON POWERS: Okay, appreciate that. We appreciate your honesty.

BASIL YOUSSEF: Yes.

CHAIRPERSON POWERS: But other—other—other reasons you can list?

BASIL YOUSSEF: There—there might be times when the—and they may say, you know, I-I'm expecting a visit. Very common, you know, during the--

CHAIRPERSON POWERS: [interposing] Which would be an undocumented refusal wouldn't it?

BASIL YOUSSEF: Right, yeah, but they all say there's the data. They don't say I'm refusing the service. They just say I'm having a visit.

CHAIRPERSON POWERS: And others said that, but I guess on the CHS side on the DOC side you believe you're staffed adequately to-for the—for this purpose you're staffed adequately?

BASIL YOUSSEF: I will say to you that we have done a lot of work, and when I say a lot of work in terms of educating our clinic officers, our clinic captains. I actually go to every of the classes now even the new hire classes for officers, the promotional classes for captains and assistant deputy wardens. That's deputy wardens to educate every one of them. We have a Power Point that we have actually

prepared that we try to educate all of our staff about the importance of clinic production, and what are the things that we expect of them. On a weekly basis I have a conference call every Thursday, which I missed today, with all the captains specifically look at and addressing production issues, any kind of clinical issues, anything that may—may arise. Once a month we do have a meeting, a collaborative meeting a joint meeting with all our Health Service Administrators from H&H the DONs, the Deputy Warden, the Chief may attend that meeting, Assistant Chief may attend that meeting once a month, and that's where actually they're nice that uses over and over again that we work very closely to address all those production issues based on work in progress day in and day out.

CHAIRPERSON POWERS: I appreciate it and just—just for the clarity and I'm happy to be corrected if I'm wrong on the numbers, but I took those from the BOC Report from end of last year just for clarity sake, but happy to be proven wrong on that otherwise. I—I will end there, but I will ask Council Member Rivera---I think you had some follow

CHAIRPERSON RIVERA: You said and undocumented refusal. When you're—when an incarcerated individual has to make a choice between school or rec time or sick call, would those count as an undocumented refusal if they choose one over the other?

BASIL YOUSSEF: The answer is yes.

CHAIRPERSON RIVERA: And I mean I think we would all say that—that rec time is incredibly important to the health of the individual. Are every sick calls and rec times scheduled in conflict?

BASIL YOUSSEF: If the—most of the time, we know we the rec so we will schedule-we call them especially sick call. We would not call the housing area. It the rec time I s at 10:00 in the morning, we definitely will not call that housing area for a sick call at 10:00 in the morning. Scheduled appointments it's a different story. If the person has an appointment to go to go to the clinic, again we will try to work around those scheduled activities within the housing area.

CHAIRPERSON RIVERA: Because we—we did get this BOC report and they have a very—a percentage of people left without being seen. So, I'm just

curious as to your description and how many people are not produced, but we can even kind of just let us know at a future date because I want to ask one last question. Who recruits the doctors, PAGNY or H&H?

DR. PATSY YANG: [off mic] H&H.

CHAIRPERSON RIVERA: So, is there a reason why people don't sign up directly with CHS for an appointment or for sick call? Why does it have to go through DOC?

DR. PATSY YANG: Did I answer a different question?

CHAIRPERSON RIVERA: I'm—I'm asking is there a reason why incarcerated individuals don't sing up directly with CHS?

DR. PATSY YANG: [background comments] The New York City Board of Correction standards right now and the way the program has been set up and run is that they—a patient can—a person can ask to be seen and DOC is obliged to produce that person to clinic.

CHAIRPERSON RIVERA: When they show up at the clinic is the order that people are seen based on some variety like their need or is it base on how

they sign up in terms of like first come first served?

BASIL YOUSSEF: So, when they're checked into the electronic medical record. It [coughing] sets a timer. So, we generally try to see people in the order that they show up. You know, that's—people feel that that's the fairest way to do it. So, we honor that. Of course, if somebody has an acute issue then we would address that in real time.

CHAIRPERSON RIVERA: Okay, thank you.

CHAIRPERSON POWERS: Good. Thank you and—and I think you might have answered the question, but I just wanted to ask just—and I know that you had—there'll be more time to review and comment so, I—I won't hold any initial comments to you, but just on the legislation that is on the table today from myself and Council Member Rivera, which does require coordination around sick calls between CHS and DOC. Any initial feedback or comments on that?

DR. PATSY YANG: Because it—they have to read it. [laughs]

CHAIRPERSON POWERS: Okay.

DR. PATSY YANG: Sorry.

CHAIRPERSON POWERS: We'll look forward to your comments. Thank you. Any other? Okay. Okay, thank you. Thanks for your time. Thank you so much.

BASIL YOUSSEF: Thank you.

CHAIRPERSON POWERS: Okay. Next up we are going to have the Board of Corrections come up Dr. Robert Cohen and Executive Director Martha King. [background comments, pause] You has a minute. [pause]

LEGAL COUNSEL: If everyone could raise your right hand, please. Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honesty to Council Member questions?

PANEL MEMBERS: [off mic] [pause]

MARTHA KING: It's on? Good afternoon, Chairs Rivera, Ayala and Powers and members of the Committees on Hospitals, Mental Health, Disabilities and Addiction and Criminal Justice. My name is Martha King, and I'm the Executive Director of the New York City Board of Correction. Today, I am joined by Emily Turner, Deputy Executive Director of Research and Dr. Robert Cohen a board member who was

appointed by the City Council and is a Correctional Health expert and former Director of the Rikers Island Correctional Health Service. The Board of Corrections is the city's independent oversight agency for the jail system. We do not manage the operations or services within the jails. Rather, we regulate and monitor them on behalf of New York. The Board writes local regulations called Minimum Standards. These include chapters dedicated to health and mental health healthcare and they cover everything from detection to treatment and patient protections, and they seek to ensure that services are maintained at a professional and quality level consistent with community standards. In many ways, the city has been a leader in correctional health for decades. For one, New York City is exceptional because it has an independent healthcare provider in the jails. Most jails have one leadership that runs both the security and health operations leading to challenging and inherent conflicts that do not always serve the patient well. Other examples of exceptional work have been Correctional Health Services successful collaboration with the Department of Corrections on intensive therapeutic mental health

units as well as CHS' longstanding and effective opioid treatment program. The Board monitors correctional health in multiple ways: Observations in the jails by our staff who are on the ground daily; tours by board members, interventions and individual complaints raised by people inside or their advocates and families and investigations into deaths and custody. In 2016 we significantly improved our ability to monitor care by working with CHS to create a monthly access report which tracks compliance with the Board standards on access and 565,000 scheduled health and mental health appointments each month. The CHS Monthly Access Report represents the most comprehensive reporting on health and mental healthcare access in jails nationally. During the last six months of 2017, 79% of Health and Mental Healthcare services scheduled, New York City jails were completed. This means more specifically that 72% of appointments included a patient seeing a clinician and 7% included a patient refusing the service. Our analysis of this data has led us to focus on four priorities: (1) Barriers to production; (2) Extending best practices; (3) Access to specialty clinic and mental health appointments

and (4) New protocols to monitor sick call and other key areas of the minimum standards. [background comments] Just over a fifth of all scheduled services were not completed in our study period. The proportions of missed appointments vary by service category and facility. However, the main reason that patients missed appointments for all months studied and across all services was because the patient was not produce by DOC. Almost 70% of all missed appointments were due to DOC not producing the person to the clinician. CHS does not currently report reasons for non-production and these reasons are not always known to clinical staff. We all should better understand if failure to produce a patient is because of a lockdown, staff shortage, scheduling conflict, search or some other reason. We need DOC and CHS to track and report on the reasons for non-production in a coordinated way. They need to develop a plan to track and address barriers to production, the main cause of missed appointments. Appointment completion rates varied by facility during the last six months of 2017 ranging from a 67% overall completion rate at VCBC to a 92% completion rate at NIC. Completion rates for medical and dental services in particular

varied widely across facilities. Medical Services ranged from a low 54% completion rate at AMKC to a 98% completion rate at MDC. Dental completion rates ranged from 48% at VCBC to 84% at RNDC. There are jail services that have consistently higher rates of production and access. DOC and CHS should review the reason for this and the best practices from jails with high rates of completed appointments including NIC, West Facility and Rose M. Singer Center. This information should be used to generate benchmarks and plans for improvement and other service areas and facilities where current rates are unacceptable. During the last six months of 2017 about 30% of mental health appointments were missed. In this critical service area, 64% of all missed services were due DOC non-production and 19% were due to CHS rescheduling the appointment, the highest rate of rescheduling across all services. Over 39,500 mental health appointments were missed in this period. This is over five times as many missed appointments than any other area. Considering that 45% of people detained in the city's jails have mental needs, and that these patients are some of the most vulnerable. Reviewing and minimizing barriers to access for them

should be a priority. The next category of service most likely to be missed was on-island specialty clinics. Twenty-seven percent of these appointments were missed. In addition, too many appointments of this type are refused by patients. EKDC had a refusal rate of 55% for on-island specialty clinic appointments. Specialty clinic—specialty clinics are reserved for some of the most medically vulnerable patients who are awaiting advanced surgeries, procedures and appointments that cannot be carried out in facility clinics. Almost half of completed off-island specialty clinic appointments and 31% of completed on-island specialty clinic appointments involved a patient refusing services. Seven jails had refusal rates for 50% or higher for off-island appointments. People in custody and jail staff report that high rates of patient refusals for these appointments are due lengthy wait times, overbooking, waiting area conditions including a lack of space and transportation challenges. DOC and CHS should conduct and in-depth review of access in these areas to identify and adjust factors thought to be related to patient refusals. DOC will also release and in-depth look at specialty clinic access in 2019. After

intake, sick call is the primary way people in custody access care. The proposed Council bill will greatly enhance the accurate tracking of sick call. Our monitoring suggests people requesting sick call regularly do not receive it. We have called on DOC and CHS to implement new tracking protocols to assess compliance with the minimum standards on sick call, the intake process, timeliness of services and substance use treatment services. Access to health and mental healthcare in New York City jails has been discussed at 12 public board meetings since January 2016. During these public discussions board members have frequently cited the concerns related to access to care including lockdowns, production, escorting, transportation to Bellevue and Elmhurst Hospitals, sick call and specialty clinic policies. Discussions on these issues have repeatedly confronted the need for improved tracking and outcomes related to the minimum standards on health and mental healthcare. This information is necessary to minimize barriers and improve access to and ultimately improve the quality of care via measurable reforms. In closing, access is a fundamental policy and principle of the Board's minimum standards, and at all nationally

recognized jail standards. It is supported by longstanding legal opinions that require the state provide quality healthcare to people while in its custody, and it is central to safe and more humane jails. We look forward to working with DOC, CHS and the Council on efforts to improve you. Thank you for the opportunity to testify, and we're happy to take any questions. Thank you.

DR. ROBERT COHEN: Yeah, I appreciate the chance to make just a few comments, an I am actually going to give Martha credit because it was her decision several years ago to work with DOC and CHS to collect the kind of data that is being published on a monthly basis to look at access and, you know, and I'm very proud of that—of that work, and you're seeing some of the results of it before you. I endorse everything that—that Martha just said. The department and CHS is well aware that for example, and I just want to stress this thing. The specialty on and off Island cares those are the— those other than the mental health, which is a separate and critical issues, and I'll talk about some terrible consequences of-of—of lack of access to, you know, if a patient is not brought to care and mental health.

The--the persons on Rikers Island and off Rikers Island in Brooklyn House in particular are refusing their—their appointments at Bellevue or coming to Rikers Island for—for specialty here because they have to get at 4:00 in the morning, which is not, you know, which is explainable, and understandable. There's lot of transportation difficulties in New York, but then when they get there they're not seen. When they get there, there's not a place to be seen. So many people got on buses and were brought to Bellevue after the clinics were over. So, these kinds of, you know, everybody is aware that nobody is working very hard to fix it. It's not been fixed yet, and I—I don't' think that—that the major problem here—-I just disagree with—with, you know, USEF about it's—it's to blame the victim, you know, for—for this one. On several occasions, I just have to respond to Patsy's and others complaints about the Board of Correction saying we think the reason why there's no coordination between the medial and—and the medical program and DOC. We do—we do require that there be daily access to sick call. That is a very difficult thing to do. If it's not being done, we would like to know it, you would like to know it,

and we'd like to figure out what can be done to—to fix it, but—but you can't fix it if you don't know it, and -and the Board of Corrections standards do not prevent CHS from understanding who is asking for sick call. From my—my perspective, I do not want a commitment to try to figure out what's going on with sick call to take away from any of the other terrific work that CHS is doing and—I, you know, I don't it came out of nothing in the whole discussion, but it is an amazing program and, you know, and you know, and it's much better than what I did when I—when I worked there, and some of the changes that have occurred recently, we should be very proud of as, you know, as—as, you know, people who are responsible for what goes on in the city. But, we—when someone requests sick call, that should be added in the CHS electronic medical record and then we could figure out whether it's happening or not happening, if it's a staffing issues, if it's a production issues, and there really—there really is a production issue, and—and that is fundamental to correctional healthcare. There are contradictions between what the—providing medical care and providing care, custody and control. These are—these are different—these are different

projects and they will be in conflict, and that doesn't meant that people aren't of good will or serious or we're not in New York City where people really care about this right now, you know, particularly including the Department of Corrections but those problems are real. They're going to happen and if we don't look at them, then we won't get as far. Then we won't—we won't solve them. Two other points, and one of these I think occurred during—I believe it may have occurred by CHS' current watch in terms of actually providing care, and one of the may have been before, but there were two suicides in the past period where—where the—where the person was identified as needing medical—one where a person was identified as needing medication. They knew they were depressed, they were on medication. They weren't responding and on about five occasions—--I'd have to go back and check it. I know this is stuff that you, and I can't give you the chart and I don't have the chart where their appointment as not—they were not produced, and they said it's not working. So, these are real—these are real—real-real issues and everybody is working very hard, but it—but it is the fact that the mental health numbers are so high

is really problematic, and one of the reasons and this is a larger story, but there are 2,000 in AMKC. It is a dysfunctional institution from the perspective of delivering program services, and I think the city should be careful about building new institutions that are 1,500 beds because that's too many also, but a 2,000-person institution doesn't work and when I was there in the 1980s, we were building mini clinic to solve this problem. It's too big. It's not going to be solved by that. It should be broken up into two commands, but that's a—that's another subject. I think—I think I'll just stop right now and be available and stay for questions.

CHAIRPERSON POWERS: Thank you. Thanks for both that kinds of testimony. I had a couple of earlier questions, and then I'll hand it off. On the non-production, which I think we'll all ask questions about because they were so big. You know some of that we've heard (sic) of not being able to get clear data. You guys have marked it as something that you were concerned about as well in your report, and I think something that we always want to make sure if you access, you need access, and I understand the challenges with that. Can you—can you share with us

any—any insights into why there might be no-production for not produced by DOC is such a high category and what some categories might fall into that in terms of sort of high—high reasons for—for non-production?

MARTHA KING: Well, again, tracking this systematically is going to be critical. The department does track their own—have their own tracking around reasons for non-production. They're not doing it particularly well, and that's probably why they didn't feel comfortable getting new numbers. One of the reasons that they track alarms related lockdowns. So, when a lockdown occurs, all movement in the facility needs to stop. Another reason is if, as was mentioned earlier, if there is a conflict between and a scheduled appointment or another mandated service or another service that an individual may want to participate in, those conflicts do—may lead to people not making their appointments. There is an escort issue. That is a reason the department is, in fact, tracking. So, I'm not clear why they wouldn't just tell you that sometimes people can't be escorted to their appointments, and—but—but tracking and—and clearly

tracking what those reasons are, we've been told sometimes from the department that they will—they can't bring people to their appointment because there isn't enough space to house someone at the clinic. There may be too many appointment booked at that time. They can't safely house people with certain security designations together. That's another example of why it may not happen, but again, if that's an issues, we need to track it, and we need to know it, and need to address those challenges. I mean another—another issue here is I think with respect to this issues of patients not wanting to go to their appointment. That varies sort of by the type of appointment we're talking about. So, if it is of these specialty clinic appointments where the individual needs to be transported, that can be a very unpleasant experience. It can be an all-day experience. It can involve getting on buses and waiting on buses, being retrained while waiting on buses and then ultimately end up in missing and appointment, and so, if you're rescheduled and you're told okay, it's time for you to go back on the bus for your appointment that you missed, you've already had a bad experience with the system and you may not

want to go through that process again, but that's why the board will be doing an in-depth look at what's going on in terms of completion of specialty clinic appointments in the next—in the coming years.

CHAIRPERSON POWERS: Thank you. I appreciate that answer. I wish I had received an answer like that when we were asking it to the earlier panel, something with a little more substance. On the—on the discrepancies between the jails and as you noted with 2,000-2,000 folks and—then changes and difference in population and also being a part of it, can you tell us and—and especially as we look forward here some of the challenges, in more detail some of the challenges around—we had talked about physical limitations earlier with the—with the—with the two agencies, but can you talk to us more about what you're seeing in terms low completion rates at AMKC around 50% and MDC 98% and others in terms of why variations, and thoughts on how we can improve those sort of across the board, close gaps between how different jails are—are completing?

DR. ROBERT COHEN: I want to say it's really hard to at 2,000 and it was even 2,700 at some

point at MKC. It's just really difficult, and I thin the department should be careful going forward to not close another facility on Rikers Island when it doesn't really, you know, it would be better to—to decompress one of the—one of the facilities, and—and rather than just close it down and lose, you know, and keep things as—keep, you know, keep them—keep things at the same density. I think the—the measure that—that—that we're describing form just setting up other clinics is a—is a good idea. I think that the—that—that the DOC and—and CHS can work better in terms of actually having the clinics function over a longer period of time. When you go there, there are lots of times when nothing is happening it seems to me, and there are all kinds of reasons, mainly from the—from the Correctional operation of the facility, which can be improved. There are efficiencies without increasing staff, there are staff there when there aren't persons there, and so I—I—and I am sure that they are working on that, but that's the—that's the kind of thing, but I, you know, but it is—it is a very large place, and it shouldn't. When there's the opportunity, it should be decompressed rather than another facility closed prematurely just to prove

that they're closing a facility. The point is not closing the jails of our design, it's closing—it's the process, and that was an error I think the department I hope realizes in terms of the closing of GMBC.

MARTHA KING: For—for additional context, the—the three facilities mentioned in testimony, NIC facility, West facility and Rosie's are the facilities with the highest production rates, but they also together represent less than 10% of the average daily population. So I think to Dr. Cohen's point the size of the facility does not vary.

CHAIRPERSON POWERS: Alright think you and one of the things that that I think DOC just noted was that even though you might miss on a certain day that you'll get rescheduled, and you will—you will make your-you will make your appointment if you choose to or there will be an effort to. Can you tell us any information about the efforts or the tracking that you may have around that process happening?

MARTHA KING: Rescheduled is captured outside in a different category--

CHAIRPERSON POWERS: [interposing] Right

MARTHA KING: --but not-

CHAIRPERSON POWERS: [interposing] Right, and I know that then.

MARTHA KING: So, I'm not sure what they mean by missed. So the appointments that we are calling missed, and which actually they call missed in their report do not include rescheduled appointments, which is a separate part of the report. So, I'm not sure--

CHAIRPERSON POWERS: [interposing] We had that conversation. I think that the—well, let's—let's go on—they had mentioned that—well, if you're-if you—I think it was about the undocumented refusals and the ability that you could then be rescheduled later on, or maybe you could tell me about anything--

MARTHA KING: Sure.

CHAIRPERSON POWERS: --or the undocumented if you will.

MARTHA KING: So, I believe Ross is saying that for everybody that's not produced by DOC there's a review, and then a rescheduling of the people that ultimately missed their appointment due to production, and we do not know. So, one of the limitations of our access report is that we don't

know the initial time of an appointment is first scheduled. So, we don't know how many attempts. So, we just completion or non-completion.

CHAIRPERSON POWERS: Right, right, right.

MARTHA KING: We don't know how many attempts were made from the first scheduling of an appointment, and that is one of the areas that we're going to be working on in terms of getting better metrics and improving our understanding of timeliness of scheduling to actual time individuals are actually seen.

CHAIRPERSON POWERS: Is there information that—that the Board would like to see reported more thoroughly or efficiently?

MARTHA KING: Yes. So, in addition to the sick call efforts that this new bill presents, which we fully support, there are metrics around intake and in particular to your question about the 24 hours and—and around that timing that we would like to see included in the access report. Again, additional metrics about how many attempts it's taking for scheduled services to actually be completed. So, other timeliness metrics and then we have data waiting for quite some time for metrics on

substance use care treatment services to be included in the Access Reports, and we'll be pushing to get those included in the reports as well, and we also want to include the reasons for non-production.

CHAIRPERSON POWERS: Got it, and have you requested them to report that to you? Do have heard from them for this non-production.

MARTHA KING: Yeah, when the report was released publicly in May at the public board meeting, we encouraged both DOC and Correctional Health to make a public commitment to do joint tracking so that that information could be included in the reports.

CHAIRPERSON POWERS: And they—what was their response?

MARTHA KING: Their response at the meeting was that they track different things, and their tracking is separate.

CHAIRPERSON POWERS: Yeah, thanks. My final question: You, I think, that's known and I think you mentioned some of the positive aspects here of the changeover from Corizon to H&H. Can you share some of the—some of the aspects of correctional healthcare that have seen the most improvement, and talk about some of the progress that's been made.

Obviously, we've—we've heard people where it had to do more. It also needs fixing and monitoring, but can you share with us some of the positive aspects that you feel have been improved upon in the last years?

DR. ROBERT COHEN: Right, and I will be requoting things that were said, by I think they're worth—they're worth emphasizing. The improvement in the—in the series in the mental health services for seriously mentally ill people has been terrific, and that happened some before, but it's this group of people who have made it happen, and they are expanding it substantially. That needs to be further expanded. There are things called PACE and CAPS units but there are also things called Mental Observation, which are not impressive, and need to be and need to be supported, but I know that the—I know –I believe everyone is committed to them, but overall that's been a very positive area. More to be done. I think we're talking about seriously mentally ill. We're not talking just about the M designation Rikers Island, but there are a lot of seriously mentally ill people who need really enhanced mental health services with—with enhanced support from security.

The—the opiate work—work that the—you know, that's—that's been done is terrific expanding Buprenorphine and Methadone services, and making sure that everybody who's coming in, who's on Methadone is maintained on Methadone rather than having most of them kicked off. There's a tremendous—that's a CHS, you know, accomplishment, which I'm very—I'm very proud of, and it just—it demonstrated that, you know, large numbers of people. I think it's about 40 to 60% of people who would not have been allowed to continue with their Methadone because they thought they were going to be going Upstate aren't. So, lots and lots of people going onto Rikers Island don't go Upstate, and we should keep that in mind when we think about other issues or decreasing this population. So, mental health, opiates, and I think the—you know, I think that the—the quality of—of professionals, the staffing is also something, which has been mentioned here, and which I'm—which I'm very proud of as well.

CHAIRPERSON POWERS: And just, I'm sorry, one last question. I think you mentioned the uniqueness of New York City versus other places of terms or our separation, in terms of the—the—two

different agencies involved in this process. Are there other cities or states that you know that have something similar to that?

DR. ROBERT COHEN: There are a few, and those are—and those are among the best situations. I mean it's true in Chicago, and it has been true there for—for a long time. It is now getting true in LA. I don't think it was true before. There's still substantial parts of the LA system, which are under DOC, but—but a lot of them—the programs have been moved down-in—in—into an LA. So there are some other places that do it, but in general having medical services that are run by the health authority of a—of a county or city, or state and—and security services provided by the Department of Corrections is I think the—the best way to—to deal with all kinds of issues we've been talking about.

CHAIRPERSON POWERS: Thank you, thank you for testifying and answering the questions and, of course, providing the reports, and we feel that also helps the committee get a better understanding. I think together between us and the BOC and the DOC so you just will have a shared mission here, or making sure people get quality access when they need it,

and—but I think a lot of this—this conversation and the information and reports that the DOC has done and helped us, you know, understand that better. So, thank you for you both your advocacy and your reporting. [background comment]

CHAIRPERSON RIVERA: Thank you. Do you think there is anything that we can include in that report that will help us ascertain better outcomes in terms of what I mentioned during the beginning of the hearing?

MARTHA KING: Yes, I think the additional metrics that—that we've been focused on and prioritizing for inclusion around intake, timeliness of access to care, and then the substance use services, information on substance use services and outcomes. Also, some just basic information about screening. Like how many people are screening with a disability? How many people are screening with a mental health need at intake or screening with a substance use care need? So, without knowing how many people are screening to begin with, it's sort of hard to interpret these numbers of people who are receiving care. Like is that actually the full population in need? So, having those baselined

screenings. Intake numbers are important there as well.

CHAIRPERSON RIVERA: And—and the last--

DR. ROBERT COHEN: [interposing] And—well, just in addition—

CHAIRPERSON RIVERA: [interposing] Yes.

DR. ROBERT COHEN: --is the reasons for refusal. We need to have a very clear set of—set of—set of reasons that everybody agrees to, and then that we can then analyze so productively. This would include, you know, for example, you know, there are a lot of lockdowns, you know, in—in the facility. So that number has increased over time. As a matter of fact it's—

EMILY TURNER: Yes. So clearly—clearly defined reasons for non-production and clearly defined reasons for patient refusals.

CHAIRPERSON RIVERA: And I'll ask this of the advocates, or hopefully we'll hear from the advocates, and I want to thank you all for waiting and considering the weather outside. Have—they mentioned the—I'm going to call them walk-ins for lack of a better word, people that do not sign up for sick call that can show up and receive services. Do

you feel—have you heard of any issues with—with these particular incarcerated individuals? They made it seem like it was easy in practice to show up and receive medical attention.

DR. ROBERT COHEN: I'm not aware of this. I—I did hear today about, you know, there's the Law Library that's close to one clinic and theirs is—there is sort of a back door between the Law Library and the clinic, but generally, I don't think that that—that's not how it goes. So--

EMILY TURNER: A high percentage of those facilities are escort only facilities. So, the only way someone would be permitted to get from their housing area to the clinic would be via an escort.

CHAIRPERSON RIVERA: Okay, thank you.

CHAIRPERSON POWERS: I think that just to clarify, I think the issue was about people who don't sign up, but why not sign up.

MARTHA KING: Yeah, they don't officially sign up. Yeah, they can say, I want to go.

EMILY TURNER: [off mic] I think we require that there be—

DR. ROBERT COHEN: [interposing] I mean we require that there be emergency access to care, and-

and so, you know, that was called—and that really is a different category than signing up for—for sick call. I'm glad, you know, if that happens, but those numbers are not the—are not really what we're talking about.

CHAIRPERSON RIVERA: Would you be able to tell me what happened to an individual with a mental illness who should be taking medication, but is refusing to take medication, how is that addressed?

DR. ROBERT COHEN: [background comments] It's probably better done by them. I believe that there is a policy which says if you miss a certain number of doses that are, you know, which is—I forget what it is. Some of them—they're not here right now. You know, it's probably 2 or 3 days of medication. All psychiatric medications are delivered—are given directly through directly in terms of therapy. S o, they don't have bottles themselves. They have to go to the—to a pharmacy area. 99% of medications are administered. When the department wants to do something and CHS wants to, they can, but almost everybody who's-who's prescribed medication gets it every day, and—and if you refuse it or you don't show up, then—then there's a requirement that the medical

staff bring you to the clinic to discuss what the problem with you medication.

CHAIRPERSON RIVERA: That is it. Thank you.

CHAIRPERSON POWERS: I have one last question actually, which we didn't discuss. If you're in punitive segregation, does that disconnect you from any necessary treatment, appointment, sick call or anything that you might really need or require?

DR. ROBERT COHEN: [background comments] I don't believe it is. I mean there are medical— medical staff visit Punitive Segregation every day to ask for—if people have any new medical problems or medications are distributed within—within Punitive Segregation, and this isn't something I follow closely, and I'm not aware of—of problems with—with access to medical care there right now, but it requires people going every day to visit with those people, somebody from CHS.

CHAIRPERSON POWERS: Great. Thank you. Any other questions? Okay, thank you. Thanks for all your work and your testimony.

DR. ROBERT COHEN: Thank—thank you.

MARTHA KING: Thank you.

CHAIRPERSON POWERS: Thanks. Next up w are going to have a panel—because it is snowing out, and the time and—and so we are going to ask for two minutes a piece. We have, it's Mik Kinkead Sylvia Rivera Law Project. Sorry, if I got that name wrong. We have Dionna King--Dionna King, Drug Policy Alliance and Jennifer Parish and the Urban Justice Center. [background comments, pause] Thank you and I think we're going to and I know that some of you have testimony. It's probably beyond the two minutes. So, I would ask you. I mean I appreciate you waiting. It is I think they are snowing out and so, I want to get some people home, but-but we—we rally want to hear your points. So, you know, we'll get—that—and it's all about this. So, and we'll have a series of questions, too. So, we'll start left to right and unless it works my left—to my left then, and just if you don't mind say your name, your organization and then you can begin testimony. Thanks.

MIK KINKADE: Sure. I'm Mik Kinkead, and you pronounced it perfectly.

CHAIRPERSON POWERS: Okay.

MIK KINKEAD: I'm with the Sylvia Rivera Law Project. I'm the Director of their Prisoner Justice Project and one of their staff attorneys. I had planed to read so that's not going to be in two minutes, but I will do my best. So, thank you for the invitation to testify on this issue of healthcare in correctional settings. They Sylvia Rivera Law Project is one of the oldest non-profits in New York City offering legal services to transgender, gender non-conforming and intersex people by transgender to non-conforming intersex people. We often use the acronym TGNCI or TGNC. So we specifically work on those issues. That's what I'm going to be testifying about. My written testimony is specific to the written policies for transgender healthcare, but since the other testimony has happened, I made a short list of all the other things I should have said, but as a bit of background, I have personally worked with over 100 TGNCI individuals in the New York City Department of Corrections in the past 4 to 5 years. I go twice a month to the transgender housing unit, and I teach a legal and cultural programming class. So that was—that's been since August 2015, and that's continued now that the

transgender housing unit has moved to Rose. Over the healthcare operations is—is that there's only one policy, and a number—it's MED 24B, which is the policy on transgender healthcare. That was last updated in July 2015. It is a policy, which relies on very outdated practices. As a general overview, TGNC people require the same care as their cisgender counterparts, but in addition some must need care specific to transitions. Transitions are highly individualized, and they require individualized care. That's probably true for any kind of medical care. Every TGNC person experiencing gender dysphoria and the steps that we must take to thrive with that dysphoria are different. There can be no cookie cutter approach. As I just said, that's probably true for almost every type of healthcare. Transitionally, related care can range from knowledgeable counseling to hormone replacement therapy. [bell] Oh, my God, Jesus—which is HTR and various types of surgeries. The existing policy only allows for one type of medical care, and it says in the purpose of it that it will minimize the use of non-standard or high does regimens (sic) which may be appropriate under the direct supervision of expert

community providers. They may also confer under this Magellan (sic) environment. It brings everything down to 3 milligrams of Estradol for the feminizing hormones and 25 milligrams of Spironolactone, and 200 milligrams of Testosterone. These are against all the clinical—updated clinical standards for best practices, and in particular it's very upsetting for transgender women. Such a low, low does of Speronolactone, which should be up to 200 milligrams or close to 25 milligrams, means that you're not blocking testosterone, which means that all of the effects of the Estradol are wiped out completely. There's effect of the feminizing hormone, which means that if everyone who goes into the prison system gets cut down to that specifically, that basically means there's no point in having them on Estrogen at all. So, this is not acceptable. It's a really horrific practice. There's no reason to have no specialists in the City Center when if you are at NDC the Apicha Community Healthcare Center is literally five blocks away. There's so many transgender healthcare specialists in the city. This needs to be addressed, and this needs to be updated.

CHAIRPERSON POWERS: Great. Thank you. We'll do the panel and then we'll ask final questions after that. Thanks so much. Just introduce yourself is all.

Sure. My name is Dionna King. I'm with the Drug Policy Alliance. We are the nation's leading organization working to advance policies and attitudes that best reduce the harms of both drug use and drug prohibition. She read her testimony, but I will keep it short. So, this is the second day we've been talking about Methadone and Buprenorphine access in correctional facilities. As advocates, we do work closely with the KEEP Program. We—we look at it as a model that New York State should emulate, and make those same medications accessible statewide. We do sort of struggle externally with the lack of data about that program as it relates to programmatic outcomes, referral services, what does a warm handoff look like? What are reentry services provided? So, it's difficult to present like what—are our best testimony with a limited amount of information that is made public to the—those outside. The most recent report about the services there was done in 2001 I think. That's the one that's the most accessible,

and it talks about Medicaid services being necessary for them to promote a war hand-off, but we need better information about why this works. We need it for our state advocacy as well. So, if you guys are pushing to make that data more transparent, it will be a service to us. Another thing that we want to re-lift and I think DOC is taking this on is just to improve the reentry services. As it stands now, it seems as if people are getting referred to treatment facilities to return to, but this is a high need and vulnerable population. They need a warm handoff. They need someone with them at the front line taking them directly to treatment services, taking them directly to harm reduction services to make sure that people stay in their program, and right now that doesn't seem to be happening as efficiently as it should. I think Fortune Society is going to step in to help fill that gap, but other agencies, specifically harm reduction service providers that aren't really listed in a treatment profiles in reentry services, need to be part of that process because not everyone is going to return to optional base facility. We need to integrate harm reduction services into Rikers in a real way. The third thing

I want to lift up is what your resolution would do: Promote access statewide. Not everyone is going to return back to their communities unfortunately after being detained for a period in Rikers, and once you leave that facility, you're going to go statewide where there's no access to any of the services that are afforded there, and DOCS does not seem to be moving in any kind rapid—rapidly to fill this gap. We also need to make sure that whatever DOCS (sic) does, mirrors what DOC is doing that all three forms of medication are provided in that space and not just Vivatrol. This is what we see happening now. So, everything else in our testimony, and I will pass it to—right here.

JENNIFER PARISH: Okay. Hi. My name is Jennifer Parish. I'm the Director of Criminal Justice Advocacy at the Urban Justice Center Mental Health Project. We represent the Brad H. Class, which is basically everyone who is receiving mental health treatment in the city jails. There's a settlement agreement, which the city entered into in 2003, which requires them to provide discharge planning services to people. I think that, you know, since services have certainly improved and Correctional Health

Services has made fundamental improvements to service delivery, but they still remain non-compliant with key discharge planning services, and I've included in my testimony a couple of charts at the end that show you kind of overall where they are non-compliant. So, the failure to provide initial mental health assessments, comprehensive treatment plans and discharge plans in a timely manner can result in class members being released from the jails without the vital services. When they incorrectly diagnose a person whether they have a serious mental illness or not, that affects the level services that people are entitled to in discharge planning. There are many more services available to people who have that SMI designation as opposed to people who just have a mental health base. So, they need to get that diagnosis correct. Also providing individualized appropriate treatment referrals, supportive housing assistance and case management services is essential to ensuring that class members can successfully transition from jail to community. Yet, CHS's compliance with these performance measures although improved, remains well below expectations. Providing these services requires communication with past

treatment providers as well as coordination with services that they're referring people to. In addition the Department of Correction has a role in providing discharge planning services and I—I think you saw a display here of how little they think of their roll in Correctional Health Services generally. They certainly weren't—certainly weren't prepared to answer your questions, and I think that reflects their overall commitment to the health [bell] of people. But, specifically—sorry—just specifically related to people in discharge planning is that they have to produce individuals for these appointments with mental health and social work. They also have to transmit information about who's been released to HRA to make sure that their Medicaid get turned on correctly. They have failed to do that sometimes, and when the court appointed monitors and Brad H. ask about that, they say, Well, we fixed it, but we have no way to check on the quality of that going forward. It's completely unacceptable, and also they are charged with releasing people during daylight hours and for people who are in on alleged parole violations, they frequently fail to do so. So, the rest of our specific recommendations are included in

our written testimony. I'm happy to answer any questions.

CHAIRPERSON RIVERA: Is there any reason— any concern that TGNC, Transgender and Non-Conforming individuals are not self-reporting about medical needs to DOC or CHS because of fear for their safety within the correction facilities, and are there adequate protections in place for them now?

MIK KINKEAD: That's a great question. Absolutely. So, there's a range of answers to that. I have worked with a number of transgender women who have remained with us and called Stealths throughout their entire time inside. They had not reported themselves as being trans to anyone, and as such they have not gone on their hormones because they are so worried that any access to care will out them. These are women who are in the women's facilities, and so— and they were very concerned that if they were outed as transgender, they're removed to the men's facilities, but Council Member we know that under the Prisoner's Rights Law you're supposed to be doing an interview with people, you're supposed to contributing to their idea of healthcare, you're supposed to be under the Department of Justice's

interpretation of it. You're supposed to be defaulting to placing people as they identify unless there's a—they don't request it, which often happens with transgender men or if there's a reason unrelated to their gender identity and another person's perception of it to house them as how they are identified. The department doesn't do that. Almost everyone gets housed according to their birth and their presented sex. (sic) The sex they present at birth, and so they—it's great. So, there's a lot of reasons why they—folks don't come forward, and in addition, if you are a transgender woman, for instance you are already housed in the men's facility, if you think that you can get through that housing situation safer by never coming out as trans, most people are going to do that. Yeah.

CHAIRPERSON RIVERA: [pause] I have—I have a question. So, do you ever in terms of we continue to ask why—why aren't people produced at their appointments, and I know that there's a ton of reasons. Yeah, you do—I see in your testimony then—sorry we didn't have a chance to read all of it and it looks extremely comprehensive, and I will after the hearing. Do you—can you concisely say how DOC

and HMH can improve the access to and delivery of care? [pause] I know it can be a long answer, but if you could kind of just hit on couple of the most important points you think.

JENNIFER PARISH: Well, for one thing they could start being accountable for what's actually happening. I mean they almost said that there was no problem with escorts, which we know that there is. Frequently, when we're in the jails seeing people, we see that, you know, someone who has been assigned a particular post gets reassigned. The jails are chaotic and all of a sudden there's no person to do that job, and people don't get seen. I mean I certainly can't say all of the reasons that it happens, but I think that they should be documenting those reasons, and being able to report to the Council on that. I certainly think there's an obligation CHS as well, but I think you saw that DOC really couldn't forward—come forward with any answers about it. [coughing] I think overall, yeah, I mean I think that, you know, the Menos Monitor's Report came out recently that shows that the jails continue to be an incredibly brutal place that the use of force is still incredibly high. That has an impact

on the way healthcare is provided and all other services as well. So, I think it's a complex sentence. (sic)

CHAIRPERSON RIVERA: Thank you.

DIONNA KING: I have to say just streamlining it so that it's only through HHC that—that the sick calls are made in particular in terms of vulnerable populations anyone who has an illness or a concern that they don't want the general population to know about, having it go through the officers outs them completely whether that's just through people talking or whether that's through the officer checking in with them and then like escalating up to the captain why didn't you come? Why didn't you come in front of everyone? That's a real invasion of people's medical privacy, and as far as discharge planning is concerned, to my knowledge people are getting information about where to go in the community and once they return home, but that—in that time frame that's a particular vulnerable period, and that's when you're most susceptible to fatal overdose if you relapse. So, you need someone there to support you in that transition point to get you directly to the place so you can have your next

appointment if that's Methadone or Buprenorphine or to take home medication with you just to fill that gap. But the transitional services need to be really more detailed, and really more person centered, and really to integrate harm reduction into that practice. If someone has real support in coming home, and that can be done through peer programs. We would suggest that everyone do a peer program with someone who—with direct experience in both substance use and navigating integration as a formerly incarcerated person.

CHAIRPERSON RIVERA: And do you think that all that being said that an incarcerated individual know when they should declare whatever they're feeling or whatever is going on with them in emergency versus when they should go to sick call? Do you think that they have that information as soon as they're assessed? [pause]

JENNIFER PARISH: [off mic] I'm not sure I understand the question.

CHAIRPERSON RIVERA: So, for example if—if when someone describes some of the people that had been untreated and who had passed away, do you think that when the assessment—when as soon as they get in

that they are given that information like hey, like you know that when you're not feeling well, and when it's an emergency like versus 911 versus making an appointment with the doctor. Do you feel like that sort of education or that information is given to the people there considering some of their—either their medical conditions or what they're going through or their medications that they're taking based on your experience and talking with some of the people?

JENNIFER PARISH: I think there could certainly be more communication for people about how they access services, but I think probably the bigger problem is that when they make those complaints to the officers on the housing area, they're ignored. And we know that in the past, and we certainly under the previous provider that there are people who died because the correction officers didn't recognize how in need they were. So, I think yes there can be education and that will help people be able to access that, but I think it also has to be engrained in the correctional self that this is a priority, and when someone makes that complaint, we make sure that that they get there.

CHAIRPERSON POWERS: Thank you and—and I'm—we'd be happy just because we—you have less time, but we'd certainly be happy to do a follow-up conversation it being on any issues as well. I know and I think you know this as well, and we'll take your recommendations and—and if you have questions, follow up with them as well. Thank you. Thank you for your patience as well. Next up we are going to have Julia Solomons from the Bronx Defenders; Julia McCarthy from the Prisoner's Rights Project at Legal Aid Society; and Brooklyn Defender Services, Brooke Menschel. I'm doing okay with names. [pause]

LEGAL COUNSEL: If everyone could raise your right hand, please.

CHAIRPERSON POWERS: They need to do that do.

LEGAL COUNSEL: Oh, they don't. You're right. I'm sorry.

CHAIRPERSON POWERS: Thank you. Thanks for being here. So, we'll—we'll start and go this way, and we'll same thing with our clock. If you're making—making—finishing comments, obviously, you can keep going and then we'll ask some questions. So, thanks and thank you for your patience.

BROOKE MENSCHEL: [off mic] My name is Brooke Menschel and so-[pause] [on mic] My name is Brooke Menschel. I'm the Civil Rights Counsel at the Brooklyn Defender Services. Thank you for the opportunity to address this group today. Correctional Healthcare in city jails cannot be viewed in a vacuum. Instead, part—it's part of the continuum of card that starts long people enter the Criminal Justice System, and extends far beyond their discharge. The lack of access of care that the people we represent often face is itself the cause—a cause that often leads to incarceration or problematic behavior and that lack of access further does nothing to improve the security of our communities. Decarceration while investing in healthy communities will ultimately result in a safer, healthier society that will benefit both the people we represent as well as the community at large. The people we represent are frequently hamstrung in their attempts to access care by distinct, but interconnected issues. First, many DOC practices ostensibly in the interest of security often come at the expense of care for clients' needs. Second, physical design and staffing allocations

often impede clients' ability to readily access treatment that they require and third, administrative hurdles frequently hamper our clients' attempts to access indicated mental health or medical care. Access to care can a lynchpin to improving security. Contrary to an assertion we frequently hear, that there is tension between security and care, robust accessible medical care is necessary to ensuring safe, healthy and secure communities and correctional facilities. Too often, correctional staff without requisite knowledge or training, take it upon themselves to block access to care. The result is significant harm to the wellbeing of the people we represent. Today we've heard a lot about sick call and refusals. Unfortunately, the experience that was portrayed to you in the earliest panel, is not the [bell] experience of the people we represent. We have many examples that I'd be happy to share either now or at some later point, but the reality for many of our clients is despite frequent attempts and requests to access sick call or access medical care, they are unfortunately blocked from doing so, and we support increased transparency and accountability in the system, and urge the Council to adopt Intro 1236

to ensure that necessary data collection and reporting. The other point I would like to just quickly make would be that the—the system regularly denies—denies access to particular programs or treatment because of high security classifications or infractions, and that's a regular problem for our clients that has long-lasting and problematic results, and we would also—we also support the Resolution 581 to improve access around—access to those programs. So, the impediments are to—clearly too many to name today, but we've attempted to outline both here and in—in the written testimony major hurdles that the people we represent face on a daily basis. It's that we echo the sentiment of the other organizations, and appreciate the Council's efforts to improve the health and safety of our communities both in correctional facilities, and before and after time that's spent there. Thank you.

CHAIRPERSON POWERS: Great. Thank you. The same thing. We'll do the panel. Then we'll ask our questions. Thanks.

MEGHAN MCCARTHY: Okay. Hi. My name is Meghan McCarthy. I'm here for the—from the Prisoner's Rights Project of the Legal Aid Society.

I'm a paralegal case handler and speak with upwards of 200 people each month who are incarcerated, and hear about all types of issues facing those in custody. The vast majority of the calls we field they're about medical care in city jails. In contrast with testimony we heard from DOC today the Department of Correction's failure to provide sick call seems to be a pervasive problem across city jails. Whether an individual is spitting up blood or attempting to renew a prescription we receive reports of people being denied sick call on a regular basis. Last month, several incarcerated people from the same housing area in one city jail organized to reach out to us sharing their experiences of not having access to sick call. These individuals reported that they informed multiple officer, captains and deputies about the lack of access to services, but nothing changed. They told us that often the only course of actin that seemed to work was calling 311. There are plenty of reasons that can contribute to lack of access to sick call. As stated previously, many incarcerated people tell us that officers seem to be acting as gate keepers when it comes to getting— deciding who gets access to sick call. All the

decisions regarding need for medical attention shall be made by healthcare personnel. It comes directly from the minimum standards. This section exists for a very good reason: Correction officers are not medical staff, and are not equipped to make medical assessments. We also hear reports of retaliation with clients reporting to us that they are not being called for sick call, and they are being singled out because they've reported DOC misconduct in the past. We also often hear reports of clients telling us they were marked as a refusal despite never refusing care. Another common refrain from our clients is an apparent staffing issue. Officers tell them that their housing area cannot attend certain services because there is simply not enough staff to take them. This problem is pervasive and not just in assigned housing areas. Clients tell us about waiting for hours or day in intake areas before being brought to sick call even if they are visibly in need of medical care. Several incarcerated people have reported to us that after being assaulted, they will wait [bell] in intake areas for several hours while profuse bleeding before seeing medical staff. We also regularly hear from clients that they cannot get

adequate treatment for serious medical problems, a legal and paralegal saw bleeding, visible rods protruding from one of the client's legs at one of the counsel visits and said that the wounds looked infected. Or client reported that the pain he was experiencing was so extreme, many days he was unable to walk. He repeatedly attempted to access a cane to help him ambulate, but was told by medical staff that a specialist would need to prescribe this device to him. They then did not schedule an appointment for him, and he never received a cane. So, we receive reports of this on a daily basis, and hopefully we would like to see some reform in terms of access to serious medical treatment and access to daily sick call.

JULIA SOLOMON: Good afternoon. Thank you for the opportunity to speak on this matter. My name is Julia Solomon. I'm a Social Worker in the Criminal Defense Practice at Bronx Defenders. As a social worker in our Criminal Defense Practice my role often involves providing extra support and advocacy to clients who are incarcerated, many of whom are battling physical or mental health challenges, drug and alcohol addiction or some

combination thereof. Our clients often speak of the delay they experience between their initial arrest, and the first time they see a doctor a Rikers Island. The process of being arrested, processed through Central Bookings, arraigned and transported to Rikers Island alone can take up to 36 hours. Once they arrive on the island, they begin an intake process that takes several days. This means that now this person has likely been without medical attention and at times critical medication for four to five days. Five days without medication can be a matter of life and death and unfortunately we've witnessed the gravity of this delay first hand resulting in consequences as great as death. Even more alarming, however, is that even when clients have seen a doctor three or four times, they still report receiving inadequate care. I want to share one example of a client Kevin. Kevin is a young man, but has experienced more trauma and suffering than many of us will experience in our lifetimes. After facing a great deal of loss, Kevin found himself turning to opiates to numb the pain. His Heroine habit eventually cost him his physical health, first with diag—first with diagnoses of several chronic health

conditions and ultimately Kevin's heart became severely compromised. As a result, he began taking several cardiac and blood pressure medications to support his cardiovascular functioning. Despite efforts by our staff and Kevin's own advocacy to receive these mediations through Correctional Health, and after speaking with him—after two weeks of being on Rikers Island, he was still not receiving any of the necessary—these necessary heart medications. This is a problem we see often that clients with serious health issues communicate their condition to doctors on Rikers Island, but doctors may not act on information they receive from clients' reports alone waiting to receive documentation to validate those self-reported [bell] needs. I just want to share one other example of Ron who was a client that signed up on several occasions for sick call to be produced to Correctional Health and followed the protocol repeatedly, but no officer was ever available to escort. He had chronic knee issues that went unaddressed for weeks as a result of this and I believe this illustrates gaps in the collaboration between correctional health and the Department of Corrections as we've heard today. [coughs] We find

encouraging that the—these committees are taking this issues seriously, and we would welcome the creation of some type of system that would allow inmates and their advocates to submit complaints when they're not receiving adequate healthcare. These complaints could be tracked and managed, and it would help to identify patterns and recurrent gaps in care, which would help to uphold our clients' right to access adequate healthcare. Thank you.

CHAIRPERSON POWERS: Thank you. Just to the last point-to follow-up on your last point about a system for making complaints. What would that look like? Is 311 not adequate for that today, and to all folks on the panel, just to talk-in terms of talking about 311 it came up earlier, about why somebody might use that as a way to talk about medical care and need for medical care versus other—other available methods. Can you tell us any experience on that as well in terms of why you're hearing folks who are using that as a—as a—as a way to file a complaint or make—make a call for a need for healthcare?

MEGHAN MCCARTHY: So, on your last question about 311, one of the things that I think we hear frequently is just the amount of time it takes.

So, somebody has signed up for sick call, made an effort to go through what they believe to be the appropriate mechanisms, and then thy call 311 and they still haven't gotten care, we may hear about through our office, and then we might decide to get involve often by doing direct advocacy with DOC and the Board of Correction and only then seemingly as a result of our involvement do they actually get the care. So, those particular people then the next time around just aren't going to both, and they will come to us and say I only get care when you get involved.

JULIA SOLOMON: I would echo that same point. I've had several clients report that they only receive care once I've sent the email to Correctional Health requesting that they be seen, and I think something that I would like to see is just sort of what happens on the back end when we make those requests, and some sort of tracking mechanism to, you know, how often action is taken as a result of—of those interventions.

CHAIRPERSON POWERS: Thanks, and—and I think, two of the testimonies talked about, and they're reading I think more than you got an opportunity to talk about it, but I wanted to bring

it up, is the gate keep status here of staff. Can you tell us more about what you're seeing? Is it documented, measured in any way? It sounds like some of it is anecdotal, but the ideas that the non-production is—is a result of—it could be punitive or something else. Could you talk to us more about what those agencies that you're referring to are, and other—other efforts to document them or to raise them in a more systematic manner?

JULIA SOLOMON: I think one of the things that we hear often is that even though housing areas are supposed to have a sign-up sheet, there is no sing-up sheet. So, then it sort of becomes a free-for-all the following day when sick call is called by the officers, and officers are seemingly making just random decisions about who get access to care. Frequently people will say they signed up multiple days in a row before they get access or if they are somebody who is known by the officers just for signing up a lot, they feel as if they're not getting the treatment they require even though they're going through the procedures that are laid out by DOC. So, it's a combination of just the housing areas not following the procedures that they have laid out for

incarcerated people to follow, and also just people sort of using a variety of methods to obtain treatment, and nothing is working.

CHAIRPERSON POWERS: And can I ask a final question? Is that—does—are—is the belief that it's punitive or it is a staffing issue or it is a—a failure somewhere in the system that somebody, you know, there is—there is a day somebody doesn't do the sick call, and it is—but what is the—what is the belief in terms of what that actually—why the motivation prep or the reason for that?

JULIA SOLOMON: I think it' a combination of things, but largely staffing. We've heard a lot recently in the last couple of months just in absolutely no access to sick call and multiple days in a row.

CHAIRPERSON POWERS: Staffing meaning they're not doing their job? I mean that they're not, you know performing--

JULIA SOLOMON: [interposing] No, they're not.

CHAIRPERSON POWERS: --that function or job or that or the lack of--

JULIA SOLOMON: We'll have escorts to provide housing areas with access to the clinic.

MEGHAN MCCARTHY: And I think in addition it is—I agree with that. I think there are a lot of problems that we hear about with—with escort access and availability, but we also hear a lot about retaliatory or punitive decisions. We had a client who had complained about treatment from correctional officers, and then needed a sick call because of a cut on his arm. Arm or leg. I'm not exactly sure but signed up repeatedly and was just told no you can't. No, we're not going to take you, and over and over and over again, and ultimately developed Gangrene and almost had to have the limb amputated. So, I think it is both staffing allocations as well as—as well as retaliation or punishment, and to your question earlier about the frequency and kind of the systematized way of raising it. This is one of—if not the most frequent problem that we hear around medical care is just the ideal that people can't actually even access the medical care, in the first instance. So, that's a very, very real problem for our clients, and I think we are trying to raise it in a helpful way with you in conversation—in ongoing

conversations with the Board of Correction and—and with DOC, but we're certainly open to any additional conversations or suggestions about how we can be more helpful on this point.

CHAIRPERSON POWERS: And the—and I think one solution would be to have CHS participate if that's one of the issues to participate and see that information as well so we know that it does not keep happening if that is happening. The—but more systematically, how do we—how do we uncover if that is the case where folks are receiving sick call slips and not—not delivering them or punitive. Are there other measures that anyone—anyone would recommend to—to take that discretionary part out of the process or the punitive part out of the process?

JULIA SOLOMON: I don't have a specific recommendation, but I do think the point made about clients refusing sick call, I think anything that can be done to sort of promote greater sort of accountability about what that refusal looked like, the signature piece that was mentioned earlier requiring a signature if a client refuses their—their escort to the clinic because I think we do hear frequently. We—were told that a client refused and

the client reports that they did not, in fact, refuse. So, knowing when that's a real refusal and when it's not, I think would--

CHAIRPERSON POWERS: [interposing] So with that communication of all or the Spanish you can't read for this. (sic)

MEGHAN MCCARTHY: I think also parsing out the types of refusals, as was discussed during the Board of Correction panel is a helpful step, and we certainly would be interested in that, and I also think that having accountability within DOC and we heard at the earliest panel the—the perception of oh, our clients decide not to go, or it's just they don't feel like it, they don't feel like waiting. The people we hear from are often desperate for medical care, and so having a situation where we're hearing people say oh, it's all the client's fault, is really—really problematic, and if that's coming down from the top level when an officer is found to have claimed that a person refuses access to medical care, that person—that officer should be disciplined, should be trained. There should be steps taken in that instance so that it doesn't ultimately come back

around to it being the—the individual's fault who's trying to the requisite care.

CHAIRPERSON POWERS: That's right and—and I—and I recognize that there are instances where people would say I have—since the conference I'm okay and we wouldn't—you or I probably would not receive a call from that person because it was optional, but I—I understand the—the other categories involved. I—that was my other—any questions from the Chairs? Okay.

CHAIRPERSON AYALA: Sorry. I had a live feed. I didn't even notice. So, this question might be—you might not be able to answer, but just out of curiosity, would you know if the—the Transgender Housing Unit gives access to medicated assistance treatments to individuals that are housed there? I mean, we've—because we've heard at previous hearings that the THV doesn't offer Methadone and that the-so a person has to choose between receiving either Methadone or the THV. So—

BROOKE MENSCHEL: Yeah. So, I don't know if that has changed as of right now. I believe in our written testimony, if no we can follow up after this hearing, that there was at least—we've had

clients who have expressed that as a problem of having to choose between types of care they require. I don't off the top of my head know whether it's specifically Methadone but there's often a problem with for our clients when they are trying to be in the THU for real, very real reasons and needs, and they can't be because a particular other type of medical care that they need is not offered there. So, we can look into it and—and figure out if we have any recent reports of that specific instance, but it is an ongoing problem not just for Methadone but for other types of care as well.

CHAIRPERSON AYALA: Thank you. I really appreciate that.

CHAIRPERSON POWERS: Thank you. Thanks for your testimony, Ms. Manschel. So, our—our last panel here we have-I have Sade Dixon. Alright and I'm sorry if I got that wrong and then Jordyn Rosenthal from College and Community Fellowship. [background comments, pause] Thank you, and thank you for your patience, and-and then for waiting, and hopefully not to bad weather when we all—when we all get out of here. Thank you again. We have your testimony. We'll put you on the clock and we'll ask

you questions and we'll start from this direction and go that way, and then I'll have an opportunity, and as we look through your testimony we'll also ask some questions. [background comments]

JORDYN ROSENTHAL: Oh, wait, should I. Okay.

MALE SPEAKER: You want to go first?

JORDYN ROSENTHAL: Yeah, I'll go first. Oh, sorry. So, hi everyone. Thank you so much for having us. My name is Jordyn Rosenthal, and I'm the Senior Associate of Policy and Advocacy at College and Community Fellowship, a non-profit that partners with women of criminal convictions to help them earn their college degrees so that they, their families and communities can thrive. I'm here today on behalf a student in our program, Naquasia who was pre-trial detention for the duration of her pregnancy and has lived through the trauma of being on Rikers and has been at the mercy or correctional health system. These are her words: When I was arrested, I had no idea I was pregnant and didn't find out unit I had already been held for a month. I had a high risk pregnancy, which is by definition suggests that in order to have a healthy and successful pregnancy and

delivery, extra care is needed, but that didn't stop DOCS from shackling for the first six months of my pregnancy because of the nature of my crime. I had access to and was seen by an OBGYN, but wasn't given adequate care or monitoring. My prenatal care consisted of an extra snack and some milk. This is unacceptable when most women in jail are mothers and 5% are pregnant. I wish more than anything I could have advocated—advocated for better care for myself and my daughter, but I was consumed with my own legal case to do so. I was so desperate to have my case heard and have bail set that I hid the fact that I was in labor. I remember being transported to my bail hearing, and trying so hard to swallow the pain and not bring attention to my contractions because I couldn't handle the thought of my hearing being rescheduled. When the judge saw me in the state I was in, he scolded the guards, sent me to the hospital to give birth and then right back to detention. By the time I was able to have my bail hearing, I had spent a total of 15 months in pre-trial detention. Due to the nature of my crime, I was not allowed to stay in the nursery and bond with my baby girl. I suffered from postpartum depression

and didn't see a psychiatrist until after I was sentenced when my child was already eight months old. During this time, we both suffered, and all of this happened before I even had my bail set. Through the duration of my pregnancy and for months after [bell] I was legally innocent, but I was treated as if I had been found guilty, stripped of my basic human rights and dignity, and the lack of care didn't just affect me, it affected my daughter whose only crime was being my child. She is—I want to thank Naquasia) for graciously allowing us to share her story so no other woman and their child can endure—has to endure the pain and trauma suffered. As the city moves forward with closing Rikers and building smaller, safer borough based facilities, I ask that you keep in mind the specific needs of women and girls. Thank you.

CHAIRPERSON POWERS: Thank you.

SADE DIXON: Good afternoon. My name is Sade Dixon. I am here represent--

CHAIRPERSON POWERS: Yeah, the mic.

SADE DIXON: I am here representing the Corrections Accountability Project at the Urban Justice Center. We are a non-profit criminal justice advocate—advocacy organization committed to ending

the financial exploitation of people involved in the criminal legal system. I want to thank Chair Rivera, Chair Powers, and Chair Ayala as well as the members of their committees for—for the opportunity to speak to you today. As a part of your joint oversee—oversight hearing on Correctional Health, I am here today to speak about my experiences accessing healthcare while incarcerated here in New York City. I spent eight months incarcerated at Rikers Island between 2012 and 2013. During this time, there were two instances that I required medical attention. With both—which both resulted in abuses and lack of care. In one case during an extreme summer heatwave, I became physically ill, and was never given the opportunity to visit medical staff. Temperatures to that summer rose to 105—105 degrees within the cinder block walls of Rikers. With no fans or air conditioning to—to help with the heat. After days of living in these conditions, I finally fainted from the heat exhaustion. I was discovered by Correction Officers who didn't even attempt to send me to the doctor and refused to give me water. Finally, a different correction officer finally gave a water out of her own lunch bag, but I remained in my cell

without any sort of medical attention, access to medical care or eat—or—or medical care when you really need it is entirely non-existent in side of Rikers. In another instance, my tooth was in sever— in severe pain. I urgent—urgently required dental care, but—but I had put in my multiple sick calls, and talked to several correctional officers, but I wasn't seen by dentist [bell] until 2-1/2 weeks later. I was never given a reason for the delays, and when I did finally go to the dentist, I was rerated with subpar care that would not have been tolerated outside of the jail. I would not have—I would not have trusted them with—with putting a needle I my mouth anyway knowing what kind of medical treatment is given inside of the jail. All of this happened by Corizon, a national correctional healthcare company based in Tennessee managed healthcare on Rikers. During this period Corizon was being sued on average every other national— nationally, but it is not surprising because their entire business model relies on treating people in jail at the lowest cost possible, which at times means not treating them at all. In 2015, New York City Health and Hospitals assumed control of

healthcare in city jails, but this does not mean that medical abuses no longer occur or that the commercial of it—commercialization of the system and financial exploitation of people involved—involved in—involved no longer exists. Even if you manage to get access the subpar medical attention on Rikers, you or-you or your loved ones may be forced to pay for treatment. Now, luckily I had healthcare through my father, but most people are not as fortunate as me to be covered—to be covered by their family and support networks—networks outside. They must cover the high co-pays themselves. People inside are penalized if they—if they have no one to pay, and their commissary accounts are garnished by the city. I know people that this has happened to personally. Final—finally, I want to—finally, while not critic—while not a critical issue for me, I want to bring your attention briefly to abuses within Correctional Healthcare of pharmaceuticals. Pharmaceutical companies like Alt—Alcamez (sic) my make millions through selling opioid addiction treatments, medications like Vivitrol to prisons and jails like Rikers. In fact, they make so much incarcerated people—the make—in fact they make so much on incarcerated people that they are annual—

annual corporate sponsor of the American Corrections Associations. I urge to investigate—investigate the use of pharmaceuticals in New York City. Regardless of who is exploiting you, at the end of the—at the end of the day, when you are in prison, you are nothing but a number. There is no quality of care because you do not have the same rights as someone outside. You are treated like nothing. Your are denied healthcare. You are abused medically and you are exploited financially. The experience I mentioned are far from unique. Every day I heard from people about their inability to access healthcare and the costs they face that they did. Courts and jail is traumatic enough without worrying whether there will be anyone to care for you in the event of a medical emergency. Thank you for your time, for listening to my testimony, and I look forward to seeing concrete solutions for the Council that are just exploitation. So thank you.

CHAIRPERSON POWERS: Thank you. Thank you both for your testimony and I—I—I note that we probably could spend even more time on the issue of addiction and then also the pharmaceutical part of it. So, I appreciate that, and it's something I

think we want to—would also want to be interested and probably could take up a whole different type of hearing around that issues and I think the Council has spent some time recently thinking about opioid addiction truthfully outside—outside of our correction system, but obviously there's a—there's a—there's a link and it's also an important issue. So, I appreciate that. I just want to also note I don't think we received written testimony. If you want to submit or email. [background comments] Okay, great.

JORDYN ROSENTHAL: Yeah, she was actually planning on sharing it herself--

CHAIRPERSON POWERS: [interposing] Oh, okay.

JORDYN ROSENTHAL: --and she didn't know if she wanted to physically like hand it out. I will ask her and then I can send it over to you.

CHAIRPERSON POWERS: Yeah, it's on the record. I know. I just wanted to--

JORDYN ROSENTHAL: Yeah.

CHAIRPERSON POWERS: Do any members have questions. Okay. Okay, thank you and thank you for being here for the--

SADE DIXON: [interposing] Thank you.

CHAIRPERSON POWERS: --hearing. Thanks so much. Thank you. That is the end of the hearing. Thank you to everybody. Get home safe and there's all the snow out there.

FEMALE SPEAKER: We got a lot of it.

CHAIRPERSON POWERS: We got it. [gavel] [background comments] I said it. Yeah. Thanks.

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date December 5, 2018