CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH,
JOINTLY WITH COMMITTEE ON FIRE AND
CRIMINAL JUSTICE SERVICES

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[background comments]

[gavel]

CHAIRPERSON JOHNSON: Good morning everyone. My name is Council Member Corey Johnson; I am Chair of the Council's Committee on Health. I wanna thank my friend and colleague, Council Member Elizabeth Crowley, Chair of the Committee on Fire and Criminal Justice Services for joining us today for this important oversight and legislative hearing. Council Member Crowley has been an extraordinary leader on correctional issues.

Our hearing today, entitled Health Care Delivery in the New York City Jails: Examining Quality of Care and Access to Care, along with Int. No. 0440, a bill that I introduced, is an opportunity to examine the discreet and incredibly important issue of health services in jails.

This is just one component of a complex and interlocking problem facing our city's correctional facilities. With proper examination I think that we can better understand how the system is performing, who is accountable and what we can do to fix it. The availability of and timely access to medical and mental health care is determinative of

health outcomes. The people coming in to our city's jails are overwhelmingly poor and are overwhelmingly sick and desperately in need of quality health services. Inmates enter the system with high rates of HIV, Hepatitis C, asthma, hypertension and substance abuse, all at rates significantly higher than the general population. We are concerned that the contractor providing health services in many of our city's jails, Corizon Health, Inc., formerly known as Prison Health Services, is not doing an adequate job. The allegations that have mounted over the years suggest that Corizon is failing to provide comprehensive and safe services to people under their care. These reports suggest that treatment provided to inmates may have been a factor in at least 15 deaths over the past five years and that these deaths may have been preventable. In all of these cases, quality or timeliness of health care was a key issue.

Furthermore, a recent report by the New York State Commission of Corrections investigating the death of Bradley Ballard, an inmate at Rikers, called the mental and medical care he received "so incompetent and inadequate as to shock the conscience." The State Commission of Corrections

report recommended that DOHMH consider whether Corizon is "fit to continue in light of delivery of flagrantly inadequate, substandard and dangerous medical and mental health care to Bradley Ballard." These allegations are incredibly damning and I am eager to hear where the Department of Health and Mental Hygiene is in its comprehensive review of Corizon and the services it provides.

The first step in addressing these problems is getting a better picture of the adequacy of services being provided. This hearing and Int. 0440 would improve transparency by identifying the metrics by which we should evaluate this system. We need to hold the providers and agencies that oversee them responsible for performance in key areas; like wait times, sick calls, access to medication, follow-up visits and preventable hospitalizations. This reporting lays the groundwork for a broader conversation about accountability. In such a complex system where the Department of Corrections runs the facilities, the Department of Health and Mental Hygiene oversees Corizon and Corizon manages the affiliate companies providing care. It is difficult to know who is responsible for what. We need to peel

back these layers of governance and figure out where the buck actually stops. It's easy to blame mistakes and tragedies on the other guy, but ultimately someone has to be the adult in the room.

I look forward to an honest conversation today to help get a better understanding of these roles and to hopefully lay the basis for future collaboration. It is no secret that the City's jail system is in crisis, with an investigation by the Justice Department into the treatment of juveniles, the debate roiling around the issue of punitive segregation and the Mayor's Task Force on Behavioral Health, we have a real opportunity here to look at the problem differently and do something bold for our system. We can't lose sight of the fact that many people in these facilities haven't been found guilty of anything; it mocks our justice system's principle of innocence until proven guilty. If somewhere along the way you might die because you didn't get your medication in time, a follow-up exam or guards didn't take your pleas for help seriously. At the same time I think it is easy to underestimate how hard it actually is to provide services at a correctional facility. Health care staffers are too often victims

of violence and corrections officers may not have the training or knowledge to know when an inmate needs medical attention. Between 2013 and 2014, 39 assaults on civilian staff have occurred; mostly against health care workers. I am grateful to the over 1,100 health care staff who dedicates themselves to a helping profession in one of the most challenging environments that you could imagine. So while we can and must do more to provide better care to these inmates, I believe that we can improve health care by having fewer inmates to begin with; that means keeping kids out of jail and doing more to divert people from the criminal justice system who have behavioral and mental health needs. It also means innovative measures, like the Speaker's proposal to create a bail fund so a turnstile jumper doesn't spend two years in Rikers because he didn't have $200 for bail. The challenges before our jail system are deep, complicated and seemingly intractable; we indeed have a lot of work to do. Health is just one piece of a very complicated puzzle; of course other factors influence health care delivery, but that can't deter us from holding our health care providers and the City's oversight of

those providers to the highest standard. This is one piece of the puzzle that I know that we can do something about.

I want to acknowledge my colleagues on the Health Committee who have joined us today; we're joined by Council Member Rosie Mendez, who has also been a leader on these issues. I want to thank my Legislative Director, Louis Cholden Brown, Health Committee counsel, Dan Hafetz, Policy Analyst for the Health Committee, Crystal Pond, Crilhien Francisco; the Finance Analyst for the Health Committee and the staff for the Committee on Fire and Criminal Justice Services for their work in preparing for today's hearing. I also wanna thank Council Member Crowley's Legislative Director, Jeff Mailman, who is always very helpful and important in preparing for these hearings.

And before I turn it over to Council Member Crowley, you know today is not about trying to make one person the enemy; today is about, as I said, looking at a complicated puzzle before us under challenging and difficult circumstances and understanding what we can do better, and it's also about ultimately figuring out who is responsible;

where does the buck stop. I visited Rikers at the beginning of December and the people who are there working are dedicated, compassionate people that are trying to do the best, but right now we don't know how to judge the contracted provider Corizon and I want to figure it out -- $400 million is a lot of money to spend in our city budget, so it's time to look and see how we create greater accountability. With that I wanna turn it over to my colleague and friend, who's gonna co-chair this hearing with me, Council Member and Chair Elizabeth Crowley.

CO-CHAIR CROWLEY: Good morning. Thank you, Chair Johnson. My name's Elizabeth Crowley; I am the Chair of the Fire and Criminal Justice Services Committee.

I wanna thank Chair Corey Johnson for his leadership on this issue and the staff for helping to prepare the Committee for this oversight hearing.

Today we will also hear Council Member Johnson's bill, Int. 0440, which will bring much needed transparency into the medical care that is administered on Rikers Island.

As the chair of this committee, I have serious concerns about the quality of health care

administered to inmates and the safety of health care providers in clinics on Rikers Island, especially when they are seeing violent inmates. My concerns are only heightened by the hundreds of lawsuits against Corizon that have been brought up by inmates, not only here in New York City, but across the country. The medical mistakes that have brought about lawsuits seem to be the result of medical staff that is being spread too thin. Providing medical services to those detained is a basic right; inmates in need of medical attention must have timely access to such care. When someone is denied such care, the consequences are often tragic. Even worse, when inmates are seen by the medical staff and sent back to their cells with the wrong diagnosis, this not only wastes time, but can lead to avoidable deaths.

An example reported in the Associate Press about a 19-year-old who complained about chest pain for seven months was seen eight different times and never given a chest x-ray; he died, a 19-year-old in 2013 from a tear in the aorta. I am concerned that Corizon, a for-profit company, has indemnification and is not responsible for

malpractice, as the city covers the cost of its lawsuits.

I am also concerned about the cost of the contracts and why our city does not incorporate these health services into our HHC system. Over the past several years the number of inmates diagnosed with mental health illness has grown substantially, accounting for approximately 40 percent of the population. I am concerned that there is inadequate staffing of mental health professionals for these mental health needs on Rikers Island. I am interested in learning about how Corizon assesses and treats the growing population with mental illness, especially those who are under 21.

Equally troubling are the reports about health care workers being beaten and physically abused by inmates. Inmate assaults on health care staff has risen 144 percent, from 2013 to 2014. This Committee is concerned that DOC is not doing enough to protect the staff from dangerous inmates and not providing enough staff to ensure their safety. The physical layouts of some of these clinics create safety risks that place an undo burden on doctors and medical staff. I am interested to learn about what

plans are in place to address these physical structural issues.

The Mayor's Management Report provides insufficient performance indicators to determine whether or not inmates are receiving timely access to health services. Chair Johnson's bill addresses this deficiency and I have signed on as a co-sponsor.

Separate from these fundamentally important safety issues are funding issues with correctional health care. This Committee is interested in learning more about to what extent the State and Federal governments fund our health care correctional facilities and what efforts DOC has made to obtain such funding from outside sources. Ultimately we would all like an efficient and effective correctional health care system.

This Committee is interested in discussing what steps the DOC is taking to address the systemic problems that have continued to pervade our system. The Committee is also interested in discussing what steps the Council can take to address these important issues.

I look forward to hearing from Corizon, DOC and DOHMH and from all of the interested parties. I will now turn it back to Chair Johnson. Thank you.

CHAIRPERSON JOHNSON: Thank you, Chair Crowley. We have been joined by Council Member Andrew Cohen, who is Chair of the Council's Committee on Mental Health. With that I want to -- and we've also been joined by a member of the Health Committee, Council Member Peter Koo from Queens and Council Member Peter Vallone from Queens… Paul Vallone from Queens. [background comment] I've never done that before. [laughter] Sorry, Paul.

So with that we're going to start with our first panel; it is the administration, the Department of Health and Mental Hygiene and the Department of Corrections. We're joined by Dr. Sonia Angell, the Deputy Commissioner at DOHMH; Homer Venters, also from the Department of Health and Mental Hygiene and Erik Berliner, a Deputy Commissioner at the Department of Corrections.

Before you start with your testimony I have to swear you in; if you could please raise your right hand. 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 all Council Member questions? Thank you very much. You may begin in whatever order you'd like.

DR. SONIA ANGELL: Thank you. Good morning Chairs Johnson and Crowley and members of the Committee. I'm Dr. Sonia Angell, Deputy Commissioner of the Division of Prevention and Primary Care at the New York City Department of Health and Mental Hygiene.

I'm joined here today, to my right, by Dr. Homer Venters, the Department's Assistant Commissioner for Correctional Health Services and to my left, Erik Berliner, the Deputy Commissioner for Strategic Planning and Programs at the Department of Corrections.

On behalf of Commissioner Bassett and Commissioner Ponte, thank you for the opportunity to testify today on the topic of Health Care Delivery in New York City Jails and Int. 0440.

Ensuring the delivery of quality health and mental health services in our jails is a critically important and very complicated issue and I

thank the Council today for your continued interest in it.

As you know, Commissioner Bassett testified before this committee in June 2014 about the provision of correctional health and mental health services in the city's jails and on the issue of violence against health care workers. In there interest of time, I'll refrain from going into detail on the topics we discussed then, although I do think it's worth mentioning some of the basic facts and figures related.

The Health Department is responsible under the City Charter with providing health and mental health services in the City's correctional facilities. Our mission is to provide the best possible medical assessment and treatment during an inmate's detention, as well as appropriate health and mental health discharge planning services.

Our health system is a national leader in providing health care that not only addresses urgent needs for patients while in jail, but also provides preventive and chronic care interventions, like testing for HIV, hepatitis and sexually transmitted infections, as well as vaccines that can prevent

illness later in life. We pursue these goals by focusing on patient safety, population health and human rights as an essential element of our health system. High quality correctional health services are critical for patients' safety and health while they're in jail, but they are also important in safeguarding the health of our communities, those communities to which individuals discharged from jail return.

All inmates receive a full medical intake examination within their first 24 hours of entering custody; New York City is a national leader in this regard, as it takes most jurisdictions one and two weeks to complete such exams. This intake exam allows us to screen patients and guides referral to a range of services they may need and includes a comprehensive health assessment, sexually transmitted disease screening and initial mental health assessment. These inmates enter the jail system with a high burden of disease -- rates of HIV, Hepatitis C, asthmas, hypertension and substance abuse are all significantly higher than they are among the general population, as noted earlier by Chair Johnson. The intake screenings really help us to guide further

treatment, discharge planning and entitlement applications.

Approximately 11,000 inmates are housed within the jail's 12 facilities and approximately 70,000 admissions occur annually in the jail system. Each month the Department provides over 65,000 health care visits in jail facilities, most of which occur at Rikers Island. We also provide discharge planning to eligible inmates with mental illness. These discharge services are provided to approximately 20,000 individuals annually; they include arranging for post-release medical and mental health care, applying for or reactivating Medicaid, applying for public assistance, providing a supply of and prescription for medication, arranging for transportation and organizing post-release follow-up.

The Department is also a national leader in the adoption and use of prevention oriented health care records in our jail facilities, allowing our health care workers to better coordinate and provide care for our patients.

Although the oversight of health services and discharge planning in the city jails is the Department's responsibility, direct medical, mental

health and dental care services are performed by contracted personnel from the health services provider, Corizon and Damian Family Care Centers. Hospital inpatient services are provided by the New York City Health and Hospitals Corporation.

Corizon, the largest private for-profit correctional health services provider in the United States, manages the day to day medical and mental health operations at Rikers and two other jail facilities, employing approximately 1,100 staff to deliver this care.

Damian, which employs approximately 90 staff, provides services at the Vernon C. Bain Correctional Center, a jail facility in the Bronx which houses approximately 600 inmates. Damian is a New York State licensed Article 28 diagnostic and treatment center and a nonprofit, federally qualified health center with a long history of providing high quality health care to the city's underserved.

Both Corizon and Damian were selected as vendors via a competitive proposal process. Solicitations for correctional health services were issued by the City in 2000, 2004, 2007, 2010 and 2012. During these solicitations, hospitals,

federally qualified health centers and health care networks in the city were contacted, along with national correctional health providers. Since January 2001, Corizon has received the contract to provide correctional health services for all of the city's jail facilities, with the exception of the Vernon C. Bain Correctional Center. The Corizon contract is approximately $140 million per year and it expires on December 31st, 2015. The contract with Damian is approximately $7.4 million per year and expires November 2016.

Now prior to 2007, solicitations were offered for the entire jail system; beginning in 2007 however, solicitations were offered for individuals or groups of jails rather than a single contract for all jail facilities, with the goal of increasing the pool of potential vendor applicants, particularly community-based providers. Given that most of the patients within city jails return to their community within days or weeks of arrest, community-based providers may be able to offer greater continuity of care. Since 2007, Damian has been the only nonprofit vendor to submit a viable comprehensive proposal. In 2013, Damian won the bid to provide care at the

Vernon C. Bain Correctional Center and the contract began in November 2013.

In addition to oversight of clinical operations, discharge planning and all other aspects of health services, the Department is responsible for establishing and determining the medical and mental health policies that vendors are required to adhere to. We base all of our nursing, medical, mental health and substance use policies and procedures on evidence-based best practices. Although Corizon and Damian are included in policymaking discussions, ultimately health and mental health care policies are designed, implemented and measured wholly by the Department. The Department closely monitors our vendors through multiple lines of supervision. From a financial standpoint, our contracts are structured so that there is no incentive to limit care, medication or treatment.

From a clinical perspective, we oversee the credentialing of physicians and physician assistants and monitor compliance of all policies through a rigorous quality assurance process. Corizon and Damian undergo routine quality comprehensive evaluations and are responsible for

meeting 40 performance measures, in areas including mental care, dental care, mental health care, women's health, chronic disease, infectious disease, substance use, medical records, management and preventable hospitalizations.

The Department meets weekly with our vendors to proactively identify issues and address them immediately. We also utilize rigorous morbidity and mortality reviews to assess potential errors in health care activities. If our vendors fail to meet the established standards or if morbidity and mortalities reveal shortcoming in service, the Department employs a structured process to swiftly remediate issues. This process includes the development of corrective action plans to ensure problems are addressed.

In addition to measuring compliance with existing standards, the Department is committed to improving the quality of care. To that end, we created a Quality Improvement Executive Committee, which is chaired by Commissioner Bassett and includes senior health department leadership. This committee is based on the approach to quality that is found in hospitals and other community health systems and

meets on a quarterly basis to review data, including quality assurance efforts, quality improvement projects and performance indicators.

As part of this effort, we are focused on empowering health staff to deliver patient-centered, high quality care and fostering a sense of teamwork in each facility, especially among health and DOC staff in important processes, such as inner-facility patient transfers.

Finally, we must keep our health care workers safe; staff cannot be expected to meaningfully engage with patients when they are worried about their safety and jail violence impacts workers as much as it does patients. Many assaults against staff occur in high-security housing areas where health staff must provide care because of limitations on patient movement. The Administration is committed to protecting the health and safety of our health care workers and the Health Department has been working closely with the unions, Corizon Management and DOC to improve training and increase the availability of safety equipment, such as cameras and alarms.

These are difficult issues to address, but we are making progress, instituting routine safety communication between security and health staff, retrofitting clinics and other settings to improve staff safety and closing units that are unsafe for staff and for patients.

With respect to Int. 0440, the Administration supports improving transparency throughout the jail system, including in the provision of health care services. We share a commitment to this approach, but as the providers of health care, we also have a legal and ethical responsibility to protect confidentiality of our patients' health information. Although the legislation as currently written would not require the reporting of patient identifying information, the information required by this law, combined with other publicly available data, may cause the patient to become identified. In some instances this unattended affect could violate our legal responsibility to protect the confidentiality of our medical records. This is of particular concern in the jail setting because inmates are identified on the DOC website. In certain circumstances it is statistically possible

to re-identify individuals using separate data sources of demographic information.

The Department does believe, however, that we can meet the goals of the legislation and still protect patient confidentiality and we would be glad to discuss this feedback in detail after the hearing.

Lastly, I would like to reiterate the quality of health care in the City's jails requires collaboration between the Health Department, the Department of Corrections and the vendors with whom we work. We are proud of the progress we've made to date, our clinical alternatives to punitive segregations, called CAPS program, is one example how working together we can improve health outcomes for individuals at Rikers. Furthermore, the program for accelerating clinical effectiveness, the so-called PACE unit, functions well because the health and security staff train and work on the units together as a team. Likewise, the improvements that we have made in staff safety reflect routine joint meetings that occur in every jail, include line staff and managers from both health and safety and security teams.

In addition, our two agencies are working closely to successfully implement initiatives developed through the Mayor's task force on criminal justice and behavioral health, which aimed to enhance the jail system's capacity to provide therapeutic responses to inmates with acute mental health crises and connect individuals to care and services in the community at discharge.

However, despite the success of these new programs and innovations, we recognize our work is far from done; the Administration is committed to improving the services available to patients and is evaluating the best approach and model for medical and mental health care delivery in the jails beyond 2015. An interagency team, including members from the Health Department, Department of Corrections, Health and Hospital Corporation, the Law Department and OMB is examining potential new strategies for health care delivery in our jails.

We are using four guiding principles as we consider future directions -- first, to maximizing existing links to the extraordinary health care resources of the City, such as our local hospitals and our medical schools; second, ensuring the

continuity of care between the jail and the community; third, continuing to improve cohesion and partnership between the Department of Corrections, Department of Health and Mental Hygiene and Health and Hospital Corporation, and fourth, applying national best practices for innovative quality care. Our review will be complete this summer and we look forward to sharing the results of the analysis with the Council then.

Thank you again for this opportunity to testify. My colleagues and I are happy to answer any questions.

CHAIRPERSON JOHNSON: Thank you, Dr. Angell for your testimony. When I visited Rikers Island, I was with Dr. Bassett and with Dr. Venters and I know again how difficult it is, and also, being there with Dr. Bassett, I know how committed, just in her bones how committed she is to really try to turn things around and make things better on the Island. So I'm not questioning the Department's commitment, because I know that Dr. Bassett really truly cares about trying to figure out how to improve things on the Island.

I do have some questions for you and then I wanna turn it over to my colleagues. Before I get into those questions, I wanna recognize some of my colleagues that have now joined us. We're joined by Council Member Danny Dromm from Queens and Council Member Fernando Cabrera from the Bronx.

So I understand that last year the Department of Health and Mental Hygiene downgraded Corizon's performance from good to fair; what was the reason for this downgrade: on what basis was it made; what changed in Corizon's performance; how and to what extent does the Department communicate this downgrade to Corizon?

DR. HOMER VENTERS: So… [crosstalk]

CHAIRPERSON JOHNSON: And was it accompanied with the corrective action planning that Dr. Angell talked about?

DR. HOMER VENTERS: Certainly. So I will address those in order, but please… [crosstalk]

CHAIRPERSON JOHNSON: If you could just identify yourself.

DR. HOMER VENTERS: Yeah, sorry. Dr. Homer Venters; I'm the Assistant Commissioner for the Bureau of Correctional Health Services, so I oversee

health care in the jail system and I report to Dr. Angell and ultimately to Dr. Bassett.

So the downgrading of that evaluation, which was done by me, with support by my staff on the data from quality assurance, quality improvement and morbidity and mortality reviews; those are three big areas of data, that downgrade really referenced two areas of concern that we had with Corizon performance in that year, which was 2013; one was performance on mental health units, so the provision of care to the most seriously mentally ill, those who are sick enough to be in a mental observation unit, and the other was an inconsistency in the senior leadership at Corizon. Corizon had had some turnover and some very important open lines in their senior leadership. So the way that we came to that assessment was both through looking at the performance on the units, looking at several bad patient outcomes that occurred on some of these units; one of which you referenced, that revealed to us that some of the policies that we as a department had promulgated weren't being followed. We also looked at reports from quality improvement efforts and also quality assurance, which is the performance indicators data that we look at,

and so all that taken together really left me with concerns about these two areas that I referenced, performance on the mental observation units and also the consistency of the senior leadership.

So in 2014, both of those areas have improved dramatically. If I look at the mental observation areas, you visited the CAPS unit. So one of the things we realized after the really horrible, tragic case you referenced earlier, was that in the mental observation areas where we have our more seriously mentally ill, we did not have enough staff and so the mental health staff that were tasked with caring for the sickest patients in the whole jail system were running from unit to unit to unit trying to find the sickest people or the people that were most obviously in need of their care… [interpose]

CHAIRPERSON JOHNSON: When you say we; are you referencing the Department or Corizon?

DR. HOMER VENTERS: Yeah, the Department. So Corizon follows the policies that we set forth and they staff based on the amount of money that comes through the City and comes through the design metrics that we have. And so I think that the CAPS unit you were on the PACE units, which have just recently

opened, really are the most important systems response to some of these horrible cases. When we find bad outcomes in the jails, they're generally the result of systems failures, not of individual failure, so it's a tenant of improving health care, it's a tenant of improving large complex systems. And so while we did find that Corizon had failings that led to the downgrade of their overall rating; they went from good to fair and in that fair, as I mentioned, there were two subpower areas; we had very specific corrective action plans for them. So on one of the mental health units where we had a bad outcome, the rounding that was supposed to happen every day wasn't happening, so within 24 hours we had developed a system to ensure that not only does the mental health leader of the building know that rounding has been done, but all the senior leadership, all the way up to myself can attest to that. And so that's the kind of systems response that comes out of a corrective action plan that results from a bad outcome.

CHAIRPERSON JOHNSON: But that seems like a pretty big deal to me; a downgrade from good to fair seems like it's something -- as you said, there

are clear failings; something's not working properly. And my question is; is that the Department's fault because you were not providing the proper instruction and supervision in staffing, in overseeing Corizon and their employees in the proper way or is that Corizon's inability to actually deliver these things in the most appropriate and adequate way? Who ultimately is responsible?

DR. HOMER VENTERS: Well I'll reference something that you mentioned earlier, which is there's no single person that is responsible for this. I'm responsible for health care in the jail, so I'm responsible for the failings of policy and procedure; I think however that we had experienced in a very short order about a 40 percent expansion in the number of seriously mentally ill people in that mail and so in a very short period of time we had a rapid expansion of the number of people that needed high level housing and so the Corizon staff, along with the correctional health services staff, our mental health leadership, really were working to find the sickest people, but what we didn't have in place was adequate systems to ensure, not just that care was delivered, but that when there was a lapse, if we

couldn't find a patient for instance, if a patient had been transferred multiple times, that we knew how to find that patient in an expeditious manner; we have that now. Right now people who come back from the hospital, our sickest patients, they go into a PACE unit; it was the first PACE unit we opened, with support from the City, and that PACE unit has staff all throughout the day, they have multiple levels of staff that we didn't have before, like the treatment aides you saw, talking to the patients, finding out who's not doing well; who is doing well.

CHAIRPERSON JOHNSON: How new is all of that?

DR. HOMER VENTERS: The CAPS unit, which you visited, is about a year-and-a-half old; the two PACE units have just opened in the last three months and we have two more that we've received funding for, so we'll have a total of four of these PACE units open… [crosstalk]

CHAIRPERSON JOHNSON: How many inmates does that cover, out of the entire population; how many people are we talking about that are housed in these units?

DR. HOMER VENTERS: Right now, when we get the fourth PACE unit open, we'll have between 1-200 and so we have a footprint -- the people who are seriously mentally ill who need high level care like this, is probably 6-800 and so that's an ongoing challenge that we're really working with, is how can we put together data from these units; we have preliminary data to show that people fair much better in these units than the traditional units; that's clear, but we need to assemble that data, report all of this to oversight and stakeholders around us to gather support for the next steps.

CHAIRPERSON JOHNSON: So it sounds like that it's your belief, Dr. Venters, that we're moving in the right direction and that there have been some key improvements with the CAPS unit and with the PACE unit coming online, but still we don't have the bandwidth or space available to treat all of the seriously mentally ill people that would need these specialty units. Is that right?

DR. HOMER VENTERS: That's a fair characterization.

CHAIRPERSON JOHNSON: And part of the money that was put in, in the November plan and in

last year's budget, the tens of millions of dollars, was to set up these units to start to take care of the seriously mentally ill population at Rikers?

DR. HOMER VENTERS: Absolutely.

CHAIRPERSON JOHNSON: So in what areas do you still currently see Corizon performing poorly and where do they need improvement?

DR. HOMER VENTERS: I don't currently see poor performance in any of the areas that we oversee; I think there are several areas for improvement that we think are really critical. One that we've also received support for is development of treatment for people with substance abuse disorders. So the two most common sets of diagnoses for people that come to jail are mental health and substance use disorders; those far outpace any other medical diagnosis, and we have spoken at length about treatment of mental health disorders, seriously mentally ill people; we really pay scant attention to people who come into jail with profound substance abuse concerns; those often are the reason people come to jail; they certainly are much more determinative in post-jail mortality, so the big bump that we see in the rate of death of people who leave jail and prison, including

in New York City, is often linked to substance abuse, and so we really need to push ourselves and we're doing this right now, to develop a more comprehensive, not just for a small number of people who might go through like what we would think of as a day treatment center, which we have in Rikers, but actually a much more broad-based approach. And so we're working with Corizon to develop, with the funding we received through the task force, an approach that will allow us to not just identify people who come into the jail with substance abuse disorders, but also do discharge planning for them so that we connect them to some resource after jail that could potentially be life-saving.

CHAIRPERSON JOHNSON: Do the Department of Corrections staff and the health staff on the Island have the opportunity to train together?

DR. HOMER VENTERS: Absolutely. So that's another example of what we've started to do very well, but we need to do much, much more of. The unit that you were on, and for everybody here who's been on the CAPS unit or the PACE unit, those units don't open until we've identified the staff that are gonna work there every day and that they train

together as a team, they're invested in finding problems, they're invested in fixing them before they become, you know, could lead to a bad outcome. So that kind of training we need much more of. So we've been working, again, with task force support to develop crisis intervention teams where, you know it's a horrible circumstance when you have a seriously mentally ill person somewhere in the jail and the only possible response is a probe team; I mean it almost predicts a horrible outcome. So the crisis intervention model, which is used by police departments all over the country and some state prisons, is something that we're developing so that we can train together a team that can respond to patients that are having problems in the jail.

CHAIRPERSON JOHNSON: So the contract with Corizon and its affiliates, as Chair Crowley mentioned in her opening, and I'm gonna go to her in a moment; I know a lot of my colleagues have questions, it has an indemnification clause by which the City will pay for Corizon's legal expenses and litigation in malpractice suits; I wanna understand if this is typical for city contractors; is this included in Damian's contract for the Barge and is

this typical for contractors providing health services for jails across the country?

DR. HOMER VENTERS: So I'll have to refer some of the legal fine points to the corporate counsel and our counsel. I will say, however… [interpose]

CHAIRPERSON JOHNSON: Are they here?

DR. HOMER VENTERS: Corp counsel I don't believe is, so we… legal points I'm not, you know… [crosstalk]

CHAIRPERSON JOHNSON: Okay.

DR. HOMER VENTERS: expert in. I will say however that Damian has the same type of contract with the City that involves indemnification; however, I will say that very few jails around this country have any of the oversight that we have here. If you go to most big jails around the country, you have a handful of people involved in overseeing of contract; none of them are doctors; none of them see patients in the jails and you'll rarely have performance indicators or liquidated damages; the whole raft of oversight that we have here. And so much of this is unique to our setting, but the actual legal question

about the indemnification maybe we can follow up with you on.

CHAIRPERSON JOHNSON: Yeah, I mean, you didn't answer the question, which is fine, because you're not with the law department, but I take you know real issue with the fact that if we have a contracted out provider that is having serious problems where there are preventable deaths and then the City faces malpractice suits or negligence suits over that, that we are in fact paying those expenses when an outside for-profit contractor has made serious mistakes that have resulted in death; I take issue with that and I think that the City should really look on whether or not that indemnification clause should be included if this contract does in fact get renewed at the end of this year.

I have a lot more questions, but I wanna turn it over to my chair, Chair Crowley and then I also wanna then go to Council Member, who chairs the Committee on Mental Health and then we have a bunch of other questions as well from Council Members and then I'll come back for a second round. Chair Crowley.

CO-CHAIR CROWLEY: Thank you, Chair Johnson. So to follow up Chair Johnson's line of questions about indemnification and the Corizon contract; why don't we use HHC as a system? I know years ago, before we contracted with Corizon, we did and we have some of the best public hospitals in the world and we have them in comparison to private hospitals in the City, we have some of the best hospitals that are public; why can't we have that care for our inmates; why are we contracting out to a profit company, and then, covering the cost of their lawsuits?

DR. SONIA ANGELL: I think your point is an excellent point; we have some of the most amazing medical health care systems in the country here, really an extraordinary bounty of resources within the City of New York through Health and Hospitals Corporation and through our medical schools, and it's absolutely one of the areas that we are exploring; we fully recognize that the model of care delivery that we currently have isn't meeting the goals of this administration and our community at large, so that's one of the areas that we are looking very closely… [crosstalk]

CO-CHAIR CROWLEY: But sorry; if the model is not meeting the goals, [background comment] then how did it receive a fair rating? I would think that -- when you're saying fair; it's okay, it's good.

DR. SONIA ANGELL: So I appreciate what you're saying; the rating that they receive is based upon the requirements of the contract; that's a reflection in how they're being evaluated by the contract. The model of care that I'm referring to is really thinking about the environment and the way in which we're serving our inmates' health care needs within the jails at large, which includes the Corizon contract, but also includes the whole sort of complex environment within which we provide care; how we work closely with Department of Corrections and how, as you mentioned, we think about pulling in these resources that we have through Health and Hospital Corporations, etc… [crosstalk]

CO-CHAIR CROWLEY: Sure. No…

DR. SONIA ANGELL: So… So…

CO-CHAIR CROWLEY: we're only a few months away from the contract ending… [crosstalk]

DR. SONIA ANGELL: Yeah.

CO-CHAIR CROWLEY: and we have an opportunity here to improve health care delivery in our jails…

DR. SONIA ANGELL: Yes.

CO-CHAIR CROWLEY: and I firmly believe that if we incorporate the HHC system more or have the system run the jails that our inmates will have better health care and we'll see fewer deaths and probably save a significant amount of money in lawsuits.

Now what is the Health Department doing in preparation, to see if we can put this together in a short amount of time?

DR. SONIA ANGELL: Yeah. So I absolutely reassure you that we're aware of the contract requirement in terms of when the contract will expire and we're working very closely with City Hall, with Health and Hospital Corporation, with Department of Corrections, with OMB and with the Legal Department to address this, so this is absolutely a priority as we think about how to structure the best care delivery. It includes your observation, that Health and Hospitals Corporation is an incredible resource; that is fully incorporated and they're at the table

in these discussions. So I'm sorry that we don't come today with a model to present to you in its entirety; it's a complicated issue, and that's not an excuse, it's just a comment about how carefully all of the different areas need to be addressed; it's not as simple as simply turning over care to Health and Hospital Corporation… [crosstalk]

CO-CHAIR CROWLEY: Right. No, I understand that.

DR. SONIA ANGELL: Yeah.

CO-CHAIR CROWLEY: When our inmates leave the jail, when they're diagnosed or when they need serious care they go to one of our hospitals, they'll either go to Bellevue or they'll go to Elmhurst Hospital where they will receive better care; not only 'cause they're in the hospital, but because there's more staff there to meet their needs, but what many of my colleagues may not realize is that when they leave the Island, then their Medicaid kicks in again; when they go to one of these hospitals, the Federal government and the State starts providing some of that cost. Who's funding this Corizon contact? I know it comes from the DOH, but how much

of federal or state resources are covering the cost of this contract?

[background comments]

DR. HOMER VENTERS: Yeah. We have a very small grant from the Federal government to support substance abuse housed for co-occurring disorders, but aside from that, none of it, because there's a federal prohibition on this; the Social Security Act prohibits billing of Medicaid for care of people who are, you know, who… [crosstalk]

CO-CHAIR CROWLEY: Right. Okay. Okay. I figured that much and it's unfortunate because, as you mentioned, 40 percent of the inmate population has a mental health diagnosis; of that, anywhere from 600-800 in any given day has a serious mental health diagnosis; a recent report that this administration put out a few months ago documented that there are approximately 300 people who circle in and our of our jail system a number of times each year that have been diagnosed with a significant mental health diagnosis; those people, if they were put in a different facility that wasn't a jail, we may be able to access federal dollars and therefore reduce the number of people who are in the jail with… so what is

the plan to divert those inmates from revisiting? I know in the budget that we okayed in November, we gave you more money for discharge planning and monitoring inmates after they leave so that they don't end up back in and you know for the purpose of the Committee, some people end up back in jail who fall within this category for sleeping in a stairwell and so often not only do they have significant diagnoses; they also have substance abuse problems. What are we doing as a city to prevent that population from circling in and out of the system and to make sure that they're getting the health care that they deserve and that we're making sure the federal government's helping towards paying for that?

DR. HOMER VENTERS: Okay. So those are important points, because the fact is, there are very few problems that get better in jail. So discharge planning you mentioned is our obligation and we wanna do more of it, with the support I mentioned earlier on the substance abuse treatment discharge planning; however, our agency and the Police Department have received money through the task force and that's not our area of expertise, but in support of diversion centers, which will allow people who heretofore would

have gone through the criminal justice pipeline to go into treatment out on the street level when the Police Department has an initial contact with them. So another part of our agency is… [crosstalk]

CO-CHAIR CROWLEY: Has that started yet or is still in planning stages?

DR. HOMER VENTERS: They're in the planning stages, but I have to admit; we would have to consult with the other part of our agency and the Police Department, 'cause they're the ones that are rolling out this initiative. But it goes exactly to the point you raised… [crosstalk]

CO-CHAIR CROWLEY: Right. It says that we're spending $1.175 million and that we've hired in your division or in health care delivery there's gonna be 28 people hired in this fiscal year; have you hired those people?

DR. HOMER VENTERS: Some of those have been hired. One of the things I… So there are several new things that aren't the diversion centers I mentioned, but we, for instance, the substance abuse planning and treatment, that program we're just now designing and we'll start hiring people for that fairly soon. I think that we also have another

initiative, the crisis intervention teams I mentioned; we plan to have those rolled out by the summer, and then we have a third… [interpose]

CO-CHAIR CROWLEY: Where do your crisis intervention teams work? Where are they meant to work; in DOC facilities?

DR. HOMER VENTERS: Yes. So in jails that have a mental observation unit in them… [interpose]

CO-CHAIR CROWLEY: Is that to… What type of crisis are they looking to prevent or intervene upon?

DR. HOMER VENTERS: The simplest way to describe them is; something that would elicit a probe team today; that is a response of DOC officers with riot gear and batons and shields; when something that elicits that response happens in a mental observation unit, instead we're gonna have a crisis intervention team that responds that's a team of both mental health and specially trained DOC officers to de-escalate.

CO-CHAIR CROWLEY: Are those officers being trained right now?

DR. HOMER VENTERS: No, we're finalizing the training model; we actually have to -- because this is new for jails, there are some prisons that do this and there are some police departments that do this; we actually right now are working very hard to find people that can adequately train the health staff and the correctional staff in the jail setting, 'cause jails are very chaotic; it's different than training police officers, it is different than raining people in a state prison, but we plan to have that rolled out by the summer.

CO-CHAIR CROWLEY: Okay. So earlier you mentioned because you downgraded Corizon's rating; it had to do a lot with how they were working with the mental health population and you mentioned that you're expanding the CAPS unit and creating a PACE unit; how is a PACE unit different than a CAPS unit; you also mentioned that it's only still serving 1-200 people, yet the population you need is 6-800, so how did you increase; is it just by opening the new units or was there a significant number of mental health staff put on to the Corizon contract; did you require them to hire more people?

DR. HOMER VENTERS: Absolutely, and so that's actually -- their expansion of the mental health staffing is the primary reason for the expansion -- you've seen the amount of the Corizon contract go from about $125 million to about $140 million and that's primarily expansion of hiring more mental health staff. So the CAPS unit was the first of these new units; opened about a year-and-a-half ago, and that was because in the jail system we had a very problematic practice of taking seriously mentally ill people and putting them in solitary confinement; that was called the Maui [sp?]; everybody… many people in this room are familiar with, and we documented through quite a bit of data analysis, the bad outcomes associated with that. So our first, most pressing job was to get seriously mentally ill people out of solitary confinement and so that was the creation of the CAPS unit a year-and-a-half ago. So that was to take people who had had some problem with a jail rule find a purely clinical setting for them.

CO-CHAIR CROWLEY: Just to examine that population a little bit further; are these people who are in Rikers Island because they've been arrested

for violent crime or are they somebody who might have been sleeping in the stairwell, where you could possibly go to a judge and work out a situation where you could take them off the Island and put them in a real hospital facility, and whereby charge the federal government, rather than using your limited resources?

DR. HOMER VENTERS: So it's a mixture of both, but I would say overall most of the people in jail, in Rikers and across the country are there for non-violent reasons. [background comment] That's right.

CO-CHAIR CROWLEY: So is there a plan in place, other than diverting them within the Police Department or to try to take your -- 'cause you're backlogged, you're super backlogged and you don't have a place -- you don't have a plan that's going to meet the 6-800 people anytime soon, it appears? I mean… [crosstalk]

DR. HOMER VENTERS: That's…

CO-CHAIR CROWLEY: a year or two ago you were serving about 90 people in the CAPS unit; it started under the previous administration and now you've expanded to somewhere between 1-200; you're

not clear about the number of beds, which is still somewhere… serving less than 25 percent of the population that needs it.

DR. HOMER VENTERS: I apologize. So I was referencing the PACE units, which are new, so you referenced the footprint of the CAPS units; those were the first to open about a year-and-a-half ago. Once we opened the CAPS unit, we had such dramatic improvements in the clinical outcomes of patients -- reductions in self-harm, improvements in medication management; people take their medicines; people don't lash out. [background comments] We've decided that what we needed to do is not simply have that for people who have had a problem with a jail rule, but have it for the people who are in mental observation units and so the PACE units are simply that commitment of lots of staff and lots of programming to the MO… [crosstalk]

CO-CHAIR CROWLEY: And I'm gonna let my colleagues ask a few more questions… [crosstalk]

DR. HOMER VENTERS: Yeah.

CO-CHAIR CROWLEY: but I just wanna clarify the answers to those questions. Now, CAPS is often a diversion to punitive segregated house [sic],

so they've done something or been accused of and found to have infractions; PACE as well; is that somebody… [crosstalk]

DR. HOMER VENTERS: No, PACE is for just taking regular mental health units, high-level mental health units, but giving them really the staff they need.

CO-CHAIR CROWLEY: And just, if you could clarify the number of beds in each of those units?

DR. HOMER VENTERS: Sure. So I think the confusion is, we've opened up two of the PACE units, so that's about 60 beds… [crosstalk]

CO-CHAIR CROWLEY: Okay.

DR. HOMER VENTERS: we have two more to go, which we're going to open up in the coming months. And so you know that will get us to well over 100, maybe 150 for the PACE footprint, but as I said, we have many more mental observations… [crosstalk]

CO-CHAIR CROWLEY: And then just, how many beds are in CAPS?

DR. HOMER VENTERS: I would say probably about 60.

CO-CHAIR CROWLEY: Okay, that's it. I'll come back around for questions.

[background comment]

CHAIRPERSON JOHNSON: Thank you, Chair Crowley. I want to go to Chair Cohen, followed by Council Member Vallone.

COUNCIL MEMBER COHEN: Good morning; thank you for your testimony. Someone has tried to explain this to me before and I didn't understand it, so I'm gonna try again. In terms of the budget for the contract, the $140 million, you said there's no disincentives to provide service. Could you explain to me how that works maybe one more time so that I… I'll try my best.

DR. SONIA ANGELL: No, so… absolutely, I'm happy to do so. So the way it's structured with the Corizon contract is it's something called the Cost Plus Contract, in that Corizon directly bills us for all allowable items within the contract, so these are largely personnel services. The Department of Health and Mental Hygiene pays directly for all medications, for all off Island services, so sending somebody to a specialty service off Island or for hospitalizations, as mentioned earlier. So there is

no incentive for Corizon not to provide those medications; services because it wouldn't lead to any increase in profits. The one thing that this Corizon contract does have is a fixed overhead of $5.5 million, which equals about a 4 percent profit rate. The one variable item within the Corizon contract covers those facilities which are off Island and for those they get a 4.25 overhead; those can vary, so if we open a new facility, then they would get additional funds for that. So in that sense there is no incentive for Corizon to decide that they don't wanna provide a specific medication that they don't wanna send them to the hospital if they need to be seen otherwise, etc.

COUNCIL MEMBER COHEN: So there's no actual cap in other words on health care costs in the City prison system; it's just consistently running a certain number?

DR. SONIA ANGELL: Yeah, so the contract is designed -- it's about $140 million -- to cover, as mentioned, the Corizon largely covers the personnel services, so it's based upon a projected understanding of what the personnel services are for all of the health care delivery.

COUNCIL MEMBER COHEN: I do understand. Thank you.

DR. SONIA ANGELL: Yeah? Good.

DR. HOMER VENTERS: The mental observation units are different than the CAPS and the PACE unit, that's a third category, so I apologize; this is an unfortunate nomenclature overload. So the PACE units are actually just regular mental observation units that we've converted to this higher level of staffing. The CAPS unit is different because as I mentioned, the CAPS unit is for people who have serious mental illness who had some problem with jail rules and instead of having them go into solitary confinement we think they should go in a treatment unit, and so that's what the CAPS unit is. The PACE units however represent -- you know we have about 20 mental observation units around the jail system, so these are places where people with mental health problems go because they need a higher level of staffing, they need to be seen much more frequently; they need help with medicines. So in that around 20 or so mental observation units, depending on which time of the year you would've checked, we've secured funding to convert four of

those to a much higher level of staffing, and those are the PACE units, and so what we've done is, with Dr. Elizabeth Ford, who's here with us today, who just actually came over from Bellevue; she set up and ran the forensic ward at Bellevue, which has taken such great care of our patients for years, so she has come over to lead our mental health service in the jail system and so what we're doing under her guidance is, taking the funding that we've secured from the City and coming up with special high intensity units, the PACE units, for people with the most serious mental health concerns. So the first one we opened was for people returning from the hospital, the second one is for people who are subacute, who might be on their way up, might be getting worse; they're needing to go to the hospital and so as we roll out these PACE units, as we secure funding for them and really cement the data behind them to support what we see everyday, which is much better outcomes for our patients, we'll probably end up with a network of units that are somewhat specialized like you would see in a hospital setting, if you go to an inpatient psychiatric facility you don't have a bunch of units that are all the same,

you have different stripes for different needs for the patients.

COUNCIL MEMBER COHEN: Commissioner, you made reference in your testimony to a rapid expansion of the mentally ill population; I wonder if that's really a rapid expansion or a rapid recognition?

[background comment]

DR. SONIA ANGELL: I'll ask Dr. Venters to respond to specific data related to that element, because the recognition relates to diagnoses as well, so.

DR. HOMER VENTERS: So we have seen over the years an increase in the share of the population that comes into the mental health service; I think also we've seen from year to year changes by facility in the number of seriously mentally ill people there. The thing I referenced was specific to AMKC, this building, and so we've had a pretty consistent percentage of the population that's seriously mentally ill over the years, but what happens is, as we build new units, as we move new units around, we may have many more seriously mentally ill people in a building from year to the next and so that's important for the staff because that means a lot more

work for them, and what is important to remember is seriously mentally ill patients, and this is true in the community, in the United States; persons who are seriously mentally ill live about 20 years less than everybody else; that's not from suicide; that's from chronic medical problems that are unattended. So when we see an increase in the share of seriously mentally ill patients in a jail, like we did in AMKC, what that means is a lot more mental health work and a lot more medical work and that can overwhelm a facility very quickly and so the extent to which a jail is either about something like that or a jail becomes something about, like focused on punishment; what you see is unintended consequences on the medical service, the nursing service, the discharge planning service and so that's what happened in AMKC and I think that with the PACE units opening in AMKC, you know, we're meeting our commitment to those patients.

COUNCIL MEMBER COHEN: It seems though, by your own testimony, that any given time two-thirds of the seriously mentally ill inmates are not in a CAPS or PACE unit; I think that's a serious concern of everybody here in the Council.

DR. HOMER VENTERS: It's a concern of ours; I mean we asked for this money, we asked for this because we saw bad outcomes among our patients. Dr. Ford; myself, we see patients in the jails; the Corizon providers; Damian providers, they're on the frontlines caring for these patients. The DOC officers who are there when a patient doesn't get their medication or doesn't get access to the care they need, they really pay the price, as does the patient. So we are committed to bringing all the services and care we need to these patients. I will say that having opened the first few of these PACE units, we're getting the sickest patients in the whole mental health footprint into those units; that is gonna take stress off of the rest of the footprint of the mental observation areas, but we don't by any circumstance think that we're done improving this mental health system.

COUNCIL MEMBER COHEN: I mean though, I wonder if you don't think that CAPS and PACE is sort of a floor, a minimum standard that seriously mentally ill inmates need to be -- that we're not meeting that challenge, we're not meeting -- again, you know, treat inmates humanely who have serious

mental health issues, that they're not being provided in an appropriate facility; I mean I think we need a rapid response to try and get at least, again, a floor that there's standardized inmate care for people with serious mental health problems.

DR. HOMER VENTERS: I agree.

COUNCIL MEMBER COHEN: I have a couple more. You testified that obviously Social Security prevents Medicaid from reimbursement; what about… but HIPAA you think is applicable in the corrections system?

DR. HOMER VENTERS: Yeah, absolutely; I mean, I'll let Dr. Angell… [crosstalk]

DR. SONIA ANGELL: No; you can take it. [sic]

DR. HOMER VENTERS: Yeah, so our… we're in a unique setting, because we care for our patients, our primary obligation is to the health and human rights of our patients in the jails; that's number one; we however need to partner with the Department of Corrections and other City agencies in order to provide that care and so what that means is; there are some types of information that we do wanna share, but in general HIPAA, and we have our own

internal policies that are actually not just from HIPAA, but there are several State laws -- there are State and Federal laws that govern sharing of information, not just in general about your health, but also about HIV status, about mental health and substance use information, so 42.2 CFR, for instance, is an important federal regulation, so we take those very seriously, we follow those. We have also though recently come up with ways that we can share relevant bits of information with our partners in corrections so that it's not necessarily sharing the medicine that I am on, but it could be saying look, this is the trigger for patient venters [sic]; this is the thing that may set him off, look for this; things like that help us prevent bad outcomes, because to be fair, the correctional staff are with the patients much more than we ever will be and so we have to build this team approach that involves sharing of some information that's in the patient's best interest without violating their confidentiality.

COUNCIL MEMBER COHEN: Thank you very much.

CHAIRPERSON JOHNSON: So we're going to go to Council Member Vallone; we've been joined by

Council Members Barron and Levine. My colleagues, we're gonna put each one of you on the clock, because we only have this room until 1 p.m. and we have dozens of people who wanna testify and we still haven't heard from Corizon. So if folks could try to maybe even not take their entire time that would be great. Council Member Vallone, followed by Council Member Cabrera; followed by Council Member Dromm… [crosstalk]

COUNCIL MEMBER VALLONE: Thank you… Thank you to the chairs for this very important hearing and I think probably I have spent the last decade either on the Board of Corrections, now as a Council Member; there are systematic issues that will not be resolved today; I like the answers we're hearing today, but I have to tell you, if I could bring up the testimony from 2003, 2005, 2008, last year and today, it was the same answers; it was, we need better coordination between the Department of Corrections and the Department of Health, we need more providers for contract providers when the RFPs go out to bid, yet we only have one; we had PHS, now we're stuck with Corizon and Damian; the contract's coming up in December 2015 and with this great team that's on the

table, the doctors, I really would like to hear or see a new vision for what the plan is gonna be when this contract comes out for bid again that will be different to maybe enhance or entice additional community-based providers to maybe break up like you did the last time some of the services so it's not one giant monolithic contract that has to go out, so that we don't get stuck with one provider; that would be my first question, is what changes do you have planned for this upcoming contract? And then based on that, what other changes can we implement to deal with these systematic issues? I mean it wasn't just too long ago, it was 2008 when I had asked the question then on the Board of Corrections; how do you get the information from intake to the doctor when the doctor or the social worker schedule a doctor's appointment with one of the detainees or inmates and say they had to locate the folder and walk it over to the other facility; I almost had a heart attack. And then they put in this great case management system -- I see you smiling on the corner, 'cause you're the one that testified -- the case management system to allow, finally, computer systems to go throughout the Island. So there are so many structural defects to

Rikers Island in general, but you're not going to cure all that, 'cause you just really need a whole new system; these buildings are so old, they're all leaking, it's a disaster; there's not air conditioning. So you've taken so many steps to get us to where we are, but I don't want to continue this battle between Department of Corrections and Department of Health; keep hearing the recidivism, discharge planning, continuum of care concerns that we hear every testimony, so I'd like to hear some of the things -- So first off, 'cause I know we're running out of time; what would be some of the changes for the upcoming contract that you could use for the next RFP that we could maybe not see these same issues?

DR. SONIA ANGELL: So I will say that we can't speak directly to the specifics of the contract because as mentioned a little bit earlier, they are in very direct conversation right now between the agency, the Department of Health, Department of Corrections, OMB, Health and Hospitals Corporation and City Hall, but what I… [interpose]

COUNCIL MEMBER VALLONE: Well not specifics, but maybe some of your policy wish list

and/or budget too, because the other thing we hear every year is, we don't enough finances to put the proper personnel on the Island, 'cause that's every year… [crosstalk]

DR. SONIA ANGELL: Right.

COUNCIL MEMBER VALLONE: we don't have enough social workers, or enough doctors, or enough mental health providers, and then the issue is the safety of those workers and where they can provide the treatment and that's where you always have that dichotomy between the Corrections and Department of Health; how you can get these detainees into safe treatment and the workers, 'cause they have to be kept safe too, so all of that I think should be kind of like your wish list, I would think.

DR. SONIA ANGELL: Yeah, no and I will say, there are key priorities here; worker safety is absolutely one of them; assuring that quality care is delivered in an appropriate amount of time, within… also recognizing the financial realities of the situation and being very clear where the limitations are so that we can be very concrete and specific about additional needs. There are a few really clear tenants as we're thinking specifically about a new

model that we're considering; I mentioned them earlier in my testimony, but I'll just reiterate them here, because I do really think they're clear guiding principles which really help us envision what the possibilities are. One of them is really thinking about the extraordinary services that we have throughout the city, Health and Hospitals, the medical schools -- as mentioned, you said earlier, the Department of Corrections and Department of Health, this has come up in prior testimonies about the importance that we collaborate and think very carefully about the way we provide care so that it's most efficient. Let me just say in this administration, I can't speak to the many administrations before, but as I sit and participate in these discussions, these conversations are happening in earnest and I think they're real practical ways in which we're seeing already manifestations of those, from all the way down to… [interpose]

COUNCIL MEMBER VALLONE: Is there talk of getting the medical students involved for internships there? I know there was some federal law to that and we were trying to find a way to remove that so we can

get additional interns and volunteers who are future doctors that are coming through to actually spend some time there, and our future clinicalists [sic] and psychologists and all the rest that wanted to help; is there any movement to doing that?

DR. SONIA ANGELL: Yeah. So there is -- just confirming that -- there is an abar [sic] to that and [bell] I think the point that you're making also is, are we utilizing those extra resources that we haven't historically probably taken the greatest advantage of to improve our services. I think that's an absolutely appropriate thing to think about, but I would also say that the thing that we're concurrently thinking about is what is a larger vision; how do we create the larger infrastructure so that those extra resources that we can think about do get efficiently integrated into the system and used to improve care delivery. So having a resident there, a fellow there is a great way, not only to provide really attentive care, 'cause those people come in… [crosstalk]

COUNCIL MEMBER VALLONE: That's right.

DR. SONIA ANGELL: passionately to the service, but they then become people who become committed to care delivery as a tenant of their

career trajectory; we need those people, correctional health services all over the country needs those people, so that's a clear avenue… [crosstalk]

COUNCIL MEMBER VALLONE: And I would just ask, not even as a question, the last point… [crosstalk]

DR. SONIA ANGELL: Yeah.

COUNCIL MEMBER VALLONE: I just checked with our Chair; so the information that's provided to the Board of Corrections on a monthly basis is not coming to the Council, so I'd ask now that the reports that are brought to the Board of Corrections from the Department of Health, and the same request is gonna be made to Department of Corrections, is brought to the proper committees at the Council so we can have that information for our future hearings.

[background comments]

DR. SONIA ANGELL: Okay. Thank you for that comment.

COUNCIL MEMBER VALLONE: Thank you.

CHAIRPERSON JOHNSON: Thank you, Council Member Vallone; we're gonna go to Council Member Cabrera, followed by Council Member Dromm.

COUNCIL MEMBER CABRERA: Thank you so much to all the chairs; welcome. I have to tell you that I'm really [background comment] baffled and I'm lost for words that so many of the inmates who are mentally ill and have a substance abuse problem are not getting the services -- I can't even think of any other system in the city where you have two-thirds of its population that they're serving that they're not getting the proper services. So following up with Vallone's question, and I know you don't wanna get into specifics about the contracts and so forth, but what ends up happening is; then next year or the year after we come back here, talking about how many people we're not servicing again. So let me ask you this question; five years from now what is the projected goal of the amount of inmates you're gonna be able to service?

DR. HOMER VENTERS: So I'm not sure exactly the question. So is this in reference to the mental observation units or…

COUNCIL MEMBER CABRERA: Yes.

DR. HOMER VENTERS: So the mental observation units, while we are rolling out the PACE model, four of them, and we've sought that money just

recently, I think that all of the mental observation units that people are in are places that have mental health staff that's far in excess of what's in the general population center, but our goal is, and it's not just our goal, it's our obligation; is to provide the level of care that every single person needs in the jails.

COUNCIL MEMBER CABRERA: Maybe I misunderstood; that there are -- you have inmates who are mentally ill and have substance abuse problems that are not being serviced; correct?

DR. HOMER VENTERS: No, that's incorrect.

COUNCIL MEMBER CABRERA: Okay. So explain to me about the two-thirds of the population that was mentioned earlier that you didn't have the capacity for.

DR. HOMER VENTERS: So I may have misspoke… [crosstalk]

COUNCIL MEMBER CABRERA: Okay.

DR. HOMER VENTERS: that is not a lack in capacity.

COUNCIL MEMBER CABRERA: Well maybe I misunderstood.

DR. HOMER VENTERS: The difference is that the PACE units I referenced -- so we have about 20 mental observation units; those are all high-level units, so… [crosstalk]

COUNCIL MEMBER CABRERA: Okay.

DR. HOMER VENTERS: so unlike a general population setting, all of these 20 mental observation units have mental health staff that come, they do groups inside… [crosstalk]

COUNCIL MEMBER CABRERA: Right.

DR. HOMER VENTERS: these units; it's a higher level of staffing. What we found, however is that -- and the people who are in those units have higher levels of needs…

COUNCIL MEMBER CABRERA: Okay.

DR. HOMER VENTERS: however, even amongst that commitment of higher levels of staff; higher levels of resources, we found that we need to do more, and particularly more for some of the patients that are very acutely ill, so the first -- and these are the PACE units, the PACE units are even a higher level of commitment. So the first PACE unit we opened is specifically for people that have just come back from the hospital, so there's only a handful of

people coming back from the hospital in a given week, maybe 5 or 10 people a week coming into this PACE center, so it wouldn't help us to have, you know, a 150 PACE beds for hospital returns, but we built one and we may need a second one. The second PACE unit we opened, and this is the second of four we have support for, [background comments] was for people that seem like they're subacute; that is, they may be getting worse in the regular mental observation units; they need a higher level of care… [interpose]

COUNCIL MEMBER CABRERA: And those are the ones where we're finding the gap?

DR. HOMER VENTERS: Well the gap is filled [background comment] with this PACE unit. So they go from a regular mental observation unit, they go to a higher level unit called a PACE unit; we have two more of these PACE units that we're going to open in the coming months; that's not to say that, you know, we don't think there might be a role for other PACE units, but you know, two years ago there were zero PACE units and zero CAPS units and because we took the data and not just the bad outcomes that people know about, but the data behind them, we were able to go to OMB and go to our partners in

Corrections and come up with a model that we don't think is done.

COUNCIL MEMBER CABRERA: So, 'cause I have less than a minute here, so let me ask you two quick questions. Have you talked to the courts; instead of sending, especially people with substance abuse problems into the jails to go into inpatient programs, because essentially they're gonna get the same service, different environment and probably better services at an inpatient program, and do you have a mentorship program set up so when the men and the women get out of the system that they have some kind of a follow-up?

DR. HOMER VENTERS: Sure, I'll let Deputy Commissioner Berliner take the mentorship training program. But so your first answer, yes, we actually have a very high level substance abuse program, it's very successful, it's called A Road Not Taken, and so a lot of our referrals come from the courts, people come from drug courts [bell] but these are patients who have high levels of substance abuse, specifically substance abuse needs and we work very hard, we have community providers come in and meet them in the jail and then they go to inpatient, and sometimes

outpatient, but many inpatient substance abuse treatment after jail and it's a very successful program.

COUNCIL MEMBER CABRERA: Okay. Thank you so much.

[background comment]

CHAIRPERSON JOHNSON: Council Member Dromm.

COUNCIL MEMBER DROMM: Thank you very much, Mr. Chair and Chairs; thank you for the opportunity to ask some questions. I agree that the A Road Not Taken is a successful program, but I just don't think that it gets to enough people and I have questions about that as well. But I wanna go back a little bit to suicide watch, because I think that's a more pressing need at this point.

From my understanding, at the February 10th, 2015 hearing with the Board of Corrections it was mentioned that suicide watch would be implemented in the ESH, the CPSH and the five north units; is that correct?

DR. HOMER VENTERS: The ESHUs, the enhanced supervision units, are not mental health units; patients are not going to be there on suicide

watch; however, what the Department of Corrections has done is; if somebody's identified as needing a suicide watch, in the hours that it sometimes takes to transfer somebody off that unit, there are cells that they could be in while they're awaiting transfer, but the security units, whether it's the CPSU, which is the regular solitary confinement, or the ESHU, aren't places that we're gonna be doing suicide watch.

COUNCIL MEMBER DROMM: So you would agree that treatment should not be in that setting?

DR. HOMER VENTERS: That particular thing, that's right… [crosstalk]

COUNCIL MEMBER DROMM: For suicide watch?

DR. HOMER VENTERS: very complex task.

COUNCIL MEMBER DROMM: How do you identify people on suicide watch?

DR. HOMER VENTERS: Well actually, many people come to us through a correction officer saying that a patient said that they were despondent or they said that they were going -- you know, they made a comment; we also have a large general population mental health service, so out in the regular housing areas people are seeing mental health; however,

suicide prevention is everybody's job in jail; if you work in a jail, if you have any concerns about somebody, whether you're a security person, a health person, a medical person; a pharmacist, it's your responsibility to get that information to the right place immediately, and so we have lots and lots of referrals that come to us, but once we know or we suspect or even we're worried that somebody might harm themselves, it's our responsibility, not just to work with corrections that they be watched, but to do a real clinical assessment of what are the risks today that this person's gonna harm themselves and do they need some type of care that we didn't know about or that they didn't get before.

COUNCIL MEMBER DROMM: I'm glad to hear you say that it's everybody's responsibility on the Island and I think that's a good approach. My concern is that I've read in the newspapers, in the Times and in the Daily News, instances where suicides might have been prevented had corrections officers been watching and doing what they're supposed to do, and in several instances where it was identified that they may have been negligent, very little discipline and no prosecution took place. What type of measures

are you implementing now to ensure that those who are not doing their job in terms of suicide watch, even though they may be there for a few hours between the transfer between the unit they're in to the treatment setting taking place; what are you doing to ensure that the proper approach is taken by those corrections officers?

DR. HOMER VENTERS: I'll turn to Deputy Commissioner Berliner.

ERIK BERLINER: Erik Berliner from the Department of Corrections. So the point you raise is obviously an extremely important one. One of the things we've done over the last couple of months, and we discussed it at the Board of Corrections meeting in February, is; we've tightened the procedures that we have in place for the ways in which suicide watches get initiated, so at the moment that a mental health clinician provides a suicide watch determination for a patient, the officer who receives that piece of paper becomes the suicide watch officer. In the past, that person has called for a watch officer and usually the inmate sort of remains in the area, but we've made that person responsible for constantly observing the person in front of them

until the suicide watch officer arrives; in addition, we're focused on the responsibility to get that person to the care environment that they need. So the only responsibility that the officer has beyond the constant observation of the person in front of them is to notify their area supervisor who becomes responsible for effecting a transfer either to the mental health center or to a mental observation unit or to the clinic, depending on the appropriate circumstance there.

COUNCIL MEMBER DROMM: Do you have an estimate, have a number or do you have an actual number of how many people might be on suicide watch at any given time?

ERIK BERLINER: Usually about 30-40 per day.

COUNCIL MEMBER DROMM: And you have enough officers to cover that?

ERIK BERLINER: Yes.

COUNCIL MEMBER DROMM: Let me go, because I think I have 18 seconds let and I wanna get this in; I have an Education Committee hearing as well today that I have to go to which I chair. The Road Not Taken, I see from the numbers that the Council

gave us; in fiscal year 12 there were 579 people who completed the 45-day substance abuse program, [bell] in 2013 it went down to 354, in 2014 it went down to 257; why is that happening; I don't think there's less people with substance abuse problems on Rikers and is that because a different program has been put in, and also, I would just like you to address briefly how the follow up is conducted; I have known people who were referred to the program, who were put into general population because there was no room for them in the Road to Recovery program and actually, the paperwork was lost between the courthouse and Rikers. So can you go over that for me a little bit?

DR. HOMER VENTERS: Sure. So the Road Not Taken is a very high level unit, because it's a special housing area for people often referred from the courts, so we rely on the courts often to refer people to us; also people tell us on intake if they have special needs; we then turn over a list of people that we want into the units to Department of Corrections and then we have to coordinate getting them there, and so that actually can be quite a cumbersome process. I do wanna say that the funding we've received from the Mayor's task force to do

discharge planning for people with substance abuse issues, this is to bring this approach to people with lower levels of need that aren't gonna go into a very good silo, it's really a silo, right; it's a high level day treatment facility. So we're gonna be rolling out, we're gonna be hiring staff and rolling out discharge planning, where we find people with substance abuse problems that didn't come through the drug courts, but as you said, the many, many others who have these needs and who really do need help coordinating connection to some care outside the facility. So those staff that will receive support for are gonna be doing just that for the people outside the Road Not Taken program, because the Road Not Taken Program is very successful, it's very small; we do rely on both referrals from the courts and also there's a very high level of coordination between us and Corrections to get people into the unit while they're still in jail.

COUNCIL MEMBER DROMM: Did you answer the part about the number of people referred from the courts and the number of cases you're able to deal with that are actually placed in the program?

DR. HOMER VENTERS: So I'll have to get back to you, because I don't know; I believe that about a third to a half of the people are coming from the courts and I don't know what's happened with the number of court referrals over the year, but we certainly will give you a comprehensive response.

COUNCIL MEMBER DROMM: Sure and that number has just dropped; I mean it's less than half of actually what it was in fiscal 12.

DR. HOMER VENTERS: That's right. And so, I apologize; I'll have to get those exact numbers of the court referrals back to you.

COUNCIL MEMBER DROMM: Okay. Thank you.

DR. HOMER VENTERS: Thank you.

CHAIRPERSON JOHNSON: Thank you, Council Member Dromm. Before I go to Chair Crowley, I understand that there has been some concern that's been raised that the reports in the bill that's been proposed should be posted on the Department's website and made public available so that people have access to this information; I agree and this is something that we will look at and discuss as this legislation moves forward, the reporting measures that I'm talking about, so I also encourage anyone here today

who has any recommendations on how the bill should be changed to please give us feedback as this moves through the legislative process. And now I wanna turn it back to Council Member Crowley; before that, we've been joined by Council Member Mathieu Eugene.

CO-CHAIR CROWLEY: I'm troubled by the reports of health care workers being beaten and physically abused by the inmates. Last year there was a 144 percent increase, from 2013-2014, in assaults on health care workers in your facilities. What is DOC doing to make sure that their safety is a priority? I've met with the doctors' counsel; I understand that there are risks there that could be avoided if DOC was to ensure that correction officers were in rooms when the health care staff is seeing violent inmates and I also understand that there are physical limitations in the structures that limit sightline and create a real danger for those health care workers. So this increase in assaults, one assault is too much, but to see that it's increased significantly, we need to know what DOC is doing.

ERIK BERLINER: Sure and I just wanna start by saying we take this matter extremely seriously. I agree with you; even one assault is too

many. We've gone facility by facility with medical staff at the facility level, with maintenance and construction staff and with facility uniformed leadership through every jail in the system over the last several months and have made comprehensive lists of areas that require some modifications; some were able to remediate right there while we're standing there; others, of course, take more time for planning and construction, but the goal is to make the -- to the degree possible within our facilities, the goal is to make the areas safer, provide better sightlines or physical plant improvements; we've added panic alarms to I think nearly all areas where medical staff see patients and we are working with the clinic staff to ensure that officers are appropriately positioned so that they can see inmates and their medical providers in treatment areas. We're also doing the same work in the housing areas in which medical care is provided at the housing area level, so that's typically mentally observation areas or infirmary settings; we've gone place by place through those areas to make sure that we've got the best possible set of physical plant circumstances. We've also done trainings with medical staff in all the

facilities; those are conducted by a senior member of our security operations division and a uniformed member of my staff who are doing situational awareness and medical staff safety trainings for medical staff in all facilities, and those will be continued on an ongoing basis as refreshers or as new trainings for newly hired staff.

CO-CHAIR CROWLEY: There was an awful attack on a health care worker that was leaked to the press, a video of such an attack and we find out later that that inmate was known to be violent and abusive towards specifically women, but the health care clinician had no idea that this particular inmate was that violent and there was no correction officer that could have stopped this inmate from attacking. How can we be assured that enough staff, especially the correction officers, are there when there are violent inmates and to also make sure that the health care staff knows that they're about to see somebody who's been arrested for a violent crime or convicted of a violent crime?

ERIK BERLINER: Yeah, that was obviously a particularly shocking circumstance. The… [interpose]

CO-CHAIR CROWLEY: But I'm looking at the numbers, so that… [crosstalk]

ERIK BERLINER: No, no…

CO-CHAIR CROWLEY: that was one example we saw the video footage of…

ERIK BERLINER: Yes, that's right.

CO-CHAIR CROWLEY: but the numbers are saying that -- this happened last year, significant increase last year.

ERIK BERLINER: So what we've done about that is, and Dr. Venters mentioned this a little earlier, is about the communication that's going on on the units; this is not just unique to the CAPS or PACE units, it's true in all mental observation settings; the staff at the beginning of every day discuss with another everybody who's on the unit and any issues or people of concern. One of the things that has been historically true and that that incident that you raised pointed out to us, is that for many, many reasons information about inmate criminal status is rarely communicated at the housing area level, it's available to the officer… [interpose]

CO-CHAIR CROWLEY: But the moment that officer… the moment the DOC is doing the intake, the medical intake, you see… you pride yourselves as being a facility that, unlike any other jail in the country, within 24 hours you have a medical assessment; can you not put on that medical assessment what the individual was arrested for; this way any medical staff seeing this individual later on will know that?

ERIK BERLINER: We certainly are… [interpose]

CO-CHAIR CROWLEY: Are you limited -- See I know that there is limits to what the officers can know about the health status of the inmates, but can your health care staff know about what the inmates have been arrested for? It's public knowledge, I mean if they do the research; can we just make sure that they're aware, so that when or before they're seeing the inmate they're prepared, more prepared? I mean and you can prepare and train the medical staff all you want, but when you have a violent inmate that's about to see the medical staff, we need to be assured that there'll be enough correction officers there protecting the health care staff.

ERIK BERLINER: Yes, of course I agree. We can share charge information and the problem is that that doesn't always imply the circumstances of the charge, so an assault can mean many things and it wouldn't necessarily provide information that the person was assaultive toward women. You know what we have at the sharable level is just the basic charge data and that's not an issue.

As I said, we're going facility by facility and location by location to make sure that where health services are provided by staff that there are enough officers and that the right sightlines do exist, and we're not going to do that once and then say okay, we're done, it's a continuing process to make sure that everything changes… anything changes… [crosstalk]

CO-CHAIR CROWLEY: Mr. Berliner, I'm not gonna ask anymore questions; I'm just alarmed by the increase because it's substantial and even though it appears that you're doing more in what you're saying in your testimony, the numbers don't lie.

CHAIRPERSON JOHNSON: Thank you, Chair Crowley. We're gonna go to Council Member Barron.

COUNCIL MEMBER BARRON: Thank you to the chairs and thank you to the panel. I will have a chance to review your testimony; I wasn't here to hear it directly, but I have a follow-up question, following up with Council Member Vallone and Cabrera about two-thirds of the population and you said no, I misspoke, so I wanna understand what does the two-thirds refer to; are you saying that it's not that number of patients who are not getting the services or is it another number and is everybody being serviced fully? So what is the two-thirds and what is the population that is not being serviced?

DR. HOMER VENTERS: Sure. So we have about 20 units that are called mental observation units, so that are units where people who need a high level of mental health care go… [interpose]

COUNCIL MEMBER BARRON: Yes.

DR. HOMER VENTERS: so all of those units have high levels of staffing… [interpose]

COUNCIL MEMBER BARRON: Right.

DR. HOMER VENTERS: they have staff that come that do groups on the units, they take care of people on the units; we bring the clinical staff into

those units, and those are by and large for people who are seriously mentally ill… [crosstalk]

COUNCIL MEMBER BARRON: Right. But what does the two-thirds refer to? I missed that.

DR. HOMER VENTERS: I believe somebody asked how many of the mental observation units have been converted to the PACE units. Now the PACE units are, if you… [interpose]

COUNCIL MEMBER BARRON: Is that what the two-thirds is?

DR. HOMER VENTERS: Well I think that somebody had put together PACE units and CAPS units, so if you think about the MO, the mental observation units, [background comment] I mentioned being like hospital, like in a hospital and then in a hospital you have a small footprint of places, like an intensive care unit, [background comment] where you have even higher levels of staff. So the PACE units, we have two that we've opened and we have two more that about to open in the coming months; those are some of these mental observation units where we've gotten funding for an even higher level of staff for the most seriously ill folks.

COUNCIL MEMBER BARRON: Is every inmate getting all of the services that they're entitled to every day?

DR. HOMER VENTERS: In the jail system I would say no, there are some… [interpose]

COUNCIL MEMBER BARRON: What percentage is not getting the services that they are entitled to or that they are expected, based on a plan of a medical practitioner, a mental practitioner?

DR. HOMER VENTERS: It depends on the type of care. If we schedule, for instance, 100 visits, probably a third to half of those people will come to the clinic [background comment] and they may not come to the clinic; they may not get their care [background comment] because they refuse that day or they were doing something else and so then that care then gets rescheduled for the next day and so… [interpose]

COUNCIL MEMBER BARRON: So you're saying one-third is perhaps not getting the services that are outlined on a care plan?

DR. HOMER VENTERS: No, I think that we would actually have a much more specific question about, you know we have 10,000 patients…

COUNCIL MEMBER BARRON: Yeah.

DR. HOMER VENTERS: and we have lots of types of care and so… [crosstalk]

COUNCIL MEMBER BARRON: Yes.

DR. HOMER VENTERS: I think that what would be… I couldn't give you a number for all the different types of care that we give and who might miss what on a given day [background comment… [interpose]

COUNCIL MEMBER BARRON: So then we don't know where the prob… this is a big problem; you can't tell us, whether a person is getting what they need based on a chronic medical condition or mental health or substance abuse, you can't give us a number as to how these inmates or detainees are being serviced; [background comment] that's serious and we don't even know…? [crosstalk]

DR. HOMER VENTERS: Well so you just… you just gave me some specificity… [crosstalk]

COUNCIL MEMBER BARRON: Okay.

DR. HOMER VENTERS: that I can answer.

COUNCIL MEMBER BARRON: Okay.

DR. HOMER VENTERS: So for instance, one of the performance indicators we have is for chronic care…

COUNCIL MEMBER BARRON: Yes.

DR. HOMER VENTERS: people who come in who are diagnosed on the intake with diabetes, hypertension, a chronic medical problem, we then measure the performance of both Corizon and Damian in terms of getting them their chronic care visit; that's one specific thing that we can measure… [interpose]

COUNCIL MEMBER BARRON: And what does that measurement show?

DR. HOMER VENTERS: It shows that quarter over quarter about 90-95 percent of the visits that are supposed to happen happen on time.

COUNCIL MEMBER BARRON: Okay. And then substance abuse?

DR. HOMER VENTERS: So substance abuse, again, we look at the people that are referred, that come in, that are referred to a program [background comment] and so substance abuse -- we actually have four or five different types of encounters -- I will

say that we have 40 performance indicators that we mentioned in the testimony that you see… [crosstalk]

COUNCIL MEMBER BARRON: Okay and what percentage would you say is reported as having received the services?

DR. HOMER VENTERS: Again, 90-95 percent.

COUNCIL MEMBER BARRON: And then for mental health?

DR. HOMER VENTERS: So mental health, we look at both the timeliness, so I'm a medical doctor; if I refer somebody to the mental health service, we want that for most people, like in the community, to happen within three days; [background comment] there are also some stat referrals that happen immediately, [background comment] but mental health referrals, between 80-90 percent of those generally happen within the 72 hours.

COUNCIL MEMBER BARRON: Okay, so those are the referrals and then the plan that's devised for them, that's maintained at that same degree of 90 percent?

DR. HOMER VENTERS: Well so the plan, there's no one plan, so… [crosstalk]

COUNCIL MEMBER BARRON: Right.

DR. HOMER VENTERS: mental health service, to be…

COUNCIL MEMBER BARRON: But whatever the plan is for those persons that are in the system…

DR. HOMER VENTERS: Yeah, so jail care is very different from the community, because… [interpose]

COUNCIL MEMBER BARRON: Okay.

DR. HOMER VENTERS: in the first three times we meet a patient [bell] we may change their plan three times because every time we're checking community records, we're getting to know them better, so the plan… [interpose]

COUNCIL MEMBER BARRON: And when the final plan is resolved, is that maintained; what's the level of maintenance for that plan, whatever that final plan is?

DR. HOMER VENTERS: So again, I'm not sure the… that question isn't really specific to us; I think that… [interpose]

COUNCIL MEMBER BARRON: Okay.

DR. HOMER VENTERS: we try -- for instance, medications, we measure how often people get their medications, so we'll look at the frequency

with which people who are prescribed the medication get it and we find that if they don't get their medication it's often a combination of refusals; we haven't done a good job sometimes working with people to increase their medication compliance. We don't have one care plan that can be measured just as a one off, but we have many, many measures. As I mentioned, we have 40 measures that we look at and the compliance rate for those measures is either 90 or 95 percent most of the time.

COUNCIL MEMBER BARRON: Thank you. Thank you, Mr. Chair.

CHAIRPERSON JOHNSON: Thank you, Council Member Barron. I have a bunch of questions and we're gonna try to rifle through these as quickly as possible, because I know that we still have a lot of people to testify, but these are questions that I'd rather ask in a hearing setting than wait for written answers.

So do you think that there is any inherent limitation in having a for-profit company provide services as opposed to having a mission-oriented provider? I mean I'm not against to having a for-profit contractor, if you can get the job done,

great, but I question whether Corizon has the drive to strive for excellence and go beyond the minimum standards that were laid out by the Board of Corrections. I wanted to hear your thoughts on this, Dr. Angell or Dr. Venters.

DR. SONIA ANGELL: So I think it's an important question and ultimately I think there's no simple answer to this. Absolutely the kind of institution or entity that provides the best care is the one that's best qualified, best resourced and best organized to be able to deliver that care in a systematic way and also done in an environment where the oversight institution is committed to health as well. I think in this instance, uniquely in New York City; this isn't common in many other situations, we do have the Department of Health that is overseeing the delivery of care and through that mechanism it provides us with a means to really understand and assure that the entity that's providing care will be meeting the mission and needs of the patients at large.

I don't think that it's either one or the other; this is my assessment of having viewed this, but I do think that it's very important that we have

an entity that meets the requirements and needs of what that administration has and I think that's what we're facing right now as we look at this contract coming up for rebidding.

CHAIRPERSON JOHNSON: Thank you. Who is on the Quality Improvement Executive Committee? Who sits on that committee?

DR. HOMER VENTERS: Sure. So it's chaired by Commissioner Bassett and then the senior staff who sit on the committee are senior physicians and a couple of other senior health staff in the Department of Health, and then once a quarter we come; myself and my team, as well as Corizon and Damian come, report out the 40 performance indicators I mentioned, how we did no them; we also report out things like morbidity and mortality reviews… [crosstalk]

CHAIRPERSON JOHNSON: Are there any Corizon or Corrections staff that sit on that committee?

DR. HOMER VENTERS: So the committee is the oversight, so Corizon -- it's the oversight of Corizon, so Corizon wouldn't sit on the committee, but Corizon comes… [crosstalk]

CHAIRPERSON JOHNSON: Is Corrections?

DR. HOMER VENTERS: to report out. No…

[crosstalk]

CHAIRPERSON JOHNSON: Is Correc…

DR. HOMER VENTERS: No.

CHAIRPERSON JOHNSON: I mean, I'm just wondering, would it be helpful to have more stakeholders who are involved in the on-the-ground work to actually sit on that committee and is it helpful to potentially have physicians and clinicians who are at Rikers to sit on that committee; would that be helpful in understanding things a bit more?

DR. HOMER VENTERS: So as I mentioned, the physicians and the health staff who work at Rikers are working for Corizon, so this is the committee that oversees Corizon, so it certainly would be innovative to have the people who are being overseen also be on their oversight committee; however, we do work closely in preparation for these committees and certainly certain parts, such as investigating deaths, which we report into this committee, it's a collaborative process with Corrections, because we benefit from their insights and knowledge into, you know, what happens in a

housing area before we have a patient come into the clinic.

CHAIRPERSON JOHNSON: So what are some of the lessons and/or recommendations that have come out of that committee, out of the Quality Improvement Executive Committee that you can share?

DR. HOMER VENTERS: Well we've talked about several -- the PACE units; it's… [crosstalk]

CHAIRPERSON JOHNSON: That came out of that committee?

DR. HOMER VENTERS: Well that committee reflects the work of everybody who works in the health system and so yeah, so we brought to the Commissioner and the Quality Improvement Executive Committee the findings from a couple of cases, one of which you mentioned, and the fact that we didn't think that we had met the standard of care and really our concerns were not simply about individual areas, but that we had a system of care that needed change and so the PACE units, like the CAPS unit before it, it is really a fundamental improvement that's come out of this process.

CHAIRPERSON JOHNSON: You said, Dr. Venters, that health staff and Corrections staff,

earlier, when you answered my question, that they have the opportunity to train together. How often do they train together and when such staff requests trainings or have ideas, are those requests granted?

DR. HOMER VENTERS: So we support training in a lot of different settings. So it starts actually with the academy for the correction officers; we have health staff that go and talk about -- not just about mental health issues, but our Medical Director, Dr. McDonald has just been out to the academy to talk about traumatic brain injury, which is very high prevalence among the adolescents coming into the jail, it's important for officers who are looking at kids with behavioral problems to know about traumatic brain injury, so we start at the academy, with the officers; then when people get to the jails, when they work in the clinics, but also when they work in these special housing areas we've been talking about, we roll out all these housing areas with joint training, so the CAPS unit, the PACE units; Commissioner Berliner mentioned that on all the mental observation areas… [interpose]

CHAIRPERSON JOHNSON: So how often do the trainings happen…

DR. HOMER VENTERS: That… [interpose]

CHAIRPERSON JOHNSON: Between Corrections and health staff?

DR. HOMER VENTERS: It would vary by type of training. There are refresher trainings that happen, for mental health refresher trainings and that's a corrections training; I don't know… [crosstalk]

CHAIRPERSON JOHNSON: But is it like once a year; is it four times a year; is it once every two years?

ERIK BERLINER: We do the trainings each time we open a new unit and then we try to refresh it every couple of months to make sure that it's… [crosstalk]

CHAIRPERSON JOHNSON: What does that mean; try to refresh it; like there's no set plan; who makes the decision of when there's gonna be a refresher…? [crosstalk]

ERIK BERLINER: Well in each case, so on the PACE units, which are new, we haven't obviously yet done a refresher 'cause they've only been opened for the past couple of months; at the CAPS level there is staff level training that goes on every two

to three months and there's a mental health leadership and DOC leadership in the facilities who make a decision about whether or not people need another round of the training or not and then we bring that training to them.

CHAIRPERSON JOHNSON: To what extent do you all engage staff on systems reform, you know, if they believe that there needs to be some systematic reform implemented; is staff engaged in those conversations?

ERIK BERLINER: We wouldn't implement a systems reform without the staff, so… [interpose]

CHAIRPERSON JOHNSON: Okay.

ERIK BERLINER: that's the… [crosstalk]

CHAIRPERSON JOHNSON: Okay. Dr. Venters, I appreciate that you indentified the PACE and CAPS programs as responses to what you all saw as potential system failures; it was an innovative way to try to take care of the seriously mentally ill; what are the biggest system failures that you all have seen, if you could maybe name the top three, and if you could tell us who you think was responsible for those to help us understand how we identify system failures when they occur?

DR. HOMER VENTERS: So we, through our morbidity and mortality process, often identify systems problems with the delivery care; these aren't problems that we identify and fix and then they're done; these are persistent problems that everybody who works in the jails is aware of. So one area that was referenced by Council Member Dromm is; how do we handle patients that we put on a suicide watch or need to go from point A to point B for a mental health reason; that is an area that has persisted for us, the two agencies and I think that that's one of the top concerns. So we recently have developed new community reporting strategies that make sure that everybody knows when a patient needs to go from one setting to a higher level of mental health setting, particularly patients on suicide watch, and the way we've done that is by -- DOC has taken the measures that Commissioner Berliner mentioned, but also on our side, we actually have a uniform reporting tool now that goes around overnight every two hours that tells us every patient that needs to be transferred into the mental health center; everybody knows; everybody, both on the DOC leadership side and the health leadership side, Corizon, we're all tracking the

hours that it's taken to transfer somebody, so that's an example of a systems problem; there's been a very grave systems problem that's been associated with morbidity and mortality that we've developed a systems fix to.

CHAIRPERSON JOHNSON: That sounds great; I mean that's what I was looking for to understand, you know where you've seen problems and then how changes have been made to improve those types of things, you know that's what we're looking for, to get better and to see where there are potential failures and what we could do better.

You know, I just wanna touch on this briefly. Dr. Venters, is it your opinion, someone who's there on the ground at Rikers; I know that Corrections announced, in conjunction with the Administration, that we're gonna be getting rid of solitary confinement, punitive segregation; whatever you wanna call it, for adolescents, 16-, 17- and 18-years-olds, but there's still gonna be widespread punitive seg used amongst the general population; do you believe that punitive segregation exacerbates people with serious mental illness, that it harms them?

DR. HOMER VENTERS: Well as an epidemiologist, I'll tell you what we now from our data, [background comment] this isn't my conjecture; it's that if we look at self-harm, the act of harming oneself as an outcome, an outcome we all want to avoid, and we also look at high lethality self-harm; that's self-harm that could lead to your death, we find that the groups of people that are much more highly disposed to be in the self-harm group are kids who are adolescents, people with serious mental illness and people who are ever in solitary confinement; we published that data; we're the first jail in the history of the United States to publish that type of data and it's not -- you know we in our hearts have felt that as clinicians on the ground for a long time, but what should move policy is not simply what's in our hearts or what we care for about our patients, but what our data shows.

CHAIRPERSON JOHNSON: Well I appreciate you sharing that and you're absolutely right, that is what should inform how we handle these type of things; it's my opinion, not as a clinician, so maybe my opinion doesn't count as much; I mean I think punitive segregation and solitary confinement is

cruel and unusual punishment and I don't even know how -- I don't believe it should still exist in our correctional systems in the City or across the country and I hope one day we get a ruling that says such, that we can actually rehabilitate people instead of harm them even further or hurt them in a way that they inflict self-harm. So I wanna move on quickly and then we're gonna have Council Member Rosenthal and then we're gonna be done with you all and I really appreciate you guys sticking around and being so helpful. So we don't have much time remaining; I wanna shift from the mental health issues to issues relating to medical care; I have a lot of questions and staff will send some of these along, 'cause we're not gonna have time to get to all of them. Who manages the scheduling of patients?

DR. HOMER VENTERS: So the individual clinics have an administrator, they have doctors and nurses and so the nurses will schedule the nursing follow-up visits, the doctors and physician assistants will often schedule their follow-up visits, if they're, for instance, let's say a chronic care visit, they'll decide the person needs to be seen in a week or two.

CHAIRPERSON JOHNSON: What happens if someone refuses a scheduled medical appointment?

DR. HOMER VENTERS: Depending on the type of encounter, but generally what happens is they're brought to the medical clinic and then they can refuse; that's where they sign a refusal, just like you would in a hospital where it's witnessed by a health care person, and then there's a discussion; if they refuse multiple times, then it depends -- you know, do they have decisional capacity, do we need a mental health evaluation; are they getting sick, or did the actually end up being scheduled for things they don't need, which happens in our system.

CHAIRPERSON JOHNSON: When the Department of Corrections fails to produce a person for his or her appointment or the person does not appear, what action does the clinical staff take?

DR. HOMER VENTERS: Well the clinical staff is faced with this circumstance many, many times a day across the jail system and so what they first do is look and see about the severity of the illness and the clinical implications for not having care; if it's somebody who wanted some hand lotion and they didn't come, nobody's gonna go out to the

housing area. But for patients that have life-saving medication, who have life-threatening disease, often clinical staff and administrative staff from Corizon or Damian will go out into housing areas and work with correction officers to get them connected to their care.

CHAIRPERSON JOHNSON: Is the health staff given a reason why the person has not been presented?

DR. HOMER VENTERS: Generally, no.

[pause]

CHAIRPERSON JOHNSON: So when someone doesn't show up, is each incident tracked? You said often there's follow-up, but if every time that some doesn't show up, is that put into a computer system?

DR. HOMER VENTERS: Yes, we have an electronic health record… [crosstalk]

CHAIRPERSON JOHNSON: Okay.

DR. HOMER VENTERS: all of our visits are scheduled in there.

CHAIRPERSON JOHNSON: And what if the person is not getting the life-saving medicine or treatment that they need; what happens; what type of intervention occurs?

DR. HOMER VENTERS: Well we talk to the patient and we find out why and if it's somebody who's missed mental health medications, there's a consideration, do they need a higher level of care; transfer to the hospital; for medical medications they may need to go to the infirmary.

CHAIRPERSON JOHNSON: But is that incident always flagged for the Department? Is someone flagging that so you know that that's happening…? [crosstalk]

DR. HOMER VENTERS: Yes, the sight medical directors, the directors of nursing and the health service administrators of every jail, that's a big part of their job every day.

CHAIRPERSON JOHNSON: So we have a lot of other questions that we're just not gonna get to; I'm gonna turn it over to Council Member Rosenthal and then we're gonna move on.

COUNCIL MEMBER ROSENTHAL: Thank you, Council Member Johnson. You know I'm gonna go really fast, so if you wanna pick up on a few things, I don't wanna get in your way; this has been an amazing hearing; I'm sorry I could only just jump in now.

But I guess fundamentally I wanna understand if there's a budget problem here, you know and I guess the way I'd ask it is; I know that money was added into the budget and I'm sure that'll go a long way, it's a lot of money, but given the nature of the mental health demands of people coming into Rikers and what happens to them on the Island; do you feel that the systems are in place to identify people with mental health needs and that we, you know, especially with the additional funds, are taking care of people reasonably well? From an epidemiological standpoint this could be a point of entry, right, for access to care for somebody who wouldn't otherwise get captured in the system. Is there an opportunity here that we're missing, maybe?

DR. HOMER VENTERS: So because we have such a large intake history and physical, it looks like a hospital admission, we really do a good job of identifying people coming into jail I think as best we can in a jail; I think it doesn't mean that we don't have people that we don't identify in the first few days; I think that we routinely will find people that we didn't come across in the first few days that a correction officer or somebody else refers to us.

I think though that we do believe there is more to be done because, you know two years ago we didn't have the CAPS unit and we didn't have the PACE unit and so we really are pushing reform of our approach to the sickest patients; we don't feel like we're done with that process; we think that we need to improve the quality of the units we have still and we also need to think about the structure of the units, so the two new PACE units will be coming online in the coming months, so we don't believe that we're done and you're absolutely right that, not only is jail a place where we find people who had problems in the community that went untreated, but it's also a place where we treat problems that stem from exposure to the jail, so jail confers health risk to people, we must account for the fact, and it's the responsibility of the independent health authority to account for the ways in which jail confers new health risk to people; this is not simply their own personal risk that alone might have led to a bad outcome, and so all that's very complex; we certainly believe that we have more to do.

COUNCIL MEMBER ROSENTHAL: Is that type of information -- you talked about two different

categories of people then; people who come in with issues; people whose issues are either exacerbated or started once they're in; do you capture that information on your electronic medical record and how long have those medical -- I'm sorry I missed -- this already came out -- but how long have you had the electronic medical record, so how far back in time could you go?

DR. HOMER VENTERS: We started collecting it in 2008. And yes, we absolutely do track both of those types of concerns.

COUNCIL MEMBER ROSENTHAL: Sounds like there's a lot of work to be done; would it be accurate to say that the new funding and what's happening now is helping those people probably most severely in need, but there are people who are in need?

DR. HOMER VENTERS: Our approach as the health system is, we focus on reducing mortality and morbidity, but we can make gains in those and we actually have made significant gains in those, but that doesn't mean that we've met everybody's need across the board.

COUNCIL MEMBER ROSENTHAL: Will you be making alterations to the requirements in the contract for health based on these types of insights so that when the next RFP goes out and if it's Corizon or whoever, that you'll be trying to capture addressing these issues or do you believe you have enough money that could be allocated; you know I'm sort of going all over the place, but do you think that when you issue your next RFP that in the deliverables, for what you'll be asking for the provider to do for inmates, that you'll be asking for them to do additional or different or more nuanced things based on what we see happening with mental health services today?

DR. HOMER VENTERS: Absolutely. The current contract with Corizon for the first time reflects preventable hospitalizations; that's an approached performing quality that we took from hospital settings; it's not really present in any other correctional settings. Also the current contract has [bell] explicitly written in participation in human rights activities, which there's no other jail really even using the word human rights, because we think it's really

fundamental to getting people connected to their care, and so whoever is providing the care is gonna be participating in these types of activities.

COUNCIL MEMBER ROSENTHAL: Thank you.

CHAIRPERSON JOHNSON: Chair Crowley.

CO-CHAIR CROWLEY: Thank you, Chair Johnson. And summary, because we're getting Corizon up in a few minutes, you said you choose the best, be it a profit or a nonprofit company that will provide the needs, basic health care needs of those in our jails, but Corizon has fallen short; in far too many cases we have had deaths brought on because somebody didn't get their basic seizure medication, a death because somebody didn't get their basic blood pressure medication and one of the most egregious deaths that I read about was a young 19-year-old who had chest pains for seven long months and had seen a health care professional eight times; that young boy died in his cell because he had a tear in his aorta, and never once did he ever get a chest x-ray, and that's Corizon. We need a more efficient health care provider in our jails and that is your job.

CHAIRPERSON JOHNSON: Thank you, thank you, Chair Crowley. I wanna say, you know Dr. Angell

and Dr. Venters, and I really mean this and I know you're not doing this type of work to get praise and adulation, but I am very grateful for your expertise, especially you, Dr. Venters, who is on Rikers Island every day; I know that inmates' care and treating them with compassion is really you know your guiding post as a doctor and you have shown that consistently, not just through your answers here today, but when I was on Rikers Island with you, the level of insight and expertise that this City has through your service I think is really commendable; there are systematic issues and problems; it's a complicated place; the answers aren't always easy, but I think that you have done a tremendous job and it's important to recognize that when we see it. So I just wanted to thank you for the level of questioning that you went through today to give us some more insight, but I also wanna say that, you know, there are still big problems, as we know, and I know that you recognize that as well and I also know that the thing that may not be easy to say is the Department of Health and Mental Hygiene is not in the easiest position; you don't control Rikers Island, the Department of Corrections does. So the

relationship between the two departments is sensitive and tricky because you're providing care while Corrections is in charge of the administration and of your safety and your staff's safety, so it's complicated and that dynamic needs to be recognized.

I just wanna say that before Corizon comes up that Council Member Crowley was referring to Andy Enriquez, who died, 19 years old, didn't get a chest x-ray, torn aorta, basic, simple thing. We look further and we see that -- I just think it's important to say this, because it's easy when you talk about numbers, but when you actually talk about individuals, 36-year-old man with a severe seizure disorder died two days after he's placed in solitary confinement and denied his medication; 59-year-old drug addict who was not properly assessed for constipation, a common side effect of methadone, died, bacterial infection in his stomach and intestines because of bloody stools; inmates suffering from asthma who are not properly treated; and inmate who died of sepsis after being turned away from a clinic because of a high number of emergency patients who were in line before him; an inmate that within two days of arriving at Rikers died of a

diabetic coma; an inmate that was placed in a holding cell with his hands cuffed behind his back and died of a sudden heart problem, and an inmate that was confined to his cell for seven days and denied access to food, water and medical care for his schizophrenia or insulin for his diabetes. These are people's lives and I know, Dr. Venters, that you take this seriously, but my question is; does Corizon take this seriously and are they doing all they can do to prevent these tragedies from happening? Thank you very much for your testimony today; I really appreciate it.

So up next we're gonna have Dr. Jay Cohen, Cowan from Corizon Health and is that it? And Calvin Johnson, or is that… [background comments] and Calvin Johnson from Corizon Health as well. [background comments]

So if folks could go outside, that would be really helpful so that we can keep going, because we really are under the gun as it relates to time, we're supposed to be out of here by 1; that's not gonna happen; we probably have until 1:30 and we wanna get everyone to testify.

Do you all have testimony for us? [background comment] Yes. You may begin in whatever order you'd like; if you could please identify yourselves for the records.

[background comment]

DR. CALVIN JOHNSON: Thank you. Good afternoon Chairman Johnson and Chairwoman Crowley. I am Dr. Calvin Johnson, the Chief Medical Officer of Corizon Health. I wanna thank you for this opportunity to speak with you today; it's clearly timely and important hearing at which we can discuss our shared objective for improving the quality of health care on Rikers Island.

By way of background, I am, as I said, Chief Medical Officer for Corizon Health; a graduate of Morehouse College and I've earned my medical degree and masters in public health at Johns Hopkins. Working to protect the public's health and safety has been a continuous thread throughout my career. I've had the opportunity to serve several years as the Secretary of Health for the Commonwealth of Pennsylvania, where among other things I was successful in significantly increasing the funding for HIV-AIDS prevention and early detection and

establishing data-driven management systems to improve performance management and outcome measurements.

Earlier in my career I had the privilege to be the Medical Director of Family Health Services, actually here in New York City Department of Health.

With me today are Jessica Lee and Susan Shrands [sp?]. Miss Lee, to my left here, is a registered nurse who is the Vice President of Operations for Corizon Health here in New York City and she oversees the implementation of our contract with the City. Miss Shrands, who is sitting in the third row of the audience here, is Corizon Health's Chief Operating Officer for the Northeast Region. I'm also joined at the table by my colleague, Dr. Jay Cowan, the President of Correctional Medical Associates of New York, whom you'll hear from in just a few minutes.

Corizon Health is the founder of Modern Contract Correctional Health Services. Our company, whose origins are more than 35 years old, was created by a merger of the company Prison Health Services and Correctional Medical Services.

We serve approximately 345,000 inmates in 27 states, we operate the health care systems in jails, such as Philadelphia and St. Louis in addition to New York City.

Our Chief Executive is Dr. Woodrow Myers, a nationally recognized public health expert and a former Commissioner of the New York City Department of Health.

Corizon Health, first through its predecessor PHS provided comprehensive health care services to New York City's inmates since January 1, 2001. Our contract with New York City is unique; first, New York City provides more services to inmates than any other jurisdiction in the United States. The care you required to be provided is more complete and comprehensive than anywhere else in the country, something certainly to be proud of. Second, the Department of Health and Mental Hygiene programs for Rikers actually have three components to them -- Corizon Health, Correctional Medical Associates of New York (CMA) and Correctional Dental Associates of New York (CDA). In the most simplified description, CMA is the entity that provides all the medical and mental health services, which CDA provides all the

dental and oral surgery services. Corizon Health provides the administrative and business management services, such as overseeing the entire contract and making sure that there is full compliance with its terms, such as issues of staffing, purchasing; information technology support. We provide all human resources services, including credentialing, screening potential employees, orienting new hires to safety procedures and policies and tracking the statistical data of all the patients. We are the administrative liaison to the Department of Health and Mental Hygiene and the three unions. We also coordinate the care of the patients, for example, scheduling and coordinating their off Island appointments, such as when they need to see a doctor at Bellevue or at Elmhurst Hospitals.

Corizon Health, CMA and CDA each contribute their expertise. The other outside world this consortium appears seamless, as it should and like public hospitals, many of the approximately 78,000 admissions that we receive each year present with at least one chronic illness and often associated complications and many of our patients had not received regular or consistent care over time.

We work very closely with the Department of Health and Mental Health and I wanna thank Dr. Angell and Dr. Venters who you heard from for their assistance, guidance and collaboration and Commissioner Bassett for her leadership and personal interest in improving correctional health.

Working in partnership with the Department our program is constantly evolving to meet the needs of this underserved segment of our community and to bolster DOHMH's public health initiative. We also especially appreciate Commissioner Ponte's interest and direct involvement in addressing safety issues on the Island. Both Commissioners have opened up new channels of discussion and cooperation, unheard of previously in the history of this contract, to better serve the patients on Rikers Island and to address issues of concern amongst us.

We have seen a significant change in the last year or so and are greatly appreciative of it and look forward to expanding that collaboration even further. We also applaud Mayor de Blasio for his reforms and innovations especially in the area of mental health and look forward to implementing those

initiatives. We cannot agree more that the mental health services at Rikers need to be viewed as part of a full continuum, from police encounter to discharge after incarceration for those who cannot be diverted along the way.

Before I turn to Dr. Cowan, let me make one more point and that is that every person who works for CMA or Corizon Health is personally affected when a patient suffers an adverse outcome. Our goal is to give the best care that we know how to give; we don't cut corners, we have no incentive to do anything but give the best care that we can possibly give. And let me explain. We have, as you heard, Dr. Angell describe the Cost Plus contract; in that contract staffing levels, range of services; quality measurements are all established by DOHMH. Failing to provide these services is wrong and contrary to the values of our company and our providers; to say otherwise is not understanding the contract and really not understanding the dedicated men and women who do serve on the frontlines, providing care to a very difficult population in very difficult circumstances.

Dr. Cowan will now talk about medical services and operations on Rikers and then we'd be happy to answer any questions that you may have.

DR. JAY COWAN: Thank you, Dr. Johnson. [background comment] Thank you, Dr. Johnson. And thank you to Chair Johnson, Chair Crowley and members of both committees for this opportunity to address you this afternoon regarding the quality and access of health care at Rikers Island.

My name is Jay Cowan; I'm a physician and I'm President of Correctional Medical Associates of New York, commonly known at CMA. As Dr. Johnson mentioned, my colleagues and I provide the actual medical care to Rikers Island inmates. I am Board Certified in internal medicine and gastroenterology and licensed to practice medicine in the state of New York. I've been practicing internal medicine for more than 25 years. I'm a graduate of Brown University, Howard University Medical School and prior to my current position I practiced medicine in Harlem for 15 years, both at Harlem Hospital and North General Hospital.

I'm joined by my partners, Dr. Neil Leibowitz, a Board Certified psychiatrist and

Director of our Mental Health Services and Dr. Luis Cintron, my Deputy Medical Director, who's also Board Certified in internal medicine.

As Dr. Johnson explained, CMA operates all of the medical and mental health services on Rikers Island. It is our responsibility to make sure that the medical care is provided at the highest level, a responsibility I take very seriously.

Our services being as soon as inmates enter DOC custody. We are charged with providing a thorough and complete examination of every patient prior to them being housed. This is a service that is provided 24 hours a day, 7 days a week 365 days a year. East patient receives an examination that takes on average of an hour to complete. This is an underserved patient population that suffers from health care disparities.

Some of the patients of course have been through the system before, but no matter how recently they've been through the system, they still receive a thorough examination. We give each patient a careful and thorough examination. The clinician determines what lab tests and other screenings need to be done for each patient. The mental health screening is

also conducted and inmates with mental illness are referred for further evaluation and treatment. In addition, patients are tested for tuberculosis, provided counseling with regard to their respective condition, given the appropriate medication and offered the opportunity to take an HIV test and counselor with regards to sexually transmitted diseases.

About 35 percent of new admissions to Rikers Island have a chronic medical problem. Since the institution of electronic medical records, we are now better able to track these patients throughout their stay. Our doctors, physician assistants, nurse practitioners, nurses, pharmacists and psychologists and others provide comprehensive services in 11 facilities across the Island. We provide primary care, specialty care and emergency services. There is an on-site dialysis unit, a communicable disease unit, OB-GYN services, a nursery, methadone maintenance, as well as drug and alcohol detoxification programs.

We do this in an extremely complex environment for a patient population that is not there of their own choice. We staff clinics 24 hours

a day; patients can access these services through sick call, chronic care follow-up, medical emergencies and specialty services. An on-site emergency care is available 24 hours a day at our urgi center. The center is staffed by Board Certified emergency room physician that are equipped to handle a wide range of medical emergencies.

Patients who have needs that cannot be met on the Island and those with life-threatening conditions are transferred to an HHC hospital by FDNY Emergency Medical Services.

As you all know, the percentage of inmates with mental illness issues has greatly increased; this has put additional strain on our ability to provide care for all of our patients. We are deeply appreciative and thankful for the additional funding that the Mayor and the City Council provided which has allowed us to almost double the number of mental health professionals that we employ on Rikers Island.

Violence continues to be a major problem on the Island, but as an employer who cares about the well-being of patients, the correctional staff and every one of our employees, I wanna acknowledge the

reforms that have been begun by Mayor de Blasio and Commissioners Bassett and Ponte.

For example, panic buttons are now being installed in mental health cubicles, where correctional officers cannot be within hearing distance for privacy reasons. Also, the DOC is working with us on enhanced safety training for all of our staff. No one should have to come to work and worry about their personal safety. We continue to work with our counterparts to secure a safe environment for all of our staff.

Finding people who want to enter such an environment is difficult; it takes a special person to wanna work in a jail setting. Our 900 employees come to work every day to provide the highest quality care to the 11,000 individuals on Rikers Island. They come to work with the understanding that they deliver this care in an often hostile environment. Our employees see it as a calling to help others who don't have any other health care available to them.

We work very closely with the officials of the Department of Health and Corizon to find new and innovative ways to deliver care. Over the last year our partnership with DOHMH has enabled us to

institute some cutting edge programs that are already leading to better results for our patients. For example, there are not specialized housing units for the mentally ill, which provide more nurses, more observation opportunities and more programming. Medication compliance has increased. Our medical staff keeps up-to-date on new advances and trends in medicine; to further this, we instituted Island-wide monthly conferences and weekly lectures specifically concerning correctional medicine so all of our practitioners can continue learning and give back to their patients.

Our employees are ethnically diverse and most of them are from New York City. Virtually all of our employees are members of 1199 SEIU, New York State Nurses Association and Doctor's Council SEIU; they deserve the respect they earn through their hard work.

Providing comprehensive health care in this complex environment is a daunting task, but one that we are honored to perform every day on behalf of the citizens of this great city. We are committed to working with the de Blasio Administration, the Department of Health, the Department of Corrections

and the City Council in any way we can to continuously improve the quality of care at Rikers Island. Thank you.

CHAIRPERSON JOHNSON: Thank you, Dr. Johnson and thank you, Dr. Cowan for being here today and for your testimony; I really do have no doubt that the health care workers employed by CMA are dedicated and that they take their mission seriously and furthermore, that they are deeply affected when a patient dies in their care.

I wanna read this again, because you didn't talk about any of this. In the past five years there have been over 15 deaths at Rikers Island in which the quality or timeliness of health care was an issue. The deaths reported include a 36-year-old man with a severe seizure disorder who died two days after he was place din solitary confinement and was denied medication. A 59-year-old drug addict was not properly assessed for constipation, a common side effect of methadone, and died of a bacterial infection in his stomach and intestines after days of bloody stools. Inmates suffering from asthma who were not properly treated. An inmate who died of sepsis after being turned away from the clinic

because of a high number of emergency patients before him. An inmate that within two days of arriving at Rikers died under diabetic coma. An inmate that was placed in a holding cell with his hands cuffed behind his back and died of a sudden heart problem. An inmate that was confined to his cell for seven days, denied access to food, water; medical care for his schizophrenia or insulin for his diabetes and as Chair Crowley has mentioned a few times, Andy Enriquez, a 19-year-old who was never given a chest x-ray and died from a tear in his aorta.

None of that was mentioned in your testimony. So what we have to distinguish between is not the able and committed job that these workers are doing, and I believe that they're likely doing on Rikers Island in these challenging circumstances; I think that you outlined quite well the difficulty that we see at Rikers; the question is whether your leadership, the leadership at Corizon, at CMA brings the drive and commitment to innovate that this system needs. What kinds of process and system reforms are you recommending and implementing? When there is an arguably preventable death, do you undertake the kind of root cause analysis that hospitals and other

first-rate institutions undertake? I'm happy to hear that you're happy to get all these additional monies for the seriously mentally ill; were you requesting that? Were you identifying for years, here are the endemic problems at Rikers Island that we're facing so that these preventable deaths don't happen? These patients and inmates are in your custody and care, they're in the Corrections Department custody, but they're in your care. What is the leadership doing at Corizon to stop this from happening? That is what I wanna know, because you didn't mention any of that in your testimony. So we can go through case-by-case, but what are you doing to stop this, because I don't wanna come back three years from now after a contract's renewed and we have more of these awful cases that we're hearing about because people are being denied the treatment that they deserve?

DR. CALVIN JOHNSON: Alright, thank you, Chairman Johnson and you posed very fair and legitimate questions and we certainly understand and respect your indignation and seeming [sic] frustration around this.

So let me answer first by telling you that yes, absolutely, the leadership of Corizon is

very committed to providing very high quality health care, to identifying the causes and the problems when horrible events like ones you described happen to people, to patients, people who have family, people who came with an expectation of getting good care and getting better, in typical instances, so we are very committee to that. And we do have very real systems in place to address what often are systems issues and breakdowns, because to your point, the individuals who are the care providers are credentialed, license professionals who are doing the absolute best job that they can, given circumstances that they're in, given very complex medical conditions, very complex and difficult environments to work in. So every time there is a death or an injury or some other significant healthcare-related event, Corizon, it triggers what is called a sentinel event and that sentinel event is that this a company-wide trigger and when a sentinel event happens, what that triggers is a very comprehensive and thorough review that takes place at multiple levels, it takes place at the site level where that incident occurred, it takes place at a regional level, a step away that can then take into account issues, concerns; irregularities

that would not necessarily be identified, recognized or seen as clearly at the site level.

CHAIRPERSON JOHNSON: Can you walk me through an incident where a sentinel event occurred and let me understand specifically what you all did in response to that sentinel event?

DR. CALVIN JOHNSON: So I don't know if I'm allowed to speak to any specifics… [crosstalk]

CHAIRPERSON JOHNSON: Speak generally.

DR. CALVIN JOHNSON: specific case, but I will speak to -- so in generally. So there was a bit of talk about and concern around suicides and suicide prevention and so a suicide will trigger an immediate sentinel event and so what then happens is that at the site level the chart is then gathered by the senior medical official at the site level and then the regional medical official comes in and does a thorough chart review to ensure that the appropriate care was delivered, appropriate screenings were done, appropriate diagnosis was made and appropriate treatment was written for and carried out for that individual. That incident is also then driven up to the sentinel event committee, which is a committee of multiple professionals that includes health care

professionals, as well as legal professionals and operational professionals, those who make sure that obviously the trains run on time and that the clinic processes are in place. A review is done primarily by the clinical element there that then again looks at a higher level as to what was done, what was not done in that instance of care; what is required of the site then where the incident occurred is something called a corrective action plan; that corrective action plan, as prescribed, elements of it speak to the specifics of the incident and what specifically triggered it, what specific steps will be taken then to correct it and prevent it from happening again; who was responsible for carrying out elements. That corrective action plan is then monitored and tracked and elements of it ensured or carried out by the sentinel event committee and our quality and patient safety; we have a vice president of quality and safety who is responsible for ensuring then that those corrective action plans get carried out. So it bas… [crosstalk]

CHAIRPERSON JOHNSON: So Dr. Johnson, you just took me through what, and I appreciate that you took me through what is basically root cause

analysis, I mean that's what's done at hospitals and at institutions and you know, the Office of the Chief Medical Examiner, these things are done regularly to have a check and to understand what happened in that individual case. I assume that in the 15 cases that I outlined that I would hope that that was done in those 15 cases, but what I want to really understand is what came out of that; have there been any specific reforms; have there been any recommendations that after performing these cause analyses after these sentinel events, what have you all learned and tried to implement so that this doesn't happen again?

[background comment]

DR. CALVIN JOHNSON: All the cases you've identified, and I cannot discuss them, you know, individually, but generally speaking, all the cases that you have identified at Rikers Island have gone under stringent review as a chart review, mortality review, internally with CMA staff and Corizon and Island-wide with oversight from DOHMH. We review every chart from day of admission to day of discharge, day of death and corrective actions have been identified for each particular case if and when we believe an omission or commission has taken place.

CHAIRPERSON JOHNSON: But I was asking for something system-wide; not individual cases, but are there recommended reforms that look at the broader picture Island-wide or facility-wide that you've learned from looking at these sentinel events?

DR. CALVIN JOHNSON: I apologize. So the corrective action plans that are addressed look to system issues that transcend an individual case and may involve one or many facilities. For example, transportation of people on suicide watch, it's a concern for us; we now as a medical company track movement of our patients in custody from one facility to another facility, ensuring that they get to where we want them to be in a timely manner and get the services that that facility can provide for them.

CHAIRPERSON JOHNSON: Okay, I'm gonna move to my colleagues in a moment for questions. I just want to drive home the point, and correct me if I'm wrong; I mean I am very sympathetic with the de Blasio Administration and the new leadership of the Department of Health and Mental Hygiene and the new leadership of the Department of Corrections, because they inherited a goddamn mess from the Bloomberg Administration; Rikers Island was like the

wild west and as much as people wanna talk about what a great manager Mayor Bloomberg was, what the hell was happening on Rikers Island all these years under different corrections commissioners? These new monies that have been identified and that this administration has put in the budget for seriously mentally ill people, for the CAPS unit, for the PACE unit, for diversion issues, all of these things; were you guys recommending that years ago? You've been there a long time. What recommendations have you all made, over years of dysfunction, to make the place better? You're thanking us for the money now, but what proactive steps have you all taken to say here are the issues, help make it better for our workers and for the inmates?

DR. CALVIN JOHNSON: So first of all, in regards to the safety concerns for our workers, that's a priority for us. Our workers should not be subjected to coming to work every day in an unsafe environment.

CHAIRPERSON JOHNSON: You're not answering the questions. What is the answer to what recommendations you have made over the years to try to make Rikers Island a better place? What have you

asked the City for? Besides getting $140 million a year to provide the services, what have you all done to say this is what we do to make it better? The testimony was great; I'm wondering, you know, what actual proactive things you're doing.

[background comments]

DR. JAY COWAN: So there are some significant problematic issues at Rikers Island; I think we all agree; I am passionate about the care that we deliver at Rikers Island, but there are some obstacles to us being able to deliver that care in a timely manner and I think we're all aware of what some of those obstacles are. We work with our client, the New York City Department of Health on a weekly -- actually, daily basis at Rikers Island, discussing issues that are pertinent to the way in which we can deliver quality care in our clinics across the Island, we… [interpose]

CHAIRPERSON JOHNSON: Were you asking for these monies a long time ago… [crosstalk]

DR. JAY COWAN: We…

CHAIRPERSON JOHNSON: for more mental health providers?

DR. JAY COWAN: We work with our client…

CHAIRPERSON JOHNSON: You're not answering the questions.

DR. CALVIN JOHNSON: Mr. Chairman, I think that discussions… [crosstalk]

DR. JAY COWAN: We… we…

CHAIRPERSON JOHNSON: He's being evasive.

DR. JAY COWAN: I don't mean to be evasive, sir… [crosstalk]

DR. CALVIN JOHNSON: Let me respond this way. And so, you indicated and your colleagues indicated, in the course of this morning, the complexity of the structure of care delivery for inmates at Rikers Island and so that complexity I think works in many ways and there are reasons for it being in place, but I think it also speaks to the fact that it's not as simple and direct a one-to-one correlation as ask and receive, and so when issues like this occur, the partners involved -- there are, as Dr. Cowan's indicated, there is regular and consistent dialog, engagement and involvement. This is a partnership in delivering care on Rikers Island; there's… [crosstalk]

CHAIRPERSON JOHNSON: Okay, you're still not answering the questions; I'm gonna turn it over to the chair, but… [crosstalk]

DR. CALVIN JOHNSON: Mr. Chair, I certainly… I am trying to answer questions… [crosstalk]

CHAIRPERSON JOHNSON: Well I'm saying; what recommendations have you made over the years to try to make the place a better place? The de Blasio Administration stepped up, came up with tens of millions of dollars to try to change course at Rikers Island after years of violence and endemic systematic problems; you've been there for a long time; you were there in the Bloomberg years and you're there in the de Blasio years; I'm not hearing anything specific about what you all have recommended over the years to make the place a better place to get more money to provide care in the way that you think would benefit your workers and to benefit the inmates on Rikers Island. So you know, I'm not gonna keep asking; I'm gonna turn it over to Chair Crowley.

CO-CHAIR CROWLEY: Thank you, Chair Johnson. Before I begin my line of questions, Council Member Cohen has quick questions; he has to

go, he has a 1:00 appointment; I'm allowing him to ask questions; he's next after me and then I'm gonna come back to me.

COUNCIL MEMBER COHEN: Thank you so much, thank you, Chair Crowley and Chair Johnson; thank you doctors for your testimony. I just have two lines of questioning. You talked about in your testimony panic buttons for when it might not be appropriate because of privacy concerns to have a corrections officer present during treatment; how do you strike that balance; I mean that seems like a very difficult -- what are the parameters on which decisions are made?

DR. JAY COWAN: And thank you for that question; you're absolutely right, it's a difficult decision to have to make. In our mental areas it's extremely important that the doctor-patient relationship be a good relationship, especially when it comes to mental health. There's privacy issues, so correctional officers should not be privileged to that conversation that occurs between a clinician and their patient; however, jail is a violent place; we do have what's known as an aggressive patient alert list; it was referenced to before in the Department

of Health's conversation. There are some 265 people on the aggressive patient alert list; providers, before they see a patient, review this list and see if the patient pops up; if they do, they -- if the patient is on the list and they're about to see this patient, they reach out to a correctional officer in the clinic and possibly even the captain, to assist with that encounter. They do have cuff bars in certain cubicles now for extremely aggressive patients, but it's a balance that we deal with every day, sir and it is difficult.

COUNCIL MEMBER COHEN: Just going back to the financing question; I don't wanna get myself in trouble, but the Department of Health said that you had no disincentive to not provide services, but I guess is really the model sort of where the Department of Health is like the insurance company, you're the provider and the inmates are the patient; if you wanted to provide services, do you have to go to the Department of Health and say this inmate needs something unusual or do you have to clear services with Department of Health before you provide the services?

DR. JAY COWAN: The analogy you just utilized, I don't agree that I look at the Department of Health as an insurance company. We work hand in hand with the Department of Health every day. We have what's known as a matrix and it's approved by the Department of Health, it's a staffing matrix that tells us how many physicians, how many physician assistants, how many mental clinicians; how many nurses are in a specific clinic at a designated hour on an 8-hour tour, and the funding is provided for that. This is something that is agreed upon by CMA, Corizon and the Department of Health.

DR. CALVIN JOHNSON: So if I could just add to that, Councilman. So it is a planned process where expenses are essentially determined what expected expenses would be, and so there's formulas; there's calculations that go into what the expense would likely be and so that's what the budget is built around. In instances where there may be a particularly unusual high expense, there is, as Dr. Cowan indicates, there's consistent and continuous dialogue between Corizon and CMA and the Department of Health so that it's not a blank check in any way and that the care… that the care

decisions, cost of care, if exorbitant, are actually discussed so that if there's something that deviates from what is planned other than staffing issues or otherwise that way. So I hope that answers your question some, sir.

COUNCIL MEMBER COHEN: Thank you.

CHAIRPERSON JOHNSON: Council Member Barron.

COUNCIL MEMBER BARRON: I wanna thank the Chairs for allowing me to get my quick question in and brief comment, because I do have another committee hearing. Dr. Cowan…

DR. JAY COWAN: Excuse me, yes.

COUNCIL MEMBER BARRON: and Dr… [background comment] Johnson; Dr. Johnson, in your day-to-day operation, to whom do you report?

DR. CALVIN JOHNSON: I report to the Chief Executive Officer of the company.

COUNCIL MEMBER BARRON: And you do that on a daily basis?

DR. CALVIN JOHNSON: Yes.

COUNCIL MEMBER BARRON: Okay. And they didn't think that it was important enough for them to come and be here?

DR. CALVIN JOHNSON: No, I wouldn't say that, ma'am.

COUNCIL MEMBER BARRON: Okay. I'm surprised that given the nature and the severity of this hearing that someone else wouldn't be here in addition to you. And my comment is; I was very, very disheartened and annoyed and angered that in none of your testimony did you cite the deaths of those persons who were at Rikers; not to give any personal details or individual information, but to make mention of the fact that it happened; to me it sends a signal that those lives are perhaps not as important as other lives and I'm very offended that you wouldn't at least mention that that's a big problem with your organization, not to have mentioned that they occurred.

DR. CALVIN JOHNSON: Councilwoman, if I may, again, I understand your… I understand what you're articulating; please don't take from us the lack of a specific mention in prepared remarks any consideration or… [crosstalk]

COUNCIL MEMBER BARRON: Or you… I said it's not in the prepared remarks or perhaps they will make an insertion to acknowledge that this is a

problem. You talked about the employee problems and all of that, but to not have mentioned it is really offensive… [crosstalk]

DR. CALVIN JOHNSON: Well I think we… I think, with all due respect, that we have indicated that when these events occur as have happened on Rikers Island, it is a very serious event; it is taken very seriously. We recognize these individuals who have lost their lives or who have been injured not as numbers; not as indiscriminate or no-name patients, but as people. They're our patients; we know that they are connected to and attached to real people and so please, please, if we gave that impression… [crosstalk]

COUNCIL MEMBER BARRON: That's the impression I got.

DR. CALVIN JOHNSON: I apologize… I apologize directly to you… [crosstalk]

COUNCIL MEMBER BARRON: It is the Chair who had to bring it to your attention that this is significant and was not in your testimony.

DR. CALVIN JOHNSON: Well that was not our intent in any way.

COUNCIL MEMBER BARRON: Thank you, Mr. Chair.

CHAIRPERSON JOHNSON: Thank you. Chair Crowley.

CO-CHAIR CROWLEY: Thank you, Chair. I have a question as it relates to other municipal contracts Corizon has. Is the contract with New York City your largest contract?

DR. CALVIN JOHNSON: No; the New York City contract is not our largest contract… [crosstalk]

CO-CHAIR CROWLEY: Well what…

DR. CALVIN JOHNSON: it may be our largest municipal contract, jail contract, yes. Yes. I'm sorry, yes… [crosstalk]

CO-CHAIR CROWLEY: Yeah, so it's your largest municipal contract… [crosstalk]

DR. CALVIN JOHNSON: Uhm-hm.

CO-CHAIR CROWLEY: And despite your performance, you still get your profit?

DR. CALVIN JOHNSON: Well in the contract, as Dr. Angell indicated, there is a flat fee that is part of this contract… [crosstalk]

CO-CHAIR CROWLEY: But regardless of your performance, you still get the same profit?

[background comments]

DR. CALVIN JOHNSON: So there are ways that the City takes back money, or financial penalties if certain measures are not adhered to or met.

CO-CHAIR CROWLEY: Did you receive any financial penalties when you were downgraded in your rating last year?

DR. CALVIN JOHNSON: Dr. Cowan; you wanna speak to that?

DR. JAY COWAN: Could you please repeat the question?

CO-CHAIR CROWLEY: My question earlier was; despite your performance, you still receive a profit from your work that you do on Rikers Island? When you were downgraded last year in your performance rating, did you receive any penalties or did you still receive the profit you were expecting?

DR. JAY COWAN: The penalties that are assessed at Rikers Island are based upon the performance indicators…

CO-CHAIR CROWLEY: Right.

DR. JAY COWAN: the 40 performance indicators. When we… [interpose]

CO-CHAIR CROWLEY: Did you receive a penalty last year? That's a base question -- yes or no; if yes, then I would like to know how much.

[background comments]

DR. JAY COWAN: There were penalties assessed last year, yes, Councilwoman. [background comment] When you look over time with those performance indicators and the amount of penalties that have been assessed, they have declined over time, so that last year was less than in previous years… [crosstalk]

CO-CHAIR CROWLEY: How much was your penalty that you were assessed with last year?

DR. JAY COWAN: Do you have that? I don't have the exact figure; I can get that for you though. Our penalties are assessed on a quarterly basis, our PIs are monitored -- the 40 PIs that were referenced to earlier are monitored by oversight from the Department of Health on a quarterly basis.

CO-CHAIR CROWLEY: Did you receive any penalty for your downgrading, anything specific to that?

DR. JAY COWAN: No, there was no financial loss for the downgrade from good to fair on the evaluation for 2013 that we were aware of in 2014.

CO-CHAIR CROWLEY: Okay. And now, your contract in any given year is over $120 million; you receive at least a 4 percent profit, based on what the Department of Health said.

DR. CALVIN JOHNSON: In their calculations, I think she may have referenced that it may average out to that; there's a flat feet and then there is a small profit of 4.25 percent is what she indicated… [crosstalk]

CO-CHAIR CROWLEY: Okay. Well what was your profit last year, after you paid for your staff; I know you're not paying for malpractice insurance, so what was your profit?

DR. CALVIN JOHNSON: I don't have the profit information here with me; I can give you… we can give it… [crosstalk]

CO-CHAIR CROWLEY: How do you not know your profit from last year?

[background comments]

DR. CALVIN JOHNSON: I didn't come prepared with profit; I came to talk about the health care aspects of this… [crosstalk]

CO-CHAIR CROWLEY: I mean, representatives, you said -- and I feel for your staff, I do; I can't imagine what it's like [background comment] for them to be stretched as thin as they are to try to provide quality service when there aren't enough clinicians or doctors [background comment] and make matters worse, they worry about their own physical [background comment] safety, okay… [background comment] you said it's complex, there are obstacles, it's daunting; what are those obstacles that are daunting and complex?

DR. JAY COWAN: Well, and getting back to your question, Councilman, the new PACE units; the new CAPS units, we work with Department of Health and design those units, the opening of the CAPS unit that opened up a year-and-a-half ago for patients with serious mental illness, we work with our client and we worked on staffing and budgetary guidelines for those units with Department of Health. The PACE units as well, Dr. Leibowitz and the mental health staff work with the mental health staff of Department

of Health, looking at the staffing needs and the requirements of the mentally ill and come up with proposed requests for funds, if that's what you're referring to.

CO-CHAIR CROWLEY: No, I wanna know what your excuse is for not providing care when you have inmates in need of care, when they go undiagnosed or untreated.

DR. CALVIN JOHNSON: Councilwoman, I think… I think it is… it's unfair to characterize us as wanting to or seeming to want to withhold care; there are issues Dr. Cowan has described that certainly indicate that there are issues in delivery of care to 11,000 inmates at any given time, 78,000 admissions a year; that is no question about that; any health system, any health care provider has that and we are no different in that and we acknowledge that. We've tried to share with you as well processes that we have and efforts that we've taken to correct those issues when they come to light, to try an identify them in advance to try and prevent reoccurrences of the same type of instances. And it is an ongoing challenge, there is no question about it.

CHAIRPERSON JOHNSON: Thank you. Thank you, Chair Crowley. I mean we're gonna… I have a few more questions. You know, Corizon has been subject to multiple investigations by the New York State Commission of Corrections, including recent inquiries into the deaths of inmates and inmate injuries; the SCOC report cited lapses by the City and Corizon that violated State Law and that "directly implicated in the death of Bradley Ballard." The report concluded that "had Ballard received adequate and appropriate medical and mental health care and supervision intervention when he became critically ill, his death would have been prevented." The medical and mental health care was so incompetent and inadequate as to "shock the conscience." Among the report's recommendations for the Department of Health was to consider whether Corizon "is fit to continue in light of delivery of flagrantly inadequate substandard and dangerous medical and mental health care to this individual." I know you can't talk about it because there is litigation that's ongoing; that's damning, that's a damning excerpt from this report; think it's important to say; I mean we're talking about people's lives here.

Okay, you made some -- I wanna understand; you stated in your testimony that the relationships between DOC, DOHMH, Corizon, CMA and CDA is complicated; we know that. You stated that it could be improved somehow; how could it be improved? How could this interplay amongst all these different players be improved?

DR. CALVIN JOHNSON: Well can I first say that with regard to the case that you mentioned, that we stand ready to work with Department of Health and Mental Hygiene, Department of Corrections and all others to ensure that nothing like that ever happens again, so. In terms of what can be better, a specific thing [sic].

DR. JAY COWAN: For example, as President of CMA, I'm on the Island every day, Monday through Friday supervising and caring for patients; one of our concerns is better communications with Department of Corrections so that Health and Department of Corrections understand the similar mission when it comes to caring for inmates. We now have established a clinic-captain's meeting where medical staff, nursing staff and correctional captains in the clinic that are in charge of production of patients at the

clinic meet on a monthly basis to discuss productivity.

CHAIRPERSON JOHNSON: Does the contract that you all receive through Corizon, CMA and CDA, does it provide for enough staff to properly administer health services?

DR. JAY COWAN: We certainly welcome additional funding for… [interpose]

CHAIRPERSON JOHNSON: Does it provide, currently, right now; does it provide enough money to adequately deliver health care services to the current inmate population on Rikers Island?

DR. JAY COWAN: Given…

CHAIRPERSON JOHNSON: It's a yes or no. The money that you receive right now; can you deliver the care?

DR. JAY COWAN: Given the significant issues regarding mental health, I would have to say no.

CHAIRPERSON JOHNSON: No. Okay. So that's good to hear, because I think that's in line with what DOHMH said; they got new monies, they expanded PACE, they created CAPS, they're trying to

do these things to help the serious mentally ill people on Rikers Island.

DOHMH has implemented an innovative EHR (Electronic Health Record) system for the correctional system; is Corizon staff fully trained in using this system? Does your staff know how to use it?

DR. JAY COWAN: Yes.

CHAIRPERSON JOHNSON: How can it be leveraged to improve health outcomes?

DR. JAY COWAN: We use it every day. The issues regarding eClinicalWorks, which is the electronic health record we have, it took a while to get it up and running; it's an electronic medical record that was utilized in the community and now we've attempted to taper it for correctional health care. We, working with IT from the Department of Health have been able to design templates that track chronic care illnesses, such as diabetes, hypertension, seizure disorder, chronic Hepatitis C; asthma. So as I referenced the 35 percent of patients that are coming on intake with a chronic medical problem, we're able to closely monitor them and track them throughout their stay.

DR. CALVIN JOHNSON: And on EHR can have triggers built into it that will do things, like flag when a certain parameter of care may not have been completed or prevents you from going on to the next step of care if a particular pathway was not done to ensure that a particular condition may have been ruled out. So it can be used in that way as an adjunct to the clinical care to help make sure that certain clinical signs; symptoms are not missed and avoid poor outcomes that way.

CHAIRPERSON JOHNSON: And… and… [crosstalk]

DR. JAY COWAN: And it also allows us to work more toward outcome measures of quality of care, which I believe is one of the reasons why this meeting was called today, to look at the quality of care at Rikers Island, how you measure quality of care in a correctional facility. And I believe that the electronic health record allows us to do a better job and track process improvements as well as outcome improvements.

CHAIRPERSON JOHNSON: I think you're right and I'm very glad that this was implanted in 2008 and I hope that it's working to help your

clinicians and doctors to actually improve care and quality of care there.

Last year Corizon was issued the highest level of censure by the Federal Occupational Safety and Health Administration (OSHA) for failing to protect its employees from violence at Rikers Island and was fined $71,000; you talked about, both of you, in your testimony that the safety and well-being of your employees is of utmost importance to you all in a very dangerous environment; you talked about how or we heard from that panic buttons are now being installed in places where correction officers don't have a direct line of vision and for privacy reasons for the inmates that are being handled at the time; why were you fined $71,000 for not protecting your employees?

DR. JAY COWAN: I'm not able to speak to the OSHA complaint directly, but I can tell you what we're doing now. Specifically, we've looked at safety in each of our 11 medical clinics on the Island; we work with employees, Corrections, captains and wardens at the facility level and meet with them on a monthly basis; we've gone through walkthroughs of work areas, the clinic areas where our staff work

day in and day out with Department of Health, with Department of Corrections, with the warden and we've identified issues such as lines of sight, we've identified issues such as requesting officers to roam through the clinic to keep an eye on staff. So we work with the Department of Corrections, who's in charge of providing the security in the correctional facilities.

CHAIRPERSON JOHNSON: So I'm grateful that you all came today; I am very grateful for the work that your clinicians, doctors, nurses; providers do on a daily basis; as you said, Dr. Cowan, 365 days a year, 24 hours a day on Rikers Island; I'm grateful that the system has things in place, like a 24-hour intake so that we're getting information right away. You know, I still feel like there are serious questions which haven't been answered and this is not in any way criticizing individuals who are on Rikers Island providing these services, but again, the leadership question is a big one. When I talked to your chief executive officer before, I went through some of these things; he had no idea; it was embarrassing, I was going through basic information with him; he didn't know what the hell I was talking

about. I'm saying, you're the CEO of Corizon and you don't even know some of the basic things in this report? So you know I'm glad you're there and hopefully getting information, but we need some leadership, we need you all to say okay, we now have 200 beds under CAPS and PACE, we need to get up to 800, given the seriously mentally ill population on Rikers Island; let's work together with Corrections and DOHMH and the City Council to identify how much money that is. You all are the ones providing the care, be proactive, come up with proposals to help the City fulfill its mission in getting people the standard services that they deserve and need. So I hope that there are visions to the contract to bake some of this in a little further if the contract gets renewed and I hope that you all take this -- you know you're saying you take it seriously, but you know, hearing about these families who have lost people on Rikers Island is heartbreaking, because you know, they're not getting insulin medicine or they're being locked in their cells and not getting -- it's awful; that's why I am so outraged and until we get a change in leadership from the top down figuring out how to fix these things, we're gonna keep hearing these

awful things and thank god the press has been all over this; the New York Times has done an outstanding job, as has the AP and others, in really driving this home and it's not gonna stop. So I'm grateful you came here today; I hope that you come to us proactively or in budget season; we can work to get more money to fix things on Rikers Island, but I, you know don't feel confident given that you've been there for so long and that these problems have persisted and have been so endemic and rooted there. Start to change course, come to us proactively with systems reforms and what you need to fix things at Rikers Island. Thank you for coming today. We're gonna go to our next panel.

DR. CALVIN JOHNSON: Thank you, Mr. Chair.

DR. JAY COWAN: Thank you.

CHAIRPERSON JOHNSON: Lillie Carino and Dr. Matthews Hurley from Doctors Council.

[pause]

CHAIRPERSON JOHNSON: So we have to be out of this room in the next 15 minutes, but we're not ending the hearing because I wanna hear from everyone and this is very important, as you can tell.

So what we're gonna do it, we're gonna hear from this panel and their testimony and then we're gonna move next door to the cafeteria and we're gonna set that up as a hearing room, because there's another hearing after this, so we have to be out to be respectful to the Civil Rights Committee which is meeting and then we're gonna move next door so that everyone has the opportunity to testify. You may begin in whatever order you'd like; please identify yourself for the record and speak directly into the mic.

LILLIE CARINO HIGGINS: Good afternoon. I'm Lillie Carino Higgins; I'm the Director of the Political Fund at 1199. In the interest of time, I am not going to read my testimony; it is four pages long, but I want to point out the three issues that we at 1199 find need to be addressed in order to improve the conditions for the workers.

The first is the issue of the 40 percent of inmates suffering from mental illness and there not being sufficient beds to treat them. Many of them are in prison for low-level crimes and/or violations and just can't post bail. If that number is accurate, corrections officers must receive training on how to deal with that population; that is

currently not occurring at levels that we are comfortable with.

With regard to workers' safety, we know that not all inmates are mentally ill or violent, but these are prisons and the City is responsible for ensuring the safety of these workers, the visitors and the inmates. We can sit here and blame Corizon, but coordinating with DOC has been a big issue for us and if this is not addressed, every successor provider, be it HHC or Damian, will have the exact same issues and the exact same results. Corizon doesn't run the facilities and they cannot assign or direct the officers to protect anyone.

And then the third is that the staffing levels of corrections officers are just inadequate; there have been cuts and given the change in the population, it is absolutely essential that they increase the levels of staffing, because one shutdown in the facility, you basically have to redirect all of the medical appointments and patients are just not getting medication, which just leads to other incidents.

So generally we support the concept of Int. 0440; we would like to have all of these reports online, and I'll be answer any questions you have.

CHAIRPERSON JOHNSON: Dr. Hurley.

DR. MATTHEWS HURLEY: Good afternoon, Chairman… [crosstalk]

CHAIRPERSON JOHNSON: If you could turn your mic on; make sure the red light's on. Thank you.

DR. MATTHEWS HURLEY: Good afternoon, Chairman Crowley, Chairman Johnson and members of the Health and Criminal Justice and Fire Committees. My name is Dr. Matthews Hurley; I'm Vice President of Doctors Council SEIU, which represents thousands of doctors in the metropolitan area, including every HHC facility, the DOH and New York City jails, including Rikers and Vernon C. Bain Barge.

Doctors Council SEIU is here today in support of Int. 0440 and to provide input in the state of access to quality care at Rikers and VCBC, from the perspective of the frontline medical workers.

Over the course of the last two years Doctors Council has worked with the New York City

Board of Corrections in helping to convene various parties, including the DOC, Corizon, DOHMH, NYSNA, 1199, COBA and other stakeholders to ensure that stronger workplace safety standards at Rikers Island continue to be a priority. The environment in which doctors and nurses and other health care staff operate has clear implications for patient care. Last year the U.S. Department of Labor (OSHA) cited Corizon for two violations of federal workplace safety laws; the allegations include a charge that the company willfully failed to protect its employees from violence; we call on Corizon and DOC to work together to follow the important recommendations that OSHA made to correct the safety violations.

While many of our members are incredibly dedicated doctors who have worked at Rikers for 10 years recruiting and retaining doctors and psychiatrists in this difficult and sometimes dangerous work environment is very challenging and VCBC, an outside vendor, has recently taken over medical services and continues to face significant recruitment challenges.

Health care workers need to know that the work environment is secure and there exists a culture

of engagement and collaboration among agencies working at Rikers. Employee training on safety and security procedures is critical for Corizon staff, as well as training on how to prevent or minimize risk of assault. Doctors Council supports the recommendations of OSHA findings, which recommends protocols for treating inmates that pose a high risk for violence, implementing physical plant changes, such as reconfiguring treatment areas for better egress and sightlines with correction officers, installing panic alarm buttons, cuff bars and Plexiglas in treatment rooms. Collecting statistics on medical worker assaults is important to understanding the climate that the doctors work in.

Currently staffing is below where it should be at Rikers and VCBC. For example, there are 11 full-time vacancies and 1 psychiatry vacancy at Rikers out of 60 full-time doctors; that is about 20 percent full-time vacancy rate. Furthermore, mandated overtime totaled about 3,000 hours in 2014; one psychiatrist was mandated 300 hours overtime in 2014, which equals to about 37 tours. This is not including voluntary overtime.

While the overall number of inmates at Rikers has declined, the complexity, acuity and percentage of mentally ill inmates has increased; more doctors are badly needed on the Island to address these demographic changes. While Corizon is the employer of health care staff at Rikers and they have a responsibility to act, the reality is that all of the involved parties must work together to enact change. For example, getting inmates to the clinic for treatment in a timely fashion is the domain of the DOC, the number of cancelled follow-up appointments, wait times and over-crowding waiting areas at Rikers are all indicators that access to care is falling short. Emergencies and lockdowns that shut down clinic operations on a regular basis, as well as lack of escorts further limit access to care. During the second half of 2014, more than 15,000 follow-up appointments made at the AMKC, 8,000 of those were cancelled; that is more than 50 percent of follow-ups were cancelled. We feel that this is imperative that better scheduling and escort systems be established to reduce waiting time for sick inmates and to ensure their timely follow-up care. Inmates at Rikers and VCBC are not in jail for a long

time, they may be there only for several weeks; patient care means ensuring that the bureaucracy is streamlined so that the health care records are available to the medical staff immediately at intake; furthermore, upon release we would recommend coordinating follow-up care in the community at the HHC facilities or hospital of choice and focus on including health insurance access, clinic appointments and necessary prescriptions.

In conclusion, Doctors Council supports the collection and reporting of data on health inmates in the City correctional facilities and recommends looking at appointments, wait times, cancelled follow-ups, examining transfer protocols and times and streamlining health record access, along with increasing workplace safety standards to make Rikers a viable place of employment and accessible in terms of health care to its patients. Thank you for the opportunity to testify.

[background comment]

CHAIRPERSON JOHNSON: Thank you, Dr. Hurley and thank you, Miss Carino for being here today. You know, anyone who takes a job on Rikers Island delivering health care services has to be

commended; I mean it's such a difficult place to work and provide services in.

Dr. Hurley, thank you for educating me today; I did not realize that, you know, close to 20 percent of the needed staff at VCBC is vacant, especially one psychiatry vacancy and we're talking about how large the seriously mentally ill population is there and the number of overtime hours, 3,000 hours in 2014, one psychiatrist mandated 300 hours, which equals 37 tours, is unbelievable; I mean we have to hire more clinicians and physicians and nurses and clinical staff to actually be there to treat on the Island.

How much more staff do you think we need?

DR. MATTHEWS HURLEY: I can't tell you exactly the number; I would have to get back to you… [interpose]

CHAIRPERSON JOHNSON: We at least have to fill the vacancies right away… [crosstalk]

DR. MATTHEWS HURLEY: Yes. Yes.

CHAIRPERSON JOHNSON: And why are they not being filled; because it's hard to attract people?

DR. MATTHEWS HURLEY: It's hard to attract and with the safety record, and those have become great concern, there are disparities between salary structure for those who work on the Island and those who work in HHC facilities, so a lot of psychiatrists and all that will tend to go other places. But those things could be worked out.

CHAIRPERSON JOHNSON: Has… [crosstalk]

LILLIE CARINO HIGGINS: And may…

CHAIRPERSON JOHNSON: Oh go ahead.

LILLIE CARINO HIGGINS: May I just add that the number of additional staff needed is not something that we're prepared to answer, but if we look at the overtime records it would indicate what staff deficiencies exist.

CHAIRPERSON JOHNSON: That's helpful. Has 1199 or the Doctors Council recently, given all of the attention that's being paid to Rikers, have you guys been… the leadership at your unions been asked to sit down with the Department of Corrections, Department of Health and Mental Hygiene and Corizon to talk about what improvements you think could be made to the system?

LILLIE CARINO HIGGINS: There is a safety committee that meets regularly and Dr. Homer Venters is a part of that, as is Corizon and all of the unions that provide health care.

The other thing I wanna point out is that there are closer to 20 unions on the Island, not just the three health care providing unions. You know you've got UFT and DC37, there are a lot of unions there that also need to be brought to the table.

CHAIRPERSON JOHNSON: Do you recommend a similar committee for the provision of medical care?

LILLIE CARINO HIGGINS: There is a committee for medical care.

DR. MATTHEWS HURLEY: I would just say yes, we've been involved from the beginning about patient safety; I know Laurie Davison, our Contract Administrator on Rikers has been very vocal and working hard and Doctors Council as a whole on this issue from the beginning; I'll leave it at that.

CHAIRPERSON JOHNSON: Well thank you both for being so patient and being here all afternoon to testify; I really appreciate that you're here on behalf of your members and they should know that we really do appreciate their service and the important

compassionate work that they provide on Rikers Island and in our facilities, so thank you very much. So… [crosstalk]

LILLIE CARINO HIGGINS: Thank you.

CHAIRPERSON JOHNSON: Oh, do you have a question? Oh I'm sorry. Chair Crowley has questions; I apologize.

CO-CHAIR CROWLEY: Just a few. Thank you. First Miss Carino, well thank you for your testimony; you mentioned about the regular committees that meet, that are already in existence and I'd bet at every one of these meetings there are recommendations that must be put forth to the Department of Health and Department of Corrections; have you felt that they've been meeting your recommendations; have they been doing more to help?

LILLIE CARINO HIGGINS: Absolutely not. The situation, as someone testified earlier, is very complex. Something as simple as getting cuff bars, for example, came out of our committee, but the implementation… [interpose]

CO-CHAIR CROWLEY: Can you explain what that is?

LILLIE CARINO HIGGINS: I think the doctor would be able to better describe; I've never seen them or used them or… [interpose]

CO-CHAIR CROWLEY: Cuff bars? Cuff bars?

LILLIE CARINO HIGGINS: Yes. It's just basically where you cuff [background comment] inmates so that they're not free to move around. But implementing cuff bars or installation of cuff bars is in the purview of the Department of Corrections, so we can sit at a table and make all kinds of recommendations; the panic buttons, for example, is one that we've been talking about for over two years and they finally did install them, but first there's a question about the effectiveness of what they've done, but it really falls under the Department of Corrections. And then the last thing is, a lot of decisions are made, like we can make recommendations about the panic buttons, for example, and the Department of Corrections will install them when they see fit, but in executing they don't always consult the staff, so the placement, for example, of the panic buttons was one that raised concerns, because you have a doctor against the wall and then a patient and the panic button is by the door, so you can't get

to it [background comment] in case of an incident… [crosstalk]

CO-CHAIR CROWLEY: That's a problem to me is that they're relying on technology… [crosstalk]

LILLIE CARINO HIGGINS: Correct.

CO-CHAIR CROWLEY: or a button across the room; why… [crosstalk]

LILLIE CARINO HIGGINS: Electrical wiring…

CO-CHAIR CROWLEY: is there not a correction officer escorting the inmate to the doctor's room?

LILLIE CARINO HIGGINS: There are privacy issues, there are a lot of other issues, but there are ways to mitigate that… [crosstalk]

CO-CHAIR CROWLEY: Is it privacy issues that get in the way?

LILLIE CARINO HIGGINS: That is a big part of it, I think, and the other is the staffing levels; I mean I don't think that there are enough correction officers to escort every patient and to remain with every inmate while they're being treated.

CO-CHAIR CROWLEY: Well that's not a good enough answer, more has to be done, certainly could

be some way of putting some device on the officer's head so they don't hear or listen to… [crosstalk]

LILLIE CARINO HIGGINS: We agree. We agree.

CO-CHAIR CROWLEY: make sure that HIPAA laws are not violated, because your members should not be in danger… [crosstalk]

LILLIE CARINO HIGGINS: Correct.

CO-CHAIR CROWLEY: when they're trying to give care. I'm shocked by the percentage of fall-off on follow-up visits and I could imagine how frustrated people who are mentally ill must be when having to wait a long time, which could aggravate the system… [crosstalk]

DR. MATTHEWS HURLEY: Just to give an example of that; after intake, if a patient has to see a psychiatrist for prescriptions, they may wait up to five days to being able to see psychiatrist, which is just simply too long when you have certain types of medical illnesses, psychiatric illnesses.

CO-CHAIR CROWLEY: How bad has the staffing been…

DR. MATTHEWS HURLEY: Current… [crosstalk]

CO-CHAIR CROWLEY: in terms of there not being enough doctors and clinicians? I understand that you're not… there's approximately 20 percent of vacancies, but even if those vacancies were filled, what is the excuse that there are so many inmates that are not being seen or not getting the diagnosis? When Corey Johnson read off the list of the various different inmates who died and -- what is the exchange… [crosstalk]

DR. MATTHEWS HURLEY: One of the things that happens at Rikers is that if an incident happens at another site, an alarm goes off and everything shuts down and that happens frequently throughout the course of the day and what tends to happen is that an 8-hour session, clinical session is reduced down to about 5 hours or so, 4 or 5 hours, so cut in-half, so even though you have the short staffing that you have, on top of that you have these alarms that are not, you know, just to that particular site; are just broad-based and shut down the whole operation, even in the medical clinic, which is problematic.

CO-CHAIR CROWLEY: Problematic, of course. And Just final question, in comparison to the HHC system; I know that you have members, various

different unions that work, whether it be doctors or health care professionals; are they getting paid more; why are there so many vacancies in Rikers; are they paying less, Corizon, in comparison to HHC?

DR. MATTHEWS HURLEY: If you look at… and you would have to look at different HHC facilities, it's kinda different across the board, but if you compare some of the hospitals, it's about a 20 percent differential or lower salary. In addition to the historic knowledge of the problems that exist at Rikers, it makes it a challenge to staff it.

CO-CHAIR CROWLEY: I have a tremendous amount of respect and am very grateful for the work that your members do. And just, what you're telling me now, that in addition to them having to fear for their safety being in the process of doing their provision giving care, that they're paid actually less than other public facilities in our city, substantially less. Thank you.

CHAIRPERSON JOHNSON: Thank you, Chair Crowley. We are going to take a 10-minute adjournment, just so everyone can move over to the room, go to the bathroom [background comments] and we're gonna start back up. And then, just so folks

know, the next panel is Jennifer Parish, John Boston, Deandra Kahn, Riley Doyle Evans and Barry Campbell and then following that, Deirdre Shore, Alex Abell, Evie Litwok, Victoria Phillips and Terry Hubbard, and that's it. So five-minute adjournment.

[gavel]

[background comments]

CO-CHAIR CROWLEY: Okay. Good afternoon; this is resuming the Health Committee and the Committee on Fire and Criminal Justice. I'm Council Member Elizabeth Crowley, co-chairing this hearing with Council Member Johnson; we will now hear more testimony from the public. First to testify we have Jennifer Parish, who is from the Urban Justice Center; we John Boston from The Legal Aid Society; Deborah [sic] Kahn, who is with New York City Civil Liberties Union; Riley Doyle Evans, Brooklyn Defender Services; Barry Campbell from The Fortune Society.

Thank you for being here; please begin your testimony if you can in the order that I've announced your name. [background comment] Well if you, Miss Parish, would not like to start your testimony until Chairman Johnson is here; anybody

else on the panel, do you feel comfortable starting your testimony?

[background comment]

CO-CHAIR CROWLEY: I believe he'll be here in a few minutes; my time is limited as well and whatever you say here is part of the record, as well as any written testimony you are introducing into the record. [background comment] Thank you.

[background comment]

JOHN BOSTON: Hi, I'm John Boston from The Legal Aid Society, Prisoners' Rights Project; I appreciate the opportunity to be here, although one comment I would make is that a lot of people were not able to get into the hearing earlier in the day and we were getting some emails about that and I hope in the future -- you know, please, if there's a larger room -- people care about these issues in a way that maybe they didn't, you know 10 years ago and the public wants to hear and be heard… [interpose]

CO-CHAIR CROWLEY: I would just interrupt and say I share your frustration; I'm not happy that we had to move our location and that our location was not large enough.

JOHN BOSTON: As to the substance of what we're here for, Legal Aid presents a patient's eye view of this problem, because we are the people that prisoners call or their relatives call or their defense lawyers call when they can't get the medical care that they think that they need, and from our clients' perspective and our perspective, the entire system of medical care provision and delivery is pretty seriously problematical.

We have provided extensive written testimony and I'm not going to go through every aspect, given the limited time; I would mention that the most fundamental aspect of the medical care system, which is access to sick call, is seriously troubled; we get complaints from people that they've been waiting days and sometimes weeks to get to sick call even though, according to the Board of Corrections minimum standards it's supposed to be called every day, five days a week; that is not complied with and has not been for years and if anything, the problem is getting worse. And one reason it's getting worse, for reasons we've already heard from the Doctors Council people, is because of the habit of the Department of Corrections of

shutting down entire institutions based on incidents that occur at particular locations; that seems to me completely gratuitous, unless the issue is that they don't have enough staff to run the institution if people have to go to a particular location to respond to an incident, in which case they need to have enough staff. That is a disastrous limit on access to medical care in the jails; we mentioned it as a major problem to Commissioner Ponte when we first met with him when he arrived here; it does not seem to have changed or improved in any way at all. And this aspect of the problem -- and I think many other aspects -- are as much problems with Corrections as they are with Corizon. So in evaluating the provider also, consider all the things that go into getting access for the provider and how they might be changed.

Now our testimony about the various problems of access are in our written testimony; with respect to the quality of care from the provider, we do not, as a general matter, obtain our clients' medical records and have them analyzed by a doctor, so we can't give you the kind of technical assessment that I would like to be able to give you, but there

are people who do; notably, the State Commission of Corrections, and we have studied the State Commission Report on the death of Bradley Ballard; we represent his estate, and I think that that report speaks volumes about the problems of quality of care in the system and nothing that I heard in the hearing from earlier today really addresses what you find in that report. The thing that's been publicized about Mr. Ballard is that for roughly the last week of his life, even though he was in the mental observation unit where he was supposed to be out of his cell and receiving treatment, he was locked in his cell and essentially ignored, both by the correctional staff and by the mental health staff, which is just inexcusable and proved disastrous. But if you look at the findings of the State Commission based on the review of his records, he was getting terrible care long before that happened. There were two things wrong with this man, speaking very generally; he had diabetes before he was locked in that room; they stopped giving him insulin, he received no insulin for the last 10 days of his life and that's what killed him, diabetic ketoacidosis. He also had a very serious mental health problem; among the many

bad things that happened with his mental health care, a license practical nurse changed his medication from a regimen that was working to a regimen that had previously been disapproved by a doctor; this change was not approved by a doctor and nobody followed up on it, just as nobody followed up on his diabetic care and the fact that he had missed many clinic appointments. So… [interpose]

CO-CHAIR CROWLEY: Mr. Boston, I'm sorry; your testimony will be part of the record; I don't wanna cut you off; the three-minute bell rang about two minutes ago; we were being courteous, but in the interest of, you know, the time constraints that we have here, if you could wrap up your testimony, please… [crosstalk]

JOHN BOSTON: I will. I will do that. I think that report demonstrates there's a very serious problem with the quality of care and the question about whether Corizon is fit to continue is a very good question, one to which I think the answer is no.

Very quickly, some recommendations about what the Council or others can and should do about all this. 1. Pass your proposed legislation, but enhance it before you do. As almost everyone has

said, [background comment] the information should be made public; arguably it should be provided quarterly, if once they're set up to provide it, and the underlying data should be made public as well, to the extent that privacy permits; [background comments] preferably in a format that's widely used by the public, by CSV, so other people can do their own analyses. And also, add some meaningful measures of sick call access. At the present, [background comment] sick call access is measured by whether anyone showed up to a particular housing area, no matter how many people signed up. There needs to be a measure of how many people signed up and how many people have gotten sick call and presently there is not. And also, we respectfully suggest that information on the complaints that people made; there is a complaint system there, although people tell us they didn't really get answers from it. And also, perhaps they should do a patient satisfaction survey and you should find out from the patients directly, as well as from us, what is really going on on a day-to-day basis and that should be reflected in the report. 2. Get a new medical provider or create one. We understand that no medical institution has been

prepared to step forward; I wonder if the City could arrange for a consortium of them to combine resources to provide jail medical care… [interpose]

CHAIRPERSON JOHNSON: Thank you, Mr. Boston, I'm sorry; we have to keep moving… [crosstalk]

JOHN BOSTON: My last…

CHAIRPERSON JOHNSON: but we have your testimony.

JOHN BOSTON: Okay. Indulge me with one more. Fund the Board of Corrections to have enough field staff so they can observe and troubleshoot and so they can report as well as people like us on the problems that exist. Thank you.

CHAIRPERSON JOHNSON: Thank you very much.

JENNIFER PARISH: Good afternoon. My name is Jennifer Parish; I'm the Director of Criminal Justice Advocacy at the Urban Justice Center's Mental Health Project. Thank you for having me here to testify.

The information we have about what goes in the City jails comes from our interviews with people; primarily we're talking to them about

discharge planning services, but many of them bring their treatment needs to our attention and we report these to the Health Department; we frequently do not receive responses, other than to say that they'll look into it.

But providing adequate health care in the City jails requires not only that the clinical staff providing it be capable, well-trained, be properly supervised and I think that's been well discussed earlier in the hearing. But what's also needed is cooperation and coordination between correction and health staff, and I think that Department of Corrections' role in providing access to health care has been completely ignored in this hearing, up until the panel right before ours, where the Doctors Council started to describe to you some of the real barriers to providing care and part of that's Department of Corrections.

Department of Corrections staff are on the frontline when it comes to ensuring access to health care; they have the most direct and frequent contact with incarcerated individuals; they're in a position to hear and to respond to requests for medical attention and also to identify untreated

illness. Incarcerated people cannot access health care without DOC's cooperation.

The tragic deaths which you talked about, many of them are evidence of correction staff's complete disregard for the health and safety of the people who are in their care. These deaths are the most extreme results of correction staff's failure to act when an incarcerated person needs medical attention, but hundreds and possibly thousands of others suffer needless pain and worsening conditions when corrections staff ignore their treatment needs and do not assist them in obtaining medical attention.

The culture of violence in the City jails has been well documented, but possibly equally harmful is the culture of indifference that permeates the system. This indifference to the basic needs of incarcerated individuals results in their symptoms worsening, their health deteriorating and jeopardizes their lives.

I'll just add on; in addition to the State Commission of Corrections' report revealing all of the problems with Corizon, it also documents significant failures in DOC, who was right there on

the unit, observing what was going on and not reporting it to anyone and not getting Mr. Ballard help.

In my written testimony I document several examples of complaints we receive regarding getting care; many of these are failures to access sick calls, long waits for treatment; even once problems are diagnosed, actually getting the care people need, so that's set out in my testimony. I also am glad that you're planning to pass legislation regarding reporting; I do have some specific suggestions about additional measures that need to be included and I thought that in the last panel the Doctors Council also provided some [bell] suggestions which would be good to incorporate. We really need to know how frequently people who are trying to get treatment aren't brought to the clinic because of that, and I think even Dr. Venters mentioned that when people aren't brought down, if they have serious needs; that requires that the health staff go and try to figure out what's going on; well they certainly have the time or the capacity to do that, so really Department of Corrections needs to be held accountable. Thank you.

CHAIRPERSON JOHNSON: Thank you.

BARRY CAMPBELL: Good afternoon. My name is Barry Campbell and I've provided you all with the written testimony that I am not going to read today. Part of the reason being is because I think you've touched on all the topics, John Boston to Miss Parish. But what I do wanna say is that, you know, if this were any other corporation providing services at this level to any other population in New York State they would've lost their contract and criminal charges would've been brought up against them; let me first just say that.

The other thing that I wanna say is that I am formerly incarcerated; my last day on Rikers Island was in 2003; I'm not that far removed, because I work at The Fortune Society where I deal with this population on a daily basis. Just late last year I got a call from a Fortune client who was incarcerated who was in a mental health unit who was being denied his psychotropic drugs after he had provided them with proof of the drugs that he was prescribed; it took us almost two months before we could reach out to Marty Horn [sic] to use his contacts to get him

the psychotropic meds that he needed and was prescribed.

One of the points is is that you've got individuals that are employed with these corporations and the Department of Corrections that view this subpopulation or this particular population as not human; we are not human to some of these individuals, so we are treated as such. You know, when someone puts in for a sick call and let's say the officer doesn't like you that much or they're not having a great day today, they look at you and you could just be a fly on the wall and they will walk past you, walk past your request like it was never even made. The problem is is that most of this population is viewed as not human; this is a problem. I mean you can call them inmates, you can call them prisoners; you can call them whatever you wand to call them, but the end of the bottom line is that these are human beings and I'll say it again, if any other corporation was providing the services that they are getting now on Rikers Island for medical care, problems would arise in the criminal condition and they would've lost that contract. And with that being said, I wanna thank you for the opportunity to

testify here today. Again, my name is Barry Campbell.

CHAIRPERSON JOHNSON: Thank you, Mr. Campbell.

BARRY CAMPBELL: You're welcome.

DEANDRA KAHN: Good afternoon and thanks for this opportunity. My name is Deandra Kahn and I'm an organizer at the New York Civil Liberties Union.

We're here today to urge the Council to enact Int. 0440. Today we already heard about major barriers to the provision of fundamentally adequate health care in City jails, including the rising number of people with mental health conditions, the willful neglect of their contracted health care provider, the excessive and punitive use of force by correction officers, which is often used against individuals who are suffering from inadequate mental health care. We believe that the data reported under Int. 0440, with our proposed amendments, will be a major step forward in addressing these barriers.

First, it will permit the City to better assess the number of individuals detained at Rikers who suffer from mental health or medical conditions

so serious that they should never be incarcerated in the first instance; this supports the laudable goals of the Mayor's Action Plan that calls for diverting many individuals from incarceration to a more appropriate therapeutic setting.

Second, the data will permit a long overdue comprehensive assessment of medical and mental health care at Rikers and can be used to inform sweeping improvements in the quality and delivery of that care.

We offer a few amendments to clarify and expand reporting requirements under Int. 0440.

First, since health care quality and access are impacted by multiple agencies, like the Department of Corrections, DOHMH and Corizon, it's imperative that all agencies involved in health care be required to collect and report relevant data and that one agency at least be identified as having final responsibility for compiling and publicizing the final report.

Second, we recommend that the reporting requirements at least align with the minimum standards of care outlined by the New York City Board of Corrections, the agency that establishes and

ensures compliance with jail minimum standards. This would capture where health standards are not being met for categories like emergency services, pharmaceutical services and alcohol and drug treatment.

Third, we recommend that any data involving the number of individuals requesting or receiving care be disaggregated by important demographics, like age, race and gender. This is essential for identifying discrepancies in care and developing targeted responses, including identification of who should not be held in the jail at all.

Finally, in order to meet and remedy some aspects of the culture of brutality on Rikers Island, whereby correction staff use excessive force on the most vulnerable people, we recommend reporting on the types and lengths of training given to correctional staff on health care matters.

Thank you for this opportunity and we urge you again to enact Int. 0440.

CHAIRPERSON JOHNSON: Thank you very much for your testimony. I wanna call up Riley Doyle Evans to testify as well.

RILEY DOYLE EVANS: Thanks for the opportunity. Sorry to see that the audience has shrunk so much. I'm here on behalf of Brooklyn Defender Services; my name is Riley Doyle Evans; I'm the Jail Services Coordinator for our office and I'm here to speak about our experiences representing more than 45,000 New Yorkers each year, thousands of whom will pass through the City jail system.

From arrest to incarceration and release, contact with the criminal justice system causes and exacerbates health outcomes for individuals in the system and their communities. In light of incarceration rates, 5 and 12 times higher for Latino and black New Yorkers, respectively, when compared to their white neighbors, the public health crisis in the City jail system must also be acknowledged as an urgent civil rights issue.

The surest way to east the health care burden in the City jails is to reduce the population in custody by diverting as many people as possible out of the criminal justice system before arrest, at arraignment and by reviewing bail practices to reduce the number of people who remain incarcerated simply because they are too poor to post bail.

The nightmare for our clients held often begins at the moment police arrive at the scene, escalating conflicts between individuals with mental illness and desperate family members with no one else to call. Once in police custody, essential medical care is often denied, as was the case with an elderly client of ours who died shortly after her arraignment because NYPD would not give her the insulin her sister had brought to the precinct.

The vast majority of our clients who are detained in City jails are held prior to conviction because they cannot pail bail; in other words, they are in jail because they are poor.

Our clients with mental illness are especially likely to be detained pre-trial, even when they face only a low level of non-violent offenses. When our clients are admitted to Department of Corrections custody, they encounter a health care delivery system that is plagued with chronic deficiencies and a culture of neglect.

Any positive changes to health care in City jails hinge on the medical provider, which by any measuring stick has proven itself incompetent. Corizon is at the center of growing controversies in

New York City's jails due to recurring patient deaths and everyday neglect; the company has been sued 660 times.

Our staff makes hundreds of referrals to DOHMH personnel each year on behalf of our clients suffering methadone continuation, lapses in essential medications, failure by medical staff to take seriously suicidal ideations and depression, failure to provide ordered specialty care, failure to provide glasses or hearing aids and OB-GYN care, among many other issues.

While our referrals to DOHMH typically provoke a speed response, in the past year alone we've had to make four or more follow-up requests to DOHMH to secure essential treatment for individual clients with serious conditions such as asthma, seizures and diabetes.

Pressure by outside advocates to ensure basic heath care should not be the procedure relied upon by medical staff to meet the needs of their patients, many of whom lack any supportive structure on the outside.

Many of our clients report that they did not promptly receive a mental health evaluation or

medications once committed to City custody; nonetheless, medication remains the only treatment for nearly all of our clients in City jails. One client summed it up like this recently. "Once a month someone renews my pills and asks me if I want to kill myself."

Additionally, confidential treatment space is extremely limited in DOC facilities; many mental health visits are performed at cell front or in dorms within ear shot of other patients or DOC staff and punitive segregation in these interviews are facilitated through a small slot in a closed cell door through which a clinician and a patient must yell to each other in order to communicate. Understandably, our clients do not feel comfortable being entirely forthcoming with clinical staff.

Finally, to reiterate, DOC personnel are often part of the failure to deliver quality care. A lack of escorts is frequently given as an excuse for why an incarcerated individual might not get timely care, especially in the context of outside specialty care. Additionally, in the cases of brutality, our clients are told to hold it down, which means not to seek medical attention.

Finally, I'd like to recognize that the abhorrent use of solitary confinement at Rikers Island is out of line with international standards, calling for an end to the practice for future all [sic] detainees and is a major barrier to health care delivery.

Solitary confinement leads directly to lapses in medications and care. In the recent DOC reporting on solitary as required under Council Member Dromm's bill there were apparently 30,166 request for medical care at OBCC during that quarter, with an agency response rate of less than 50 percent. Additionally, in segregation units, as noted during the recent BOC meeting, patients languished in isolated confinement for weeks on suicide watch, despite DOHMH empowerment to remove those people from segregation.

I'll finish up quickly, skipping some of the last things here. The primary driver to reform must be prioritizing the use of correctional facilities as a last resort and reinvesting the savings produced by declining jail populations into the communities from which our clients come. By reducing the number of people incarcerated in City

jails, programming and infrastructure can be implemented to meet the needs of this population. Jails are not therapeutic, they're not treatment facilities and they should no longer be used as such.

Thanks.

CHAIRPERSON JOHNSON: Thank you for that really important testimony.

Next up, Deirdre Shore, Alex Abell, Evie Litwok, Victoria Phillips and Terry Hubbard. [background comments] You may begin.

ALEX ABELL: Okay, thank you. So my name is Alex Abell; I'm the Criminal Justice Advocate with the Urban Justice Center and a member of the Jails Action Coalition and I'm here today on behalf of the Jails Action Coalition.

The New York City Jails Action Coalition would like to thank the Committee on Health and the Committee on Fire and Criminal Justice Services for holding this hearing and for the opportunity to testify on this crucial issue.

The New York City Jails Action Coalition is a collective of activists that includes formerly and currently incarcerated individuals, family members and other community members working to

promote human rights, dignity and safety for people in New York City jails. Our goals include increasing transparency in DOC policies in New York City jails and accountability for DOC practices and abuses, ending the use of solitary confinement in New York City jails, addressing the physical and mental health needs of people in New York City jails and ensuring access to continued care in the community upon release, advocating for increased rehabilitative services in New York City jails to promote reintegration and fighting the racist and discriminatory policies leading to mass incarceration. We exist because the treatment of people in New York City jails is fundamentally inhumane; this inhumane treatment includes health care systems which are in place to protect incarcerate people, which often results in neglect and abuse. The devastating and inadequate level of care in New York City jails results not in treatment, but in effect, a second punishment.

As you're well aware, within the past several years there have been numerous reports on and investigations into the dangers that incarcerated individuals face due to healthcare-related

negligence, negligence that is perpetrated by staff in every department within the jails, countless people have suffered; many have lost their lives.

The death of Bradley Ballard demonstrates both negligent individual actions and the endemic problems at the heart of a broken system. In September 2013, Mr. Ballard, who suffered from thoroughly documented severe psychiatric symptoms, was placed on a MO unit at AMKC. In this unit he was supposed to be monitored at regular intervals and provided with treatment for mental health and medical conditions; instead, Mr. Ballard was locked in his cell for seven days and denied his medication and medical attention. After seven days of horrific neglect, he was carried out of his cell, covered in feces and blood; he died a few hours later. Unmedicated and unmonitored, he had been self-mutilating for five days.

I don't wanna be redundant here, 'cause a lot of this stuff -- we already talked about Mr. Ballard and about some of the specific stuff, but I just wanna say that -- I just wanna -- from the testimony that I've seen so far, I feel like there's a huge gap between what's actually… you know, what is

said, what's supposed to be happening on the Island right now; what is actually happening; what the reality is for people who are currently incarcerated who were formerly incarcerated, and the Jails Action Coalition, there's a lot of formerly and currently incarcerated members in that coalition, family members and a lot of our members have constant contact with these people who are out there right now existing in this and the reality is is that, you know, someone already touched upon sick call access, for example; people get on the list for a sick call and they don't get seen for two, three weeks at a time; medication management is often the only kind of mental health services that people receive. Like Riley said, you know they get seen once a month to see if you're gonna kill yourself and that's it. And in general I just… I just wanna draw that this is happening right now, so Mr. Ballard died in 2013 at the end; as recently as December, New Year's Day in 2015, one individual, Fabian Cruz, committed suicide. A psychiatrist had ordered his placement in a special observation unit because of suicidality, but it was not carried out, in violation of protocol, and there's a gap between protocol, procedure and what is

actually happening. And I wanna draw, that that's happening right now, it's current, people are dying because of the abhorrent level of health care in New York City jails.

CHAIRPERSON JOHNSON: Thank you.

DEIRDRE SHORE: Hi, my name is Deirdre Shore and I'm also a member of the Jails Action Coalition and I'm going to be picking up on our testimony where Alex left off.

I'd like to first start by stressing how important it is for some of these families and community provider input. Also, in terms of discharge planning, it's very important to involve family members and healthcare providers that people trust. Incarceration does not negate an individual's health care needs.

One member of JAC has a son who's currently incarcerated at Rikers and he's receiving haphazard mental health treatment; the timing and dosage of his medication has been changed several times despite the adverse affects that these changes have had on both his mental and physical health. His mother's calls to medical professionals overseeing her son's care have been ignored. It is important

that a message be sent on the City level that family members' involvement is valued.

Not only is health care in City jails inadequate, but DOHMH and DOC are not held accountable for their systemic and individual violations.

Our testimony includes the findings of Drs. James Gilligan and Brandy Lee reporting on the mental health services in New York City jails that violate the Board of Corrections' minimum standards. That's included in the testimony; I'm not gonna go through each one. What I will say is that we have yet hear from the DOC or DOHMH on how they plan to improve the quality of mental health treatment and as well as the environment that inmates are receiving health services. Also, the DOC reported that they would no longer be admitting people with mental illness into punitive segregation; however, there's a lack of transparency around the conditions in which these people are actually being held now.

As the population of people with mental illness in New York City's jails continues to grow, there is an undeniable need for a complete overhaul

of the health and mental healthcare systems within the jails.

The following points have already been touched upon, so in conclusion I would like to say that DOC and DOHMH must be accountable to meeting standards set by outside bodies and to the public at large. We urge the City Council to pass Int. 0440 to require reporting about the health of people in City correctional facilities as another step towards transparency and accountability. And although this deep structural change may not happen overnight and efforts like the Mayor's task force on behavioral health in the criminal justice system are designed to make long-term reforms, the departments must immediately remedy the suffering of people today in our City jails because of substandard and negligent healthcare. This cannot wait for another study or another death. [bell] Thank you.

CHAIRPERSON JOHNSON: Thank you very much.

EVIE LITWOK: Hi. My name is Evie Litwok; I'm formerly incarcerated. I wanna start off by saying I'm disappointed that there are only two City Council people to hear the public comment and I

think this is probably the most important part of today's show, if I may say that, because what I saw this morning was agencies who have to report to the City Council giving you report cards on themselves and frankly, they gave themselves an A- when I give 'em an F. And if you listen to their numbers, they actually believe that these numbers, as high was 80 or 90 percent that they were tossing out, when I, as someone who was incarcerated, know that they're not even close. You are responsible for the safety of every person that walks into a prison or jail; that safety means you're responsible for their health and mental health. As we sit here today, as someone who was incarcerated, I can tell you there are absolutely no metrics, no measurements, no assessment that is ever taken of somebody when they walk into prison to even determine their mental health. So any numbers as to how -- and on the health side, I was personally asked a handful of questions -- what medicines do I take -- but no long intake medical process to determine what were my problems was done; instead, it was me saying what medicines I took and what conditions I've had.

So the profile you have of a person entering prison is zero and the fact that we're tossing around a number like 40 percent and claiming that 40 percent of the people have problems, that number is being deducted from the number of people reporting in for an appointment; therefore I don't think you have an accurate measurement. What I will tell you is that the minute you walk into prison, the minute you're stripped naked, the minute those doors close is the minute that three things happen -- you no longer want to speak, you no longer wanna think; you no longer want to react in any kind of normal way; therefore, I suggest to you; you have a 100 percent mentally unhealthy people because of the stress and because of the zone and the space that you have to get in to survive. And under that I've not heard the word stress used by anybody and as an aide I wanna say I feel sometimes, when they talk about the mentally ill, that we're talking about ISIS in prison and it's like the mentally ill -- we seem to have three things that happen when you begin to talk about the seriously mentally ill; we talk about the safety of officers, 'cause we get right off the seriously mentally ill, the safety of officers and

the violence, and I have yet to see a correlation between [bell] the serious mentally ill, the violence and the safety; I mean literally, a data-driven program. You need to take a… instead of $400 million to Corizon I recommend, for free, but it would be nice if they got paid, you get five formerly incarcerated people to be a committee for you that would have to meet no less than anywhere between 10-40 hours which could outline a plan for you which could solve this, 'cause they could tell you in writing, point by point, from arrest to incarceration to post-conviction, exactly what you need to do to measure and to even watch over the other organizations that are giving them the help. So I propose you create some kind of a committee, a working group of formerly incarcerated people, 'cause as I could spit out for you, so can they and it wouldn't cost you that much, it would cost you our time. Anyway, thank you for your time.

CHAIRPERSON JOHNSON: Thank you, Miss Litwok. You may begin.

VICTORIA PHILLIPS: Good afternoon. My name is Victoria Phillips and I'm an advocate for the Urban Justice Center Mental Health Project, also a

member of the Jails Action Coalition. I don't have an elaborate speech prepared today; I think that it's best when you speak the truth to speak from your heart. I speak from personal experience; I was an inmate on Rikers Island, but I did do cognitive behavioral therapy on Rikers Island in several of the jails on Rikers Island and I would like to speak about that experience.

You had a lot of people on different panels today that some answered questions and some could not and I would like to say, when you first enter Rikers, DOC is very clear to let you know you are now a ward of the state, you are their property, you do what they say when they say do it. So the fact that we sit here today because of all these other concerns, it really bothers me and -- I've been on the Board -- I've spoken at BOC hearings on the brutality and all the physical things that occur on Rikers, but when we speak about mental health and one of the things that was stated earlier; somebody had stated that all the staff is responsible for reporting mental health concerns or referrals or for observing suicidal ideations; I'm here to let you know that, one, all the staff does not perform as if

they have been trained to do so; all the staff does not make those referrals; quite often -- from only physical experience -- quite often I've seen staff and see people decompensating and instead of referring them, tell them shut up, you're an animal, you're stupid; completely do all types of things to set off triggers that will continue to allow those to decompensate, instead of making a simple referral. It's a simple piece of paper that they would actually have to fill out or walk them to the medical clinic.

It was also reported that staff is being trained in TVI [sic] now, but you don't see it, you don't see it anywhere and while working on Rikers, I have spoken to many officers who received a three-day training and basically culture and cognitive behavioral therapy and how to address the detainees and they all… a lot… no, I won't say all of 'em, but a lot of them came back and their exact words were, "forget that new correction." There's an attitude on Rikers Island that is disgusting and it's horrific; there is terroristic behavior that occurs on a daily basis and there is a lack of accountability that needs to be addressed and it needs to be addressed immediately. And you will have Corizon and them

saying that because of alarms many people are not receiving medication, but what they fail to mention is that the only [bell] people -- I'm almost done -- the only people other than DOC allowed to move during alarms is medical staff, but that wasn't brought up at all today. So please don't allow people to continue to give you excuses when they should have the answer or they should be a part of the answer.

There's a lot of other things I could say, but I will definitely pass it on; I don't wanna hold up your time. But please, when it comes to DOC; when it comes to any provider on there, do not allow them to false feed you fake data, which is something that occurs quite often. And please, if you are able to or if you can tell BOC to make more visits and don't go to the buildings that they expect you to be at, because they are prepared to handle that also. DOC are bullies, bottom line; I don't believe in beatin' around the bush, there is a cultural violence there that violates every human right we have and it needs to be handled, and people are afraid to speak up out of fear. I'm one of the few people who would work on the Island and actually speak up because I cannot drive over a bridge every day and go to sleep

at night and have a healthy conscience knowing that all this is going on and we call ourselves Americans and a great country; it's unacceptable.

CHAIRPERSON JOHNSON: Thank you.

TERRY HUBBARD: Good afternoon. My name is Terry Hubbard; I'm a Jails Action member, as well as a member of the National Alliance on Mental Illness; I'm also the liaison for the families and the inmates on Rikers Island.

It is just excruciating to hear what other agencies have come to say or to try to relay to us. My issue is; what constitutes a right to urgent care when an inmate is spewing blood from his mouth uncontrollably; what constitutes the right to urgent care when an inmate cries out for help because the pain he or she is enduring is so excruciating that the only help they receive is a Tylenol 3 tablet or Motrin or nothing at all; what constitutes the right for urgent care when an inmate has had his stomach stomped in as the bootprint of an officer leaves permanent damage in his stomach and his thighs, or the visual cramps and the contusions and the lumps in his head, or perhaps the broken ribs or extremities of severely damaged inmates. They no longer see the

medical staff, they are denied access; all that is offered is an MRI. The inmate should be taken off Rikers Island and taken to a hospital where CAT Scans are performed that can pinpoint the contusions of the anatomy to better help serve that individual; that is also denied. The capacity of having CAT Scans on Rikers Island is obsolete. If money is to be given in large amounts to this industrial complex, we need to have CAT Scans onboard. While we're sitting here now, I got calls that inmates are laying there bleeding and dying; some have been stuffed in closets where they're brutally beaten by their superiors; some of them are very ill but cannot ask for help; some cannot see their loved ones; right now I get calls that parents cannot go in, loved ones cannot go in to see their loved ones, else there will be a repercussion to pay. We're talking about ISIS; this is ISIS; I'm not afraid of people coming across America's waters because there's something even deeper than that lying in that cesspool we call Rikers Island.

I have a son that is there that was stomped abusively; right to this day, gentlemen, he has not seen a doctor in five months; the print of

that officer's boot is in my son's stomach. Contusions, I've had to take news reporters in, to sneak them in to see my son's -- the contusions that his head was holding; they said Terry, blood clots may form; any minute he can die in his sleep. He has not yet been off of that Island to get help. A doctor once told him; this was last month, that his ligaments are torn and there's no way to help. This is commonality on Rikers Island.

I am asking everyone on this panel not to just sit here and listen to us, because we will be held accountable for the blood spilt in Rikers Island prison. Thank you.

CHAIRPERSON JOHNSON: Thank you, Miss Hubbard; thank you all for [bell] being here today and for just the total forthright honesty on what is currently occurring in our jail system and our correctional facilities. The cycle and culture of violence of locking people up who probably shouldn't be in a correctional facility to begin with, and then when they're there, not being treated with the human dignity that they respect and that we should be treating to every person. It's real, this oversight hearing and this piece of legislation

doesn't do it all justice; it's a much larger, systemic, endemic problem that needs to tackled and I appreciate the fact that for a population that many people wanna forget exists because it's too hard to look at for many people, that we have activists and organizations that are continuing to tell the truth, to advocate on behalf of their needs and to move the conversation forward to try to make our city more humane and more dignified, because it's a real problem and you know, you have my commitment to keep putting the pressure on to ensure that every human being is treated with dignity and respect and that's what this really is all about. So I'm sorry that we had to move into this room, but I appreciate the fact that you all have put together really substantive, thoughtful testimony, both on what policy changes need to take place, but also, in many ways more importantly, the experiences and the anecdotes that you all carry with you from visiting Rikers Island and from talking to the human beings that are currently there and their families, because it's a big, big, big problem and you know, here in the Council I look, as part of my own inner constitution, that we work and fight on behalf of every person,

every human being to be treated with dignity and respect and I know that's the type of work that you all are doing as advocates in trying to make our city a more just and humane place.

I want to recognize that we were joined here by Council Member Robert Cornegy and after a very long day, I wanna thank you… [laugh] I wanna thank you for your patience and testifying and Robert, I've been here since 10 a.m., so you get one minute, and then we're adjourning [laughter] this hearing. [background comments]

COUNCIL MEMBER CORNEGY: No problem, Chair. Thank you for allowing me… I just wanted to say that your testimony is not wasted on me. As somebody who served in a capacity of assistant director for substance abuse on Rikers Island for a few years and assistant director of social services for a few years, and I wish that these stories were made from fantasy and made for movies, but I had the displeasure of witnessing exactly some of the things that you have described today, and especially as it relates to access to health care for inmates, especially mental health care. So I just wanted you to know that although I'm here at this time, your

testimony's not wasted on me or falling on deaf ears; it was just a reminder for me of atrocity that I know is taking place because I was there, so I wanna thank you for sharing these particular stories and giving us a refresher course in what's necessary for a humane society, even behind bars. So thank you and thank you again, Chair.

CHAIRPERSON JOHNSON: Thank you all very much and with that the hearing's adjourned.

[gavel]

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 March 12, 2015