

Healthcare in New York Prisons 2004-2007

A REPORT BY
THE CORRECTIONAL ASSOCIATION
OF NEW YORK



The Correctional Association of New York

“Because the dangers of abuse inherent in the penitentiary are always present, the work of the Correctional Association—an organization of knowledgeable experts unaffected by political forces—is so important.”

Judge Morris E. Lasker, Former U.S. District Court Judge, Southern District of New York

The Correctional Association of New York (CA) was formed in 1844 by citizens concerned about prison conditions and the lack of services for inmates returning to their communities. In 1846, the New York State Legislature granted the CA authority to inspect prisons and report on its findings. Through four projects — Juvenile Justice, Prison Visiting, Public Policy/Drug Law Repeal, and Women in Prison — the CA advocates for a more humane prison system and a more safe and just society.

The **Prison Visiting Project** is the arm of the Correctional Association that carries out this unique legislative authority for the male prisons. Each year, the Project visits seven to ten of New York’s 70 state correctional facilities, branching out to all corners of the prison including cellblocks and dormitories, classrooms and industry shops, psychiatric units, medical clinics, protective custody and disciplinary housing. The Project interviews inmates, correction officers, teachers, counselors and medical staff. In addition, the Project collects data about the facility from prison officials and hundreds of surveys from inmates. After evaluating this information, the Project prepares a comprehensive report focusing on such areas as medical and mental health care, educational, vocational and re-entry programs, inmate jobs, relations among inmates and staff, the physical state of a facility, and other issues of concern to the individuals who live and work behind the prison wall. The Project presents its findings and recommendations in these reports to prison officials, the Commissioner of the Department of Correctional Services (DOCS), high-level state policymakers and the public. All the prison reports prepared by the Project since 2004 are available on the Correctional Association web page.

For more information about the Prison Visiting Project, please call 212-254-5700 or visit <http://www.correctionalassociation.org/PVP/index.htm>

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**HEALTHCARE IN NEW YORK PRISONS
2004–2007**

*A Report by the
Correctional Association of New York*

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HEALTHCARE IN NEW YORK PRISONS, 2004-2007

INTRODUCTION

The New York State Assembly has requested that the Correctional Association (CA) provide its Health and Corrections Committees with an assessment of healthcare in New York State prisons. The CA has statutory authority to visit state prisons and report to the public and policymakers about the conditions it observes and its recommendations for improvements. Correctional Association staff last testified about healthcare before these committees in December 2003.

As part of its current analysis, the CA has developed a new series of recommendations for the governor, the New York State Department of Correctional Services (DOCS), the New York State Department of Health (DOH) and the legislature to address the status of medical care provided to state inmates.

As of April 2008, DOCS confined 62,070 inmates in 69 correctional facilities and the Willard Drug Treatment Center. Between September 2004 and May 2007, the CA conducted general monitoring visits to 17 state prisons and obtained medical data from two additional prisons that were visited for a limited inspection concerning prison violence. These 19 facilities confine 28,250 inmates, representing approximately 45% of the state's total inmate population.

Much of the analysis in this document is based on information from the on-site monitoring visits. (See page 17 for an explanation of the CA visit procedure.) In addition, the CA reviewed DOCS's computer records, documents and reports about the entire prison system concerning medical staffing, inmate grievances, specialty care services and DOCS's Division of Health Services medical quality improvement program. The CA also analyzed system-wide information concerning appeals of medical grievances to the DOCS Central Office. The CA has based its observations and recommendations for improvements in the delivery of medical services on both the prison visits and the system-wide information.¹

The CA has also published an Addendum to this report, provided under separate cover, containing excerpts from the medical sections of CA prison reports issued after 24 prison monitoring visits during the period September 2004 through June 2008.

¹ Due to time and resource constraints, this report does not include a full analysis of health services for women in the state's correctional facilities. Evaluating these services is a critical part of assessing DOCS's ability to meet women's specific healthcare needs, and the CA plans to issue a separate report in the future with more in-depth analysis.

EXECUTIVE SUMMARY

Each of the 69 state prisons run by the New York State Department of Correctional Services (hereinafter referred to as “DOCS” or “the Department”), as well as the Willard Drug Treatment Center, has a medical department in which DOCS medical personnel provide healthcare.² DOCS also runs approximately 45 prison infirmaries and five Regional Medical Units and provides tens of thousands of in-house and external specialty care consultations per year. DOCS had a budget of \$356 million in Fiscal Year 2008-09 for prison health services and employed more than 1,950 medical personnel to care for the 62,070 inmates (as of April 2008) in state prisons. (See **Table 2**, page 20, for a summary of DOCS medical staffing as of May 2007 and **Table 4**, page 23, for medical staffing as of the date the CA visited the 19 prisons whose services are analyzed in this report.)

Providing quality medical care in prison is good public health policy because prisons provide an opportunity to diagnose and treat patients with chronic medical conditions who will return to communities throughout the state. Educating inmates about proper health care and enrolling them in a care system benefits them, as well as their families and communities.

Currently, there are an estimated 4,000 state inmates with HIV. Thus, New York prisons remain the epicenter of this disease within the U.S. prison system, representing 20% of all HIV-infected state inmates in the country.³ DOCS is the largest provider of HIV services in New York State. New York State prisons also have 8,400 inmates infected with hepatitis C, and many others suffering from other chronic diseases such as hypertension (6,500), diabetes (2,500) and asthma (9,000).

DOCS faces significant challenges in providing care to so many patients with serious illnesses, many of whom received inadequate care even before becoming incarcerated. These challenges include: limited resources; an annual turnover rate of inmates whereby nearly 40% of the prison population changes (27,000 to 28,000 inmates are admitted or released each year); and civil service guidelines that restrict salary levels and negatively affect the ability to recruit and retain qualified care providers. While many medical staff in the prisons are dedicated individuals striving to provide appropriate care to people suffering from serious medical conditions, certain prisons cannot meet the needs of their patients because resources and support systems are insufficient to provide proper care to all inmates and/or because the medical staff lack the skill, expertise or motivation to provide appropriate care. Thus, the quality of healthcare varies throughout the state prison system, with some facilities providing timely access to care that meets community standards and others providing substandard care.

In the nine years since the CA last issued a report on healthcare, DOCS has made some significant improvements in the provision of medical care. For example:

² Each prison is given a medical classification indicating the level of medical care that can be provided at the facility, ranging from class one to class three. Class one prisons have the highest level of care, including a physician on-site or on-call 24 hours a day, a 24-hour nurse presence on site and an on-site infirmary.

³ Maruschak, L., *HIV in Prisons, 2006*, U.S. Department of Justice, Bureau of Justice Statistics, Table 1 (April 2008). <http://www.ojp.usdoj.gov/bjs/pub/html/hivp/2006/hivp06.htm>.

- The DOCS Division of Health Services (DHS) has promulgated several clinical practice guidelines on conditions such as hepatitis B, hepatitis C, asthma and men's health. It has also updated existing practice guidelines on HIV, hypertension, diabetes and female health appraisal.
- DHS has substantially enhanced its efforts to monitor the care provided in the prisons by implementing a meaningful Continuing Quality Improvement (CQI) program that includes development of audit instruments used by DHS and prison medical staff to assess compliance with the practice guidelines at each prison.
- The Department reduced some of the chronic medical staffing vacancies that have persisted for several years and increased some staffing levels even while the prison population declined.
- There are fewer AIDS deaths due to more effective treatments, and the Department has identified and is treating substantially more inmates who are infected with hepatitis C.

However, in spite of these improvements, significant problems persist. Among the most significant themes emerging from the CA's investigation were the wide variation in the quality of healthcare among prisons and often among hubs⁴ and inmate dissatisfaction with care. At some prisons, there are delays in the delivery of care and the treatment provided is inadequate. At most prisons the CA visited, healthcare accounted for more inmate grievances than any other issue. In fact, during the last few years, medical grievances have become the most highly grieved issue in the entire system.

During CA prison visits and in DOCS's formal grievance process, inmates repeatedly expressed concerns about:

- denials of and delays in access to healthcare;
- inadequate examinations by nurses and physicians;
- failures to treat chronic medical problems expeditiously;
- delays in access to specialists and inadequate follow-up by prison providers to specialists' recommendations; and
- problems receiving medications and the health education needed to comply with complex medication regimens.

Concerning inconsistency of care, it is essential to describe healthcare in the Department not only from a system-wide perspective but at the level of individual facilities, because each prison operates, to a substantial degree, independently. Consequently, the level of staffing, utilization of services and quality of patient care vary greatly from one prison to another. The challenge is to identify those prisons where care is not meeting community standards of care and DOCS's own standards, and to assess why such deficiencies exist. At some prisons, the barrier to effective care is partially a question of resources (e.g., inadequate staffing or insufficient access to specialists) where the remedy will likely require the governor and legislature to authorize additional funding for DOCS. At other prisons, certain providers are unable (due to inadequate

⁴ The Department has divided the state prisons into nine hubs, each of which is a group of neighboring prisons that share administrative support and program services. **Exhibit A** contains a map of the hub system and the location of each state prison.

training or expertise) or unwilling to respond fully to inmates' medical needs or to promptly follow-up on their patients' medical problems. At these institutions, the poor quality of the medical personnel compromises the delivery of healthcare. Better scrutiny of care and an effective system of accountability will help identify where changes in policies, practices or staff are needed at a system-wide or facility level.

The Department appears committed to providing medical care consistent with that in the community. Although DOCS has not fully achieved this objective, it can realize this goal if it continues to improve services and if the state adopts the measures suggested in the CA's recommendations.

Key Findings

Medical Grievances

Medical care is the most highly grieved issue in the Department, representing about 8,300 medical grievances a year and 18% of all grievances filed by inmates during the last six years. The CA generally observed the most significant healthcare problems at those facilities with the greatest percentage of medical grievances.

Medical Staffing and Staff Training

During the period 2004 to 2007, the Department has reduced system-wide vacancies for nurses from 14% to 8% and doctors' vacancies to 3%. Despite this progress, at some prisons, the number of medical staff is insufficient to perform the complex tasks needed to serve the large number of patients with chronic illnesses and serious medical problems. Moreover, high vacancy rates still exist for physician assistants (14%) and pharmacists (13%).

- ◆ For example, Great Meadow is missing 40% of its physicians, half of its physician assistants, and nearly 30% of its nurses; Bedford Hills has a 40% nursing vacancy rate; and Attica is missing two of its three physician assistants and three of its 17 nurses.

Some medical positions have remained unfilled for a year or more due in part to applicants' unwillingness to face the challenges in providing care in the prisons and because the state provides noncompetitive salaries for certain medical positions.

- ◆ Great Meadow reported during a CA visit in 2006 that it had nurse vacancies for more than two years, and Eastern reported in 2005 that it had an open nurse position for more than a year. Both of these prisons still had nurse vacancies as of May 2007.

Even at full staffing levels, some prisons do not have enough medical personnel to meet the needs of their inmate-patients. The number of nurses and clinic provider staff—including physicians, physician assistants and nurse practitioners—varies greatly among the prisons. These significant staff discrepancies are not justified by differences in the medical needs of the inmate populations at different prisons. In analyzing the adequacy of medical staffing, the CA determined the ratio of nurses and clinic providers to inmates at each prison and compared ratios among prisons.

- ◆ The CA identified prisons (such as Clinton and Auburn) with insufficient numbers of nurses (i.e., one nurse for every 120 to 150 inmates). At other facilities (such as Green

Haven and Fishkill), CA found substantially better ratios, such as one nurse for every 70 to 80 inmates.

◆ The CA found that at several prisons (such as Clinton, Elmira, Coxsackie and Wyoming), there were insufficient clinic staff (e.g., one clinic provider for every 600 to 850 inmates). At other prisons (such as Fishkill, Green Haven, Oneida, Sing Sing and Sullivan), there was one clinic provider for every 400 or fewer inmate-patients.

In conjunction with outside health agencies, the Department has offered voluntary medical training to its staff on specific medical topics, with a focus on HIV and hepatitis C care. Some of these programs, including the HIV-related presentations coordinated by Albany Medical Center, are nationally recognized and offer the up-to-date information crucial to providing expert care in the prisons. However, because this training is not mandatory, the Department cannot ensure that all of its providers participate in these programs and does not appear to monitor their participation. At some prisons, medical staff members are so overburdened that they often cannot attend continuing medical education programs. And while medical staff are required to participate in annual general DOCS training, there is no medical training requirement addressing the treatment of chronic diseases, even though rates for many chronic diseases are five to ten times greater among inmates than among the general public.

Routine Healthcare

At some prisons the CA visited, inmates raised numerous complaints about inadequate access to sick call—the time when inmates are seen by a nurse who determines whether further care is required (see page 27). They also made complaints about receiving improper care when they are seen. Again, there are wide discrepancies among the various prisons.

- ◆ Clinton only sees 20-40 inmates at sick call for a population of 2,000. Other prisons, such as Attica and Eastern, see inmates at twice that rate.
- ◆ At Coxsackie, the sick call nurse averages only two minutes per patient—insufficient time to adequately assess and document a patient's condition.
- ◆ Patients at many prisons complained that some sick call nurses were disrespectful and failed to refer patients to a doctor when needed.
- ◆ Fifty percent or more of inmates at Great Meadow and Wyoming rated sick call as poor.

Due to understaffed medical departments, delays in access to clinic providers are commonplace at some facilities. These delays are a direct result of the insufficient number of clinic providers at these prisons.

- ◆ At several prisons (such as Attica, Auburn and Great Meadow), inmates reported that it can take several weeks to a few months to be seen for routine care.
- ◆ Medical providers at some prisons (such as Elmira) admitted to backlogs for routine appointments of 30 to 45 days.
- ◆ When the CA visited Attica, the facility had an 11-page list of inmates waiting to be seen in the clinic.

Some inmates complained that providers were dismissive of their medical problems, failed to conduct thorough exams or adequately evaluate their complaints or symptoms, and delayed addressing their serious medical problems.

- ◆ Sixty percent of the Auburn inmates rated healthcare as poor; two-thirds of the inmates at Upstate rated the doctors as poor, and half of the inmates at Wyoming said the physicians provided poor care.

By contrast, at prisons with adequate staffing (such as Oneida and Green Haven), inmates had prompt access to providers and their medical complaints were generally addressed in a timely manner.

- ◆ Two-thirds of Oneida's inmates rated the physicians as good or fair.

Chronic Disease Care

The care provided to inmates with chronic diseases (e.g., HIV, hepatitis B and C, asthma, diabetes, hypertension, etc.) varies greatly within the Department. DOCS's Division of Health Services has made significant efforts to standardize policies and develop monitoring protocols, but some prisons are unable to fully conform to these clinical standards, and some prisons do not assign a specific provider to treat each inmate with a chronic condition.

Identification and Care of HIV-infected Inmates

Although DOCS estimates that there are 4,000 inmates with HIV in its prisons, representing HIV infection rates of 6% for men and 12% for women, it has identified only about 1,700 HIV-infected inmates—45% of the potential pool of HIV-infected inmates. There are significant unexplained differences among prisons in the percentage of identified HIV-infected inmates. There is also greater variation among prisons in HIV rates than in hepatitis C (HCV) rates and significant differences between HIV and HCV rates at the same prisons.

- ◆ In certain prisons, less than 2% of their population is identified as HIV-infected, whereas in other prisons with the same medical classification, the known HIV-infected populations represents twice that rate.
- ◆ One in four state inmates with HCV have not been tested for HIV.

Although DOCS, Department of Health (DOH) and outside community-based agencies are performing 12,000-14,000 HIV tests per year, these entities are not able to identify many HIV-infected inmates. DOCS and DOH must increase their use of peer educators to encourage more at-risk inmates to get tested and to motivate inmates who know they are HIV-infected, but are not identified as such by prison medical staff, to seek care.

- ◆ In 2006, DOH and the community-based agencies tested more than 8,000 inmates, but identified fewer than 30 patients as HIV-infected.
- ◆ It appears that inmates who are not ill and are about to be discharged (also known as the "worried well") request HIV testing, but few of the estimated 2,000 unidentified inmates with HIV seek testing and treatment.

DOCS and community standards require that HIV-infected patients who are receiving treatment but are unable to fully repress the virus should be evaluated by an HIV specialist to determine whether adjustments to their treatment regimen should be made. Unfortunately, these evaluations may not be occurring in all appropriate cases. There is significant variation, with no identifiable reason, in the use of infectious disease (IFD) specialists by the state prisons.

- ◆ Prisons in the Watertown hub had a utilization rate of IFD specialists that was one-tenth the rate in prisons in the southern region of the state.

- ◆ Use of IFD specialists also varied greatly among individual prisons within the same hub, with some prisons in a hub frequently utilizing IFD specialists, while other prisons rarely refer patients outside the prison for such services. For example, the ten male prisons with the greatest utilization of IFD services are located in five of the nine hubs. This IFD utilization rate was ten times the rate in the 14 prisons (spread throughout seven of the nine hubs) with the lowest rate. (See **Exhibit D**.) These wide disparities in IFD utilization cannot be explained by the medical classification of these prisons or differences in their patient population.
- ◆ Access to IFD specialists also varied greatly in the female prisons. Albion had only eight IFD appointments in Fiscal Year (FY) 2006-07, while Bedford Hills had 537 appointments.

DOCS's effort to implement a program to certify its physicians as HIV specialists is laudable. As of June 2007, 17 of DOCS's 150 physicians, physician assistants and nurse practitioners were certified at 16 prisons. Unfortunately, this figure has remained relatively constant for several years, and most prisons do not have a clinic provider with HIV expertise.

DOH AIDS Institute's Criminal Justice Initiative (CJI) contracts with 15 outside agencies to provide services to HIV-infected inmates throughout the system. These services include HIV prevention, HIV training of peer educators, HIV counseling and testing, HIV support services and HIV discharge planning. This important program provides some services at 60 of the state's 70 facilities. However, the peer training program exists at only half the prisons, and HIV support groups occur at approximately 40% of the prisons. Moreover, some CJI services, such as discharge planning, are not sufficient to meet the needs of all HIV-infected inmates going home; less than 60% of discharged inmates with HIV were involved in discharge planning efforts in a recent one-year period. To meet the needs of the HIV prison population and educate all inmates about the importance of HIV testing and care, the state must allocate greater resources for this impressive program.

In addition, independent peer-led HIV support programs in the prisons—such as AIDS Counseling and Education (ACE) in the female prisons and Prisoners for AIDS Counseling and Education (PACE) in the male prisons—provide effective education and support programs that should be expanded.

DOCS implemented an HIV Continuous Quality Improvement program that will assist DHS officials in monitoring the care provided in the prisons and help prison providers to identify issues that may impede the delivery of HIV care. While this represents a positive step, DHS should demand more of the prisons in meeting the audit standards and require more comprehensive corrective plans to address areas where the prisons do not fully comply with DOCS's HIV practice guidelines.

Identification and Care of Inmates Infected with Hepatitis C

Based on several DOH studies of hepatitis C (HCV) infection in newly admitted inmates, an estimated 8,400 HCV-infected inmates currently reside in the prisons, constituting approximately 13% of the male population and 22% of the female population. DOCS has improved its efforts to identify HCV-infected inmates in the last few years, resulting in an approximately 40%

increase in the number known to DOCS. But 30% of the estimated male HCV-infected population and 35% of the female HCV-infected population have still not been identified by DOCS and are consequently not being treated for this serious disease.

- ◆ At most of the male prisons, 8-10% of the population has been identified as HCV-infected, but at several prisons the rate is much lower. The reasons for these disparities should be investigated.
- ◆ The rate of known HCV-infected women in the prisons ranges from 12.25% at Bedford Hills to 17% at Albion. The Albion rate is nearly 40% higher than Bedford Hills. Department officials should investigate why Bedford Hills has the lowest HCV-infection rate of any female prison, particularly since it has the only female Regional Medical Unit and the largest female medical program.

In the community, approximately 70% of patients with HCV eventually become chronically infected. DOCS is not doing an adequate job of identifying those with chronic infection, reporting only 41% of its known male HCV-infected population as chronically infected and a surprisingly low 20% of its known female HCV-infected population as such. Since diagnosis of chronic HCV infection is the first step in evaluating a patient for treatment, the failure to diagnose such infections can result in the failure to provide life-saving therapy.

Ordinarily, HCV-infected inmates must be evaluated by a gastroenterologist (GI specialist) and receive a liver biopsy to determine whether they should receive therapy. There were significant variations among the prisons in access to GI specialists and in the frequency of liver biopsies.

- ◆ For example, Five Points, Cayuga, Great Meadow and Bare Hill have a combined population of 5,784 inmates, 524 of whom are known to be infected with HCV. But these facilities had only 12 HCV-infected patients on therapy and ordered only 23 liver biopsies during FY 2006-07—one-third the system-wide average rate. In contrast, Livingston, Marcy, Mid-State and Sing Sing, with a combined population of 5,366 inmates, 576 of whom are known to be HCV-infected, treated 52 HCV-infected inmates and ordered 125 liver biopsies. The rate of HCV therapy for Livingston group is four times the rate of the Five Points group (spread through three hubs). Similarly, the rate of liver biopsies for the Livingston group is six times the Five Point group rate. (See **Exhibit E.**) There are no significant patient differences to justify such variation in the use of specialty services and the number of treated inmates.

Although not all chronically infected HCV-infected inmates require treatment, inmates with serious liver fibrosis need therapy to avoid liver failure. As of September 2007, DOCS had initiated treatment for 2,078 inmates since the start of its treatment for this disease. As of May 2007, 383 inmates were receiving HCV therapy, more than twice the number in 2003. However, there were significant variations among prisons in the percentage of HCV-infected inmates on therapy, disparities not explained by differences in prison populations. While access to specialty services is essential to evaluate the need for treatment, low treatment rates may also be influenced by a failure to educate patients about the risks and benefits of treatment or to provide sufficient support to enable patients to complete the difficult course of therapy.

- ◆ The prisons in three hubs (Clinton, Great Meadow and Wende) are treating HCV-infected inmates at half the treatment rate of prisons in the Watertown, Sullivan and New York City hubs.

- ◆ Setting aside the analysis by hub, there are even more significant variations in treatment rates among prisons. The 15 prisons providing the most HCV care are treating known HCV-infected inmates at five times the rate of the 15 prisons with the lowest percentage of HCV treatment. (See **Exhibit F.**)

Disparities in HCV treatment effectiveness within DOCS is similar to that in communities outside of DOCS, but DOCS's plan to stop monitoring the outcomes of HCV treatment on a system-wide basis is ill-advised, since it is extremely useful in assessing the HCV treatment program. This decision should be reconsidered.

- ◆ Therapy is deemed successful if a patient no longer has the HCV virus six months after the one-year treatment regimen is completed. In a group of 411 DOCS inmates who have undergone HCV therapy and have been tracked by DOCS, 58% of the Caucasian HCV-infected inmates, 37% of the Hispanic inmates, and only 19% of the African American inmates reached sustained suppression of the virus. These figures reflect the lower response rates experienced by African American patients in the community.

DOCS's efforts to assess compliance with its Hepatitis C Practice Guidelines through a quality improvement program are commendable. The initial results of the HCV audit revealed that prisons have a few areas of noncompliance with the audit's 12 indicators, including documentation of patient education and refusal of treatment, and several other areas that could use improvement. DOCS is developing a new HCV Case Management Review Form that has the potential to significantly improve the data retrieved in the HCV audits. These changes are necessary to accurately assess HCV care in the prisons.

Other Chronic Conditions

DOCS has implemented practice guidelines concerning asthma, hypertension and chronic Hepatitis B. The 2007 audit of asthma care revealed that state prisons had several areas of noncompliance with the audit indicators and that more should be done to implement the new asthma guidelines. Similarly, the prisons should improve compliance with the hepatitis B guidelines. DHS's efforts to improve care for these chronic conditions and to make practices uniform throughout the Department are commendable, but prisons should also enhance their efforts to ensure that all patients with these illnesses are receiving adequate care.

Chronic Care System

The Department has undertaken meaningful efforts to implement a chronic care system with practice guidelines and quality improvement programs, but more progress is needed. Practice guidelines do not exist for several chronic conditions, such as high blood cholesterol. More training is necessary to ensure that providers are adequately skilled in treating chronic medical problems. Prison-based chronic care coordinators and computer-based tracking systems are not used in all prisons to manage the care of chronically ill inmates. Patients with chronic conditions are not consistently assigned to one clinic provider responsible for managing patient progress and coordinating specialty care services.

Specialty Care

When prison providers need expert assistance in diagnosing or treating their patients, they can request a consultation with a specialist. Specialists see patients in the prisons, Regional Medical

Units, outside hospitals or other outside medical facilities. DOCS utilizes a Department-wide, computer-based system to schedule specialist appointments and monitor requests for specialty care to ensure that only needed services are provided. After specialty care appointments, the specialists document their findings and recommendations, which are then presented to the prison provider who is responsible for determining what follow-up action to take. Access to specialists and follow-up to specialists' recommendations vary greatly throughout the Department without apparent justification.

- ◆ For example, 80% or more of Great Meadow and Sullivan inmates reported experiencing delays in access to specialists, and approximately 70% of inmates from these facilities stated that follow-up to specialists' recommendations was inadequate. Inmates at these prisons reported delays of three to four months in scheduling some appointments.
- ◆ Analysis of DOCS data for FY 2006-07 confirms low utilization of specialty services in certain hubs; the prisons in the Watertown hub use essential specialty care services at only one-third the rate of prisons in the Green Haven hub. There is even greater variation among prisons in access to certain specialty services; some prisons use services such as cardiology, dermatology and neurology at only 10% to 30% of the system-wide rates. Albion uses several specialty care services for its women inmates at rates that are four to nine times less than the rates for Bedford Hills inmates.

Prisons do not routinely monitor whether their providers adequately follow up on specialists' recommendations and/or schedule follow-up appointments in a timely manner. The Department must improve its monitoring of the use and outcomes of the specialty care system.

Pharmacy Operation

DOCS operates prison pharmacies that serve approximately 50 prisons in New York State. Since DOCS has experienced problems hiring pharmacists to work in many facilities, 20 prisons are using outside pharmacy services that are 27% more expensive than if the medications were provided by DOCS's Central Pharmacy. This practice results in additional yearly costs of approximately \$3.8 million for the Department. Although DOCS is developing plans for its Central Pharmacy to take over this operation, the new system will take years to implement.

Inmates reported several problems with the medication system at certain prisons, including: delays in renewing and/or refilling prescriptions; running out of essential medications for chronic conditions; failures to provide inmates with sufficient information about medications they are taking and their potential side effects; and failures to provide medications in a confidential manner. Although DOCS is making significant efforts to improve its pharmacy services with a new computer system and more staff, the state must implement additional measures to ensure that all patients receive their medications in a timely and appropriate manner.

DOCS Quality Improvement Program

DOCS's Division of Health Services has implemented a meaningful Continuing Quality Improvement (CQI) Program that attempts to standardize clinical protocols and monitor their implementation. Despite these efforts, the quality improvement programs at some prisons are inadequate. The CQI program should enhance its efforts to compel prisons to develop remedial plans to address areas in which facilities are not fully complying with clinical standards.

Medical Services for Inmates with Limited English Skills

Most prisons have very few or no medical staff members who speak a foreign language, even though 5% to 10% or more of the inmates do not speak sufficient English to communicate effectively with medical staff about their health problems. Almost all the prisons use inmates, and sometimes security staff, as translators for most of the medical encounters, raising troubling issues surrounding patient confidentiality.

Continuity of Care

Inmates are regularly transferred from one prison to another, and 27,000 to 28,000 are released back to the community each year. Inmates at some prisons assert that they are not promptly seen and evaluated when transferred. Many inmates are being discharged from custody leave without adequate documentation of their medical status and without appropriate medication or a medical discharge plan.

Legislation passed in 2007 requires the Department of Health to suspend, rather than terminate, the Medicaid benefits of inmates enrolled at the time of incarceration. Unfortunately, this provision will only apply to the approximately 20% to 25% of the prison population who meet this criterion. For the vast majority of other inmates, no application for Medicaid is made while they are in custody, and when they apply for Medicaid eligibility after they return home, they must wait 45 days to several months before receiving Medicaid benefits. The FY 2008-2009 budget allocated funds for DOCS, the Department of Health and the Division of Parole to undertake a pilot project to develop a method to file and process Medicaid applications for a small number of soon-to-be-released inmates who were not on Medicaid when incarcerated; the relevant state agencies need to do much work, however, to initiate this pilot.

Care for the Aging Inmate Population

The percentage of state inmates who are 50 years or older has more than doubled (from 4.8% to 10.3%) in the ten-year period from 1996 to 2006. With this increase, it was inevitable that there would be a commensurate increase in medical conditions associated with an elderly population. A US Department of Justice report demonstrated that inmates 45 years or older are four times more likely to have cancer; three times more likely to have diabetes; and two times likely to have heart problems, hypertension or liver problems than younger inmates. DOCS must assess its medical staff and medical facilities to ensure that it can meet the needs of its increasingly aged population.

We commend DOCS for opening a 30-bed Unit for the Cognitively Impaired, which houses inmates who are suffering from Alzheimer's, AIDS, Parkinson's or Huntington's diseases at Fishkill. This unit opened in 2006 and the Department should periodically evaluate its entire prison population to determine whether the unit's capacity is sufficient to meet the needs of DOCS's cognitively impaired inmates.

Inmate Deaths

The annual number of DOCS deaths has consistently declined since the 1990s, when many HIV-infected inmates died in prison. In 1995, AIDS-related deaths peaked at 257 but rapidly declined to just 10 by 2000. This dramatic reduction was due to the development of effective treatments

for HIV which have been provided to the HIV-infected population in prison. However, the number of DOCS deaths during 2001-2004 was the fourth highest among U.S. prisons, and the average rate of death due to illness for New York inmates was the third highest for all states excluding the southern region of the country, where much higher mortality rates generally exist. Given these data, the state should do more to reduce inmates' deaths by augmenting medical training and quality improvement activities focused on illnesses (such as heart disease and cancer) that are most likely to result in inmate mortalities.

Approximately 170 inmates have died each year in DOCS custody since 2001, yet only about a dozen inmates have been released each year on Medical Parole. In order to expand the number of compassionate releases of seriously ill or incapacitated inmates, the state should expand the Medical Parole Law consistent with proposals in the Department's FY 2008-09 budget, that were not included in the budget enacted by the Legislature. An Assembly Bill (A10863), with provisions similar to the Department's proposals is currently pending before the Legislature but does not have a Senate sponsor.

Women-Specific Healthcare Needs

In addition to particular gynecological, reproductive, nutritional and other health requirements, women's specific life experiences and circumstances have significant implications for their healthcare needs. An overwhelming majority of women in New York prisons are survivors of violence and trauma. Approximately 72% of incarcerated women are parents; incarcerated mothers frequently note that separation from their children causes depression, anxiety and low self-esteem. Incarcerated women also suffer from serious mental illness at considerably higher rates than male inmates. Training providers on the concept of women-centered healthcare (which views the complex circumstances of women's lives as integral to their treatment plans) is an important step toward enhancing providers' ability to communicate with, assess and treat female patients. We are unaware of any such training for DOCS medical staff.

Most state facilities for women provide gynecological care through on-site specialty clinics. As a result of this system, incarcerated women (unlike incarcerated men) require routine access to and follow-up from specialists, whether or not they are ill. Women also need at least yearly Pap smear tests and mammograms after they reach a certain age and have specific needs related to personal hygiene items and nutrition. Some inmates reported delays in getting abnormal gynecological test results and in receiving adequate follow-up care for gynecological issues. The Department seems to lack a comprehensive quality improvement program to monitor these and other women-specific health services.

Monitoring of Healthcare Within DOCS

Although the New York State Department of Health monitors the quality of medical care at private hospitals and clinics throughout the state pursuant to Article 28 of the Public Health Law, neither DOH nor any other state agency outside of DOCS assesses the quality of care provided within the prisons. The DOH's AIDS Institute has played a limited role in advising DOCS about protocols for prison HIV and hepatitis C care, but DOH has not interpreted the Public Health law as authorizing it to evaluate the adequacy of prison medical services.

The State Commission of Correction (SCOC) has an inmate mortality review panel, but in recent years this panel's reviews of DOCS inmate deaths due to natural causes have generally been pro forma statements, and the panel's efforts have never included any assessment of the overall quality of healthcare in DOCS. Moreover, these reviews are often delayed and generally do not require any response from DOCS. The SCOC is not monitoring DOCS medical care and would not be an effective agency to be assigned this task due to its limited resources and lack of relevant expertise.

RECOMMENDATIONS

To ensure that all inmates in DOCS custody receive appropriate healthcare, regardless of where they are confined, state policymakers should take steps to address deficiencies within the Department's healthcare system. These efforts should include regular monitoring at each prison to identify deficiencies and the development and implementation of targeted remedial plans. Corrective plans will require additional resources. The governor and the legislature should make policy decisions that enable the Department to provide healthcare conforming to community standards and consistent among all prisons in the system.

Pursuant to deficiencies identified in this report, the CA recommends that DOCS, the governor, other state agencies and the legislature implement the following recommendations with appropriate additional resources (See the full list of recommendations beginning on page 78):

Enhance Medical Staffing

- Promptly fill DOCS medical staff vacancies and increase state salaries for medical positions that are difficult to fill, bringing compensation rates in line with those for comparable providers in the community.
- Perform a staffing analysis of medical positions at each prison to determine where augmented staff is most needed and allocate additional resources for these new positions.
- Enhance medical staff skills by requiring training for providers with limited background in the care of frequently encountered medical problems and those found through reviews to need improvement. Facilitate the participation of all medical staff in training programs through incentives and by other means. Enhance training of nurses and clinicians to ensure that they are receptive to and respectful of their patients and that they provide appropriate care during all medical exams.

Improve Access to and Quality of Routine Care

- Improve the monitoring of the quality of both sick call and clinic call-outs to ensure that (1) inmates have timely access to providers, (2) medical staff provide adequate evaluation and timely and respectful treatment, and (3) these encounters occur in locations that permit confidential conversations between medical staff and inmates.

Improve Care of the Chronically Ill

- Assign each patient with a chronic illness to a single provider who is responsible for overseeing his/her care.

- Develop a chronic care system that includes chronic care coordinator positions at each prison and a computer-based record-keeping system to manage and monitor this complex care.
- Improve care provided to HIV-infected inmates and ensure that this care meets community standards at each prison. Take more aggressive measures to identify HIV-infected inmates by: increasing the use of paid peer educators; enhancing counseling, testing, and education by the community-based providers, AIDS Institute and DOCS; providing patient education about HIV at optimal times; and investigating prisons with low rates of known HIV-infected inmates to determine how to persuade more inmates to be tested and persuade those who are HIV-positive to seek care. Improve monitoring of HIV care to ensure that HIV-infected inmates are periodically evaluated by HIV specialists and that such specialists are consulted when a patient is failing on his/her current medications. Investigate prisons with low usage of HIV specialists and monitor whether prisons are promptly following up on specialists' recommendations. Use CQI results to ensure adherence to practice guidelines and provide effective treatment to all HIV-infected inmates.
- Improve care provided to inmates infected with hepatitis C (HCV) and ensure that such care meets community standards at each prison. Enhance efforts to identify more HCV-infected inmates by screening all inmates and testing those at risk. Ensure that all inmates chronically infected with HCV are properly diagnosed and that treatment is provided to those needing therapy. Investigate prisons with low rates of known HCV-infected inmates, inmates with HCV disease and inmates on therapy. Review practices at prisons that have low utilization rates of gastroenterology and liver biopsy services. Abandon the plan to stop monitoring the response of HCV-infected inmates receiving treatment. Improve the HCV quality improvement program by requiring more rigorous compliance with the HCV Practice Guidelines.
- Increase funding for the AIDS Institute's Criminal Justice Initiative to enhance its HIV prevention activities, especially peer training, support services and discharge planning.

Enhance Access to Specialty Care Services

- Enhance access to specialty care services by monitoring the utilization of specialty services by the prisons, ensuring that inmates needing these services are promptly referred to a specialist and improving the timeliness of specialty care appointments.
- Ensure that prison providers follow up on specialists' recommendations appropriately by promptly implementing the recommended care or by clearly documenting the reasons for rejecting the specialists' suggestions in the patient's chart.

Improve Pharmacy Services

- Increase the salary authorized for DOCS pharmacists and fill vacant pharmacy positions.
- Expedite implementation of the computerized pharmacy program and the plan for DOCS's Central Pharmacy to provide medications directly to patients at prisons that do not have a pharmacy in order to improve care, expedite treatment and save money.

Enhance DOCS's Quality Improvement Program

- Ensure that all prisons have a fully operational quality improvement committee that analyzes medical grievances, performs chart reviews at least four times a year and routinely assesses healthcare staff and systems utilizing DOCS's Quality Assessment Tools Manual.
- Conduct regular meetings at each prison with the Inmate Liaison Committee, Inmate Grievance Representatives, prison medical staff and prison executive team to discuss inmates' concerns about prison healthcare.
- Increase the activities of the DOCS Division of Health Services' Continuous Quality Improvement Committee, which oversees the reviews of prison healthcare by DHS Central Office medical personnel, and require prison medical administrators to develop action plans to address deficiencies. Document any failure to meet specific quality indicators and increase the threshold for compliance to 80% or higher.

Improve Services for Inmates with Limited English Skills

- Improve translation services for medical encounters with inmates who have limited English skills by providing incentives (e.g., pay differentials) for bilingual (especially Spanish-speaking) medical personnel to join DOCS and by utilizing appropriate translation services, such as the AT&T translation phone line.
- Provide medical documentation and educational materials to patients in their native language.

Improve Continuity of Care for Inmates with Medical Problems

- Improve the continuity of care for inmates transferred among DOCS facilities to prevent delays in care or interruptions in treatment.
- Develop a medical discharge plan for all inmates with serious or chronic medical problems being released from prison, including information about their condition and treatment, adequate medication, and help in scheduling an appointment with a community provider. Implement a pilot program to be coordinated among DOCS, DOH and the Division of Parole (as funded in the FY 2008-09 budget) to ensure that inmates nearing release are enrolled in Medicaid. Enact regulations and/or legislation to require that a Medicaid application be filed and processed for all eligible inmates being released from custody so they can access healthcare immediately upon returning to the community.

Improve Care for the Aging Inmate Population

- Enhance the training of medical staff concerning illnesses frequently encountered by patients over 50 and assess medical staff and facilities to ensure that adequate resources are available to treat this expanding inmate population.

Improve the Care of Seriously Ill Inmates and Expand Medical Parole

- Enhance medical training and quality improvement activities for medical conditions (such as heart disease and cancer) that are likely to result in inmate mortalities.

- Expand the Medical Parole Law to allow parole of inmates who, even if they are not dying, are so physically or cognitively incapacitated that they are no longer a danger to society.

Improve Healthcare Services for Women Inmates

- Require medical providers working in women's facilities to be trained in concepts of women-centered healthcare, including issues of trauma, domestic violence and the physical and mental health implications of abuse.
- Enhance quality improvement mechanisms intended to monitor women-specific health services. Develop more comprehensive policies and standards for women-specific health care.

Initiate External Monitoring of Prison Healthcare by DOH and Enhance that by SCOC

- Enact legislation to require the New York State Department of Health to monitor and evaluate prison medical care. Alternatively, accomplish this goal through a directive from the governor, who could, without additional statutory authority, order DOH to act pursuant to its authority under Public Health Law, Article 28.
- Improve monitoring of prison healthcare by the New York State Commission of Correction and encourage more rigorous reviews of state inmate deaths through the SCOC's mortality review committee.

SYSTEM OVERVIEW

PRISON VISITS AND MONITORING OF PRISON HEALTHCARE

A general monitoring visit to a prison by Correctional Association (CA) representatives to evaluate medical care consists of: visits to the healthcare unit at the prison; interviews of senior healthcare officials, generally the Facility Health Services Director (FHSD) or the Nurse Administrator; interviews of Inmate Liaison Committee members and inmate staff assigned to the Inmate Grievance Review Committee; oral surveys of inmates throughout the prison with a detailed instrument and collection of written survey responses from inmates contacted during the visit; and meetings with prison administrators and staff, including members of the Public Employees Federation representing healthcare workers, to discuss conditions and services in the prison, including medical care. Prior to each visit, the CA obtains information about the prison's medical staffing, healthcare services and the number of patients suffering from chronic diseases. Following the visit, CA staff prepares a detailed report of observations and recommendations.⁵

INMATE MEDICAL GRIEVANCES

Inmates can file a grievance with administrators to complain about prison conditions and/or treatment by staff. For the past six years, New York prisoners annually filed approximately 45,000 grievances system-wide. DOCS gives each grievance one of 55 codes signifying the primary issue raised by that grievance. For health services, there are three codes: 21-dental, 22-medical and 22.1-HIPAA (relating to the federal law concerning privacy of medical records).

Formal inmate complaints about conditions or treatment at a prison are reviewed by the prison grievance committee, which includes inmate representatives and DOCS grievance staff. The grievance can be disposed of through an "informal resolution" to which the inmate must consent, or it is sent for a hearing before the prison grievance committee. The decision of the grievance committee can be appealed to the prison superintendent and then to the Central Office Review Committee (CORC) in DOCS's central office. Of the 44,484 grievances filed in 2006, approximately 11% were informally resolved, 71% went to a grievance hearing, 57% were sent to the prison superintendent for review and approximately one-third were appealed to CORC. Instead of filing a grievance, an inmate can initiate a "non-calendared contact" with the grievance office to seek information or informal help with a problem. In 2006, there were 29,536 non-calendared inmate contacts with the prison grievance offices.

Over the past six years, medical care has become the most highly grieved topic in the Department. **Table 1** lists the five most highly grieved issues during 2001–2006.

⁵ The CA has issued reports on Albion (female), Attica, Auburn, Bedford Hills (female), Clinton, Coxsackie, Eastern, Elmira, Fishkill, Gowanda, Great Meadow, Green Haven, Mid-Orange, Oneida, Sullivan, Upstate and Wyoming Correctional Facilities. The CA has also compiled data on medical staffing and grievances for two other prisons, Arthur Kill and Sing Sing. There are no medical reports on these two prisons because the visits focused on assessing prison violence and did not include inspection of the medical area, interviews with medical staff or surveys of inmates about healthcare. An Addendum to this report contains excerpts from prison reports describing the CA's assessment of medical care at 24 prisons visited during the period September 2004 through June 2008.

TABLE 1 - MOST GRIEVED ISSUES BY PERCENTAGE FILED 2001-2006

Year	Total Griev	Medical		Staff Conduct		Housing		Package Room		Special Housing Unit	
		#	%	#	%	#	%	#	%	#	%
2006	44,484	8,193	18.42%	7,142	16.06%	2,913	6.55%	2,252	5.06%	2,045	4.60%
2005	45,345	8,303	18.31%	7,116	15.69%	3,206	7.07%	2,360	5.20%	1,826	4.03%
2004	44,587	8,360	18.75%	7,439	16.68%	3,652	8.19%	2,027	4.55%	1,511	3.39%
2003	45,226	8,377	18.52%	7,437	16.44%	3,742	8.27%	2,099	4.64%	1,471	3.25%
2002	44,405	8,003	18.02%	7,385	16.63%	3,868	8.71%	2,042	4.60%	1,542	3.47%
2001	45,624	7,631	16.73%	8,219	18.01%	3,524	7.72%	2,201	4.82%	1,748	3.83%

Starting in 2002, medical complaints became the most grievated issue in DOCS and represent almost one-fifth of all grievances. The total number of grievances has remained very high, but the number varies significantly among prisons, both in percentage of healthcare grievances and in absolute number filed per 100 inmates.

Exhibit B summarizes the grievance data for the 19 prisons visited in 2004 through 2007. The CA found a general correlation between the number of inmate grievances and medical problems identified during visits through observations and interviews with inmates.⁶

Data from DOCS's computer records summarizing grievances appealed from all state prisons to DOCS's Central Office Review Committee (CORC) reveal that between January 2003 and May 2006, a total of 10,975 medical grievances were appealed, representing 39% of all medical grievances filed in the prisons during that period.⁷ CORC appeals of medical grievances were four times greater than appeals for any other issue. These appeals focus on the denial of treatment, failure to provide care and specialty care, problems obtaining medications, and many other areas of concern.

Exhibit C contains an analysis of the computer summaries of CORC medical appeals for the 19 prisons the CA visited. In addition to listing the total number of medical grievance appeals for each prison, **Exhibit C** contains a compilation of the number of grievance appeals related to medications, specialty care and denial of treatment. From January 2003 through May 2006, there were 5,647 medical care grievance appeals to CORC from these prisons, representing half of the total CORC medical grievances. Observations and information gathered during visits indicate more serious problems with healthcare at most of the facilities with higher numbers of grievance appeals and fewer problems with medical care at most of the prisons with lower numbers of appeals.⁸

⁶ Rates of medical grievances contained in **Exhibit B** are very high at Arthur Kill, Auburn, Elmira, Great Meadow, Green Haven, Mid-Orange and Upstate Correctional Facilities. Conversely, grievances were relatively low at Cossackie, Eastern, Gowanda, Oneida and Wyoming Correctional Facilities.

⁷ The summary contains the date of the grievance, the prison in which the grievance arose, a code indicating the major issue raised in the grievance and a brief summary of what the grievance alleges.

⁸ Facilities that recorded particularly high numbers of grievance appeals were: Upstate (1,270); Clinton (526); Auburn (501); Green Haven (472); Elmira (448); Great Meadow (450); and Fishkill (354). Prisons with

In its annual report on grievances, DOCS found that 36% of all grievance appeals in 2006 were “meritorious or have merit in part.”⁹ The Department did not provide information on the number of medical grievances substantiated by CORC. Nevertheless, it is of concern that such a high percentage of the grievances denied at the prison level were subsequently determined to be at least partially meritorious upon Central Office review two to three months later. The fact that inmates appealed nearly 40% of their medical grievances to Central Office and that a significant number of appealed grievances were determined to have some merit indicate that inmates’ concerns about their healthcare (including access to treatment and quality of care) are of a very serious nature and lend substantial support to inmates’ claims of inadequate care.

Although medical grievances are a useful barometer of the level of inmate dissatisfaction with healthcare and can indicate systemic problems at an institution, it is unclear to what degree DOCS’s Division of Health Services uses them to identify and remedy systemic problems. Similarly, it seems that individual facilities do not consistently analyze grievances as a tool to identify and resolve recurrent medical problems.

Moreover, grievances represent only a partial representation of inmate complaints. Many inmates have reported that they have little faith in the grievance system and have therefore declined to file a legitimate grievance.

Conversely, there are prisons with a responsive grievance program where the grievance mechanism can be an effective tool to promptly address inmate complaints. When the grievance officer contacts medical staff about an inmate’s concerns gathered during the informal grievance resolution procedure or a non-calendared contact, issues can promptly be resolved, resulting in improved care and reduced treatment delays.

MEDICAL STAFFING

Vacancies

The CA visits identified several prisons that had numerous medical staff vacancies and/or appeared to have insufficient staff to meet patient needs. Filling vacancies in nursing, physician assistant and pharmacy staff has frequently been very difficult for DOCS in several regions of the state because of inadequate compensation rates for these positions.

Table 3 (page 21) contains a summary of medical staffing at 19 prisons at the time of the CA visits. These data reveal vacancy rates of 14% for nurses, 12% for physicians, 5% for physician assistants (PAs) and nurse practitioners (NPs), and 16% for pharmacists.

significantly fewer medical appeals included Eastern (167), Sullivan (149), Wyoming (131), Coxsackie (100), Oneida (81), and Gowanda (74).

⁹ See *Inmate Grievance Program, Annual Report 2006*, DOCS (2007). Comparable, but slightly lower, numbers of meritorious appeals were noted in annual reports for 2003–2005. *Inmate Grievance Program, Annual Report 2005*, DOCS (2006); *Inmate Grievance Program, Annual Report 2004*, DOCS (2005); *Inmate Grievance Program, Annual Report 2003*, DOCS (2004).

Recently, the Department has made progress in filling some positions and has managed to increase some staffing levels. An analysis of DOCS's May 2007 system-wide medical staffing data provided by DOCS Division of Health Services indicates that the Department has reduced its nursing shortages overall by more than 40% in the last few years from about 14% to 8%. The reduction in the vacancy rate for physicians to 3% indicates that the Department apparently no longer has a systemic problem filling these positions.

Table 2 contains a list of recommended and filled positions as of May 2007 for all prisons for: (1) physicians, (2) PAs and NPs, (3) registered nurses and (4) pharmacists.

TABLE 2 - SUMMARY OF MAY 2007 DOCS MEDICAL STAFFING

	Physicians	PAs/NPs	Registered Nurses	Pharmacists
Recommended Staff	114.08	48	799	54.5
Actually Filled Items	110.33	41.3	735.8	47.4
Number of Vacancies	3.75	6.7	63.2	7.1
Percent Vacant	3.3%	14.0%	7.9%	13.0%

The CA hopes this progress will continue and urges DHS to undertake an analysis to identify prisons where inadequate staffing has an adverse effect on healthcare. Despite some system-wide progress, problems still persist in filling PA/NP and pharmacist positions. Moreover, as detailed at pages 20-24, vacancies still exist at several prisons throughout the state. **Table 4** (page 23) contains May 2007 staffing levels for the 19 prisons visited by the CA.

Staff Vacancies - Nurses

The Department has experienced chronic nursing shortages for several years. The overall nurse vacancy rate reported by DOCS Chief Medical Officer Dr. Lester Wright at the Assembly hearing conducted by the Corrections and Health Committees in March 2004 was 14%; the Department reported comparable nurse vacancy rates for several years prior to Dr. Wright's testimony. Similarly, there was a 14% overall nurse vacancy rate at the time of CA visits to the 19 prisons in 2004-2007. Nine of these prisons had nursing vacancies of greater than 15%, with some vacancy rates higher than 40%. At Bedford Hills, for example, 10 of the facility's 23 registered nurse positions were vacant.

Some vacancies persist for months (and sometimes years), because there are few candidates in the community willing to work in the prisons at the compensation rates offered. Eastern, for example, was missing 6.5 nurses, 23% of nursing staff; some of these vacancies had existed for one year prior to the February 2005 CA visit. Great Meadow was missing nearly 30% of its nursing staff at the June 2006 CA visit; some of these vacancies had existed for more than two years.

Further, vacancy rates do not indicate all the missing staff. Some positions are technically "filled" with individuals who are not working because they are out on extended sick leave, workers' compensation or are otherwise unavailable to work. Other individuals cannot fill their positions, so no one is performing their duties. For example, of seven nursing positions at Mid-Orange in October 2004, only two permanent staff were present at the facility; two positions

Table 3 - Medical Staff at Time of CA Visit to Prisons in 2004-07

Prison Cls	Med PVP Cts	Visit 2006	Pop 2006	MD Staff	#1	Rate	MD Vac	% Vac	NP	PA Vac	PA Vac	% Vac	Rate #2	RN Vac	RN Vac	% Vac	LPN Vac	LPN Vac	Rate #3	Pharm Vac	Pharm Vac	% Vac																											
																							1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Albion	1	12/1/2005	1,150	2	1.74	0	0.0%	0.0%	1.5	0	0.0%	0.0%	3.04	18	2	11.1%	0	0	1.57	1.5	0.5	33.3%																											
Arthur Kill	1	12/19/2005	947	2	2.11	1	50.0%	0	0	0.0%	0	0.0%	3.04	9	2	22.2%	1	0	1.06																														
Attica	1	3/17/2005	2,204	2	0.91	1	50.0%	2	0	0.0%	0	0.0%	1.81	17	2	11.8%	0	0	0.77	3	0	0.0%																											
Auburn	1	7/19/2005	1,767	2	1.13	0	0.0%	1	0	0.0%	0	0.0%	1.70	14.5	2.5	17.2%	0	0	0.82	2	1	50.0%																											
Bedford Hills	1	7/15/2005	808	8	9.90	2	25.0%						23	10	43.5%	15	7	4.70	2	1	50.0%																												
Clinton	1	12/14/2004	2,890	4	1.38	0.5	12.5%	1.5	0	0.0%	0	0.0%	1.90	19	0	0.0%	1	0	0.69	3	1	33.3%																											
Coxsackie	1	9/30/2004	978	1.4	1.43	0	0.0%						11	3	27.3%	0	0	1.12	2	0	0.0%																												
Eastern	1	5/25/2005	1,175	2	1.70	0	0.0%						11	1.5	13.6%	0	0	0.94																															
Elmira	1	5/4/2005	1,779	3	1.69	0	0.0%	1	0	0.0%	0	0.0%	2.25	16	0	0.0%	0	0	0.90	2	1	50.0%																											
Fishkill	1	2/15/2005	1,718	4	2.33	0	0.0%	2	1	50.0%	3.49	28.5	6.5	22.8%	4	3	1.89	4	0	0.0%																													
Gowanda	2	6/28/2005	1,743	2.5	1.43	0.5	20.0%	1	0	0.0%	0	0.0%	2.01	16	0	0.0%	0	0	0.92	2	1	50.0%																											
Great Meadow	1	6/20/2006	1,681	3	1.78	0	0.0%	1	0	0.0%	2.38	14	4	28.6%	0	1	0.83	2	0	0.0%																													
Green Haven	1	5/24/2006	2,149	7	3.26	1	14.3%	2	0	0.0%	4.19	29	1	3.4%	3	1	1.49	1.5	0	0.0%																													
Mid-Orange	1	10/19/2004	721	1	1.39	0	0.0%	0.4	0	0.0%	1.94	7	2	28.6%	0	0	0.97																																
Oneida	1	3/8/2007	1,191	2	1.68	0	0.0%	1	0	0.0%	2.52	12	0	0.0%	0	0	1.01	6	0	0.0%																													
Sing Sing	1	12/2/2005	1,737	4	2.30	0	0.0%	3	0	0.0%	4.03	21	4	19.0%	1	1	1.27	2.5	0	0.0%																													
Sullivan	1	7/20/2006	746	1	1.34	0	0.0%	1	0	0.0%	2.68	10.5	0	0.0%	0	0	1.41																																
Upstate	1	12/13/2004	1,162	1.5	1.29	0.25	16.7%	2	0	0.0%	3.01	26	1	3.8%	0	0	2.24	0																															
Wyoming	1	5/21/2007	1,707	2	1.17	0	0.0%					11	2	18.2%	0	0	0.64	0																															
TOTALS			28,253	54.4	1.93	6.25	11.5%	20.4	1	4.9%	2.65	314	43.5	13.9%	25	13	1.198	33.5	5.5	16.4%																													

Rate 1: # of authorized Physician per 1000 inmates. Rate 2: # of MDs, PAs and NPs per 1000 inmates. Rate 3: # of RNs and LPNs per 100 inmates.

were vacant, two nurses were on extended sick leave, and one nurse was out on workers' compensation. In some cases, including at Mid-Orange, temporary per diem items are authorized to replace absent employees, but even these temporary positions may, at times, be vacant.

Per diem nurses are hired from the community or through state contracts with outside nursing agencies. Alternatively, when positions are vacant, the prison must supplement the nursing personnel with extensive overtime by existing staff and/or extra service nurses from other state agencies. Compulsory overtime and a lack of permanent staff lead to excessive stress and high rates of staff turnover which in turn threaten quality of care by disrupting continuity of care and undermining provider-patient relations. Under these circumstances, essential tasks (e.g., quality assurance activities, chart reviews, routine preventive care, etc.) are often discontinued or delayed.

As noted above, the Department has made progress in reducing the overall vacancy rate for nurses. But the problem has not been solved. Many of the prisons visited in 2005-2007 continued to experience difficulties in hiring nurses. The May 2007 staffing data listed in **Table 4** reveal that Bedford Hills still had a 40% nurse vacancy rate: 11 of 28 positions were unfilled. Elmira was missing 14% of its 18 regular nurses. Arthur Kill, Attica, Great Meadow and Sing Sing also had multiple nursing positions unfilled. Additional resources are needed to attract staff to these facilities to remedy these longstanding staffing problems.

Staff Vacancies - Pharmacists

Pharmacy staffing has also been a chronic problem. Thirteen of the 19 prisons the CA visited (**Table 3**) had pharmacists authorized for the facility, but there were a number of vacancies. Of the 33.5 pharmacist positions at the 13 prison pharmacies, 5.5 positions (16%) were vacant at the time of the CA visit. At four prisons, only one of two authorized pharmacists was working.

The six prisons without onsite pharmacists relied on outside pharmacy services. Four of these obtained medications from regional pharmacies at other prisons. The other two (Mid-Orange and Upstate) that relied on an outside community pharmacy had medication costs that were significantly higher than they would have been had the medications been provided by the DOCS Central Pharmacy.¹⁰

Most pharmacy vacancies have existed for many months or years. The staff shortages and the reliance on expensive outside providers have persisted primarily due to the state's failure to compensate pharmacists at rates comparable to community salaries. As the May 2007 data (**Tables 2 and 4**) demonstrate, the problems in pharmacy vacancies still persist system-wide with an overall vacancy rate of 13% and a vacancy rate of 15% at the 19 prisons visited by the CA. It appears that greater compensation rates are needed to attract sufficient applicants to fill the many vacant positions; this increase in wages will require action by officials outside DOCS.

¹⁰ See pages 58-61 for a more comprehensive description of pharmacy services and the impact of vacancies on pharmacy services in the Department.

Table 4 - 2007 Medical Staffing for Prisons Visited by CA in 2004-07

<i>Prison</i>	<i>Pop 2007</i>	<i>MD Staff</i>	<i>MD Vac</i>	<i>% MD Vacant</i>	<i>MD PA/NP Staff</i>	<i>MD PA/NP Vac</i>	<i>% PA Vac</i>	<i>Inmates/MD/PA/NP</i>	<i>RN Staff</i>	<i>RN Vac</i>	<i>% RN Vacant</i>	<i>Inmates per RN</i>	<i>Pharm Staff</i>	<i>Pharm Vac</i>	<i>% Pharm Vacant</i>
Albion	1,161	2	0	0.0%	1	-0.5	-50.0%	387	15	-0.7	-4.7%	77	3	1	33.3%
Arthur Kill	968	2	0	0.0%	0	0		484	8	2	25.0%	121	1	1	100.0%
Attica	2,210	2	0	0.0%	3	2	66.7%	442	17	3	17.6%	130	3	0	0.0%
Auburn	1,772	3	0.5	16.7%	1	0	0.0%	443	14.5	1.5	10.3%	122	4	1	25.0%
Bedford Hills	812	6.15	0	0.0%	1	0	0.0%	114	28	11.3	40.4%	29	2	0	0.0%
Clinton	2,833	2.5	0	0.0%	3	1	33.3%	515	19	1	5.3%	149	3	0	0.0%
Coxsackie	1,032	1.5	0	0.0%	0	0		688	12.5	0	0.0%	83	2.5	-0.5	-20.0%
Eastern	1,175	2	-0.5	-25.0%				588	11	1	9.1%	107	0		
Elmira	1,779	2	0	0.0%	1	0	0.0%	593	18	2.5	13.9%	99	2	0	0.0%
Fishkill	1,679	5	-0.5	-10.0%	2	0.2	10.0%	240	40.5	2	4.9%	41	3.5	-0.5	-14.3%
Gowanda	1,758	2	-0.5	-25.0%	1	0	0.0%	586	15.5	0.5	3.2%	113	3	1	33.3%
Great Meadow	1,654	2.5	1	40.0%	2	1	50.0%	368	14	4.3	30.7%	118	2	1	50.0%
Green Haven	2,131	7.5	0.25	3.3%	3	0	0.0%	203	30	5.5	18.3%	71	1.5	0	0.0%
Mid-Orange	717	1.5	0	0.0%	0	0		478	8	-0.5	-6.3%	90	0		
Oneida	1,180	2	0	0.0%	1	0	0.0%	393	11	0	0.0%	107	7	1.1	15.7%
Sing Sing	1,713	3	0	0.0%	4	1	25.0%	245	20	4.5	22.5%	86	2.5	1	40.0%
Sullivan	770	1	0	0.0%	1	0	0.0%	385	12.5	0	0.0%	62			
Upstate	1,255	1.5	0	0.0%	2	0	0.0%	359	26	2	7.7%	48	0		
Wyoming	1,705	2	0	0.0%	0	0		853	11	1	9.1%	155	0		
Totals	28,304	51.15	0.25	0.5%	26	4.7	18.1%	367	331.5	40.9	12.3%	85	40	6.1	15.3%

Staff Vacancies - Physicians

Physician staffing had been problematic, but recently, the Department has made significant progress in filling many of these positions. Overall, for the 19 visited prisons, 12% of the physician items were vacant at the time of the CA visit (**Table 3**), including seven prisons that had at least a part-time physician vacancy. Two prisons were missing half their physicians, one prison was missing a quarter of its doctors and another had a 20% vacancy rate. Some of these prisons had had physician vacancies for extended periods of time. Gowanda, for example, had not filled a half-time physician position for 18 months prior to the CA visit in 2005. Attica's FHSD position had been vacant for six months at the time of the 2005 visit. As discussed in greater detail later in this report, these vacancies had a harmful effect on healthcare, with many inmates reporting long delays to see a provider and inadequate examinations.

As noted above, the Department has reduced the overall physician vacancy rate to 3% as of May 2007. At the 19 prisons visited by the CA, the 2007 data (**Table 4**) indicates that only three prisons were missing physician staff. Auburn had increased its physician staff to three doctors as of 2007 from the two positions authorized in 2005, but the prison had been unable to fill a half-time physician position. Great Meadow was missing one physician of its 2.5 doctor items. Unfortunately, both these large prisons have had consistent problems with the quality of the medical care provided, and these vacancies will only exacerbate their difficulties. The Department should be commended for its efforts to hire doctors, but it must remain vigilant in expeditiously filling physician positions, because any absence of such providers negatively affects the prisons' ability to provide quality care.

Continuing Problems Filling Vacancies

Despite the progress made with the nurses and physicians, the Department continues to have high levels of vacancies for pharmacists (13%) and PA/NP positions (14%), apparently due to the low civil service salaries available for these jobs. The Department should renew discussions with the Division of the Budget and Civil Service Commission concerning the chronic staffing shortages in these positions and request additional salary increases for them.

Significant problems that require prompt attention still exist at individual prisons. **Table 4**, containing a summary of May 2007 staffing levels, indicates two visited prisons with serious staffing problems. As noted above, Great Meadow had several critical vacancies: one of 2.5 physician positions (40%), one of two PAs, and 4.3 positions of 14 nursing items (31%) were vacant. It is unreasonable to expect Great Meadow, a prison of nearly 1,700 inmates, to function effectively with these shortages, and the staff there may soon experience burn-out from the burden. It is notable that several nurses at Great Meadow had been hired within one year of the May 2007 data, suggesting that the prison has difficulties retaining its nursing staff.

Attica had several shortages: it was missing two of three PAs and three of 17 regular nurses. The prison was also authorized to fill two additional temporary nursing positions, but as of May 2007, both of these positions were vacant, as was a temporary pharmacist position. As a result of provider vacancies, Attica had only three clinicians for more than 2,200 patients. Given the chronic problems in staffing at the prison, responsible state officials should make greater efforts to recruit new staff and provide incentives for existing staff to remain in their positions.

Additional Medical Staffing Needs

Even if all the 2007 authorized medical positions were filled, deficiencies in care at some prisons would persist because the authorized number at some prisons is not sufficient to meet the health needs of the inmate population. Moreover, there is no apparent consistent staffing plan for each prison to ensure that comparable services are available throughout the Department.

Nursing Staff Needs

Many prisons do not have sufficient nursing staff to meet the needs of their patients, and substantially different nurse-patient ratios exist throughout the Department. For example, as of May 2007, Auburn, with 1,770 inmates and a prison infirmary, was authorized to employ only 14.5 nurses, representing one nurse for every 122 inmates. (See **Table 4.**) It was not surprising that a majority of inmates the CA surveyed rated the healthcare at Auburn as poor and that it has the second highest rate of medical grievances of the facilities the CA visited. At Clinton, there are only 19 nurses for almost 2,900 inmates in the Main and Annex buildings, a ratio of one nurse for 152 inmates. At Clinton, many fewer inmates go to sick call than at other prisons, the number of medical grievances is high, and inmates reported significant delays in access to care. Wyoming has only 11 nurses for more than 1,700 inmates, representing one nurse for every 155 inmates. Wyoming inmates were particularly critical of the quality of sick call, which is run by nurses, with half the inmates rating it as poor and only 6% assessing it as good. Other prisons had similar staffing problems.¹¹

In contrast, Green Haven, bound by a federal court order requiring specific medical staff levels, has a population of 2,139 inmates and employs 32 nurses, a ratio of one nurse for every 67 inmates, twice the rate at Clinton and Auburn. Fishkill, with 1,730 inmates, has one nurse for approximately 80 inmates,¹² and Sing Sing has one nurse for every 82 inmates.

There is no apparent medical justification for the significant differences in the allocation of nursing staff at these downstate facilities in comparison to the staffing levels at Auburn, Clinton and Great Meadow, which are prisons that have the highest prison medical classification level and operate a medical infirmary.

Some prisons have augmented nursing staff since the CA visits in 2004 and 2005. When the CA visited Elmira in May 2005, the prison had 16 nurses and no nurse vacancies, but, to provide essential services, the prison regularly utilized per diem nurses and significant staff overtime. At that time, the staff had requested two more nurses, but DOCS had not approved any additional positions. Since then, two additional nurses have been authorized for the prison. Unfortunately, the prison now has 2.5 nurse vacancies, so it has not realized the benefit of this increase in nursing staff. During the CA visit to Mid-Orange in 2004, the staff informed the Visiting Committee that the prison had requested two additional nurse items beyond its then-current level of seven, but the prison was only authorized to hire one additional nurse to work 16 hours per

¹¹ At Attica and Great Meadow, the inmate-nurse ratios are 130 and 120, respectively, and inmates at these prisons had significant complaints about healthcare.

¹² Fishkill, with a total of 40.5 nurses, has a 30-bed Regional Medical Unit (RMU) and a 30-bed Cognitively Disabled Unit (CDU) for inmates with severe dementia and other cognitive impairments. The RMU and CDU have 11 and 8.5 nurses, respectively; consequently, to serve the remaining prison population, there is one nurse for approximately 80 inmates.

week. Since our prison report, Mid-Orange was authorized to increase its nursing staff to eight nurses and as of May 2007, the prison employed 8.5 nurses, exceeding its regular staff allocation.

Physician and PA/NP Staff Needs

Similar discrepancies exist for the authorized levels of physician staff at many prisons, leaving some facilities with insufficient personnel to meet the healthcare needs of inmates. At 17 prisons visited by the CA (excluding Green Haven and Bedford Hills, prisons where litigation required augmented staffing), there were only 37.5 authorized doctors for 25,300 inmates, a ratio of one physician for every 675 inmates. These May 2007 figures include a Facility Health Services Director (FHSD) at each prison who often must spend a significant portion of their time on administrative matters.

If the authorized levels of physician assistants (PAs) and nurse practitioners (NPs) are added to the physician staffing, there is one clinician for every 425 inmates at the other 17 prisons visited by the CA. For the entire system, the ratio of authorized clinicians (physician, PA and NP) to inmates is one provider for every 392 patients.

Table 4, which contains a summary of physician, PA and NP staff as of May 2007 at the 19 visited prisons, demonstrates a continuing problem with staff allocations.

Clinton has only 2.5 physicians and three PAs authorized for 2,833 inmates, a ratio of one clinician for every 515 patients (a rate one-third higher than the system average). With one PA vacancy, the ratio at Clinton rises to one clinician for 630 patients. Elmira has only two doctors and one PA for 1,779 inmates, a ratio of one clinician for 593 patients. Gowanda has a ratio of one clinician for every 586 patients, Coxsackie has one clinician for 688 patients and Wyoming has a clinician for every 853 inmates. In contrast, the clinician to inmate ratios at Fishkill, Green Haven, Oneida, Sing Sing, and Sullivan are one clinician for fewer than 400 patients.¹³

There is no justification for clinician-patient ratios that are 25% to 50% higher at some prisons than others. During prison visits, the CA requested that the Department evaluate the adequacy of staffing at Clinton, Coxsackie and Elmira and noted delays in care at Gowanda and Wyoming. The 2007 staffing data illustrate that there have not been any significant improvements in staffing at Coxsackie, Elmira, Gowanda or Wyoming. At Clinton, the PA staff allocation has been increased by one, but the position is unfilled. More importantly, the significant discrepancies in staffing patterns at the 19 visited facilities persisted in 2007.

MEDICAL STAFF TRAINING

The medical training of DOCS providers is insufficient because there is no mandatory continuing medical education (CME) program for DOCS healthcare staff, and because at many prisons, medical personnel are so busy with their care duties, they do not have sufficient time to participate in voluntary CME programs. DOCS requires all its employees, including medical staff, to annually attend 40 hours of general Department training, but there is no health-specific

¹³ The ratio of clinician to inmates at Fishkill and Green Haven is below 400, even when the clinicians authorized for the special units are deducted from the prison total.

curriculum in this program that is mandated for medical staff. DOCS's lack of mandatory training in chronic diseases proves problematic for the many providers who are required to treat inmates with chronic conditions (e.g., HIV, hepatitis C, etc.) but who lack extensive experience in treating these diseases. It is inappropriate to require providers to care for patients with conditions that medical staff has not been sufficiently trained to treat.

Effective CME is available for prison providers who elect to participate in voluntary programs. For several years, DOCS has offered an excellent training program coordinated through Albany Medical Center that focuses on infectious diseases (particularly HIV and hepatitis C) and includes two national videoconference sessions each year and written training materials for prison providers. But DOCS clinicians are not required to attend the teleconferences, and it does not appear that the Department makes an effort to closely monitor CME participation of its staff. Prison health administrators have reported that when prisons experience staff shortages, they cannot assign personnel to the Department's training sessions. Rather, individuals must pursue training on their own time and/or take tapes of training sessions home to view during non-work hours. This practice is an unacceptable alternative to a meaningful CME program.

ACCESS TO AND QUALITY OF CARE AT ROUTINE MEDICAL APPOINTMENTS

Prison medical care is provided through a triage system in which inmates initiate requests for care and are screened by nurses who determine whether a patient requires additional examination and treatment by a prison provider. This process is called "sick call" and occurs in most prisons four to five days a week. If at sick call the nurse decides that additional care is needed, the patient must wait for an appointment with a DOCS provider who will examine the patient in the medical clinic area, an encounter that could happen the same day if it is urgent or could take weeks or months if it involves routine care. Prison clinic medical care is provided by doctors, physician assistants or nurse practitioners, most of whom are DOCS employees. Many inmates complain about delays in accessing the medical system and the quality of the care they receive. As with other aspects of the prison healthcare systems, access to routine services and the quality of the medical examinations vary greatly among the prisons.

Sick Call

During CA visits, inmates expressed mixed opinions about sick call. At some prisons, there was adequate access, and inmate-patients offered positive statements about the quality of examinations performed by sick call nurses. For example, at Gowanda, with a population of approximately 1,750 inmates and no nurse vacancies, the prison assigned two or three nurses to sick call each day, and the inmates generally had favorable comments about healthcare and the nurses. At Green Haven, more than three-quarters of the inmates stated that they could access sick call when needed.

At other prisons, inmates complained of delayed access to sick call and reported that some nurses dismissed their medical concerns. The sick call system sometimes appeared to discourage inmate participation.

For example, at Clinton's main building, which houses more than 2,000 inmates, the prison conducted sick call only four times per week, and only 20 to 40 inmates were seen each day.

This rate is less than half that documented at other prisons this size. Clinton inmates said that some security staff discourage them from requesting sick call. At Auburn, sick call is conducted in the housing areas from 5:30 a.m. to 7:00 a.m.; inmates complained that the early hour discourages their participation. At Coxsackie, sick call nurses saw 30 to 50 patients in 1.5 to two hours, an average of only about two minutes per patient. Coxsackie inmates complained that nurses sometimes refused to refer them to the prison doctor when needed. The shortage in nursing staff at this prison very likely contributed to the limited sick call time. Other prisons had similar access and quality of care problems.¹⁴

Since sick call is the entry point for most of prison healthcare, it is essential that the process function well, in terms of access *and* the quality of medical encounters. When the process fails, inmates experience delays in treatment and serious conditions can worsen. An essential purpose of sick call is for nurses to refer patients for follow-up care. Some delays in clinic access can be attributed to a breakdown in that process. The quality of the sick call encounters should be carefully scrutinized to determine if this vital function is operating effectively.

In November 2007, the Department issued a Quality Assessment Tools Manual containing, among other tools, a sick call instrument that will be useful in evaluating some aspects of sick call process by monitoring the availability of sick call for general population and disciplinary inmates, and in assessing whether the encounters were adequately documented. But the data from this tool is not sufficient to comprehensively evaluate the quality of the services provided and does not include any input from patients in assessing the sick call nurses' attitude and demeanor. Sick call nurses should receive additional training on how to properly conduct sick call and how to effectively and respectfully communicate with the inmates so that patients feel comfortable disclosing important medical information and are encouraged to cooperate in their own medical care. All of this will contribute to the ability of these nurses to properly assess patients' medical needs.

Clinic Call-Outs – Access to Physicians, Physician Assistants and Nurse Practitioners

Once an inmate has been screened by a nurse at sick call, he/she can be referred to a doctor, physician assistant (PA) or nurse practitioner (NP) in the clinic area for further evaluation and treatment. Most clinic providers are physicians; PAs and NPs represent approximately one-quarter of the clinic staff at visited prisons. Except in emergencies, inmates are generally seen by a clinician several days, weeks or even months after their sick call screening.

Inmates expressed a mixed, but somewhat negative, review of the clinic call-out system. The most frequent complaints were about the significant delays in accessing prison doctors and the cursory, disrespectful and/or inadequate care that some providers rendered.

¹⁴ At Eastern, with a population of 1,000 inmates, only one nurse conducted sick call for the approximately 40 inmates attending daily; consequently, inmates waited hours to be seen. Again, chronic nursing shortages probably contributed to this situation. At Great Meadow, 52% of the population rated sick call as poor. At Wyoming, 50% of survey participants rated sick call as poor, and only 6% reported it as good; the inmates' greatest concern was that the sick call nurses did not promptly refer inmates with serious medical problems to physicians for treatment. At Mid-Orange, where only two of the seven authorized nurses were actively working, inmates complained of delays in access to care and the failure of nursing staff to screen newly admitted inmates properly or to perform routine physicals. At Upstate (a prison primarily housing inmates in disciplinary confinement), the majority of inmates surveyed reported problems accessing sick call at their cells, and three-quarters rated sick call services as poor.

At prisons with a higher ratio of medical providers, inmates reported they had adequate access to physicians. For example, at Oneida, with one clinician for every 400 inmates, inmates reported that it takes only two weeks to see a clinic provider for routine care, and two-thirds of the inmates rated the physicians as good or fair. At Sullivan, with one provider for every 370 patients, inmates estimated that they can see a clinician within three weeks, and the medical staff reported it generally takes only two weeks for a clinic appointment. At Bedford Hills, where healthcare was monitored for more than two decades following a consent decree that resulted in more providers per inmate at this prison than at most facilities, inmates said they generally see a physician within two weeks for routine care.¹⁵

At many other prisons, particularly those with fewer providers and/or more physician vacancies, problems persisted. For example, at Great Meadow, which had one clinician for every 560 patients, more than three-quarters of the surveyed inmates reported delays in access to clinic providers, estimating that it took 45 days on average to see a clinician for routine care. The medical staff admitted to delays of a month. Of greater concern was inmates' assessment of the quality of care provided. Sixty-five percent of surveyed inmates rated physician care as poor; only 7.5% considered it good. There were complaints about care provided by some, but not all, of the providers, including poor attitude and lack of respect when dealing with inmates and failure to address problems in a timely manner and to provide treatment for longstanding medical problems.

At Elmira, staff admitted that it could take up to 30 days for an inmate to be seen for routine care. A majority of Elmira inmates interviewed said they did not have adequate access to medical providers and rated overall healthcare as poor. At Attica, where the FHSD position was vacant when the CA visited, inmates reported delays of six weeks or more in accessing a provider, and the medical staff admitted they had an 11-page list of inmates waiting to be seen by clinic staff.

At Auburn, inmates reported that it could take a month or more to see a clinic provider, and more than 60% of the interviewed inmates rated healthcare as poor. Inmates surveyed at several other prison reported similar problems.¹⁶

The Department's Quality Assessment Tools Manual contains a clinician chart review tool, issued in October 2007, to evaluate the documentation of clinic encounters with primary care providers. This tool could be an important component in monitoring the performance of DOCS providers by focusing on the adequacy of the notations made in the patient's chart and by assessing whether the primary care provider has reviewed laboratory results and other tests, documented continuity between the provider and the specialists and documented follow-up to any previous plan of care. No results from the use of this tool were available for CA review, but

¹⁵ At Fishkill, inmates had mixed reviews of healthcare depending on which provider they were seeing. The recently hired FHSD was praised as attentive and helpful, medical screening had become more comprehensive, and medical grievances had declined.

¹⁶ At Clinton, inmates complained that some providers were dismissive or disrespectful during medical encounters, but they praised the new PA and the care she provided. At Gowanda, where there was a long-term physician vacancy, inmates reported delays in access to care. At Upstate, a majority of disciplinary inmates reported frequent delays in access to a physician; two-thirds rated the doctors as poor, and not one inmate rated healthcare as good. At Wyoming, almost 50% of survey participants rated physician care as poor, and only 9% assessed it as good. At Albion, about half the female inmates surveyed reported that it can take one month or more to be seen by a provider.

this instrument could substantially enhance the Department's effort to monitor the quality of clinic encounters. Beyond this, additional efforts are needed to ensure that clinicians are adequately responding to patients' medical concerns and are conducting these encounters in a respectful and sensitive manner.

Serious medical consequences can occur when prison providers do not see inmates in a timely manner, do not respond appropriately to medical complaints, or fail to manage complex medical cases. Inadequate clinic care can result in problems with specialty care, since prison clinicians are responsible for referring inmates with serious conditions to a specialist and for following up on specialists' recommendations when the patient returns to prison. A review of CORC grievance reports concerning inadequate treatment (see **Exhibit C**) reveals higher rates of such grievances at Auburn, Clinton, Great Meadow and Upstate—the same prisons where the CA noted significant complaints about medical care.

CHRONIC DISEASES: HIV, HEPATITIS C AND OTHER ILLNESSES

New York State inmates suffer from high rates of chronic diseases, and a significant portion of DOCS's healthcare system is devoted to providing medical services for them. Recent data on HIV and hepatitis C (HCV) infection rates released by the New York State Department of Health, along with DOCS's estimates, indicate that approximately 4,000 DOCS inmates are HIV-infected and 8,400 inmates are infected with HCV.

Recent Improvements in Healthcare Systems and Chronic Care

DOCS's Division of Health Services (DHS) has promulgated separate Practice Guidelines for HIV and HCV treatment that provide instructions to prison staff concerning accepted protocols for examining and treating patients with these diseases and documentation that prison medical staff are expected to complete during treatment. The CA commends DHS for developing these guidelines along with routine amendments to attempt to keep DOCS's practices consistent with community standards of care. The challenge is to ensure that prison practices conform to these standards. Some prisons are apparently doing an effective job, while others are falling short.

The Department has made progress over the last few years in the diagnosis and treatment of HIV and HCV. HIV care has improved with the development of new antiretroviral medications that are readily available in all state prisons; as a result, fewer inmates are dying from AIDS. DHS has adopted a policy that HIV-infected inmates experiencing problems on their current regimen must be evaluated by an HIV specialist. Most importantly, DHS has now fully implemented an HIV quality improvement program to better monitor HIV care in the prisons.

More inmates infected with hepatitis C receive medications than did a few years ago, and it appears that many patients are responding well to treatment. DHS expanded the population that can qualify for HCV treatment by no longer requiring inmates to enroll in a substance abuse treatment program before initiating HCV treatment and by implementing a program to develop discharge treatment plans for inmates who will be released to the community before their treatment is completed. DHS also expanded its quality improvement activities concerning other chronic diseases and is developing more comprehensive instruments to assess prisons'

compliance with the hepatitis C Treatment Practice Guidelines. These steps have resulted in improvements in care and better monitoring of prison operations.

Problems in Identification and Treatment of Inmates with HIV and/or HCV

There is still more that must be accomplished to consistently meet community standards of care for all inmates with HIV and/or HCV. Persistent problems include the following: (1) the Department has not been successful in identifying a significant portion of inmates with these chronic diseases; (2) not all prisons are implementing policies requiring access to expert care for those identified as having a chronic disease; and (3) not all prisons are aggressively treating their HIV- or HCV-infected populations.

The CA obtained data during each prison visit about the number of inmates infected with HIV and HCV in the prison, as well as the number of patients with these illnesses on active treatment. **Table 5** (page 32) lists this information. More recent system-wide data from the Department on the number of HIV- and HCV-infected inmates at every prison, along with data for FY 2006-07 detailing specialty care services accessed by DOCS inmates, were evaluated and are reported in **Exhibit D** and **Exhibit E** for male prisons. Comparable data for the female prisons are presented in **Exhibit G** and **Exhibit H**. Both at the time of CA visits and into 2007, there were greatly varying levels of disease identification and treatment, particularly for HCV.

HIV Infection in the Male and Female Prison Populations

Since 1988 (and approximately every two years thereafter), the Department of Health (DOH) has tested a sample of inmates newly admitted to DOCS custody to determine the number of HIV-infected inmates.

The most recent DOH data available from tests in 2005 show that the rate of HIV infection for newly admitted male inmates was 4.0%, a slight decrease from the 2003 rate. Based upon these data and previous DOH studies, the estimated current male HIV population is approximately 3,700 inmates, representing an overall male HIV infection rate of approximately 6.1%.

The HIV infection rate for women is twice the rate for the men. The 2005 DOH study of newly admitted female inmates found an HIV infection rate of 10.6%, a small decrease compared to 2003. Based on DOH's studies, an estimated 12% of female inmates (approximately 340 women) are HIV-infected. At an AIDS Institute Conference in October 2007, DOCS officials stated that the system housed approximately 4,000 HIV-infected male and female inmates, an estimate consistent with CA's projections.

The HIV infection rate in state prisons has consistently decreased in the last 20 years, although the rate of decline for men has slowed during the past few years. The DOH studies of newly admitted DOCS inmates illustrate these declines. In 1992, 11.5% of newly admitted men and 20.3% of the women were HIV-infected, rates that declined to 4.7% for men and 13.9% for women admitted in 2000-01 and to 4% for men and 10.6% for women admitted in 2005.

However, these figures do not represent the actual HIV infection rate in the prisons because DOH tests only a sample of the nearly 27,000 newly admitted inmates and not the entire prison

Table 5 - HIV and Hepatitis C in CA Visited Prisons in 2004-07

<i>Prison</i>	<i>Visit Date</i>	<i>Pop 2005</i>	<i>HIV positive</i>	<i>% HIV +</i>	<i>HIV on Treatment</i>	<i>% HIV+ on Tx</i>	<i>HCV Positive</i>	<i>HCV on Treatment</i>	<i>% HCV+</i>
Albion	12/1/2005	1,184	66	5.57%	36	54.55%	171	1	14.44%
Arthur Kill	12/19/2005	947	34	3.59%	27	79.41%	70	8	7.39%
Attica	3/17/2005	2,181	100	4.59%				6	
Auburn	7/19/2005	1,765	56	3.17%	28	50.00%	53	6	3.00%
Bedford Hills	7/15/2005	792	56	7.07%	50	89.29%	43	4	5.43%
Clinton	12/14/2004	2,843	300	10.55%			142	12	4.99%
Coxsackie	9/30/2004	1,033	20	1.94%	12	60.00%	60	6	5.81%
Eastern	5/25/2005	1,168	34	2.91%	31	91.18%	30	7	2.57%
Elmira	5/4/2005	1,782	24	1.35%				8	
Fishkill	2/15/2005	1,719	100	5.82%	70	70.00%	100	17	5.82%
Gowanda	6/28/2005	1,746	34	1.95%	16	47.06%	57	3	3.26%
Great Meadow	6/20/2006	1,642	65	3.96%	45	69.23%	350	2	21.32%
Green Haven	5/24/2006	2,145	67	3.12%	44	65.67%	232	11	10.82%
Mid-Orange	10/19/2004	727	40	5.50%				7	
Oneida	3/8/2007	1,199	32	2.67%	27	84.38%	99	4	8.26%
Sing Sing	12/2/2005	1,744	56	3.21%	34	60.71%	94	19	5.39%
Sullivan	7/20/2006	718	23	3.20%	23	100.00%	53	10	7.38%
Upstate	12/13/2004	1,251	29	2.32%	20	68.97%	46	4	3.68%
Wyoming	5/21/2007	1,672	34	2.03%	26	76.47%	114	7	6.82%
TOTALS		28,258	1,170	4.14%	489		1,714	142	

population, and the DOH samples from intake prisons do not mirror the actual prison population.¹⁷ Still, based upon the 2003 DOH data, DOCS estimated that as of year-end 2005, there were approximately 4,440 HIV-infected inmates in its system (4,040 male and 400 female).¹⁸ DOCS's latest estimate (2007) represents a 10% decline in the infection rate during the last two years.

Despite the slow decline in the HIV infection rate, with more than 4,000 DOCS inmates HIV-infected, New York prisons still remain the epicenter of this disease for the U.S. prison system, representing 20% of all HIV state prisoners in the country as of year-end 2006.¹⁹ DOCS is also the largest provider of HIV services in New York State.

Identification of HIV-Infected Male Inmates

Although the number of HIV-infected male inmates has declined, most prisons have identified less than one-half of their estimated HIV-infected population. Documents provided by DOCS in 2007 indicate that the Department is aware of approximately 1,550 male HIV-infected inmates.²⁰ This number means that only 2.5% of the male inmate population is known to be HIV-infected. Thus, DOCS has identified only 42% of the estimated HIV-infected male inmates in the system.

Exhibit D provides a summary for each male prison of the number of: (a) inmates at the prison; (b) HIV-infected inmates as identified in DOCS's computerized medical problems list (recorded in a document from a January 2007 DHS Continuous Quality Improvement Meeting); and (c) infectious disease appointments for FY 2006-07. Based upon these figures, the CA has computed for each prison: the HIV infection rate, rates of infectious disease (IFD) appointments for all inmates in each prison, and rate of IFD appointments for those with HIV.²¹ These data demonstrate that the prisons vary greatly in the percentage of identified HIV-infected inmates and the number of annual IFD appointments per HIV-infected inmate.

The number and rate of male inmates known by DOCS to be infected with HIV vary greatly among hubs and among prisons within the hubs. The Attica hub had the lowest rate of known HIV-positive inmates (2.0%), followed by the Great Meadow Hub (2.32%) and the Sullivan Hub

¹⁷ The DOH protocol for testing newly admitted inmates seeks approximately equal number of samples from each of the male reception centers. However, the actual admission rates are lower at reception centers in the western region of the state where the HCV and HIV infection rates are lower than among inmates entering the eastern reception centers. The CA analysis has attempted to adjust for these differences in the estimates of HIV and HCV rates for the current DOCS population. In addition, the entire prison population contains inmates admitted in the earlier years when there was a higher HIV infection rate. DOCS has developed a model to account for these differences in computing estimated HIV infection rates. Our estimate is based upon the current inmate population and the HIV infection rates that existed at the time inmates were incarcerated.

¹⁸ Maruschak, L., *HIV in Prisons, 2005*, U.S. Department of Justice, Bureau of Justice Statistics, 10 (2007). This estimate is based upon a New York State Department of Health study of newly admitted inmates to DOCS custody performed in 2003.

¹⁹ Maruschak, L., *HIV in Prisons, 2006*, U.S. Department of Justice, Bureau of Justice Statistics, Table 1 (April 2008). This recently released report states that New York's prison HIV population is 4,000 as of year-end 2006.

²⁰ Data provided from a January 2007 Quality Improvement Meeting contained a chart listing 1,514 male inmates and 163 female inmates as HIV-infected. Another document from May 2007 stated that 1,739 DOCS inmates, including women, had a medical problem indicating they were infected with HIV; given the January 2007 figure for female HIV-infected inmates, the May 2007 data would indicate about 1,575 male inmates were HIV infected.

²¹ Although infectious disease consultations are used both for patients who are HIV-infected and those who are not, the bulk of these appointments are used for patients with HIV.

(2.35%). The highest rates of identified HIV-infected inmates were in the Watertown Hub (3.05%), New York City Hub (3.02%) and Oneida Hub (2.98%). These latter hubs have a rate of identified HIV-infected men almost 40% higher than that of the three hubs with the lowest rates. Since it does not appear that DOCS is concentrating HIV-infected inmates in any particular locations or hubs, these variations suggest that several hubs have problems identifying inmates with HIV infection.

More importantly, there are significant differences in the ability of various prisons to identify their HIV-infected populations. Focusing on 43 maximum and medium security prisons that are classified as capable of providing the highest level of medical care (medical class one prisons), ten prisons distributed among seven different hubs had an identified HIV infection rate over 3.0%, and eight prisons in four hubs had a known HIV infection rate below 2.0%.²²

These differences are substantial, representing rates of identified HIV cases in some “higher rate” facilities that are two to three times greater than those in some “lower rate” prisons. The prisons with high and low rates are scattered throughout the Department; none are facilities with specialized units that would either draw or exclude HIV-infected inmates. Therefore, it would appear that action or inaction by prison medical staff or others is having an effect on each prison’s ability to identify HIV-infected inmates. DOCS’s Division of Health Services officials should review the number of HIV-infected inmates at each prison to determine how facilities with low HIV rates can take steps both to encourage inmates to be tested and to persuade inmates who know they are HIV-positive to come forward and seek treatment.

The information on the number of known HIV-infected inmates gathered during the CA visits (**Table 5**) generally was similar to the 2007 data from DOCS’s Division of Health Services (**Exhibit D**), although the figures from visits were slightly higher than those from DHS. One notable exception to this congruency was the HIV-infection figure for Clinton; in this case, the CA figures greatly exceeded the DHS data. In 2004, during a CA visit to Clinton, the FHSD estimated that there were 300 HIV-infected inmates in the prison; however, the 2007 DHS data indicated only 60 HIV-infected Clinton inmates. It is doubtful that the known HIV-infected population at Clinton could have declined so drastically during this period; the prison may be aware of more inmates with HIV than it is reporting to DHS officials and/or the FHSD may have overestimated the prison’s HIV-positive population. Smaller discrepancies at two other prisons may also be due to inaccurate estimates by prison officials.²³

²² Prisons with low HIV infection rates included: Otisville (1.3%), Livingston (1.5%), Eastern (1.6%), Wyoming (1.7%), Elmira (1.7%) and Five Points (1.8%). Prisons that have been much more successful in identifying HIV-positive inmates included Mid-State (4.5%), Ogdensburg (4.5%), Southport (3.9%), Mt. McGregor (3.8%), Franklin (3.6%), Sullivan (3.5%), Auburn (3.2%), Bare Hill (3.2%), Sing Sing (3.2%) and Watertown (3.1%).

²³ There are differences between figures received during visits to Fishkill and Attica and the 2007 data. During the 2005 Fishkill visit, medical staff said there were approximately 100 HIV-infected inmates in the prison, whereas the 2007 DHS data indicate only 42 known HIV-infected inmates. During a 2005 CA visit, Attica medical staff estimated that the prison had about 100 HIV-infected inmates, whereas the 2007 DHS data indicate 64 known HIV-infected inmates there in 2007. The 2005 Attica and Fishkill figures were oral statements by staff without reference to Department records. The differences between the 2005 numbers and the 2007 data probably reflect rough estimates by staff and not a change in the number of identified HIV-infected inmates at these facilities.

It is important that DHS has an accurate picture of the disease burden within its prisons so that it can appropriately allocate resources and estimate funding needs. DHS should investigate the potential discrepancies between its data and prison reports to determine whether prison medical personnel are aware of a greater number of HIV-infected inmates than are reflected in DHS records. Better reporting may be necessary to gauge the true HIV case rate in each prison.

Regardless of the estimates used, it is clear that approximately half or more of the inmates who are HIV-infected in the prison population either do not know their HIV status or are reluctant to disclose it to DOCS. The Department has not successfully persuaded all inmates at risk for HIV to be tested or to convince those who know their status to seek treatment.

Identification of HIV-Infected Female Inmates

Currently, there are approximately 340 HIV-infected women in custody, representing 12% of the female population. Based upon the earlier DOH studies of newly admitted women from 2000 and 2003, DOCS estimated as of year-end 2005 that 14.2% of the female inmates were HIV-infected. At Bedford Hills and Albion, which house approximately 70% of the entire female prison population, prison staff informed the CA during visits in 2005 that they had identified 122 HIV-infected inmates of the total prison population of 1,976. (See **Table 5**.) This figure represents an infection rate of 6.17%, or only 43% of the 2005 estimated HIV-infected female population.

Exhibit G contains a summary of more recent DHS data on HIV infection and infectious disease specialist access for all female facilities. These data indicate that only 6.0% of the female population is known to be HIV-positive,²⁴ half the total estimated to be infected. Greater efforts must be made to encourage women at risk for HIV to get tested and begin treatment while incarcerated.

HIV Testing of DOCS Inmates

In order to increase the number of identified HIV-infected inmates, more inmates must agree to be tested. There are several ways to initiate testing. Inmates can request a test by DOCS medical staff or the medical staff can request HIV testing if they believe a patient is at risk for the disease. Inmates can seek testing from outside contractors who provide services to the prison through the AIDS Institute's Criminal Justice Initiative (CJI), or they can be tested by staff working for the State Department of Health, Bureau of Direct Program Operations, who visit several prisons and perform HIV testing. These latter two groups conduct anonymous testing, enabling inmates to receive their HIV test results but make their own determination as to whether or not to disclose their HIV status to DOCS. HIV-infected inmates identified through these outside sources are encouraged to inform DOCS of their status, but are not required to do so.

As **Table 6** (page 36) illustrates, the CJI contractors and DOH officials perform many HIV tests on inmates, but identify very few HIV-infected inmates.

²⁴ The DHS data did not indicate the number of women at Lakeview or Willard who are HIV-infected, since these institutions confine both men and women. Therefore, in computing the rate of identified HIV-infected women, the CA also excluded these facilities.

TABLE 6 - SUMMARY OF HIV TESTING BY CJI CONTRACTORS AND DOH STAFF

Dates	CJI Contractors		DOH Bureau of Direct Program	
	Jan – Dec 2006	Jan – June 2007	Jan – Dec 2006	Jan – June 2007
# HIV Tested	3,487	1,651	4,787	2,404
# HIV Positive	9	4	20	6
% HIV +	0.26%	0.24%	0.42%	0.25%

These results are discouraging; they indicate that of the estimated 2,000 inmates who are HIV infected but unknown to DOCS, the outside agencies identified only 30 HIV-infected inmates in 2006 and only 10 in the first half of 2007. In other words, DOH and the CJI contractors were able to newly identify only 1.5% of the pool of unknown HIV-infected inmates. These testing programs are making genuine efforts to reach the infected population, but have not been successful in convincing those most at risk to come forward and be tested. Rather, it appears that inmates who are at low risk for HIV infection and soon to be released from prison utilize these services to confirm that they will not expose their families to the disease when they return home. Although testing is certainly advisable for soon-to-be-released inmates, DOH and CJI efforts should focus on reaching higher-risk inmates.

Along with the programs mentioned above, DOCS offers HIV testing as well. In 2002, DOCS conducted 4,444 tests, of which 2.1% were HIV positive. Given that some of these tests were requested by medical staff who suspected the patient might be HIV-infected, it is not surprising that DOCS testing would result in a higher rate of infected inmates. Yet even at this higher rate, DOCS was only able to identify 92 HIV-infected patients in 2002. In 2003, DOCS tested approximately 5,000 inmates. It appears that since 2003, HIV testing by DOCS has continued at nearly the same rate.

During the last six years, the total annual number of HIV tests of DOCS inmates by the Department, DOH and CJI contractors processed by the state laboratory has ranged from 14,000 in 2001 and 2002 to slightly less than 12,000 in 2006. Although there has been a slight decrease in the number of HIV tests performed in state prisons, testing in the county jails during this period increased by nearly 3,000, suggesting that the overall testing rate for inmates in the state system has remained nearly constant.

Many inmates coming into DOCS already know their HIV status or have been tested at some point prior to their incarceration in state custody. At a 2007 AIDS Institute conference on infectious diseases in the prisons, DOH officials disclosed that 80% of all newly admitted inmates tested in its 2005 prison study had previously been tested for HIV. However, a prior negative HIV test does not mean that the inmate is still negative at intake or thereafter. During DOH's 2000-01 prison study of newly admitted inmates, investigators obtained a detailed survey of participants. The study found that of 260 inmates identified as HIV-infected, 95% reported having had a previous HIV test. However, 18.5% of those previously tested reported that they were HIV-negative at their last test. These data demonstrate that many inmates are aware of their risk, but some are unwilling or unable to curtail their risk behaviors. But few of the inmates found to be HIV-infected during this study were newly infected; less than 4% of HIV-

infected inmates in the 2000-01 DOH study had been infected in the six months prior to incarceration.

Assessment of these testing programs leads to the conclusion that current practices are ineffective in identifying cases of HIV among inmates. This failure is not due to a lack of testing options, but to an inability to convince inmates at risk that they should seek testing. More extensive HIV education, peer counseling and outreach to the at-risk population are needed to motivate inmates to seek information about the disease and learn their HIV status.

For inmates who already know their HIV status, a primary obstacle to accessing appropriate HIV care is reticence about disclosing their infection to prison medical staff. Skepticism about the quality of prison healthcare and concerns about confidentiality appear to be the main reasons HIV-infected inmates refuse to disclose their status. To reach these inmates, more peer educators are needed to educate inmates about effective treatment. Prison medical staff must also demonstrate that they can provide timely and effective care to inmates with chronic diseases, which at some prisons will be a challenging task given the many grievances about healthcare. Consequently, to encourage at-risk inmates to seek care, some prisons will have to substantially improve their medical services.

Access to Infectious Disease (IFD) Specialists

There is reason for concern about the quality of the care offered to known HIV-positive inmates at some prisons. Although the CA does not have access to inmates' medical records, and therefore cannot assess whether individual inmates receive appropriate HIV care, it is known that DOCS has not implemented a system to ensure delivery of effective care to every inmate with a chronic disease at all prisons. Recent actions by DHS, detailed below, indicate that DOCS has taken steps to improve its monitoring of prison healthcare and has undertaken positive measures to monitor HIV care. But it is not yet known whether these monitoring activities will lead to improvements in care.

Of greatest concern is whether HIV-infected inmates receive timely access to infectious disease specialists required to manage the complex care needed to control HIV. National and DOCS policies require that patients who are not adequately suppressing their HIV infection with combination drug therapy should be evaluated by an HIV specialist to determine the appropriate treatment regimen. It does not appear that all prisons follow this practice.

Access to IFD Specialists at Male Prisons

The CA analyzed data on access to infectious disease specialists for each prison for FY 2006-07. **Exhibit D** contains a summary of the number of IFD appointments completed at each male prison during that fiscal year, indicating greatly varying rates of IFD appointments compared to the total inmate population and the HIV-infected population.

There is significant variation in the use of IFD specialists among the hubs. The IFD utilization rate in the Green Haven Hub is more than three times the system-wide average, and the New York City Hub's rate is twice the system-wide average. In contrast, the Watertown Hub, with

one of the highest rates of identified HIV-infected inmates,²⁵ has a utilization rate only one-tenth the system-wide rate. Other hubs with low IFD specialist utilization rates are Oneida, Wende and Elmira. The utilization rate in the remaining five hubs is nearly four times the rate in these three hubs. There is no known justification for such a discrepancy in access to HIV experts.

There is also significant variation in the use of IFD specialists among the prisons, even those within the same hub. In 10 male prisons distributed in five of the nine hubs and containing almost 10% of the HIV-infected male population, HIV-infected inmates have regular access to HIV specialists.²⁶ In these prisons, there are many more IFD appointments than HIV-infected inmates, resulting in utilization rates that are ten times the rate of access to HIV specialists in prisons infrequently using IFD specialists.

In contrast, there are 14 medical class one prisons in seven of the nine hubs that have very low utilization rates of outside IFD specialists.²⁷ These prisons contain more than 10% of all HIV-infected men in the system, and none of these prisons has a certified HIV specialist on staff. Most of these prisons have fewer infectious disease appointments in a year than the number of HIV-infected inmates at the prison.

Although it is not known whether inmates at prisons with low IFD utilization rates received inadequate care, it is likely that some patients did not have appropriate monitoring of their condition by a provider with sufficient expertise to determine whether the patient is on the most effective HIV regimen.

Low IFD utilization rates cannot be attributed to less demand for services. The rate of identified HIV-infected inmates in the low utilization prisons (2.4%) is nearly identical to the rate in the high use prisons (2.5%). There is nothing about the patients in these prisons that would justify such a discrepancy in access to HIV experts. Several high utilization prisons are in the southern region of the state, where it may be easier to identify IFD specialists willing to treat HIV-infected inmates, but some prisons providing frequent access to HIV specialists are in the same hubs in which low utilization prisons are also located.

DHS officials should investigate the differences in IFD service utilization for the male prisons to determine whether appropriate access to HIV experts is consistently provided to HIV-infected men throughout the Department.

²⁵ It could be that some prison providers in the Watertown Hub are experienced with HIV care, and one provider at Riverview is qualified as an HIV specialist. However, it is important to note that other hubs with high utilization rates also have prison staff members who are HIV specialists, and it is unlikely that the Watertown physician could provide the bulk of HIV care for the entire hub. Consequently, there is nothing about the medical staff in the Watertown Hub that would justify the extreme low utilization of infectious disease specialists.

²⁶ The prisons with the highest rates of access to an infectious disease specialist include: Adirondack and Clinton in the Clinton Hub; Eastern, Mid-Orange and Woodbourne in the Sullivan Hub; Fishkill and Green Haven in the Green Haven Hub; Coxsackie and Washington in the Great Meadow Hub; and Sing Sing in the Sing Sing Hub.

²⁷ The low IFD-use prisons are Marcy in the Oneida Hub; Cape Vincent, Gouverneur, Ogdensburg and Watertown in the Watertown Hub; Franklin in the Clinton Hub; Otisville in the Sullivan Hub; Great Meadow in the Great Meadow Hub; Groveland, Livingston and Wyoming in the Wende Hub; and Elmira, Five Points and Southport in the Elmira Hub.

Access to IFD Specialists at Female Prisons

Although women have a higher rate of access to infectious disease specialists in the prisons than men, there are significant variations in the use of IFD specialists among the female facilities.

Exhibit G summarizes the number and rate of infectious disease consultations for women during FY 2005-06 and FY 2006-07. It illustrates questionable variations in IFD utilization during both time spans.

Albion had only eight IFD appointments in FY 2006-07. Although one of Albion's providers is certified as an HIV specialist and is therefore less likely to make referrals to an outside IFD consultant, Albion had 129 IFD appointments in FY 2005-06 while the same HIV specialist physician was on staff. It seems that the change in IFD utilization occurred because the outside infectious disease specialist who provided consultations for the Albion HIV-infected population in FY 2005-06 retired prior to or early in FY 2006-07. Access to infectious disease specialists should be determined by the needs of the patients, not the availability of a specialist. At Bayview, there were only seven IFD appointments in FY 2005-06, whereas during the next fiscal year, there were 39. It is of concern that there was such a significant change from one year to the next. In contrast to Albion and Bayview, Bedford Hills had 636 and 537 IFD appointments in the last two fiscal years, an IFD utilization rate eight to ten times greater than that of the other prisons.

Department officials should explore why there has been such variation in IFD utilization among the female prisons and determine whether each female prison is providing sufficient specialty resources for its HIV-infected population.

DOCS HIV Specialists

In assessing the need for expert assistance in caring for HIV-infected patients, it is important not to limit the analysis to only considering access to outside IFD specialists. DOCS has developed a policy stating that it will certify a DOCS physician, nurse practitioner or physician assistant as an HIV specialist if the provider has completed sufficient training, has experience treating HIV-infected patients and participates in a continuing medical education program.

As of June 2007, according to DOCS records, there were 17 DOCS providers certified as HIV specialists of the 150 DOCS providers. **Exhibit D** indicates the prisons where these providers are employed and the number of HIV specialists on each prison staff. At many prisons with HIV specialists, a somewhat greater percentage of the population has been identified as HIV-infected.

It appears that some of the staff HIV specialists are managing the care of inmates with HIV without much outside assistance; consequently, at these facilities there are very few IFD appointments.²⁸

For example, Mid-State, which has 68 identified HIV-infected inmates and the highest HIV rate in the state, had only two IFD appointments in FY 2006-07. One of Mid-State's providers is a Nurse Practitioner who is certified as an HIV specialist. It is notable that Mid-State seems more

²⁸ It should be noted that none of the prisons with a staff HIV specialist were included in the analysis of prisons with low IFD utilization described on page 34.

effective than other prisons at identifying its HIV population, and CA commends the prison for having a certified HIV specialist on staff.

However, even with a staff HIV specialist, a prison could still benefit from the assistance of an infectious disease specialist. In fact, several prisons, including Eastern, Coxsackie, Hudson and Upstate, have HIV specialists on staff but still used infectious disease specialists at rates substantially higher than the system-wide average.

The CA commends the Department for encouraging its medical staff to develop expertise in the treatment of HIV and supports DOCS's certification program for staff HIV specialists. However, some patients managed by these prison HIV specialists probably would still require consultation with an outside infectious disease specialist in certain situations, particularly when a patient is failing on a particular medication regimen. DHS officials should monitor the care provided by its HIV specialists to ensure it is comparable to that available in the community.

Treatment of HIV-Infected Inmates

During prison visits, the CA obtained data on the number of HIV-infected inmates who were on therapy. This information is summarized in **Table 5** (page 32).²⁹

Several observations can be made concerning the 13 male prisons for which the CA has treatment data. The percentage of HIV-infected inmates on treatment varied significantly from 47% at Gowanda to 100% at Sullivan. Most prisons had 60-80% of their HIV-infected inmates on therapy. The situation at Gowanda is problematic; the prison was treating less than half of its known HIV-infected population, even though it had identified significantly fewer inmates with HIV than the system-wide average. Gowanda's HIV rate is below 2%, whereas the average rate of known HIV-infected inmates at the visited prisons was more than 3.2%, almost 40% higher.³⁰ Gowanda also had lower rates of access to IFD specialists, and there is concern that it may not aggressively evaluate its population for HIV treatment.

There are also questions about the adequacy of care provided to female inmates known to have HIV. Treatment data for HIV-infected women at Albion and Bedford, presented in **Table 5**, was somewhat discouraging. There were only 86 women on HIV medication, representing about one-third of the estimated HIV-infected population. Bedford Hills had substantially more of its known HIV-infected inmates on treatment (89%) compared to Albion (55%). As previously noted, Albion refers far fewer of its HIV-infected inmates to an IFD specialist; there is concern that Albion may not aggressively pursue treatment for its HIV-infected population.

DOH AIDS Institute's Criminal Justice Initiative

In addition to offering the testing services discussed above, the DOH AIDS Institute's Criminal Justice Initiative contracts with 15 agencies throughout the state that provide the following services system-wide to HIV-infected inmates: (1) HIV prevention education; (2) HIV training

²⁹ The CA did not receive any system-wide data concerning the number of inmates on HIV therapy and therefore cannot compare the treatment rates at the visited prisons to other facilities.

³⁰ The male HIV-infection rate at the visited prisons (3.2%) is computed from the data contained in Table 5, but data from Clinton was excluded since, as noted on page 31, data provided during the visit on the number of HIV-infected at Clinton was significantly different from the figure provided by DHS.

of peer educators; (3) HIV counseling and testing; (4) HIV support services; and (5) HIV/AIDS transitional planning. **Table 7** contains a summary of the services provided by the CJI contractors during the period July 1, 2006 through June 30, 2007.

TABLE 7 – AIDS INSTITUTE’S CJI HIV PREVENTION SERVICES - 7/1/06-6/30/07

Activities	# of Agencies	# of Sessions	# of Participants
Outreach	12	231	2,813
Health Information/Public Info.	12	802	11,051
Individual Interventions	8	2,424	1,898
Group Interventions	8	14,116	3,744
Support Groups	8	2,114	430
Peer Educator Training	12	4,708	845
Transitional Services	9	1,648	350
Prison Hotline	1	n/a	629
Transitional CM	2	2,093	153

Table 8 summarizes the number of prisons receiving these important services as of September 2007.

TABLE 8 - PRISONS SERVED BY AIDS INSTITUTE’S CJI CONTRACTORS – 2007

Hub	# of Prisons in Hub	Prisons with HIV Prevention	Prisons with Peer Training	Prisons with HIV Testing	Prisons with HIV Support	Prisons with Transitional Planning
1	8	7	4	6	4	7
2	5	5	5	5	5	5
3	9	9	4	6	5	9
4	8	7	6	6	0	7
5	6	6	4	6	1	4
6	8	6	0	6	2	6
7	12	11	8	7	8	10
8	7	4	4	3	3	3
9	7	6	1	6	1	7
Total	70	61	36	51	29	58
% of Prisons with Services		87%	51%	73%	41%	83%

The CA strongly endorses the use of outside contractors to provide support services to the HIV-infected inmate population. **Table 8** demonstrates that HIV prevention education, transitional services and testing exist at most prisons. Peer training, however, is in only half the prisons, and HIV support activities exist in only 41% of the facilities. These are also important services. The CA recommends that the state authorize sufficient funding to permit all five services at each maximum and medium security prison and appropriate prevention education, HIV testing and

transitional planning at every minimum security prison from which many inmates return to their communities.

It is important to note that the services provided at each prison vary greatly in frequency. At some prisons, the CJI contractor is present one or more days a week, enabling frequent and intense interactions with the HIV-infected population and more opportunity for general education programs for inmates and staff. At other facilities the contractor provides services only one or two days a month.

Support programs. HIV support programs are needed in many male prisons, and current CJI initiatives are not sufficient to reach many of the infected patients. These programs, however, must be conducted in a manner that will preserve confidentiality. There is still significant stigma associated with HIV, and many HIV-infected inmates are reluctant to participate in an activity that will reveal their status to staff and inmates who are not enrolled in the program.

Officials must take creative measures to provide support to HIV-infected inmates without placing them at risk of public disclosure. While some CJI contractors have made significant efforts to protect their clients' status, DOCS officials and CJI contractors must consult with inmates in designing programs that provide services in a setting that affords appropriate confidentiality.

Peer educators. Although the CJI providers conduct peer educator training, many prisons do not fully utilize these peer educators to encourage inmates to seek testing and care. Peer educators must have access to the inmate population in formal and informal forums and locations, with HIV education integrated into all prison activities. Some inmates may not attend a voluntary educational session focused on HIV education and testing because it may lead others to assume that the attendee is infected. Consequently, HIV education must occur frequently in routine prison activities that most inmates attend and that are not focused solely on HIV.

One-on-one discussions in the yard or at other activities are often the most effective means to reach individuals who are at risk. In contrast to current practice at some prisons, peer educators must have access to these areas and be authorized to conduct such discussions without violating prison rules. Also, the timeframes in which HIV education is offered affect whether inmates will act upon the information they receive. HIV education is often provided when an inmate first enters the system, is transferred to a new facility or is about to be released. Although these sessions are useful, these time periods are often stressful for the inmate and not conducive to follow-up requests for testing. It is best for the system to provide HIV information to inmates and to encourage them to seek HIV testing and care once they are established at a prison, but still early in their sentence.

Additional funding is essential to implement a peer-training program in the 50% of prisons that currently do not have it. The Memorandum of Understanding between DOCS and DOH should include a requirement that DOCS appropriately utilize the services of peer educators. Moreover, the state should allocate additional funds to permit DOCS to pay peer educators for their services.

Transitional planning. Resources for transitional planning at some prisons may not be adequate to perform the multiple tasks needed to develop a comprehensive plan for all HIV-infected inmates leaving the facility. Approximately 40% of the known HIV-infected population is discharged each year, totaling about 620 inmates. **Table 7** indicates that only 350 inmates were involved in transitional planning with CJI contractors during the period July 2006 through June 2007. It is likely that many of these inmates were not able to complete their discharge plans, given the limited availability of CJI providers at their prisons and delays in referring HIV-infected inmates to the discharge planners.

CJI discharge planners need additional resources to provide these services. The system should give contractors access to every identified HIV-infected inmate in sufficient time to prepare a comprehensive discharge plan prior to the inmate's release. To assist in that process, DOCS, DOH and Parole should enter into a memorandum of understanding that will clearly indicate each agency's obligation in the discharge planning process and ensure that CJI contractors have full and timely access to all necessary information and records.

Inmate-Led HIV Support and Education Programs

For many years, certain facilities have had inmate-run HIV support and education programs, such as the AIDS Counseling and Education (ACE) program at Bedford Hills and the Prisoners for AIDS Counseling and Education (PACE) programs at several male prisons.³¹ These programs run support groups for HIV-infected inmates and provide HIV education for the general prison population. The CA commends the Department for supporting these programs and, more importantly, the inmates who run them. Although the inmate staff of these programs are not necessarily HIV-infected, the programs provide a location for participants to interact with inmates living with HIV who are role models and who help other HIV-infected inmates learn about their illness and empower them to stay as healthy as possible despite the difficulties of living with HIV. By providing positive examples of inmates who have been tested, disclosed their HIV status and received medical treatment in prison, these programs benefit the entire prison population, encouraging inmates at risk for HIV but unsure of their status to get tested and seek treatment. The Department could do even more to use peer educators in this way. But HIV support programs must also be sensitive to the privacy concerns of participants. Given the barriers to real confidentiality in prison, DOCS officials must be creative in organizing support activities that do not inadvertently breach patient confidentiality.

DOCS HIV Quality Improvement Program

For several years, the Department had been developing an assessment tool to monitor HIV care in the prisons based upon DOH's computer-based quality improvement (QI) program known as HIVQUAL. Using the HIVQUAL tool as a model, in 2006 DOCS implemented a system-wide HIV Continuing Quality Improvement (CQI) program, which requires that a sample of medical records of HIV-infected inmates at each prison is reviewed by prison staff to assess whether the prison is in compliance with 20 quality indicators that address: HIV testing; antiretroviral therapy management; CD4 and HIV viral load measurements; access to HIV specialist care when the patient is unstable or in end stage; routine screening for lipids, tuberculosis and syphilis, and

³¹ PACE programs exist at Eastern, Fishkill, Green Haven, Marcy, Mid-Orange, Otisville, Shawangunk, Sullivan, Wallkill and Woodbourne.

Pap smears for women; prophylaxis care for opportunistic infections associated with HIV/AIDS; Pneumovax vaccine; HCV screening; and Hepatitis A screening and vaccination.

The CA commends the Department for undertaking this program and believes that it will assist DHS officials in monitoring the care provided in the prisons and in helping providers identify barriers or problems delivering care consistent with community standards. As part of a December 2006 settlement of federal class action litigation concerning HIV care in prisons, the Department committed to performing these audits annually at each prison. Current DOCS practice, however, goes beyond the settlement requirements. The DHS protocol is to review 10 medical charts or those from 25% of the prison's known HIV population, whichever is higher, each quarter year and provide feedback to the prisons based upon these assessments.

DOCS did not provide the results of its HIV CQI audits, so the CA cannot assess whether the prisons are conforming to the DHS HIV Practice Guidelines. But, based upon a meeting agenda of the DHS central office CQI Committee provided to the CA, it appears that results from the prisons have been documented and reviewed by DHS central office personnel. There are indications in the DHS CQI Committee minutes that some facilities have had difficulty performing the audits, primarily due to inadequate staff. The CA urges DHS to evaluate whether the state should enhance staffing allocations at these prisons to ensure that essential services are being provided.

The CA also commends the DHS CQI Committee for focusing on HIV care, but is concerned that the committee records very few references to: (1) the overall state of compliance by the system; (2) whether specific prisons have difficulties in meeting all the audit indicators; and (3) whether there are any systemic problems in providing HIV care. Although reference is made to the process of feedback to the prisons and the possibility of prison-based action plans to correct noncompliance, nothing is included in the DHS CQI Committee records that indicate whether there are any specific problems with HIV care at any facility. In the HIV CQI program, a prison is considered compliant if 70% of the medical charts meet the quality indicator. A prison must develop an action plan to address a deficiency only if an indicator falls below this 70% threshold, which is too low. DHS and its CQI Committee should set a more sensitive threshold for developing an action plan, thereby encouraging prisons to implement systemic remedies to frequently encountered problems and motivating them to improve services. The Department should also substantially increase the threshold level for acceptable compliance to 80% for several parameters. (See page 66 for further discussion of thresholds for audit indicators.)

Currently, chart reviews are performed by facility staff or by infection control nurses; however, some facilities are having difficulties performing the reviews with existing prison staff. To make assessments required by the audit and report the results, chart reviewers must have sufficient expertise in assessing medical records to identify problems in care and to develop recommendations for systematic improvements. Moreover, prisons should fully document any corrective plans, and the Regional Medical Director should carefully review them. Implementation must be monitored to determine whether actions taken have corrected deficiencies. The CA did not receive any documentation verifying this process, although the policy requires such measures. Finally, the new HIV CQI program should be integrated into the

monitoring and quality improvements activities of each prison. The CA will explore how the CQI system is functioning during future visits.

Hepatitis C Care in DOCS

The Department has made significant efforts to enhance the process of identifying inmates with hepatitis C (HCV) and to increase the number of HCV-infected inmates receiving treatment. In addition, in response to increased access by patients in the community to HCV care, litigation on behalf of HCV-infected inmates, and advocates' and legislators' concerns about barriers to HCV treatment, the Department has changed its protocol for determining who should receive HCV therapy and expanded the number of inmate-patients who are eligible for treatment. (See pages 47-48 for discussion of medical evaluation for HCV treatment.)

In the past, DHS required that an inmate have at least 15 months remaining on his/her sentence before therapy could be approved so that the one-year treatment regimen could be completed before release. DOCS removed this barrier in 2005 when DHS initiated a protocol for DOCS providers to arrange for continuity of HCV care in the community for inmate-patients who were receiving HCV therapy at the time of their release. Although, based on information obtained during prison visits, it seemed that few HCV-inmates have participated in this continuity of care program, the CA expects that the prisons will accelerate their use of this program now that AIDS Institute personnel are actively supporting it. The CA commends DOCS for undertaking this initiative and understands that to date 60 inmates have been enrolled in the program. The CA urges DHS to reinforce with prison providers the option of starting qualified HCV-infected inmates on treatment even if they are nearing release and to monitor whether the prisons are aggressively recruiting these patients for therapy.

A second change in the HCV protocol occurred in 2007 when DHS eliminated the requirement that HCV-infected inmates with a history of substance abuse at any time in their past had to be enrolled in a substance abuse treatment program prior to initiating HCV therapy. DOCS removed this requirement following a consent agreement with inmates who challenged this restriction in a federal class action suit. The CA applauds DHS for making this change. Although it is advisable for inmates with a history of substance abuse to receive substance abuse treatment, care of their HCV infection should be pursued independently, especially considering that it takes significant time to complete the HCV evaluation process and treatment regimen.

The CA urges the Department to do more to further expand the diagnostic and treatment services for HCV. Many of the same concerns about the care of inmates with HIV pertain to those with HCV: (1) identification of inmates who are HCV-infected; (2) timely and adequate treatment of known HCV-infected inmates; (3) timely access to specialty services, particularly for gastroenterologist appointments and liver biopsies; and (4) assistance to inmates in complying with their HCV medication regimen and treatment of side effects.

Progress in Identifying More HCV-Infected Inmates

New York State Department of Health testing of newly admitted inmates to DOCS custody in 2000 and 2003 revealed that 13.6% and 13.3%, respectively, of male and 23% and 24%, respectively, of female inmates were infected with HCV. In 2005, the infection rates declined, and DOH reported that 10.4% of the men and 19.4% of the women were HCV-infected. Using a

weighted distribution of the infection rates from these three studies and making adjustments for the difference between the study population and the current DOCS population,³² the CA estimates the HCV infection rate at year-end 2006 was approximately 12.8% for men and 22.1% for women. These estimates would mean that about 7,780 men and 640 women in DOCS custody at the beginning of 2007 were HCV-infected.

HCV-infected people may or may not exhibit symptoms, develop chronic infection, progress to liver disease, and/or require treatment. Careful medical monitoring and evaluation is needed to determine the appropriate level of care. Several documents received from DOCS in 2007 summarize: (1) the number of inmates at each facility included on the DHS computerized problem list as infected with HCV as of August 2006; (2) the number of DOCS inmates who were determined to have HCV disease³³; (3) the number of DOCS inmates on HCV therapy as of January 2007; and (4) the number of appointments in FY 2006-07 for gastroenterology and liver biopsies. Data for 2006-07 from these documents are listed in **Exhibit E** for the male prisons and **Exhibit H** for the female facilities.

It is clear from these data that many HCV-infected inmates are not known to DOCS and that only a small percentage of those infected is receiving treatment. An analysis of these data demonstrates that DOCS is identifying about 70% of its HCV-infected population. Moreover, the 5,884 male and female inmates identified in the August 2006 list are significantly more than the 4,250 HCV-infected inmates reported by DOCS in 2003, representing an increase of almost 40% in three years. The CA commends the Department for its efforts to reach a greater percentage of the HCV-infected population and notes that DOCS is having greater success identifying HCV-infected inmates than those who are HIV-infected. However, 30% of those infected with HCV are not being identified. Efforts should be made to reach them, and such outreach should be sustained consistently by prison providers, since 27,000 to 28,000 inmates are admitted to DOCS each year, representing more than 40% of the population. The Department should screen all new inmates for HCV.

Table 5 (page 32) illustrates data received from 13 male prisons and 2 female prisons visited by the CA from 2004 through 2007 concerning the number of inmates infected with HCV and those receiving therapy. At the male prisons, only 6.1% of the population is known to be HCV-positive, less than half of the estimated HCV population. The percentage of the inmate population identified as HCV-infected varies greatly, from low infection rates of 2% to 3% at Auburn, Eastern, Gowanda and Upstate, to 6% to 10% at Arthur Kill, Green Haven, Oneida, Sullivan and Wyoming. There is no apparent reason why some prisons should be able to identify HCV-infected inmates at rates two to four times higher than others. The CA urges DHS to investigate these discrepancies.

³² The DOH protocol seeks approximately equal number of samples from each of the male reception centers. However, the actual admission rates are less at reception centers in the western region of the state where the HCV infection rate is less than that for inmates entering the eastern reception centers. The CA attempted to adjust for these differences in estimates of the HCV rate for the current DOCS population.

³³ DOCS lists an inmate with HCV disease if the patient is chronically infected (i.e., based upon blood test it is determined the patient currently has the HCV virus in his/her system). A patient with HCV disease may or may not have any symptoms.

Several observations are apparent from examining the male HCV-infection rates in **Table 5** and **Exhibit E**. First, there is greater consistency in 2007 in the percentage of identified male HCV-infected inmates at each prison (**Exhibit E**) than was reported by the prisons during CA visits in 2004-06 (**Table 5**). Second, the 2007 HCV-infection rates are more uniform among prisons than the more variable HIV rates shown in **Exhibit D**. There is no apparent reason why rates of HCV and HIV should differ so significantly among prisons, particularly since the risk behaviors for both infections are similar. Third, while hubs generally have an overall HCV infection rate of 8% to 10%, a few facilities have lower than expected rates.

For example, in maximum and medium security prisons with a medical class one designation, the highest medical classification, most prisons are within the 8-10% range with the exception of: Upstate (6.9%), Eastern (6.5%), Greene (4.3%), Gowanda (6.6%), Lakeview (3.0%) and Wyoming (6.1%). These prisons have rates that are 30-50% lower than the system-wide average of 9.01%. There is no apparent reason why these facilities, other than Lakeview and Greene,³⁴ should have rates of known HCV-infected inmates lower than those found elsewhere in the Department. The CA urges DHS to investigate the practices at these prisons to determine if they can implement measures to identify a greater percentage of HCV-infected inmates.

Exhibit H contains a summary of data received from DOCS in 2007 concerning the number of women with HCV-infection, with HCV disease and on HCV treatment, as well as the number of appointments for gastroenterology and liver biopsies during FY 2006-07. Overall, the female prisons have identified 14.3% of their population as HCV-infected. Given the estimate of 22% of female inmates with HCV, the prisons have identified only 65% of the potential pool of infected women. The percentage of known HCV-infected women at each prison is between 12.25% and 17.04%. It is of some concern, however, that Bedford Hills has the lowest rate, even though it is the only female prison with a Regional Medical Unit and has the most comprehensive healthcare system of the women's prisons.

During the past two years, the female prisons have made progress in increasing the number of identified HCV-infected women. **Table 5** contains the information received from female prisons during CA visits. In July 2005, Bedford Hills had identified only 43 women as HCV-infected, just over 5% of its total population. Since DOCS and DOH data suggest that 22% of women system-wide are HCV-infected, Bedford Hills had identified less than one-quarter of them. However, by 2007, Bedford Hills had more than doubled the number of identified HCV-infected women to 99 (**Exhibit H**). At Albion in December 2005, 171 women were diagnosed with HCV, representing two-thirds of the estimated number. By 2007, Albion had increased its identified HCV-infected population by 15% to 196. Greater efforts are needed, however, to reach more HCV-infected women.

Treatment of HCV Disease

A series of steps are required to determine whether an HCV-infected patient requires treatment. (See also page 45 for discussion of DOCS eligibility criteria for HCV treatment.) First, a blood test for HCV antibodies reveals whether the patient was ever infected with the hepatitis C virus. If the test is positive, an HCV viral load test is then used to determine whether the patient

³⁴ Since Lakeview and Greene confine a greater percentage of young inmates, it is likely these institutions would have lower HCV infection rates than the other male prisons.

currently has the virus (a condition referred to as “chronic infection”). National figures suggest that 50% to 85% of patients infected with HCV become chronically infected.³⁵ Of these, 5% to 20% will develop cirrhosis (scarring of the liver), depending upon age at infection, alcohol intake, co-infection with Hepatitis B and sexual practices. Liver cancer develops in 1% to 5% of persons with chronic HCV.

Patients with chronic infections do not necessarily suffer any symptoms and may not experience liver inflammation or damage, which can take decades to develop. A test for elevated liver enzymes determines if a chronically infected patient’s liver is inflamed. If these enzymes are sufficiently elevated, the patient is referred to a gastroenterologist (GI) for evaluation. If the GI specialist believes the patient may have liver damage, he or she will order a liver biopsy to determine the extent of inflammation and whether fibroids or liver scarring has occurred. If the level of liver damage is significant but not severe enough to cause scarring, the patient may be offered therapy, which generally consists of multiple medications prescribed for up to a year to eradicate the virus.

The National Institutes of Health Consensus Development Conference Panel recommends that therapy for HCV be offered to those patients with fibrosis or moderate to severe degrees of inflammation and necrosis on liver biopsy and that patients with less severe liver disease be managed on an individual basis. Clearly, not all inmates with HCV need to be treated, but reasonable efforts must be made to identify and assess patients with liver damage to determine the best candidates for treatment.

Exhibit E contains data obtained from DOCS concerning the number of male inmates in the system that have HCV disease, indicating DOCS confirmation that they are chronically infected. **Exhibit H** provides data for women. As of January 2007, 2,303 inmates (2,223 males and 80 females) were designated in the DHS computerized medical problem list as having HCV disease. Just 285 of the known HCV-infected population (270 males and 15 females) were receiving therapy.

Exhibit E compares the number of known HCV-infected male patients to those with HCV disease, i.e., chronic infection. System-wide, 41% of the known HCV-infected male inmates had HCV disease. This figure appears low because, as the Department recognizes in its HCV Practice Guidelines, approximately 70% of HCV-infected persons develop a chronic infection. This discrepancy may reflect a failure by medical staff to aggressively evaluate patients for potential treatment, and/or a failure to properly document the testing and evaluation of patients in medical records. Moreover, in data from medical class one prisons, the percentage of known HCV-infected inmates classified with HCV disease varied widely from 8% to 100%. Nine of the 45 medical class one prisons had HCV disease rates under 30%.

Exhibit H contains similar HCV infection and HCV disease data for women. The reported rate of HCV disease within the known female HCV-infected population is under 20%—half the rate

³⁵ Chronic infection develops among 75%–85% of persons infected as older adults (aged >45 years) and among 50%–60% of persons infected as juveniles or young adults. Centers for Disease Control and Prevention, *Prevention and Control of Infections with Hepatitis Viruses in Correctional Settings*, MMWR 2003; 52 (No. RR-1), p. 6.

found among males and substantially lower than the 70% chronic infection rate found in the community at large. There is no apparent medical reason to support this finding.

The overall low reported rates of HCV disease, and particularly the very low rates among women, are of concern. Moreover, there is no apparent medical reason for HCV disease rates in certain prisons to be significantly lower than the system-wide average. The CA urges DHS officials to review the practices at prisons with low HCV disease statistics to assess whether the facilities are conducting adequate and timely evaluations of patients and are appropriately documenting these results in patients' medical records. Since the diagnosis of HCV disease is the first step to treatment, it is crucial that the prison provider make an HCV disease diagnosis for every inmate infected with HCV.

Access to HCV Specialty Services – Gastroenterologists and Liver Biopsies

The evaluation of patients for potential HCV treatment generally entails multiple appointments with specialists. Patients have an initial evaluation by a GI specialist, followed by a liver biopsy, and are then rescheduled for the GI specialists to determine if treatment should be provided. Once on treatment, patients are seen by the GI specialist to determine whether the therapy is working or should be discontinued. Consequently, timely access to GI services is crucial to effective HCV treatment.

However, access to a specialist does not automatically mean that patients will be treated, since the prison provider must act upon the specialist's recommendation, and the complex diagnostic procedure must be completed in a timely manner to initiate therapy. Effective HCV care requires vigilance and coordination by prison providers, plus timely access to specialty services.

Exhibit E contains a summary of the number of gastroenterology appointments and liver biopsy procedures for each male prison, along with the rates of those services in the entire prison population and in the HCV-infected population. Certain hubs and prisons apparently underutilize these services. Other locations provide better access. For example, the Elmira Hub (#8) had significantly lower rates of utilization of both GI specialists and liver biopsies than the system-wide average. Not surprisingly, it had a lower rate of identified HCV-infected patients and inmates diagnosed with HCV disease. More problematic, this hub had lower rates of patients receiving HCV therapy, both as a percentage of the hub's known HCV-infected population and the entire hub prison population, percentages that were about 20% below system-wide rates. In this hub, Five Points (with 1,367 inmates and 121 HCV-infected patients) and Cayuga (with 1,016 inmates and 78 HCV-infected patients) each had only two inmates receiving therapy. Both prisons had liver biopsy rates more than three times lower than the system-wide average.

The Great Meadow Hub (#6) had low utilization of liver biopsy procedures and, potentially as a consequence of this underutilization, an overall lower rate of identified HCV-infected inmates and lower rate of HCV therapy than the system-wide averages. For example, Coxsackie (with 1,034 inmates and 87 HCV-infected patients) ordered 10 liver biopsies during FY 2006-07 and had only two inmates on therapy. Great Meadow (with 1,681 inmates and 148 HCV-infected patients) ordered only five liver biopsies during the year and had five inmates receiving

treatment. The CA also noted lower rates for liver biopsies and/or GI specialists in the Sullivan and Watertown hubs.³⁶

Within other hubs, there were also some prisons with low utilization of GI specialists and/or liver biopsies, including Bare Hill and Franklin in the Clinton Hub (#3) and Gowanda in the Wende Hub (#7). These prisons all had fewer inmates receiving therapy.

In contrast, several male prisons had greater access to GI and/or liver biopsy services and consequently identified more inmates with HCV and/or treated more patients than the system-wide averages. Many of these prisons identified 10% or more of their population as HCV-infected and/or treated 7% or more of identified HCV-infected inmates, or close to 1% of the entire population, treatment rates that were often twice the rate of the system-wide average. These prisons include Arthur Kill, Eastern, Fishkill, Livingston, Marcy, Mid-Orange, Mid-State, Mt. McGregor, Ogdensburg and Sing Sing. These prisons come from nearly every hub in the Department, demonstrating that a more effective HCV identification and treatment program can be implemented anywhere in DOCS.

The figures on women's access to GI and liver biopsy services, presented in **Exhibit H**, also raise some concerns. Despite the substantially higher HCV infection rate for women compared to men, the utilization rates of GI and liver biopsy appointments in FY 2006-07 for women were relatively lower than for the male population, particularly for liver biopsies. Moreover, the rates for access to GI and liver biopsy services for women varied significantly from prison to prison. At Bedford Hills, the GI utilization rate was more than double the rate at Albion. In contrast, the rate for liver biopsies at Albion was significantly higher than for Bedford Hills. With so few women receiving HCV treatment, the Department should examine whether prison providers are referring female HCV-infected inmates to specialists for evaluation and potential treatment.

Overall, there is a loose correlation between access to GI and liver biopsy services and the numbers of identified HCV-infected inmates or HCV-infected inmates on therapy. For example, of the ten medical class one prisons with the lowest treatment rates, six had lower than average rates of liver biopsy procedures, and one of the remaining four had below average GI access.³⁷ In contrast, of the 15 medical class one prisons with treatment rates greater than the system average, 12 had average or higher liver biopsy rates and one of the remaining three had a high rate of GI services. A few prisons with high HCV treatment rates, such as Woodbourne and

³⁶ The Sullivan Hub (#4) had lower utilization rates of liver biopsy procedures than the system-wide average, but its rate for use of GI specialists was somewhat above the system-wide average. Within this hub, Otisville, with 602 inmates, had only four liver biopsies and only two patients were on therapy of the 58 known HCV+ inmates. Similarly, Wallkill, with 599 inmates, ordered five liver biopsies and had only one patient on treatment. Finally, Shawangunk, with 539 inmates, performed seven liver biopsies, but had no patients on therapy even though there were 50 HCV-infected inmates in the prison. The Watertown Hub (#2) had the lowest utilization rate for GI specialists, but most of the prisons in the hub exceeded the system-wide average for access to liver biopsies for both the entire prison population and HCV-infected patients. Overall, the percentages of inmates in this hub who were diagnosed with HCV or were receiving therapy were above system-wide averages, with the exception of the prison in Watertown, where significantly fewer liver biopsies were performed and no patients were on therapy even though 60 inmates were HCV-infected and 26 had HCV disease.

³⁷ The CA excludes the reception centers and short-term prisons, like Willard Drug Treatment and Lakeview, from the low treatment rate prisons because many inmates are not at these facilities long enough to initiate therapy.

Cape Vincent, had low usage of these specialty services but had identified a significant percentage of its population with HCV. And a few prisons with low treatment rates, such as Groveland and Shawangunk, had above-average usage of these services, but were treating only one HCV-infected patient. This analysis demonstrates that adequate access to specialty services is generally necessary, but not sufficient, to ensure proper HCV care.

HCV Therapy

As explained above, therapy is not recommended for all HCV-infected patients, only those with significant liver fibrosis as demonstrated by a liver biopsy, and even patients with significant liver damage generally do not have symptoms. In contrast, the year-long therapy required for the most common genotype of HCV involves multi-drug therapy that frequently causes significant adverse psychological and physical side effects. Determining whether an HCV-infected patient is eligible for therapy requires a complex analysis of his/her condition, and the CA is concerned as to whether all the state's facilities are aggressively evaluating HCV-infected inmates for treatment. Inmates deemed eligible for therapy must then decide whether to undergo this arduous treatment. Patients often need care for the side effects in order to complete the full year-long regimen. It is unclear whether HCV-infected inmates who are contemplating therapy or who have undertaken treatment receive adequate education and support from the prison medical staff.

As of September 2007, 2,078 DOCS inmates had initiated HCV treatment since the Department started providing it.³⁸ During the past few years, the Department has significantly increased the number of HCV-infected inmates receiving treatment. In 2003, 160 inmates were on HCV therapy, but that number increased to 383 as of May 2007.

DOCS has established an HCV continuity of care program that provides services for inmates in treatment who are about to be released to the community.³⁹ The program, coordinated among DOCS medical providers, Division of Parole officers, AIDS Institute staff and community-based Criminal Justice Initiative contractors, develops discharge plans that identify providers in the community who will continue HCV therapy, arranges initial appointments with these community providers and ensures that HCV medications are given to inmates upon release. At an October 2007 AIDS Institute Conference, program staff announced that 60 formerly incarcerated individuals had been enrolled in the program. This program represents an impressive model that should be replicated for inmates with other chronic conditions who are being released.

Table 5, which records data received during CA prison visits, shows that 7.1% of known HCV-infected inmates were receiving treatment at that time. Analysis of the data reveals significant variations in treatment at different prisons. For example, at Great Meadow, with an estimated 350 HCV-infected inmates, only two patients were on therapy. Great Meadow inmates reported that many had complained to medical staff about the lack of HCV care and filed grievances, but the vast majority had not been successful getting HCV treatment. At Gowanda and Auburn, prisons with nearly 1,800 inmates, only six inmates were receiving therapy, even though the

³⁸ Presentation of C. Flanigan & J. Cooper, "Hepatitis C: Solutions for Optimal Treatment Outcomes," AIDS Institute Conference: HIV and Corrections: Building Partnerships Inside and Out, October 10, 2007.

³⁹ Klein, S. et al., *Promoting HCV Treatment Completion for Prison Inmates: New York State's Hepatitis C Continuity Program*, Health Reports, 122: 83-88 (2007).

estimated HCV-infected population was about 230. In contrast, at Green Haven, Fishkill and Sing Sing, 16, 17 and 19 inmates, respectively, were on HCV therapy.

Exhibit E indicates the number of patients receiving HCV therapy at each male prison as of January 2007 and their proportion relative to the number of HCV-infected patients and the total prison population. There is significant variation in these percentages, even among medical class one prisons. Low rates of treatment could be due to a failure to: evaluate patients for therapy, recommend treatment for eligible patients, educate patients about the benefits and risks of therapy and/or support patients on therapy so they will complete their treatment.

Three hubs, Clinton (#3), Great Meadow (#6) and Wende (#7), had lower rates of treatment than the system-wide average and just half the rate of treatment in the hubs with the highest treatment rates, Watertown (#2), Sullivan (#4) and New York City (#9).

However, differences in treatment rates are even starker among individual male prisons. **Exhibit F** lists medical class one male prisons by percent of inmates receiving HCV treatment (column headed: % Tx/HCV+). The average rate of treatment for known HCV-infected inmates at the top 15 facilities (Eastern through Ogdensburg) are more than five times the average rate of the 15 facilities at the bottom of the list (Oneida through Watertown). The prisons in the group providing greater treatment come from eight different hubs and include four maximum and eleven medium security prisons. There is nothing about any of the high or low treatment prisons to justify such significant differences in the patient populations or the need for HCV treatment. The “high treatment” prisons identified only 13% more HCV-infected inmates than the “low treatment” group. It appears that medical staff at the top group of prisons are aggressively evaluating patients for potential HCV treatment and encouraging patients to accept therapy.

The Department should carefully assess prisons in the low treatment category to determine whether these prisons are adequately evaluating inmate treatment eligibility. Focus should be placed on Great Meadow (5 treated), Wyoming (5), Washington (3), Oneida (3), Wende (2), Altona (1), Clinton (6), Coxsackie (2), Cayuga (2), Adirondack (1), Bare Hill (3), Five Points (2), Groveland (1), Shawangunk (0) and Watertown (0).

The low rate of women who are receiving HCV therapy is also problematic. As of January 2007, only 15 women were on treatment out of a population of 407 known HCV-infected female inmates. The rate of treatment for HCV-infected women is 25% less than that for men. Bedford Hills is treating five women (one greater than the four noted in 2005). Albion is now treating 10 women, which represents significant progress since December 2005 when only one Albion patient was receiving treatment. Of greatest concern is that no women were in treatment at Taconic, Beacon and Bayview, which have a combined population of approximately 750 women, 110 of whom were known to be HCV-infected.⁴⁰ The CA urges DHS to investigate this situation. It appears that more liver biopsies are needed to identify female patients with liver

⁴⁰ One possible explanation for the lack of treatment at these three prisons is that women who are eligible for HCV therapy are transferred to Bedford Hills or Albion. If this is the policy, the prospect of transfer to another prison may deter many women at these three prisons from seeking HCV testing and therapy. If there is no transfer policy, it is unclear how such a large group of female inmates did not yield even one candidate for treatment.

damage, and greater efforts are necessary to convince HCV-infected women to seek and accept HCV treatment.

Effectiveness of HCV Therapy

The combination therapy now provided to HCV-infected inmates appears to be working. The CA was pleased to see that as part of DHS quality improvement efforts, the Department has performed an evaluation of outcomes on 411 patients who received the drugs Pegasys and Ribavirin. In that study, 27% of the participants were African American, 39% Hispanic and 34% Caucasian. This demographic breakdown is notable in that the inmate population is 50% African American, 27% Hispanic and 20% Caucasian. Clearly, African Americans are significantly underrepresented in the treatment group. The Department should investigate this situation, but, as discussed below, treatment outcome data suggest that African Americans seem to respond less well than other racial/ethnic groups to this treatment.

To assess the effectiveness of HCV therapy, patients are tested for the presence of the HCV virus during treatment and after completion of therapy. While patients are on treatment, they are tested at 12-, 24- and 48-weeks to determine if the amount of HCV virus in their blood is diminishing. If it is, the patient is considered a “responder.” If after 24 weeks on therapy, the virus is still detectable, in most cases the treatment will be stopped because the patient is not expected to benefit further from treatment. Patients who have completed the full 48-weeks of treatment are tested again six months after completion to determine whether they are still free of the HCV virus. Inmates who are virus-free are deemed to have a Sustained Virological Response (SVR); in such cases, it is generally anticipated that the virus will not reappear, and they are essentially considered cured. Based on the somewhat limited data on SVR testing in the 411 inmates evaluated, 58% of Caucasian HCV-infected inmates, 37% of Hispanics and only 19% of African American inmates reached SVR. Low rates of response to this regimen in African American patients in the community have also been documented. **Table 9** summarizes the completion rates for each racial/ethnic group.

Table 9 DOCS HCV Pegasys Treatment – Completion and Reasons Discontinued

2006 Data	African Am.	Hispanic	Caucasian	Total	Percent
Completed Treatment	48	85	90	223	54.3%
Nonresponder	21	34	7	62	15.1%
Refused	16	16	17	49	11.9%
Noncompliant	1	1	1	3	0.7%
Provider discontinued	14	13	11	38	9.2%
Released	8	11	7	26	6.3%
Other	2	2	6	10	2.4%
TOTAL	110	162	139	411	
Percent of Total	27%	39%	34%		

Several observations are evident from these data. First, inmates for the most part attempt to complete the treatment. Refusal and noncompliance with the medications are together less than 13%. Second, completion of therapy has substantially improved in the last five years. In 2003, DOCS reported at a hearing held by the Corrections and Health Committees of the Assembly

that only 14% of the 350 inmates who had started HCV therapy in 2002-03 had completed the full course of treatment. The CA commends the Department for its efforts to nearly quadruple that rate to 54% by 2006.

DOCS HCV Quality Improvement Initiatives

The CA is pleased to report that DHS has undertaken an effort to assess prison compliance with the Department's Hepatitis C Practice Guidelines through a quality improvement program. The Department has made significant efforts since 2005 to develop quality improvement instruments to assess quality of care through review of the medical records of HCV-infected inmates. In 2007, the DHS CQI Committee updated the HCV Case Management Audit to collect more information and increase the number of charts reviewed. This new tool will provide a more comprehensive assessment of HCV care and generate better information so that prisons can identify potential problems in their HCV care system.

The CA received data from a report submitted to DOCS Regional Medical Directors in March 2007 containing results from the 2005 HCV audit of the entire system. Three medical charts from each prison each quarter year (totaling 724 charts) were reviewed to collect this data. As with the HIV CQI program, DHS required prisons to develop remedial action plans only when an indicator fell below a 70% compliance rate. At this threshold, two of the 12 indicators used to assess HCV-related care were identified as needing attention: documentation of patient education on HCV in the medical chart and a signed refusal form for patients who declined HCV treatment. A CA review of the data, however, raises concerns about other indicators that had noncompliance rates of 20-30%, including: failure to order follow-up labs in a timely manner for patients with elevated liver functions; failure to document in the medical chart the discussion of HCV treatment with the patient; and failure to order genotype testing of the virus (an essential test to identify the appropriate course of therapy). If the Department used a more sensitive threshold to trigger prison remedial plans, each of these important procedures in HCV care could receive increased attention.

The CA does not believe the data reflected in the HCV audit demonstrate lack of system-wide attention to HCV care. Rather, they show the fully anticipated result that many prisons and providers are following the HCV Practice Guidelines and that others need to improve their performance. Since a CQI process should strive to continuously improve care, the problem is setting a 70% compliance threshold that suggests that prison staff should be satisfied with results indicating significant noncompliance with established treatment standards.

A part of this HCV audit included recording the HIV status of the patients involved. This data was recorded for 572 (79%) of the medical records reviewed. Of this group, 326 (57%) were HCV-infected and HIV-negative, 104 (18%) were both HIV- and HCV-infected and 142 (25%) were HCV-infected but of unknown HIV status. Given the high rate of HIV infection typically found in HCV-infected populations, it is unfortunate that one-quarter of this high risk group had not been tested for HIV. This data reinforces concern that the Department is not successful in convincing a significant portion of its at-risk population to be tested for HIV.

The Department is developing a new HCV Case Management Review Form, which has the potential to significantly improve the data that will be retrieved in the HCV audits. Specific

improvements will include: (1) more detailed attention to the diagnostic evaluation process; (2) data about liver biopsies; and (3) information about why treatment was refused or inappropriate. Given the problems noted above with access to liver biopsies, the new audit will likely assist DHS and the prisons in evaluating this crucial component of the care process. The CA looks forward to the Department's results and urges DHS to consider additional indicators addressing the issue of access to gastroenterologists.

A second aspect of the monitoring of HCV care by DHS was the HCV Treatment Review form. Data from this form were used to compile the information reported above concerning the outcomes for patients who have received HCV treatment. This information is crucial to assessing the effectiveness of HCV therapy and evaluating how DOCS can improve HCV care. Unfortunately, in March 2007, the DHS committee developing HCV policies decided to terminate the collection of this data, except for recording the outcomes for inmates who had already been included in the study. It was left to the discretion of the infection control nurses whether or not to use the form. The CA strongly urges DHS to reconsider its decision and to recommence the systemic collection and recording of this data.

OTHER DISEASES: ASTHMA, HYPERTENSION, DIABETES AND CHRONIC HEPATITIS B

DOCS inmates suffer from many other chronic diseases, including asthma, hypertension and diabetes. The CA received data reporting the number of inmates at each prison who have these illnesses designated in the computerized problem list contained in their DOCS medical record: asthma (9,253 patients), hypertension (6,496) and diabetes (2,472). There is incomplete information about the care provided to patients with these conditions, but it is possible to make some observations from the documents received.

DOCS has a very large asthma population requiring care. In the last three years, DHS has attempted to improve asthma care by issuing revised Asthma Practice Guidelines. These guidelines promulgate new medical problem list indicators to better distinguish different levels of the disease and provide more refined protocols for each level. They also include implementation of an asthma audit. However, records of the DHS CQI Committee indicate that prisons have not completely implemented the new problem list indicators for all asthma patients, and final results of the asthma audit issued in March 2007 show that four of the six audit indicators are below even the 70% compliance standard. Although DHS and the prisons are making a substantial effort to improve asthma practices, it is clear that more work is needed to bring asthma care up to community standards.

The Department issued Hepatitis B Practice Guidelines in 2004 and subsequently developed an audit instrument to monitor patients with this illness. As of April 2007, 46 medical charts had been audited. Results presented to the DHS CQI Committee showed that several of the audit indicators had noncompliance rates well in excess of the 30% rate considered unacceptable. Implementing this audit instrument is the first step in a process which, with attentive monitoring, should result in improvements in patient care. The CA anticipates that DHS officials will take action to correct deficiencies and that prisons will expeditiously implement remedial plans to address problems noted in the audit.

DHS has also issued practice guidelines and audit instruments for diabetes and hypertension, but the CA has not received any documentation concerning recent audits of these illnesses, and therefore, cannot comment on the state of care. As discussed below in the section on specialty care, there is significant variation in access to cardiology services throughout the Department. The CA urges DHS to perform system-wide audits of these conditions and consider including CQI indicators that provide for assessment of patients' access to specialty services as a component of this care when needed.

CHRONIC CARE SYSTEM

Six components are required for effective chronic care.

First, the Department should have policies for the treatment of chronic diseases so that patients will receive the same quality of care regardless of where they are confined. The CA commends DHS for promulgating practice guidelines for seven of the more common chronic diseases (asthma, diabetes, chronic hepatitis B, hepatitis C, HIV, hypertension and tuberculosis). DHS should consider issuing additional practice guidelines for conditions such as epilepsy and high blood cholesterol, as recommended by the National Commission on Correctional Health Care, as well as for other respiratory and digestive diseases.

Second, prison providers must be adequately trained in the care of patients with chronic illnesses. As previously noted, DOCS does not mandate such training, and it is doubtful that all providers treating inmates with chronic diseases have the required expertise.

Third, chronic care patients must have one knowledgeable provider managing all of their care. The practice of assigning a chronic care patient to a single prison provider is not followed at all prisons.

Fourth, a chronic care system should ensure that the many appointments, tests and procedures ordered for a patient with a chronic illness are performed in a timely manner. This system should also ensure that inmates are kept apprised of their care and ways to improve treatment compliance. Patient education is essential to ensure that individuals with chronic illnesses are knowledgeable about their disease, committed to their treatment protocol and vigilant in monitoring their condition and response to therapy. A chronic care coordinator, usually a nurse with special training, should be responsible for this coordination of care, as well as for communication with and education of patients. Many prisons do not have staff to perform these functions for all patients with chronic diseases.

Fifth, patients must have timely access to specialists whose recommendations should be implemented by the prison provider unless the provider documents in the medical chart that the suggested treatment is not necessary or appropriate. As discussed above, it appears that many inmates with chronic illnesses are not receiving timely attention from specialists and recommended care is not promptly implemented. These delays in treatment result in care that is not consistent with community standards. Finally, consistent monitoring by DHS personnel should ensure that chronic care throughout all facilities is consistent with community standards.

The DHS practice guidelines, new CQI programs and greater attention from DHS to these illnesses are steps in the right direction. But the CA is concerned that practices within the prisons are not sufficiently consistent with practice guidelines or community standards so that all patients, regardless of where they are housed, receive appropriate care. The CA urges DHS to continue its efforts to monitor prison care for inmates with chronic conditions and to require prisons exhibiting problems to implement remedial measures to address deficiencies.

SPECIALTY CARE

When facility providers determine that their patients would benefit from an evaluation by a medical expert and/or need treatment recommendations from a specialist, these providers issue specialty care requests describing the patients' conditions, designating the specialty services needed and specifying the level of urgency for the medical appointment. These requests are entered into DOCS's department-wide computer system and processed by DHS staff who determine whether the requested services are necessary and, if appropriate, schedule the specialty appointments. The specialists may come to a specific prison to provide services, hold specialty clinics for several prisons at the Regional Medical Centers or see inmates at outside hospitals or other outside medical facilities. Following all specialty appointments, the specialists document their findings and recommendations, which are returned to the prison providers for consideration. It is the responsibility of the prison providers to act upon these recommendations and request any follow-up evaluations and treatments.

Inmates repeatedly expressed concerns during CA prison visits about timely access to specialists and inadequate follow-up of their recommendations by prison providers. In addition, according to inmates and medical staff, certain specialty services, particularly orthopedic and neurology services, were difficult to arrange in some prisons at the frequency required to meet inmate needs. Other prisons seem to offer substantially more specialty care services, suggesting that the Department and specialists are willing to provide services when the prison medical staff seeks them.

The Department has made substantial efforts to develop systems to facilitate and coordinate access to specialists, while also monitoring use to ensure that only necessary appointments are scheduled. To coordinate services among the prisons and between the prisons and specialists, the Department has developed a computerized scheduling system that incorporates a sophisticated utilization review process and the management of appointments by regional medical staff so that appointments can be prioritized and scheduled efficiently. However, as with other components of the Department's healthcare system, although policies are in place to facilitate specialty care, prison practices do not necessarily conform to these policies. An additional apparent deficiency is the lack of any ongoing quality improvement effort to monitor the use of specialty services by prisons and assess responses to specialists' recommendations.

In some instances, delayed or denied access to specialty care seems due to the lack of sufficient specialists available to see inmates in a timely manner, while other delays/denials can be attributed to an unwillingness or reluctance of prison providers to request specialty consultations. In addition, failures to act upon specialists' recommendations may result from prison providers'

inattention to the consultants' reports or failure to document in medical charts their determination that the recommendations are not necessary to properly treat their patients.

An analysis of CORC appeal grievances during the three-and-a-half-year period of 2003 through mid-2006, reveals 1,459 appeals relating to specialty care at all the prisons. There were 753 such appeals from the prisons the CA visited. (See **Exhibit C.**) The rates of specialty care complaints were significantly higher than the rate for the whole prison system at the following prisons: Arthur Kill, Elmira, Great Meadow, Mid-Orange, Sullivan and Upstate. Inmate surveys confirmed that many inmates at these prisons had problems with specialty services. Since the CA received only brief titles for each grievance appeal, rather than a detailed description, it is likely that many more grievances also raised the issue of specialty care, because many short titles include a general description, such as, "denial of treatment" or "needs treatment."

During prison visits, the CA noted problems with specialty services at several prisons. For example, at Great Meadow, 82% of medical care survey respondents stated that they encountered delays at least some of the time in accessing specialty clinics. Moreover, 72% of the respondents said that there was not adequate follow-up by the prison staff to specialists' recommendations. At Sullivan, 80% of survey participants stated that they experienced delays in access to specialty care, and nearly 70% reported inadequate follow-up to specialists' recommendations. Inmates at other male prisons also expressed concerns with specialty care.⁴¹

At Albion, many female inmates reported that they had to wait for months to see outside specialists, even for serious medical problems. One woman told us of repeatedly complaining of uterine pain; the medical staff initially provided Tylenol and then prescribed antibiotics, but her pain did not abate. After filing two grievances, she was eventually sent for an ultrasound, which revealed an abnormal growth in her ovaries. At the time of our visit, she was still waiting for further follow-up, nine months after her initial complaint.

In a few prisons, however, inmates reported that they had adequate access to specialty care services, including Eastern, as well as Coxsackie and Fishkill, both of which have a Regional Medical Unit providing outpatient specialty care.

DHS should perform a systemic review of specialty care to determine whether inmates are seen in a timely manner consistent with the urgency priorities set for each specialty consultation. In addition, DHS should assess whether prisons are implementing recommendations for care from the specialists in a timely manner or recording in the patient's medical chart the reasons for rejecting the specialists' recommendations.

DOCS System-Wide Specialty Care Utilization

Evaluation of specialty care services throughout the Department and at specific facilities confirms observations during prison visits that significant variations in the utilization of specialty care services exist among hubs and prisons within certain hubs.

⁴¹ At Green Haven, more than half the respondents reported that the prison provider did not do a good job of following up on specialists' recommendations. At Mid-Orange, Attica, Gowanda and Auburn, the majority of survey respondents complained about delays in access to specialists.

The CA obtained data from the Department summarizing the specialty care services provided at each prison for FY 2005-06 and FY 2006-07. The CA analyzed the data from FY 2006-07 and summarized the results in **Exhibit I**, which lists the number of all specialty care appointments at each male prison and the number and rate of consultations for 11 specialty services.⁴² Rates represent the number of specialty care appointments per 100 inmates at each prison. The female population has historically more frequently used specialty care services, but the female institutions are not equally distributed throughout the hubs. Consequently, in order to compare service utilization among hubs, this analysis excluded the female prisons from **Exhibit I** and listed them separately in **Exhibit L**.

Exhibit J lists rates for each specialty service for each male prison compared (as a percent) to the overall average; **Exhibit M** is a similar exhibit for the female prisons. **Exhibit K** is a summary chart listing the overall rate of specialty care and the rates for the 11 specialty services per hub. (Hub totals are also available within **Exhibit I**.) **Exhibit N** contains specialty care utilization rates for the 19 prisons visited for this report.

Hub Utilization of Specialty Care

These data demonstrate some troubling trends concerning specialty care services. **Exhibit K**, for example, shows significant differences in the use of specialty care in different regions of the state. (A DOCS map of the prisons and hubs is included as **Exhibit A**.) The Watertown Hub (#2) has the lowest utilization rate of specialty services, just one-third the rate of specialty care in the Green Haven Hub (#5) and a little more than half the rate in the Sullivan Hub (#4). The rate in the Great Meadow Hub (#6) is less than half the rate in the Green Haven Hub and less than three-quarters of the rate in the Sullivan Hub. The rate in the Elmira Hub (#8) is approximately half the rate of the Green Haven Hub and 20% less than the Sullivan Hub.

Based upon the inmate populations in these prisons, there is no apparent justification for the differences in utilization among the hubs. The most likely explanation for the underutilization of specialty care in certain hubs is the unavailability of specialists in these regions (as in the Watertown Hub) or the reluctance of prison providers to refer patients for specialty care. DOCS's DHS should evaluate these rates and determine whether patients in need of specialty care are receiving timely access to services, and/or whether DOCS providers are delaying or refusing to order specialty care. If a DHS review determines that in certain locations there is an inability to identify specialists willing to provide sufficient services to meet the needs of the prison population, the Department should make an effort to find specialists in that location or implement a referral system for inmates to get these services via telemedicine or transport to locations where such services are readily available. If unavailability of outside specialists is not the problem, DHS officials should review a representative sample of charts of patients with medical conditions that could potentially justify referral to specialty care to determine whether patients have received timely access to specialists. The CA urges the Department to enlist the aid of specialists not providing services in the region under review to assist in assessing the quality of care provided to DOCS patients.

⁴² The specialty care services summarized in **Exhibit I** are: cardiology, dermatology, gastroenterology, infectious diseases, liver biopsies, nephrology, neurology, ophthalmology, orthopedics (other), physical therapy and urology.

Review of specialty care appointments for the 11 services analyzed in each hub (**Exhibit I** and **Exhibit J**) reveals underutilization of several specialty services in certain regions of the state. Overall, the Watertown Hub (#2) had significantly less utilization of several critical services compared to average rates throughout the system for male prisons. Specialty care per 100 inmates were one-third the average rate for cardiology, 30% for gastroenterology, one-tenth for infectious disease, 16% for nephrology, 46% for neurology, 27% for physical therapy and 45% for urology. The Elmira Hub (#8) also had significantly less utilization for selective specialty services, with utilization rates that were 54% of average for gastroenterology, 40% for infectious disease, 64% for liver biopsies and 26% for nephrology. Other hubs had low rates for some services.⁴³

Again, it is difficult to determine any justification for this kind of underutilization of specialty services, other than difficulties identifying and accessing specialists willing to provide services to an inmate population or reluctance by prison providers to refer their patients outside for specialty services.

Specialty Care Utilization at Specific Prisons

The CA also observed significant differences in the utilization of specialty services among male prisons within the same hub (**Exhibit J** and **Exhibit K**). For example, in the Oneida Hub, overall specialty care was consistent with system-wide utilization, with the exception of infectious disease. However, at Marcy, the utilization of specialty care services overall was only 55% of the system-wide rate, and certain services were significantly underutilized.⁴⁴ Rates for many services were much lower than those at nearby Oneida, where for many of these same specialty services utilization rates were near or above the system-wide average. The comparison indicates that providers for these specialty services must be available to DOCS facilities in that region, but Marcy either has no need for, or is not referring its patients to, these services. Nothing about Marcy inmates would suggest a significantly different patient population than at other medium security prisons. It should be noted that in 2005, Marcy had one of the highest proportions of medical care grievances out of all types of grievances filed by Marcy inmates—a rate three times the system-wide average. Moreover, the rate of complaints about specialty care appealed to CORC by Marcy inmates was three times the system-wide rate.

Bare Hill is another prison with a low utilization of specialty care, just 64% of the system-wide average.⁴⁵ In contrast, Franklin, which is literally across the street from Bare Hill, had an overall specialty care utilization rate that exceeded the system-wide average and had utilization rates that

⁴³ The Oneida Hub (#1) had only 40% of the average rate for infectious disease and 73% of the average rate for gastroenterology, even though utilization rates of other specialty care services were near or close to the system-wide averages. The Clinton Hub (#3) had a 60% rate for neurology and 44% for dermatology, although it generally exceeded the utilization rates for other specialty services. The Sullivan Hub exceeded the system-wide utilization rates for all services except liver biopsies, which was only 65% of the system-wide average. The Great Meadow Hub (#6) had a 71% utilization rate for liver biopsies, 51% for orthopedics and 56% for physical therapy.

⁴⁴ Marcy had low utilization rates for: dermatology (30%), infectious disease (9.5%), nephrology (15%), orthopedics (63%), physical therapy (38%) and urology (56%).

⁴⁵ Bare Hill had very low rates for certain specialty services, including: cardiology (27%), dermatology (30%), gastroenterology (37%), liver biopsies (33%), neurology (38%), physical therapy (39%) and urology (39%).

were near or above average for gastroenterology, physical therapy and urology.⁴⁶ The utilization rates at Bare Hill were significantly below the hub average,⁴⁷ and DHS should assess its use of specialty care to determine whether it is inappropriately restricting access to outside specialists.

The FY 2006-07 specialty care data presented in **Exhibit N** confirms inmates' concerns about specialty care heard during the CA's visits to 19 prisons. Great Meadow and Wyoming had the two lowest utilization rates of the visited prisons, and inmates at these facilities overwhelmingly reported problems with access to specialty care and inadequate follow-up to specialists' recommendations.

Great Meadow's overall utilization rate for specialty care was slightly more than half of the system-wide average.⁴⁸ (See inmate survey results discussed on page 58.) Given that Great Meadow has an 18-bed infirmary, which is slightly larger than many prison infirmaries, and is only 70 miles from Albany Medical Center and within two hours of the Coxsackie Regional Medical Unit, it is surprising that it had such low utilization rates for these essential services.

Elmira had a 76% utilization rate of specialty care overall and very low rates for several important services.⁴⁹ The Elmira Hub (#8) had chronic underutilization of gastroenterology, infectious disease, liver biopsies and nephrology services, and the Elmira prison was generally well below even these low hub averages. The high number of Elmira grievance appeals about specialty care, discussed above and included in **Exhibit C**, confirms inmates' dissatisfaction with these services. Given that Elmira contains an infirmary and confines many long-term inmates, DHS should carefully scrutinize these low utilization rates.

The CA visited three male prisons in the Attica Hub (#7): Attica, Gowanda and Wyoming. All three had low utilization rates for specialists in FY 2006-07. Wyoming's overall utilization of specialty care was only two-thirds the system-wide average.⁵⁰ Its low rates for several important services may account for responses to the CA survey in which 65% of Wyoming inmate respondents reported delays in access to specialty care, and 72% stated that the follow-up to the specialists' recommendations was inadequate. Gowanda had an overall utilization rate of specialty care that was approximately three-quarters the system-wide average with particularly low use of several specialists.⁵¹ Gowanda medical staff admitted that they had experienced some problems locating neurology services. Attica had an overall utilization rate comparable to system-wide averages, but it underutilized several specialty services, with particularly low rates for cardiology (44%), gastroenterology (41%), neurology (64%) and urology (62%).

⁴⁶ Franklin, however, had low rates of utilization for cardiology (47%), dermatology (39%), liver biopsies (33%) and neurology (32%).

⁴⁷ The Clinton Hub, which includes Bare Hill, generally used specialty care consistent with the overall system average, but the hub exhibited low rates of use for cardiology (73%), dermatology (44%), neurology (60%) and urology (80%).

⁴⁸ Great Meadow had particularly low use of the following services: dermatology (27%), infectious disease (36%), liver biopsies (25%), ophthalmology (52%) and physical therapy (34%).

⁴⁹ Elmira had low utilization rates for: cardiology (57%), dermatology (41%), gastroenterology (19%), infectious disease (14%), liver biopsies (64%), nephrology (15%) and physical therapy (51%).

⁵⁰ Wyoming had very low rates for cardiology (35%), dermatology (37%), infectious disease (17%), neurology (26%) and physical therapy (55%).

⁵¹ Gowanda had low use of dermatology (38%), gastroenterology (29%), infectious disease (15%), nephrology (32%), neurology (40%) and urology (44%) services.

The CA also visited several facilities that provide specialty care at rates substantially higher than the system-wide averages. It appears that at these prisons, the medical providers have ready access to the services needed for their patients with chronic or acute medical problems, and that the providers are willing to consult medical experts to assist them in diagnosing medical problems and determining appropriate treatment modalities.

For example, Fishkill used specialty care services at more than twice the average overall and at three to seven times the rate for cardiology, dermatology, infectious disease, nephrology and neurology. Similarly, Green Haven had an overall rate substantially higher than the system-wide average and utilized cardiology and dermatology services at nearly twice the rate of other prisons, infectious disease services at four times the system-wide rate and physical therapy services at two-and-a-half times the system-wide average. Arthur Kill, Coxsackie, Eastern, Mid-Orange and Sing Sing had high utilization rates for most of the specialty services examined, often using certain services one-and-a-half to three times more than the system average.

The CA's analysis supports the recommendation that utilization of specialty care must be more closely evaluated and the medical charts of patients with serious and/or chronic problems must be carefully monitored. Qualified medical evaluators from outside the Department should assess whether specialty care is being requested when needed and determine whether specialists' recommendations are being appropriately considered and promptly implemented.

Specialty Care at Female Prisons

The female population utilizes specialty care at rates that are nearly three times greater than those for the male population. **Exhibit L** contains a summary of the number of specialty care visits and rates of utilization for each female prison, and **Exhibit M** lists the utilization rates for each specialty service compared to the system-wide average for female prisons.

Services that women used substantially more than men included cardiology, dermatology, gastroenterology, infectious disease, neurology, ophthalmology, orthopedics and physical therapy. Clearly some of the higher utilization rates for these services are due to higher rates of infection with hepatitis C and HIV among women.

However, there are also significant differences in utilization rates among prisons. For example, Albion (the largest female prison) had substantially fewer specialty appointments than the average for all female prisons. In particular, it had utilization rates that were between four and ten times lower than those for Bedford Hills for the following specialty services: cardiology (four times less); dermatology (almost five times less); infectious disease (nine times less); nephrology (nine times less) and neurology (seven times less). Although Bedford Hills has a Regional Medical Unit (RMU), the RMU consultations were excluded from these comparisons. Taconic, a medium security prison, also had utilization rates that were substantially higher (often on the order of two to ten times) than Albion for many specialty services.

DOCS officials should evaluate the use of specialty care services at the female prisons, with a particular focus on Albion, to determine whether women have appropriate access to specialty care.

PHARMACY SERVICES

DOCS is clearly in the process of upgrading its pharmacy operation, both at its Central Pharmacy and at the prison pharmacies serving 49 of the prisons. The CA applauds the Department's efforts, but in view of immediate problems, the CA urges DOCS and other state officials to take interim steps to ensure that inmates at each prison have timely access to the medications they need.

Vacancies and Centralized Services

As noted previously in this report, one of the primary obstacles to effective pharmacy services is the lack of prison pharmacists. For years, the state has not authorized adequate compensation rates to attract pharmacists to the prisons. Consequently, as of May 2007, there was a 13% pharmacist vacancy rate in prisons with a DOCS pharmacy. Many prisons have abandoned their effort to have a pharmacy and rely on a DOCS regional pharmacy or outside pharmacy services to supply medications. As noted at the 2003-04 New York State Assembly hearings held by the Corrections and Health Committees on prison healthcare, the cost of medication from the outside pharmacies is 27% greater than DOCS Central Pharmacy costs. During FY 2006-07, DOCS spent \$17 million on medications provided by outside pharmacy services, which included approximately \$3.8 million more than what DOCS would have spent for the same medications if purchased through its Central Pharmacy. Twenty prisons are currently using contract pharmacy services through a new provider (Kinney Drugs) whose contract with DOCS became fully operational as of April 2007. DOCS will have to rely on this expensive system at these prisons until it can implement an alternative system.

The DOCS Central Pharmacy staff reported that the Department does have a long-term plan to take over the outside pharmacy services by expanding the Central Pharmacy and adding 17 new pharmacy positions, which were authorized in last year's budget. Under this plan, in addition to distributing bulk medications to prison pharmacies throughout the state, the Central Pharmacy will begin dispensing individual prescriptions to inmates at prisons currently served by an outside contractor. It appears, however, that it will take several years to implement this plan. This proposal represents significant progress in addressing the longstanding issue of inadequate staffing of prison pharmacies, but it will probably not fully address the need for more prison pharmacies. Consequently, the CA urges the state to make state pharmacists' salaries competitive with community rates, eliminating the ongoing challenge of staffing prison pharmacies throughout the state.

The CA recognizes that DOCS cannot control the salary levels for civil service employees and that the approval of a geographic pay differential in 2005 increased civil service salaries for pharmacists by \$11,000 per year. Although this increase enabled some prisons to fill pharmacy positions, numerous pharmacy vacancies still exist and many prison pharmacies remain closed.

The CA visited DOCS's Central Pharmacy at Oneida during a visit to the prison in March 2007 and was impressed by the facility and the staff. The CA also observed the new computerized pharmacy software. DOCS is currently in the process of installing this system at a number of prisons and training pharmacy staff on its operation. The CA anticipates the new pharmacy computer system will allow for better analysis of medications and other quality assurance

measures by the prison medical staff, including monitoring of contraindicated drugs, utilization of costly medications, and identification of inmates on chronic medications who are not filling their prescriptions.

Medication Monitoring and Problems with Medication Distribution

The Department spends substantial sums annually to provide medications to treat chronic diseases. During FY 2006-07, DOCS spent \$26.2 million for HIV medications, \$16.2 million for psychotropic medications and \$3.6 million for hepatitis C drugs, in total representing more than 60% of its medication budget. Given these expenditures and those for other chronic diseases like asthma, hypertension and diabetes, it is essential that the Department conduct effective quality assurance of the medical care provided to the chronically ill to ensure that the drugs are used appropriately and that the treatment is effective.

Distributing medications from DOCS pharmacies should enable better tracking of inmate medications using the new DOCS pharmacy computer system. However, there currently is no mechanism to integrate the computerized medication records of inmates receiving prescriptions from outside contractors with DOCS's computerized pharmacy records. Consequently, when an inmate is transferred from one prison receiving outside pharmacy services to a prison serviced by DOCS's Central Pharmacy, or vice versa, the receiving facility is unable to access any computer records about the inmate's prior medication history. This gap makes it much more difficult to appropriately monitor inmates on complex medication regimens, to assess inmate compliance with their medications, or to gauge the impact of alterations in medication regimens for patients with chronic conditions.

In addition, inadequate staffing also compromises DOCS's pharmacy operations. Inmates' medication regimens cannot be closely monitored for contraindicated prescriptions or the failure to renew chronic medications at appropriate intervals. Since strict compliance with complex regimens is crucial for effective treatment of many chronic illnesses and the pharmacy can be an invaluable source of information for providers monitoring patients' treatment, inadequate pharmacy staff and systems can significantly compromise the prison's ability to provide effective chronic care.

Inmates have reported many other problems concerning medications, including the periodic failure of prisons to: (1) renew medications in a timely fashion; (2) maintain an adequate supply of some medications for chronic conditions, resulting in shortages of essential drugs; (3) provide inmates with sufficient information about the medications they are taking and possible side effects; and (4) deliver medications in a confidential manner to prevent disclosure of the nature of inmates' illnesses to staff and other inmates. Even at prisons with a full pharmacy staff, inmates report problems with their medications. For example, at Great Meadow and Sullivan, more than 60% of the inmates on medications stated that they sometimes have problems obtaining their prescriptions. At Green Haven more than 50% of medication users complained of problems with drug access.

CORC grievance appeal data confirm survey results, revealing numerous complaints about access to medications. From January 2003 through May 2006, there were a total of 1,599 medical grievance appeals system-wide which raised the issue of inmate medications. This

figure represents 15% of all medical grievance appeals. Prisons in which inmates filed significantly more grievances about medications than the system-wide average include Upstate, Auburn, Great Meadow, Fishkill and Sullivan. In contrast, Cossackie, Gowanda and Sing Sing had far fewer medication grievances.

QUALITY IMPROVEMENT PROGRAMS

During the past two decades, the Department has attempted to develop several different quality improvement programs in the prisons and in DHS to monitor healthcare. Until recently, these efforts were unsuccessful in that: (1) the prisons have not consistently collected information, analyzed systemic trends or developed remedial plans to address problems; (2) there has been little coordination between DHS and the prisons concerning monitoring of the quality improvement program; and (3) there has been minimal follow-up by DHS and the prisons to ensure that identified problems have been corrected. However, since 2000, DHS has made significant progress in reinvigorating its quality improvement activities and has issued a mandate that prisons develop prison-based quality improvement efforts.

One component of the Department's quality improvement program is the development of clinical guidelines for prison providers to follow. Starting in the 1990s, DHS promulgated eight sets of guidelines covering asthma (latest version in 11/04), diabetes (8/99), female health appraisal protocol (3/00), hepatitis B (5/04), hepatitis C (7/04), HIV (9/05), hypertension (2/01) and men's health (6/03). DHS also issued assessment tools to determine whether prisons are following the guidelines.

In October 2000, DHS issued Health Services Policy Manual Item #7.19, which directed that a prison quality improvement program should address seven primary care areas to be reviewed by Senior Utilization Review Nurses (SURNs) during site visits. The SURNs were to report deficiencies to a DHS Central Office Continuous Quality Improvement (CQI) Committee, which would then issue reports to the prison superintendent and Facility Health Services Director about areas in need of improvement. The prison medical administration had to provide the Central Office CQI Committee with an action plan to address noted deficiencies. The Regional Medical Director (RMD) and the Regional Health Services Administrator (RHSA) for the prison were responsible for ensuring compliance with the action plan.

In February 2007, Item #7.19 was replaced by a draft protocol creating a DHS Continuous Quality Improvement (CQI) Program directed by a CQI Committee consisting of directors and assistant directors from several departments of DHS, Regional Medical Directors and other health professionals in DHS, facility staff and regional staff. The policy specified that a Quality Assessment Tools (QAT) Manual would be distributed to the prisons for use by prison staff in conducting self-evaluation audits. The important changes from the previous policy are that prison staff will conduct the audits and that the QAT Manual, rather than Policy 7.19, will specify the procedures and tools to be used in CQI activities.

The Department provided the CA with DHS materials concerning its quality improvement efforts, including records from all DHS CQI Committee meetings, for the period January 2005 through early 2007. Several observations are evident from reviewing these documents and their

attachments. First, the CQI Committee has been very active in developing new tools to assess several chronic conditions, including HIV, Hepatitis B, hepatitis C and asthma. In addition, the Committee has focused on routine medical procedures such as documentation of medical histories, physicals and periodic health appraisals for men and women.

Second, the CQI Committee has obtained system-wide data from several audits revealing that the prisons are complying with some indicators but not meeting all the required audit indicators. Results of the audits for HIV, hepatitis B, hepatitis C and asthma are discussed in the chronic care section of this report.

Third, the new CQI Program requires prison staff to be more involved in the auditing process, mandating that the prisons complete many of the audits. However, it appears some prisons are having difficulties performing these tasks. Of particular concern are indications that prisons have been unable to meet their CQI duties due to staffing deficiencies. For example, in 2006, ten prisons were identified as encountering barriers to performing an HIV audit. Staff shortages were noted at Arthur Kill, Five Points, Great Meadow, Greene, Mid-Orange, Oneida, Southport and Taconic. Meaningful CQI efforts are time-consuming, yet very important for a prison medical staff. DHS should include the CQI activities in determining staff requirements at all prisons.

Fourth, the CQI Committee considers a prison to have satisfied an audit indicator if 70% of the medical charts reviewed at the prison are determined to be in compliance. Only when a prison falls below the 70% threshold is the medical staff required to develop a remedial plan. As discussed in the chronic care section, this threshold represents too low a bar for acceptable performance. Noncompliance with an essential component of care in 20%, or even 10%, of the cases reviewed at a prison could indicate that there may be systemic problems and that improvements could be realized with closer attention to the policy requirements. Continuous quality improvement is not intended to find fault or blame, but rather to motivate medical staff to continuously find ways of improving services, just as a remedial plan does not necessarily signify the delivery of poor care, but only that there may be ways to improve care. The reviewed audit data includes many indicators that fall in the 10-30% noncompliance range. Prisons would be better served if they were encouraged to address these areas. The CA urges the CQI Committee to re-examine its criteria for acceptable compliance, particularly for indicators that measure critical elements of patient evaluation and care.

Fifth, documentation received from the CQI Committee included no indications about: (1) whether the Department now requires prisons to develop remedial plans for areas that need improvement; (2) what measures have been implemented in any such plans and whether they could be instructive to other prisons and DHS for improving care; and (3) the extent to which DHS or the Regional Medical Directors have followed up at prisons where audits have established noncompliance. It appears that the remedial steps of the CQI Program have been left to the Regional Medical Directors and/or the prison staff with little or no oversight by the DHS CQI Committee. By failing to generate and distribute remedial plans, DOCS is losing the opportunity for other prisons to learn from the experiences of prisons struggling with compliance and for the CQI Program to foster greater accountability from its prison medical programs.

The Department recently provided the CA with its Quality Assessment Tools Manual, which was issued in November 2007. The Manual is a significant addition to the Department's QI documentation, containing several additional tools to assess medical services at the prisons. It contains 18 tools to assess primary care, a dental care tool, a pharmacy tool, a mental health tool and five miscellaneous tools. **Table 10** identifies the primary care and miscellaneous tools. The primary care tools include an assessment instrument that evaluates continuity between the prison clinician and specialty care services and appropriate clinician follow-up to a patient's previous plan of care. Similarly, there is a tool concerning consultation to specialty providers that examines not only the consultation request, but also whether the prison primary care provider has reviewed the consultant's recommendations and taken appropriate action. In the miscellaneous section there is a tool to evaluate the prison provider's response and follow-up to specialist's recommendations.

Table 10 – DOCS Quality Assessment Tools Manual	
Category	Tools
Primary Care Tools	Asthma, Clinician Chart Review, Consultation to Specialty Provider, Diabetes, Emergency Medical Equipment/Response, Emergency Room Referral, Health Care During Transfer, Hepatitis B, Hepatitis C, HIV, Hypertension, Infirmary Nursing Assessment and Documentation, Infirmary Primary Care Provider Documentation, Latent TB Infection, Periodic Men's Health Appraisal, Periodic Women's Health Appraisal, Reception Health Screening, Sick Call (Nursing)
Miscellaneous Tools	Fit Test N95 Audit, HIV Rapid Test Audit, Hospital Admission and Discharge Review, Post Specialty Consultation Review, Quality Improvement Reporting

The Manual defines each indicator in the tools and generally specifies that an inmate must be at a facility at least 90 days for his/her chart to be included in the assessment process. However, the Manual does not specify the frequency with which these tools should be employed by the prison medical department. Moreover, the Manual maintains the 70% compliance rate for determining whether an indicator has been satisfied.

Overall, the CA is impressed with the efforts of the DHS CQI Program, as it reflects a clear intent to specify standards of care for all prisons and to monitor prison practices through objective assessments. Nevertheless, the CA urges the committee to expand the areas it is investigating to include specialty care and other chronic conditions and to enhance the component of the program that mandates the development of remedial plans and dissemination of those plans to DHS officials and prison providers.

The Department has also improved individual prison-based QI programs, but it should augment those efforts. Health Policy Manual Item #7.19a, issued in September 2003, requires each prison to create a facility-based Quality Improvement Committee (QIC) and to conduct at least quarterly meetings. The protocol notes that "[t]imely and periodic assessment of healthcare outcome measure values will help to assure compliance with American Correctional Association performance standards and will serve as an internal system for assessing achievement." The program "is designed to keep healthcare professionals continually involved in the monitoring and improvement of the quality of health services provided to the inmate population." For a system-

wide QI program to be effective, prison staff must regularly be engaged in QI activities at their prison.

At several prisons, the CA found that the facility-based quality improvement (QI) program was not fully operational or did not meet the goals stated in Policy Item #7.19a. At Attica, Great Meadow and Mid-Orange, the QI program was hampered by a lack of staff to perform essential tasks. Without an FHSD or a Nurse Administrator to organize the program, or adequate nursing staff to perform chart reviews, a QI program cannot function. At some prisons, such as Eastern and Gowanda, officials said there were quarterly meetings, but the CA did not have an opportunity to review program documentation. Auburn officials reported that monthly QI meetings are held and that medical chart reviews and mortality assessments are performed by prison medical staff.

While efforts to conduct regular QI activities at the prisons represent a positive step, DHS staff must be more involved to ensure that these programs are comprehensive and effective in addressing deficiencies in the prison healthcare systems. As long as staff shortages exist at certain prisons, it is unrealistic to expect these facilities to support an effective QI program while also performing necessary medical care. In determining the level of medical staff required at a prison, the Department should include a realistic allocation of time for medical administrative staff to perform QI duties.

A component of reviewing the quality of prison healthcare involves assessment of the medical staff. As noted in the section on routine care, inmate-patients frequently complain to the CA about the attitude, thoroughness, responsiveness and demeanor of the prison staff during medical encounters. There appears to be limited DOCS oversight concerning this aspect of care. The quality assessment tools of clinicians consist primarily of chart reviews of medical encounters. It is unlikely that these records will contain data about these aspects of patient-staff relations. When the CA inquired whether the Department performs overall reviews of medical staff, DHS personnel asserted that individual evaluations are conducted. As evidence of these reviews, DOCS shared with the CA a few examples of redacted evaluations by a Regional Medical Director of a prison provider. These documents were completed Performance Evaluation Program Forms prepared pursuant to the contract between the New York State Public Employees Federation (the union representing all medical staff) and the State of New York. It appears these evaluations are required for an individual to receive payment for performance advances under the contract. Although the Regional Medical Director assesses whether the provider's performance is satisfactory or unsatisfactory in this evaluation, the following issues are unclear: (1) what records were reviewed or process employed (e.g., chart reviews, interviews with staff and patients, and evaluation of grievances) to determine satisfactory performance; (2) what record is created of specific areas in which performance could be improved; (3) whether a written plan is required specifying what the employee should do to enhance his/her performance; and (4) how these evaluations are used in assigning medical personnel and determining medical operations. It appears a more comprehensive, better documented staff review process is needed to adequately assess the performance of medical personnel.

MEDICAL SERVICES FOR INMATES WITH LIMITED ENGLISH SKILLS

Most prisons the CA visited had very few or no medical staff members who spoke Spanish, even though 5% to 10% or more of the inmate population at these prisons did not speak sufficient English to communicate effectively with medical staff about their health problems. At almost all of these prisons, inmates, and sometimes security staff, are used as translators for these medical encounters. It is inappropriate and ineffective to use untrained translators in this way; it compromises confidentiality, and inmate-patients will understandably be reluctant to talk about sensitive medical issues when their peers or security staff can learn about their health conditions. Additionally, ineffective communication occurs when untrained individuals, sometimes with limited English skills themselves, try to translate medical terminology and concepts to non-English speaking patients.

Telephone services, such as one offered by AT&T, provide translations for a modest cost. They are available for dozens of languages. At a few prisons, medical staff had access to telephone translation services, but no prison was consistently using them. The Department has recently agreed to implement this program in all its prisons and to inform medical, correction and civilian staff and inmates of its availability. The CA urges the Department to monitor the system to ensure that the prisons are using the system when communicating with inmates with limited English-language skills.

Prisons also fail to consistently provide information in Spanish or other inmates' native languages about medication descriptions, instructions for dosage and warnings about potential side effects. Department officials informed the CA that DOCS pharmacy system has the capability to provide information about medication in Spanish. It is unclear whether the Department provides other medical documentation in the patient's native language, such as laboratory test results, inmate medical refusals, patient instructions following discharge from a hospital or instructions for medical tests and procedures. The CA urges DHS to conduct a system-wide assessment of prison practices concerning the provision of medical instructions and documentation comprehensible to non-English speaking patients.

CONTINUITY OF CARE

Inmates are regularly transferred from one prison to another, and 27,000 to 28,000 are released each year to the community. For inmates with chronic medical conditions, there are problems ensuring adequate continuity of care during these transitions.

Inmates at several prisons asserted that they had not been seen by a provider until several months after they arrived at a prison, even though they had chronic medical problems. Some had interruptions in their medications when they were transferred to a new facility, and in some cases medical charts did not arrive promptly. These difficulties would not occur if prisons carefully reviewed medical records of all incoming inmates and assigned chronically ill inmates to a designated provider who conducted evaluations of patients soon after their arrival at the facility.

In addition, many inmates being discharged from custody leave without adequate documentation of their medical status. Some do not receive the required two-week supply of medications upon

discharge or the 30-day supply required for discharged HIV-infected patients. Very few receive a referral to a clinic in their community for follow-up care for existing medical conditions that require treatment. Almost none of the patients with serious illnesses leave prison with a Medicaid card or with a pending application for health benefits. Inevitably, many formerly incarcerated individuals face numerous difficulties in promptly accessing healthcare in their communities. The prison medical staff generally do not provide any discharge planning services for them, and the transitional services units and parole staff in the prisons are unable or ill-equipped to perform discharge planning for essential medical care.

In 2007, the state enacted legislation requiring the Department of Health to suspend, rather than terminate, the Medicaid benefits of inmates enrolled at the time of their incarceration, so that benefits can promptly be restored when they are discharged. The CA applauds this action and commends the governor and New York State Legislature for supporting this measure. Yet more needs to be done. It is estimated by DOCS that only 20-25% of the inmate population will be affected by this law, which went into effect on April 1, 2008. In order for other inmates to have Medicaid benefits at discharge, some form of facilitated enrollment of Medicaid applications must occur while inmates are incarcerated. This service is now being provided for a very limited number of inmates, including those on dialysis for kidney disease and inmates being discharged from Queensboro. In the recently enacted FY 2008-2009 budget, funds have been allocated for DOCS, the Department of Health and the Division of Parole to undertake a pilot project to develop a method to fill and process Medicaid applications for soon-to-be-released inmates. We commend this initiative and hope that the pilot can be promptly developed and implemented.

The CA also commends the Department for starting a pilot project at Orleans in the western part of the state to facilitate reentry for inmates returning to Erie County. This project includes assistance in filing benefit applications while the inmates are still incarcerated. Moreover, DOCS's Chief Medical Officer, Dr. Lester Wright, has assembled a Medical Reentry Task Force that includes representatives of the relevant state agencies and outside advocates, including the CA, to develop recommendations for improving the reentry of inmates with medical problems. These efforts clearly demonstrate a commitment by DOCS to enhance discharge planning for inmates with medical needs and a desire to coordinate with other state and private entities to facilitate prisoner reentry. Legislation, additional resources including staffing, and changes in DOCS and parole policies must occur to make discharge planning effective for inmates with medical problems.

CONFIDENTIALITY IN MEDICAL ENCOUNTERS

At some prisons, inmates complain that their medical encounters, particularly during sick call, are not conducted in a confidential manner. Since correctional staff must be in the area where sick call occurs to provide security for the medical staff, the Department should implement measures to ensure that officers do not overhear confidential medical information.

Unfortunately, Auburn conducts sick call in the housing areas where it is even more difficult to maintain privacy, and inmates reported that correctional staff could hear medical conversations. The CA also observed problems with confidentiality at Mid-Orange, which holds medical call-

outs in the clinic area in a hallway behind a cloth screen. It was clear that inmates and security staff could overhear conversations in this area.

For inmates who are in disciplinary segregation, the problem is even more severe. In these units, sick call staff interview inmates through the cell door. At Upstate there are solid doors with small holes through which inmates and staff attempt to communicate. The CA has conducted interviews on these units and can verify that it is very difficult to communicate with an inmate without talking at a high volume. Since correctional officers follow sick call nurses during their rounds on these units, it is inevitable that security staff will overhear these medical exchanges.

Inmates also complain about the lack of privacy in the distribution of medications. At many prisons, pharmacy staff distribute medications at a window where inmates must line up at specific times of the day. At some prisons, there is insufficient space between inmates on the medication line and the patient receiving his/her prescription to allow for a private interaction. Inmates also complain that non-medical staff are sometimes given medications to distribute to inmates in their housing area and that the drugs are not adequately packaged to shield the nature of the contents from staff.

CARE FOR THE AGING INMATE POPULATION

The overall inmate population has gotten older during the last several decades, resulting in a substantial increase in the number of inmates 50 years or older, amounting to a percentage of older inmates that more than doubled between 1996 and 2006. **Table 11** contains a summary of this aging DOCS population for these years.

TABLE 11 - SUMMARY OF OLDER POPULATION IN DOCS 1996-2006											
AGE	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
50-54	1,750	1,836	2,030	1,895	2,518	2,722	2,772	2,787	2,887	3,103	3,245
55-59	871	988	1,054	1,010	1,241	1,354	1,378	1,507	1,539	1,601	1,724
60-64	398	431	446	401	538	606	702	746	756	795	848
65 and older	282	323	368	306	408	429	484	526	555	625	651
50 and older	3,301	3,578	3,898	3,612	4,705	5,111	5,336	5,566	5,737	6,124	6,468
% of Population	4.82%	5.14%	5.64%	5.16%	6.58%	7.29%	7.92%	8.34%	8.80%	9.61%	10.31%
55 and older	1,551	1,742	1,868	1,717	2,187	2,389	2,564	2,779	2,850	3,021	3,223
% of Population	2.26%	2.50%	2.70%	2.45%	3.06%	3.41%	3.80%	4.16%	4.37%	4.74%	5.14%
Total Population	68,484	69,646	69,099	70,004	71,466	70,153	67,394	66,745	65,197	63,698	62,732

Consequently, there has been a commensurate increase in the percentage of inmates with medical problems and in the prevalence of specific medical conditions associated with older patients. A recent Bureau of Justice Statistics analysis of 2004 data obtained during its survey of all state and federal inmates concerning medical problems reported that 69% of all state inmates 45 years or

older had a current medical problem, compared to only 34% and 50%, respectively, of inmates aged 25-34 and 35-44.⁵² This study also reported that certain medical conditions were much more prevalent in the 45 and older population than in the 35-44 age group: cancer was four times higher; diabetes nearly three times higher; heart problems more than twice as high; and hypertension and liver problems twice as high.⁵³ The study found that the 45 and older state inmates were two to five times more likely to require surgery while incarcerated than groups of younger inmates. These older inmates were also three to six times more likely to have disabilities related to hearing, vision or mobility than younger inmates groups.⁵⁴ Finally, the older inmate population also accounts for a disproportionate share of inmate deaths. A separate Bureau of Justice Statistics report, *Medical Causes of Death in State Prisons, 2001-2004*, reported that two-thirds of all inmate deaths involved individuals age 45 or older and that 40% of all state inmate deaths occur in five states, including New York.⁵⁵

With the increase in the older population in prison, it is inevitable that the Department will use more medical resources to serve aging inmates and that the prevalence of common medical problems of elderly inmates will increase in the prisons. There will also be additional costs for medications for chronic conditions, more extensive infirmary and skilled nursing care utilization and more frequent and lengthy hospitalizations. Older patients with chronic conditions also may require more intense nursing care when they are in an infirmary or Regional Medical Unit, and therefore, additional nurses and medical aides may be required for these units. It is important that the Department closely monitor the increasing needs of this expanding population and ensure that it has the resources, in terms of both medical staff and residential facilities, to meet the growing demand.

The CA commends the Department for creating a 30-bed Unit for the Cognitively Impaired at Fishkill in October 2006. Inmates with dementia due to Alzheimer's, AIDS, Parkinson's or Huntington's diseases are placed there. As of May 2007, the average age of the patients on this unit was 62 years old. Staff for the unit, including nurses, correction officers and housekeepers, go through a 40-hour training to learn how to interact effectively with this patient population. The unit had 20 patients as of May 2007, but it is reasonable to suspect that many more vulnerable inmates with cognitive impairments could benefit from placement on this unit.

INMATE DEATHS

The number of deaths in the Department has consistently declined since the 1990s when many HIV-infected inmates died in custody. In 1995, AIDS-related deaths peaked at 257, and a total of 396 state inmates died that year while incarcerated. In the late 1990s, the number of AIDS-related deaths declined rapidly so that in 2000 there were only ten AIDS-related deaths and a total of 172 deaths, a more than 50% reduction in all DOCS deaths from just five years earlier. The reduction in AIDS-related deaths in the 1990s was primarily due to the effectiveness of

⁵² Maruschak, L., *Medical Problems of Prisoners*, US Dept of Justice, Bureau of Justice Statistics, Table 1, April 2007 (<http://www.ojp.usdoj.gov/bjs/pub/html/mpp/mpp.htm>).

⁵³ Ibid. at Table 2.

⁵⁴ Ibid. at Table 4.

⁵⁵ Mumola, C., *Medical Causes of Death in State Prisons, 2001-2004*, US Dept of Justice, Bureau of Justice Statistics, at 1 (2007).

available treatment for HIV disease and the fact that many inmates were on therapy when they entered custody. Since then, the decline in inmate mortalities has been much less significant.

Table 12 details the total number and causes of death for DOCS inmates during the period 2001 through 2006.⁵⁶

Year	2001	2002	2003	2004	2005	2006
Homicide	3	5	2	2	1	0
Suicide	8	14	14	8	19	8
Accident	2	1	1	1	0	0
Other Causes	4	3	4	5	3	5
Natural Causes	134	149	164	125	149	118
AIDS	28	18	15	13	*	*
TOTAL	179	190	200	154	172	131

* Data is not available on AIDS-related deaths for these years.

The Bureau of Justice Statistics report on deaths in all state prisons, *Medical Causes of Death in State Prisons, 2001-2004*, analyzed the prevalence of specific causes of death and provided data for each state.⁵⁷ In New York, the number of deaths due to natural causes other than AIDS has remained relatively constant throughout the period. The number of DOCS deaths for 2001-04 was the fourth highest in the country, behind California, Texas and Florida, which all have substantially larger inmate populations. The average rate of death due to illnesses for New York inmates was also the third highest for all state prisons outside the southern region of the country, where much higher mortality rates generally exist.⁵⁸ The most important causes of death for DOCS inmates were heart disease, cancer, AIDS and liver disease. Nationally, cancer of the lung was the most common site for inmate cancer deaths. For female inmates nationally, breast, ovarian, cervical and uterine cancers accounted for 24% of all female inmate cancer deaths.⁵⁹

Given the relatively high incidence of death for DOCS inmates, it is important for the Department to have an aggressive program to identify and treat the illnesses most likely to cause inmate mortality. It is not clear that DHS has intensely focused on heart disease or cancer, and the CA is not aware of any quality improvement activities evaluating care of patients with these illnesses. The CA is also concerned that the mortality reviews conducted by the Commission of Correction are not rigorous for inmates dying of natural causes and that these reviews are not issued in a timely manner. The CA believes that legislation requiring DOH oversight should include a renewed focus on inmate mortalities to determine if measures can be taken to reduce the number of these deaths.

⁵⁶ See *Inmate Mortality Report, 2001-2004*, DOCS (2005); *Unusual Incident Reports 2005*, DOCS (2006); *Unusual Incident Reports 2006*, DOCS (2007).

⁵⁷ Mumola, C., *Medical Causes of Death in State Prisons, 2001-2004*, US Dept. of Justice, Bureau of Justice Statistics (2007).

⁵⁸ *Ibid.* at Appendix table 9.

⁵⁹ *Ibid.* at 2.

For inmates who are seriously ill, one option to enhance their end-of-life experiences and to reduce the cost of care for the Department is to release them early to the community when they no longer pose any risk to society due to their deteriorated condition. New York's Medical Parole Law has been in place since 1992 and provides for the early release of inmates who are "suffering from a terminal condition, disease or syndrome" and who are "so debilitated or incapacitated as to create a reasonable probability" that they are "physically incapable of presenting any danger to society."⁶⁰ The Medical Parole Law permits inmates to be released before they reach their minimum sentences and requires DOCS to make an assessment of the inmates' medical condition and the Division of Parole to make the final determination whether to release the individual. Since 1992, Parole has released 289 individuals on medical parole. An additional 61 inmates, who had already been before the Parole Board and been denied parole, have received an expedited reconsideration of parole when their medical condition deteriorated.⁶¹ During the early years of the Medical Parole Law, many inmates were regularly released, but during the last several years, only about 12 inmates have been released annually through Medical Parole and Full Board Case Review procedures. This figure represents less than 10% of the inmates dying in custody.

In 2008, then-Governor Eliot Spitzer and DOCS proposed an amendment to the Medical Parole Law during the budget process which would have expanded the law to cover inmates who are so physically or cognitively incapacitated that they no longer present any danger to society, even if they do not have a terminal condition. Unfortunately, the Senate opposed the provision and during negotiations over the budget, this measure was withdrawn. The CA strongly supports the expansion of the Medical Parole Law and urges state officials to pass pending legislation such as Assembly Bill A10863, which is similar to the executive's budget proposal, broadening the scope of the Medical Parole Law.

PATIENT EDUCATION AND ACCESS TO HEALTH MATERIALS

Access to comprehensive, user-friendly health materials can empower patients with basic health information such as which questions to ask medical providers, what to expect during medical exams and tests, and how to take steps toward building healthy and safe lives after release. Informed patients can more actively contribute to their own health and build effective relationships with their providers. Greater efforts are needed throughout the Department to improve patient education during all medical encounters. Moreover, patients with chronic medical conditions need ongoing education about their condition, treatment and prognosis so that they can fully participate in their treatment and recovery.

In February 2008, the CA was pleased to work with DOCS to establish a women's health section in the general library of each of New York's seven correctional facilities that house women. The CA decided to initiate this project after hearing comments from women during prison visits that library health materials were often inaccessible, scarce and outdated. The CA collaborated with

⁶⁰ Executive Law, § 259-r (McKinney's Conn. Laws of NY).

⁶¹ When inmates have already passed their minimum sentence and been denied parole, they are no longer eligible for Medical Parole, but they can be considered for parole on an expedited basis in a process known as Full Board Case Review (FBCR). Sixty-one terminally ill inmates have been released since 1992 utilizing this FBCR process during which DOCS and Parole apply the medical standards for eligibility similar to the Medical Parole Law.

medical professionals, DOCS librarians and community librarians, currently and formerly incarcerated women and other advocates to compile a comprehensive list of resources addressing the most common health issues facing incarcerated women. The CA then secured donations from publishers and individual donors to gather the materials.

The male prison population could also benefit from better patient education and access to health-related materials. Much of the information contained in the collection of health materials provided to the women facilities would be useful to men. We urge the Department to review that collection, identify what materials would be informative for men and seek funding for the purchase of these materials.

Educating the inmate population about how to access healthcare systems in the community upon release is an important component of discharge planning. The CA commends the Department for initiating the Health Reentry Taskforce, coordinated by the New York Academy of Medicine, which, in addition to other efforts described earlier concerning Medicaid eligibility, is investigating ways to provide inmates with crucial information about how they can obtain healthcare for themselves and their families once they are discharged. Moreover, the AIDS Institute's Criminal Justice Initiative will be including this type of information in its training of peer educators. We urge the Department to continue its efforts with the Reentry Taskforce and the CJI providers to explore ways to include this information in the health training that occurs in the prisons, particularly in phases II and III of the transitional services programs provided to inmates about to be released from prison.

WOMEN-SPECIFIC HEALTHCARE NEEDS

This report does not include a full analysis of health services for women in the state's correctional facilities. Evaluating these services is a critical part of assessing DOCS ability to meet the healthcare needs of individuals in its custody, and the CA plans to issue a separate report in the future with more in-depth analysis of medical care provided to incarcerated women. What follows are general comments about women-specific health care and an overview of various aspects of CA findings and observations about healthcare for women in DOCS custody.

In addition to gynecological, reproductive, nutritional and other health requirements, women's individual life experiences and circumstances significantly impact their health care issues and needs. Multiple studies have shown that a disproportionately high percentage of incarcerated women, including those in New York's prisons, are survivors of trauma and/or physical and sexual abuse, both as children and as adults.⁶² DOCS estimates that 88% of female inmates had

⁶² A study conducted in 1999 found that 82% of women incarcerated at Bedford Hills had a childhood history of severe physical and/or sexual abuse, that more than 90% had endured physical or sexual violence in their lifetimes and that 75% had experienced severe physical violence by an intimate partner during adulthood. Browne, Miller and Maguin, "Prevalence and Severity of Lifetime Physical and Sexual Victimization Among Incarcerated Women," *International Journal of Law & Psychiatry* 22(3-4) (1999). Nationwide, more than 57% of women in state prisons and 55% of women in local jails report having been physically and/or sexually abused in the past. More than 37% of women in state prisons report having been raped at some point before their incarceration. *Prior Abuse Reported by Inmates and Probationers*, Bureau of Justice Statistics, U.S. Department of Justice (April 1999), at 2, and Doris J. James, *Profile of Jail Inmates, 2002*, Bureau of Justice Statistics, U.S. Department of Justice (July 2004), at 10.

a substance abuse problem before their arrest, compared with 71% of male inmates. Many women have engaged in sex work before their incarceration, thereby increasing their exposure to sexually transmitted diseases. Approximately 72% of women in New York State prison report being parents, compared to nearly 58% of incarcerated men. Women are more likely than men to have been the primary caretakers of their children prior to arrest, and incarcerated mothers frequently note that being separated from their children contributes to feelings of depression, anxiety and low self-esteem. Incarcerated women also suffer from serious mental illness at considerably higher rates than male inmates.

Most state facilities for women provide gynecological (GYN) care through on-site specialty clinics. As a result of these arrangements, incarcerated women require routine access to and follow-up from GYN specialists, whether or not they are ill. Women also need at least yearly Pap smear tests and mammograms after they reach a certain age. During CA visits to Bedford Hills and Albion in 2005, most women inmates reported that they did not have serious problems accessing routine GYN care, and most praised the quality of the gynecologists. Many, however, reported difficulty obtaining abnormal gynecological test outcomes in a timely fashion and delays in accessing consistent and adequate follow-up care for abnormal test results and other gynecological issues that necessitated treatment from specialists other than on-site providers. Additionally, although most women reported that they had been given a Pap test and a mammogram (if they were over 40 years old) at some point in last 12 months, some indicated that they had not received either procedure in the past year.

During past CA visits, most women inmates reported that the number of sanitary napkins and rolls of toilet paper they received each month was not sufficient for their needs. Many women reported that if they needed more sanitary napkins or toilet paper, they had to request it from their housing officer, often an uncomfortable and humiliating situation, particularly if the officer was male. On a positive note, after working with DOCS recently-created Women's Task Force on this issue, the CA has received reports since these initial visits that the situation has improved at certain facilities. Unfortunately, more work needs to be done, as the CA continues to receive reports that women in certain facilities continue to encounter difficulty accessing adequate supplies.

Women consistently identified food and nutrition as areas of concern. They explained that meals were disproportionately composed of starches and fats and described the food as "disgusting" and "bland." Many women explained that prison food had led to skin problems, deteriorating nail quality and general feelings of depression. Some women noted that the prison diet, combined with limited opportunities for exercise, made it difficult for them to stay fit and maintain proper body weight.

Women also reported that certain medical providers, especially sick call nurses, sometimes refused to take seriously certain women-specific health issues and minimized problems like menstrual and menopausal symptoms as not "real enough" to warrant consideration and treatment. Women noted that some medical providers seemed predisposed to believing that female inmates complain merely to get attention or medication.

In March 2000, DOCS issued a 12-page document entitled *Female Health Appraisal Primary Care Guidelines*. This document seems to be the Department's main tool for instructing medical

staff about its standards for providing women-specific health care. Though it is a positive sign that DOCS maintains this document, the practice guidelines do not seem comprehensive and contain information from sources that are a decade old.

Additionally, the CA is not aware of: (1) any specific quality improvement mechanism used by DOCS to conduct consistent and comprehensive assessments of its women's health care services or (2) any women-centered healthcare training that DOCS requires its doctors to undergo.

Training providers in concepts of women-centered healthcare would significantly enhance DOCS's ability to ensure that providers are communicating with, assessing and treating the female patients in its custody in the most effective way possible. Without such training and perspective, a provider may:

- inadvertently traumatize female patients who have histories of abuse or trauma, or depression and/or other mental health issues (e.g., by conducting a physical exam without sufficient warning or explanation);
- dismiss health concerns specific to female patients, such as symptoms related to menstruation and menopause;
- misdiagnose female patients or fail to diagnose patients as early as possible because of illness symptoms unique to women;
- fail to effectively empower female patients to comply with treatment plans and to be active participants in their own health, especially women with low self-esteem, who may not believe that they are "worthy" or deserving of good treatment; and
- miss the opportunity to refer patients to other supportive services (e.g., domestic violence counseling, mental health services, support groups, and parenting and family services) that promote well-being and may help patients make positive choices about their health and that of their children and families after release.

DOCS could improve its health services for women by requiring medical providers to adopt a women-centered approach and integrate into their practice an understanding of women's specific health needs and symptoms, the complex circumstances of incarcerated women's lives, and the varied ways in which those circumstances affect female patients' health, behavior and communication style.

EXTERNAL OVERSIGHT OF PRISON HEALTHCARE

DOCS spends approximately \$324 million on prison healthcare annually for more than 62,000 inmates in its custody. It is providing HIV care to the largest population of HIV-infected patients in the state and the largest HIV prison population in the country. With more than 1,900 DOCS medical personnel, 45 prison infirmaries, five Regional Medical Units and tens of thousands of specialty care consultations per year, the prison healthcare system is extremely complex and cumbersome. Such a dispersed system must be externally monitored to ensure that its many parts are functioning adequately and efficiently. Such independent oversight currently does not occur.

The New York State Department of Health has had very limited involvement in the provision of healthcare to state inmates. Specifically, DOH does not exercise any general oversight function

concerning care at prison clinics, infirmaries or Regional Medical Units. An exception is the efforts by administrators at the DOH AIDS Institute (AI) who hold periodic meetings with DHS administrators and assist DOCS in developing and implementing AI's HIV Quality of Care Program (HIVQUAL) throughout the system. After nearly ten years of planning, the program was finally implemented at all prisons in 2006 as part of the resolution of litigation about HIV care. However, external oversight of HIV care or other medical care in the prisons by DOH, or any other outside agency, is nonexistent.

The State Commission of Correction (SCOC) is authorized to monitor prison operations, including healthcare, and performs reviews of all inmate deaths occurring in DOCS custody. This oversight appears minimal, however, and in the last several years, the death reviews of inmates who have died of natural causes have been mostly pro forma. The SCOC budget is insufficient to support a rigorous review of DOCS medical practices. The agency lacks the resources and expertise to undertake external oversight of the prison medical care system, and it does not perform any regular monitoring of healthcare practices at the prisons.

The CA has statutory authority to visit the prisons and report to state officials concerning its observations and recommendations. For external oversight to be effective, it is crucial that the reviewed agency actively participate in the review process and in developing and implementing a corrective plan. Recently, the CA has had constructive exchanges with the new DOCS administration about prison issues, and the CA expects to have a lively and positive dialogue with DOCS and DOH officials about the CA's concerns regarding prison healthcare.

DOH is best suited to perform external monitoring of DOCS healthcare system. With additional resources allocated in the state budget, DOH could regularly visit each prison, review system-wide data on the important components of the medical care system, inspect sample medical records of patients with specific conditions and speak with inmates and staff about their concerns about the healthcare system.

RECOMMENDATIONS

1. ENHANCE DOCS MEDICAL STAFF

A. Fill Vacant Medical Positions Expeditiously - State policymakers must take action to ensure that authorized DOCS medical positions are promptly filled. This step will require increased compensation for certain job titles (e.g., pharmacists, physician assistants and nurses) and/or geographical pay increases in parts of the state where it is difficult to recruit competent personnel. Prison administrators should more aggressively recruit staff, and DOCS's Division of Health Services (DHS) should assist prisons in identifying qualified applicants and should better supervise local efforts to hire replacement personnel.

B. Assess Medical Staff Needs and Add Staff to Prisons with the Most Serious Deficiencies - Even if all medical positions were filled, some prisons need additional positions. DOCS should perform a detailed staffing analysis, and, once this needs assessment is completed, the state should approve funding to permit DOCS to add personnel at the prisons with the greatest need.

C. Enhance Reviews of Medical Staff Performance - Although DOCS performs limited reviews of the medical staff in accordance with the union contract with medical staff, some providers appear to have minimal qualifications and poor performance records. DOCS should more closely monitor the job performance of medical personnel and require that staff identified as needing improvement participate in mandatory training.

D. Augment Training of Medical Staff - Although some DOCS medical providers are highly qualified and skilled practitioners, others could benefit from more rigorous training and updated education on medical conditions and DOCS medical protocols. Training of nurses and clinic providers should include instruction on how to be receptive and respectful to patients during all medical encounters. DHS should more closely monitor the continuing education of providers and facilitate greater participation in training by providing monetary support, approved absences for training and other incentives to enhance the skills of prison medical staff.

2. IMPROVE ROUTINE CARE WITHIN THE PRISONS

A. Enhance Sick Call Services - As part of DOCS's Quality Improvement (QI) program, prison health administrators and DHS QI personnel should routinely assess the quality of the sick call process at all DOCS facilities. This assessment should include a determination of the: adequacy of the staff assigned to sick call, timeliness of sick call services, quality of interactions between the sick call nurses and patients, and degree to which timely follow-up occurs in response to sick call examinations.

B. Ensure that Inmates Have Timely Access to Clinic Providers and Adequate Care During Clinic Call-outs - As part of DOCS's Quality Improvement program, prison health administrators and DHS QI staff should routinely assess each prison to determine whether adequate personnel is assigned to clinic call-outs and to evaluate the adequacy of clinic encounters. At prisons where it is determined that inmates do not have timely access to providers for routine care, the Department should assign additional personnel. At prisons where it is determined that clinic examinations and treatment are deficient, the Department should implement a corrective plan, including staff training and close monitoring, to improve these medical services.

3. IMPROVE CARE OF THE CHRONICALLY ILL

A. Assign Every Chronically Ill Inmate to a Regular Primary Care Provider - DOCS should assign each inmate with a chronic disease to a specific provider at the prison where the inmate is confined. Thereafter, that provider should be responsible for regularly monitoring the patient and overseeing all medical care to ensure the timely and appropriate provision of treatment.

B. Develop a Chronic Care System that includes a Chronic Care Coordinator and a Computer-based System to Schedule and Monitor Chronic Care - The complicated nature of caring for patients with chronic illnesses requires a system to organize the many aspects of effective healthcare. The system should facilitate the coordination of laboratory tests, diagnostic procedures, specialty care consultations and medical treatments. It should also include a chronic care coordinator who is assigned to performing these functions. This coordinator should be

responsible for communicating with relevant medical staff and with the patient about how to optimize care by improving patient adherence to treatment and minimizing delays in care and adverse side effects of treatment. To assist the chronic care coordinator, the prisons should have a computer-based scheduling system and other computerized records to manage patient care. Finally, DHS should continue to issue clinical practice guidelines for medical conditions frequently experienced by inmates, as recommended by the National Commission on Correctional Health Care for epilepsy and high blood cholesterol, as well as for respiratory and digestive diseases.

C. Enhance Efforts to Identify Inmates Infected with HIV and Ensure that Identified Patients are Provided Care Comparable to Community Standards for HIV Treatment -

DOCS should augment its efforts to identify a greater percentage of the HIV-infected inmate population at the time inmates are admitted to prison and throughout their incarceration, by enhancing the HIV education, counseling and testing services provided by the DOH AIDS Institute's Criminal Justice Initiative and HIV testing and counseling performed by DOCS and Department of Health personnel. Peer education should be an essential component of this outreach process. The Department should investigate why there are significant variations in the percentages of known HIV-infected inmates at different prisons and enhance efforts at problematic prisons to identify more inmates with HIV. Medical staff at each prison should ensure that identified HIV-infected inmates are periodically evaluated by an HIV specialist based upon their health status and that such specialists are consulted when it is determined that a patient is failing on his/her current medication regimen. The Department should investigate prisons with low usage of IFD specialists to ensure that all HIV-infected inmates have prompt access to a specialist when needed. To evaluate the quality of HIV care, DOCS's Continuous Quality Improvement Committee should more closely scrutinize the results from the HIV Continuous Quality Improvement audits to ensure that each prison is adhering to DOCS's HIV Practice Guidelines. In particular, officials should pay close attention to whether there is prompt access to HIV experts and appropriate follow-up to their recommendations.

D. Enhance Efforts to Identify Inmates Infected with Hepatitis C and Ensure that HCV-infected Inmates Receive Timely Care Comparable to Community Standards for HCV Treatment -

DOCS must enhance its efforts to identify inmates infected with HCV at the time they are admitted to the prison system and throughout their incarceration. All newly admitted inmates should be screened for HCV. DOCS should also eliminate delays in testing inmates for HCV and determining whether they are appropriate candidates for treatment. The Department should investigate variations among the prisons in the percentage of HCV-infected inmates, in the percentage of HCV-infected inmates diagnosed as chronically infected, in the use of gastroenterology and liver biopsy services and in the number of HCV-infected patients being treated. Prisons found to be lax in their efforts to evaluate inmates for this disease or to evaluate and treat patients with liver damage should have to implement a remedial plan to address care deficiencies. DHS should continue to maintain records of the number of patients receiving HCV therapy and monitor their response to such treatment to assess whether HCV therapy has been successful in the prison setting. DOCS Continuous Quality Improvement Committee should more vigorously monitor the results of the HCV audit process to ensure that each prison aggressively pursues identification of its HCV-infected population and treatment of those patients who would benefit from therapy.

E. Increase Funding for the DOH AIDS Institute's Criminal Justice Initiative to Enhance its HIV Prevention Activities - The Criminal Justice Initiative (CJI) has provided essential services to the HIV-infected inmate population. The state should provide additional funds so that the CJI can offer all the HIV prevention services needed at each prison, particularly peer training, support services and comprehensive transitional services for all HIV-infected inmates being discharged. DOCS and DOH should coordinate efforts so HIV peer educators trained by the CJI contractors can engage more fully in patient education and efforts to encourage the prison population to get tested and enter treatment.

4. ENHANCE ACCESS TO SPECIALTY CARE SERVICES

A. Ensure Timely Access to Specialists - DHS and prison medical administrators should more closely monitor the timeliness of specialty care services to ensure that inmates are seen in accordance with the priorities established for the medical consultation by the prison provider. In addition, the Facility Health Services Director (FHSD) should regularly review medical charts to determine whether providers are referring patients to specialists when their conditions warrant. The Department should investigate the significant variations among prisons in their use of specialty services and require a remediation plan at any prison found to be underutilizing specialty services. The Department should evaluate the effectiveness of the recently implemented Quality Assessment tools being used by the prisons to monitor specialty care. DHS's Continuous Quality Improvement Committee should closely monitor prisons' utilization of specialty services to ensure that all inmates have timely access to specialists when needed.

B. Monitor Prison Provider Follow-up to Specialists' Recommendations to Ensure Appropriate Treatment - Inmates frequently complain that prison providers are not promptly acting on recommendations of specialists for additional evaluation, treatment and follow-up services. DHS and prison medical administrators should evaluate whether the recently implemented Quality Assurance tools developed to monitor specialty care are effective in routinely assessing whether the prison providers are following up promptly on specialists' recommendations. In addition, DHS and prison medical staff should utilize the specialty care computer system to evaluate whether appropriate follow-up care is occurring as requested by specialists. Prisons identified as failing to provide timely follow-up on specialists' recommendations should be required to implement a remediation plan monitored by DHS officials.

5. IMPROVE PHARMACY SERVICES

A. Increase Pharmacist Salaries and Expediently Fill Vacant Pharmacy Positions - To fill the many pharmacy vacancies and to open closed prison pharmacies, the state will need to authorize increased salaries for prison pharmacists. Once appropriate salary levels are approved, DOCS and prison administrators should enhance their efforts to fill vacant pharmacy positions.

B. Expedite Implementation of the Computerized Pharmacy Program - DHS should expedite the implementation of the new computer system for pharmacy services. The system should be utilized to prevent medication shortages at prisons and the prescription of inappropriate therapies. Once the system is fully operational, DHS should use it to monitor

medical treatment adherence by inmates with chronic conditions. Finally, DHS should employ the computer system in other quality assurance tasks, such as evaluating the effectiveness of therapies used to treat various chronic conditions and identifying individuals for chart review to aid in this process.

C. Expedite Efforts to Replace Contract Pharmacy Services with DOCS Supplied

Medications - DOCS should accelerate its efforts to develop the capability of its Central Pharmacy to directly dispense medications to individual inmates at prisons that currently do not have a pharmacy. This step would represent a welcome advancement toward discontinuing the costly use of contract pharmacy services. In addition, DOCS should enhance efforts to recruit pharmacists to prisons that have closed their pharmacy, so that more prisons will be able to have a pharmacy in their medical unit.

6. ENHANCE DOCS'S QUALITY IMPROVEMENT PROGRAM

A. Ensure that All Prisons Have an Active Prison-Based Quality Improvement Program -

DHS and prison administrators should ensure that each prison is fully implementing DOCS's policy concerning prison-based QI activities, including quarterly QI meetings. These activities should include regular performance of random chart reviews of the care provided to inmates infected with chronic diseases, as well as assessing the routine care processes (e.g., sick call, physicals, call-outs and specialty care services) utilizing the instruments contained in DOCS's Quality Assessment Tools Manual. The prison QI team should develop written action plans to address identified deficiencies and communicate this information to the Regional Medical Directors (RMDs) and DHS CQI Committee. The implementation of these plans should be closely monitored by the RMDs, the Regional Health Services Administrators (RHSDs) and the DHS CQI Committee.

B. Conduct Regular Meetings in Each Prison with Medical Personnel, Prison Executive Staff, the Inmate Liaison Committee and Inmate Grievance Representatives to Discuss Prison Healthcare

– Each prison should conduct routine meetings with the Inmate Liaison Committee, Inmate Grievance Representatives, prison medical staff and the prison executive staff to discuss inmate concerns about prison medical care. These meetings should be used to assess inmates' satisfaction with the medical care, to identify recurrent medical problems and to communicate with inmates about updated medical procedures and policies.

C. Increase DHS' Quality Improvement Committee Activities - The DHS CQI Committee should review the medical services at each prison at least once per year through audits conducted by prison medical staff and the DOCS senior utilization review nurses with the instruments developed as part of DOCS CQI policies, including those contained in DOCS's Quality Assessment Tools Manual. The DHS CQI Committee should specify how frequently each quality assessment tool should be used at the prisons as part of their QI efforts. The DHS CQI Committee should issue written instructions for development of a remediation plan and follow-up monitoring at each prison where deficiencies are noted. The DHS CQI Program should set a more rigorous threshold for noncompliance than is currently applied. Prisons where a QI audit reveals that the care in more than 10% or 20% of the medical charts is inconsistent with an audit indicator should have to develop a remedial plan. The prisons' FHSD and Nurse Administrator

should develop these remedial plans, and the RMDs and RHSDs should monitor them. The DHS CQI Committee should develop additional assessment tools, including measures to assess the care for chronic diseases not already covered by DOCS's Clinical Practice Guidelines.

7. IMPROVE SERVICES FOR INMATES WITH LIMITED ENGLISH SKILLS

A. Implement Telephone Translation Services at Facilities that Do Not Already Have Them, and Direct Prisons to Utilize These Services When Bilingual Medical Staff Are Not Available for Exchanges with Patients with Limited English Skills - Medical staff should use translation services even if a patient has some English proficiency because understanding medical conditions, treatment recommendations and related information requires more sophisticated language skills than many inmates with poor English-speaking skills possess.

B. Provide Pay Differentials to Medical Staff Who are Bilingual and Actively Recruit Bilingual Medical Staff - Given that 8% or more of the inmate population has limited English proficiency, a greater percentage of the medical staff should be bilingual. In order to recruit such staff, the state should provide a pay differential to medical staff who perform translation duties. Such staff should also receive specific training in the proper translation of medical information.

C. Provide Medical Information for Inmates with Limited English Skills in Inmates' Native Languages - Healthcare staff at each prison should provide inmates with limited English skills access to medical documents (e.g., patient educational materials, medication instructions, discharge summaries from medical units containing patient instructions, medical refusal forms, etc.) in their native language. In this way, inmates can better understand their care, comply with their treatment protocols and alert the medical department if they experience adverse effects from their treatment.

8. IMPROVE CONTINUITY OF CARE FOR INMATES WITH MEDICAL PROBLEMS

A. Improve Continuity of Care for Inmates Transferred Among DOCS Prisons - DOCS should enhance the continuity of care for transferred inmates by ensuring that for each inmate with a medical problem or receiving medical treatment who is admitted to a prison, the medical department performs the following tasks: (1) the patient's medical chart is promptly reviewed; (2) the patient is assigned to a primary care provider; (3) the patient is promptly seen by that provider; and (4) there is no interruption in the patient's medications or care plan.

B. Provide Enhanced Discharge Planning Services for Inmates with Chronic Illnesses - DOCS should provide all inmates with a chronic illness who are about to be discharged from prison with appropriate documentation of their condition and treatment, along with an adequate supply of medications and prescriptions to continue treatment until care can be arranged in the community. In addition, corrections and parole staff should assist soon-to-be-released inmates in identifying a provider in the community to continue necessary care and in scheduling an appointment for care following release. This effort will require coordination among the prison medical department, transitional services and parole.

C. Undertake Efforts to Expedite Inmates' Enrollment in Health Insurance Upon Their Release - The vast majority of the 28,000 inmates being released each year must wait between six weeks and several months to qualify for medical benefits under programs such as Medicaid because no Medicaid application is filed or processed while they are incarcerated. DOCS, the Department of Health and the Division of Parole should implement the pilot program funded in the FY 2008-09 budget to ensure that inmates nearing release are enrolled in Medicaid. Following this pilot program, the governor and legislature should enact regulations and/or legislation to require that Medicaid applications be filed and processed for all eligible inmates prior to their release from custody so that they can access healthcare immediately upon returning to the community.

9. CONFIDENTIALITY IN MEDICAL ENCOUNTERS

A. Require Medical Services to be Provided in a Setting that Ensures Patient Confidentiality - Review medical procedures and the settings in which medical services are provided to ensure that conversations between patients and their providers are conducted in a confidential manner. In Special Housing Units, when confidential medical information will be discussed during a medical encounter, require medical staff to request that inmates are removed from their cells and taken to an area where confidential conversations can occur.

10. CARE FOR THE AGING INMATE POPULATION

A. Evaluate Medical Staffing, Training and Care Facilities to Determine if Adequate Resources are Available to Treat the Increasing Numbers of Aging Patients - Given the significant growth in the percentage of inmates 50 years and older and the resulting increase in illnesses experienced by these inmates, the Department should assess whether it has sufficient medical staff and physical resources to care for this population. In addition, DOCS should provide mandatory continuing medical education on conditions common to an older population.

B. Regularly Reassess the Demand within the DOCS Population for Care Similar to that Available in the Fishkill Unit for the Cognitively Impaired and Provide Sufficient Capacity to Meet the Need - The Fishkill Unit for the Cognitively Impaired, opened in 2006, is an important addition to DOCS's medical capacity. The Department should regularly reassess the need for these services throughout its inmate population to determine whether this Unit is adequate to meet the demand for such services.

11. INMATE DEATHS

A. Enhance the Department's Medical Training and Quality Improvement Activities for Conditions Likely to Result in Inmate Deaths - DOCS should perform a systemic analysis of the causes of inmate deaths. Once it has identified the most common causes, it should institute more intense medical training and a quality improvement program to enhance care provided for conditions (e.g., heart disease, cancer, liver disease, etc.) that are more likely to result in inmate mortalities.

B. Expand the Medical Parole Law to Include Inmates Who are so Physically or Cognitively Incapacitated that They No Longer Present Any Danger to Society - The state should enact legislation supported by DOCS to expand the Medical Parole Law, which currently permits the early release of dying inmates who are physically incapacitated and no longer present a danger to society, to include individuals whose condition may not be terminal, but who are so physically or cognitively incapacitated that they present no danger to society.

12. PATIENT EDUCATION AND ACCESS TO HEALTH MATERIALS

A. Enhance Patient Education during Medical Encounters - In order for patients to participate more effectively in their own care, it is essential that they be educated about their illness and treatment. DOCS should enhance its patient education efforts at all levels of care. For patients with chronic conditions, continuous patient involvement is crucial to successful treatment. All soon-to-be-released inmates also need education about how to access health services in the communities to which they will be returning.

B. Expand Health Materials Available to all DOCS Inmates in Prison Libraries - Building upon the successful introduction of a comprehensive health section in the women's libraries resulting from a CA initiative to provide these materials for all female institutions, DOCS should develop a comparable collection of health materials for all male facilities in the prisons' libraries.

13. IMPROVE SERVICES FOR INCARCERATED WOMEN

A. Require Medical Providers Working in Women's Facilities to be Trained in Concepts of Women-Centered Healthcare - DOCS medical providers should be trained to recognize and incorporate into treatment plans the complex and specific circumstances of the lives of incarcerated women, including issues of trauma, domestic violence and the physical and mental health implications of abuse. Such training would enhance the quality of care for women prisoners and reduce the likelihood that women-specific health issues such as yeast infections and menstrual cramps will be dismissed by providers as "not serious enough" to warrant attention and treatment.

B. Enhance Quality Improvement Activities Monitoring Women-specific Healthcare and Develop More Comprehensive Policies that Outline Standards for Women's Healthcare, Including Gynecological and Reproductive Healthcare - To ensure that women in state custody receive quality health services, DOCS should: (1) develop more comprehensive written policies that clearly outline women's healthcare standards; (2) require gynecologists to participate in DOCS's Division of Health Services and facility-based Quality Improvement Committees; (3) require Quality Improvement Committees to conduct consistent and comprehensive assessments of women-specific healthcare at each women's correctional facility; and (4) require Quality Improvement Committees to issue corrective action plans to improve women-specific healthcare when necessary and monitor the implementation of those plans.

C. Provide Women with an Adequate Supply of Hygiene Items and Proper Nutrition - DOCS should ensure that each woman in state custody has an adequate number of sanitary

napkins and rolls of toilet paper. DOCS should also review its cook-chill menu to ensure that it meets the particular nutritional requirements of women.

14. ENHANCE EXTERNAL OVERSIGHT OF PRISON HEALTHCARE BY DOH AND SCOC

A. Mandate Department of Health Oversight of Prison Healthcare - To improve prison healthcare, DOH oversight is necessary. The legislature should adopt several legislative measures, including bills like A.3787 (Gottfried) and A.3849 (Gottfried)/S.2819 (Duane), requiring DOH to monitor medical care in the prisons. Alternatively, the governor, without legislative mandate, could direct DOH to monitor prison healthcare, consistent with DOH's general duties under Article 28 of the Public Health Law. For the process to be effective, it is essential that DOH make public the results of its monitoring activities and include public input into the monitoring process. In performing this oversight, DOH should also examine carefully inmate mortalities to determine if measures can be taken to reduce the number of inmate deaths.

B. Revitalize Mortality Reviews by the State Commission of Correction (SCOC) - SCOC performs mortality reviews of all inmate deaths in New York's prisons and jails. However, in recent years, the reviews of deaths of state inmates due to illnesses have been less substantive. SCOC should conduct more rigorous, timely and comprehensive reviews of prison deaths and make public the findings of the SCOC mortality review committee.

EXHIBITS

NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES FACILITIES

EXHIBIT A

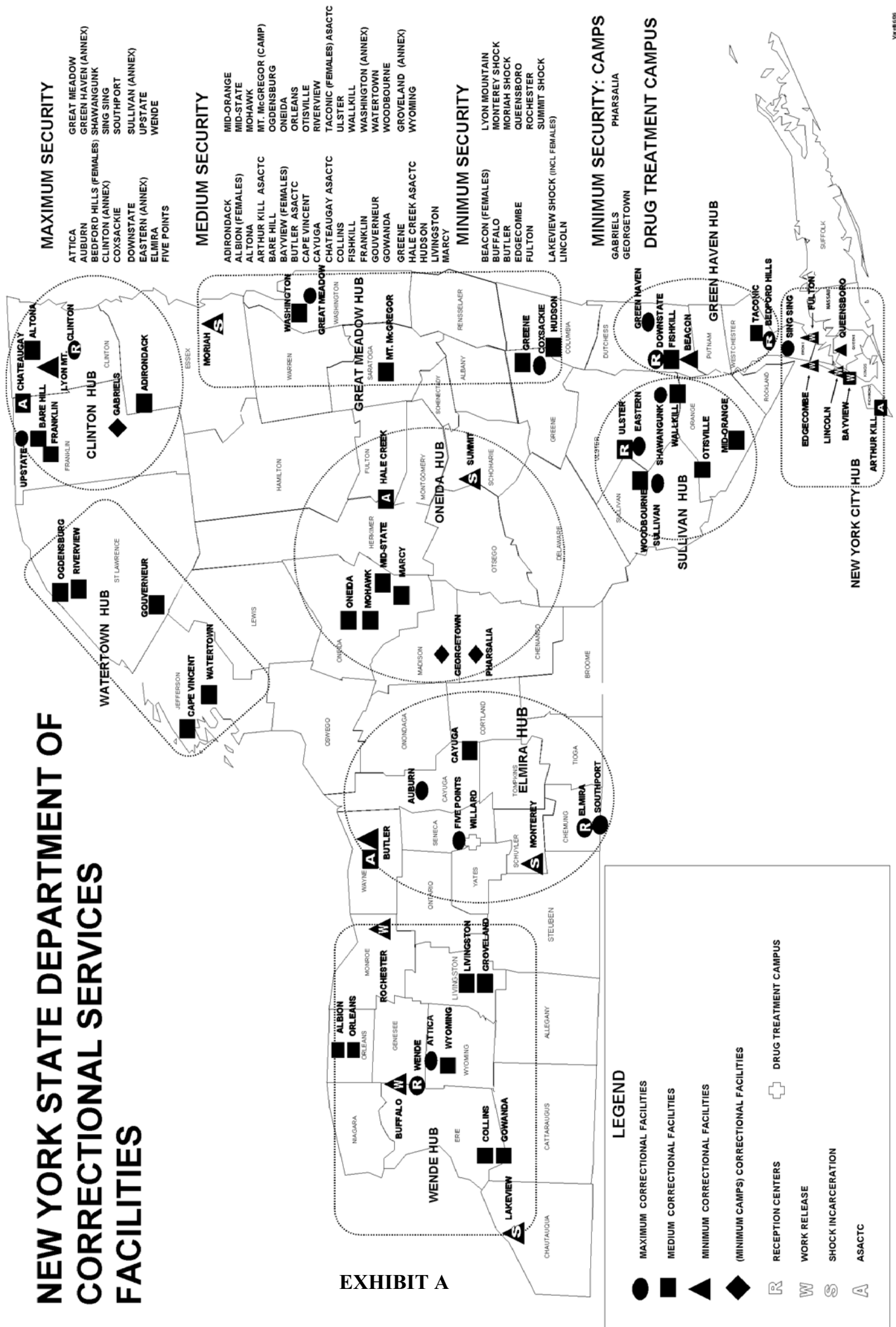


Exhibit B - 2004 and 2005 Medical Grievances at CA Visited Prisons - 2004-07

Prison	Pop 2006	Griev 2005	#/100	Dental 2005	Med #22	% Med 2005	#/100	HIPAA 2005	Pop 2005	Griev 2004	#/100	Dental 2004	Med #22	% Med 2004	#/100	HIPAA 2004
Albion	1,150	255	22.2	3	26	10.2%	2.3	0	1184	286	24.2	7	43	15.0%	3.6	0
Arthur Kill	947	1,053	111.2	2	253	24.0%	26.7	8	947	1051	111.0	7	141	13.4%	14.9	5
Attica	2,204	1,805	81.9	26	222	12.3%	10.1	6	2181	1860	85.3	38	236	12.7%	10.8	6
Auburn	1,767	2,364	133.8	14	355	15.0%	20.1	17	1765	2700	153.0	27	474	17.6%	26.9	17
Bedford Hills	808	438	54.2	1	63	14.4%	7.8	3	792	491	62.0	3	57	11.6%	7.2	2
Clinton	2,890	1,823	63.1	57	348	19.1%	12.0	13	2843	1115	39.2	26	244	21.9%	8.6	10
Coxsackie	978	883	90.3	13	103	11.7%	10.5	0	1033	699	67.7	8	79	11.3%	7.6	2
Eastern	1,175	895	76.2	3	118	13.2%	10.0	9	1168	674	57.7	0	118	17.5%	10.1	6
Elmira	1,779	1,913	107.5	73	355	18.6%	20.0	1	1782	1841	103.3	34	384	20.9%	21.5	2
Fishkill	1,718	1,448	84.3	46	241	16.6%	14.0	7	1719	1127	65.6	23	228	20.2%	13.3	22
Gowanda	1,743	956	54.8	7	60	6.3%	3.4	2	1746	1271	72.8	23	108	8.5%	6.2	5
Great Meadow	1,681	2,364	140.6	60	444	18.8%	26.4	13	1642	2130	129.7	33	509	23.9%	31.0	3
Green Haven	2,149	2,925	136.1	10	421	14.4%	19.6	2	2145	2397	111.7	3	295	12.3%	13.8	11
Mid-Orange	721	348	48.3	1	137	39.4%	19.0	3	727	499	68.6	6	133	26.7%	18.3	0
Oneida	1,191	416	34.9	7	42	10.1%	3.5	3	1199	307	25.6	3	45	14.7%	3.8	1
Sing Sing	1,737	1,275	73.4	12	205	16.1%	11.8	5	1744	1560	89.4	22	231	14.8%	13.2	9
Sullivan	746	592	79.4	11	94	15.9%	12.6	1	718	516	71.9	5	75	14.5%	10.4	0
Upstate	1,162	3,531	303.9	92	790	22.4%	68.0	20	1251	3830	306.2	97	858	22.4%	68.6	34
Wyoming	1,707	379	22.2	8	72	19.0%	4.2	0	1672	443	26.5	24	86	19.4%	5.1	0
Totals	28,253	25,663	90.8	446	4,349	15.4	113	113	28,258	24,797	87.8	389	4,344	15.4	15.4	135
Averages	1,351	1,351	23	229	229	6	6	6	1,305	1,305	20	229	229	7	7	7

Med # 22-Medical grievances code #22; % Med-% of medical grievances compared to all grievances; HIPAA-Grievances re confidentiality

EXHIBIT B

Exhibit C - CORC Appeals of Medical Grievances at CA Visited Prisons - 2004-07

Prison	Pop 2006	Griev 05	Med-22% Med	#/100	CORC*	#/100	Meds*	#/100	Spec*	#/100	Treatment*	#/100	
Albion	1,150	255	26	10.2%	2.3	63	5.48	8	0.70	12	1.04	24	2.09
Arthur Kill	947	1,053	253	24.0%	26.7	175	18.48	30	3.17	36	3.80	41	4.33
Attica	2,204	1,805	222	12.3%	10.1	293	13.29	48	2.18	23	1.04	73	3.31
Auburn	1,767	2,364	355	15.0%	20.1	501	28.35	82	4.64	41	2.32	119	6.73
Bedford Hills	808	438	63	14.4%	7.8	57	7.05	6	0.74	2	0.25	17	2.10
Clinton	2,890	1,823	348	19.1%	12.0	464	16.06	65	2.25	64	2.21	143	4.95
Coxsackie	978	883	103	11.7%	10.5	100	10.22	10	1.02	14	1.43	32	3.27
Eastern	1,175	895	118	13.2%	10.0	167	14.21	31	2.64	23	1.96	36	3.06
Elmira	1,779	1,913	355	18.6%	20.0	448	25.18	61	3.43	78	4.38	118	6.63
Fishkill	1,718	1,448	241	16.6%	14.0	354	20.61	59	3.43	53	3.08	110	6.40
Gowanda	1,743	956	60	6.3%	3.4	74	4.25	14	0.80	14	0.80	14	0.80
Great Meadow	1,681	2,364	444	18.8%	26.4	450	26.77	74	4.40	57	3.39	136	8.09
Green Haven	2,149	2,925	421	14.4%	19.6	472	21.96	55	2.56	59	2.75	127	5.91
Mid-Orange	721	348	137	39.4%	19.0	171	23.72	18	2.50	41	5.69	28	3.88
Oneida	1,191	416	42	10.1%	3.5	81	6.80	8	0.67	19	1.60	20	1.68
Sing Sing	1,737	1,275	205	16.1%	11.8	227	13.07	30	1.73	28	1.61	81	4.66
Sullivan	746	592	94	15.9%	12.6	149	19.97	23	3.08	33	4.42	25	3.35
Upstate	1,162	3,531	790	22.4%	68.0	1,270	109.29	264	22.72	123	10.59	377	32.44
Wyoming	1,707	379	72	19.0%	4.2	131	7.67	24	1.41	28	1.64	43	2.52
Totals	28,253	25,663	4,349			5,647		910		748		1,564	
Averages	1,351	1,351	229		15.4	297	20.0	48	3.2	39	2.6	82	5.5

** - Data refers to CORC appeals for the period January 2003 through May 2006. "Meds" refers to only such appeals concerning medications or prescriptions. "Spec" refers only to appeals about specialty care services. "Treatment" refers to appeals about general claims of inadequate care or treatment.*

Exhibit D-DOCS Male HIV Rates and Infectious Disease Access-FY 2006-07

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Class</i>	<i>Hub Security</i>	<i>HIV Spec</i>	<i>Tot # Spec Apt</i>	<i>Totl Spec Rate</i>	<i># of IFD Apts</i>	<i>IFD Rate</i>	<i>HIV+ Pts</i>	<i>Rate HIV+</i>	<i>IFD per HIV+</i>
Georgetown	151	3	1 Minimum	1	144	95.36	1	0.66			
Hale Creek	390	3	1 Medium	1	242	62.05	3	0.77	11	2.82%	0.27
Marcy	1,255	1	1 Medium		1,312	104.54	9	0.72	29	2.31%	0.31
Mid-State	1,503	1	1 Medium	1	2,233	148.57	2	0.13	68	4.52%	0.03
Mohawk	1,297	2	1 Medium		2,549	196.53	10	0.77	28	2.16%	0.36
Oneida	1,191	1	1 Medium	2	2,193	184.13	64	5.37	30	2.52%	2.13
Pharsalia	141	3	1 Minimum		178	126.24	0	0.00	1	0.71%	0.00
Summit	173	3	1 Minimum		116	67.05	0	0.00	1	0.58%	0.00
Walsh Medical	111	1	1 Maximum		2,121	1910.81	100	90.09	17	15.32%	5.88
Hub 1 Totals	6,212				11,088	178.49	189	3.04	185	2.98%	1.02
Cape Vincent	866	1	2 Medium		884	102.08	0	0.00	25	2.89%	0.00
Gouverneur	1,021	1	2 Medium		1,160	113.61	10	0.98	29	2.84%	0.34
Ogdensburg	605	1	2 Medium		644	106.45	3	0.50	27	4.46%	0.11
Riverview	876	1	2 Medium	1	940	107.31	4	0.46	21	2.40%	0.19
Watertown	637	1	2 Medium		980	153.85	14	2.20	20	3.14%	0.70
Hub 2 Totals	4,005				4,608	115.06	31	0.77	122	3.05%	0.25
Adirondack	552	1	3 Medium		1,167	211.41	79	14.31	16	2.90%	4.94
Altona	477	1	3 Medium	1	904	189.52	39	8.18	14	2.94%	2.79
Bare Hill	1,720	1	3 Medium		2,106	122.44	145	8.43	55	3.20%	2.64
Chateaugay	219	3	3 Medium		442	201.83	3	1.37	1	0.46%	3.00
Clinton	2,890	1	3 Maximum		5,308	183.67	262	9.07	60	2.08%	4.37

Exhibit D-DOCS Male HIV Rates and Infectious Disease Access-FY 2006-07

<i>Prison</i>	<i>Pop</i> <i>2006</i>	<i>Med</i> <i>Class</i>	<i>Hub</i> <i>Security</i>	<i>HIV</i> <i>Spec</i>	<i>Tot #</i> <i>Spec Apt</i>	<i>Totl Spec</i> <i>Rate</i>	<i># of IFD</i> <i>Apts</i>	<i>IFD</i> <i>Rate</i>	<i>HIV+</i> <i>Pts</i>	<i>Rate</i> <i>HIV+</i>	<i>IFD per</i> <i>HIV+</i>
Clinton Annex	1	3	Medium		957	76					
Franklin	1,712	1	3	Medium	3,646	212.97	94	5.49	61	3.56%	1.54
Gabriel	165	3	3	Minimum	293	177.58	5	3.03	5	3.03%	1.00
Lyon Mountain	135	3	3	Minimum	230	170.37	16	11.85	6	4.44%	2.67
Upstate	1,162	1	3	Maximum	2,533	217.99	94	8.09	28	2.41%	3.36
<i>Hub 3 Totals</i>	<i>9,032</i>				<i>17,586</i>	<i>194.71</i>	<i>813</i>	<i>9.00</i>	<i>246</i>	<i>2.72%</i>	<i>3.30</i>
Eastern	1,175	1	4	Maximum	3,203	272.60	80	6.81	19	1.62%	4.21
Mid-Orange	721	1	4	Medium	2,409	334.12	107	14.84	21	2.91%	5.10
Otisville	602	1	4	Medium	1,062	176.41	14	2.33	8	1.33%	1.75
Shawangunk	539	1	4	Maximum	1,764	327.27	52	9.65	14	2.60%	3.71
Sullivan	746	1	4	Maximum	1,992	267.02	63	8.45	26	3.49%	2.42
Ulster	746	1	4	Medium	101	13.54	0	0.00	17	2.28%	0.00
Wallkill	599	2	4	Medium	763	127.38	48	8.01	13	2.17%	3.69
Woodbourne	793	1	4	Medium	2,574	324.59	85	10.72	21	2.65%	4.05
<i>Hub 4 Totals</i>	<i>5,921</i>				<i>13,868</i>	<i>234.22</i>	<i>449</i>	<i>7.58</i>	<i>139</i>	<i>2.35%</i>	<i>3.23</i>
Downstate	1,229	1	5	Maximum	1,668	135.72	33	2.69	31	2.52%	1.06
Fishkill	1,689	1	5	Medium	6,918	409.59	635	37.60	42	2.49%	15.12
Fishkill RMU	29	1	5	Maximum	864	2979.31	38	131.03			
Green Haven	2,149	1	5	Maximum	7,655	356.21	692	32.20	61	2.84%	11.34
<i>Hub 5 Totals</i>	<i>5,096</i>				<i>17,105</i>	<i>335.66</i>	<i>1,398</i>	<i>27.43</i>	<i>134</i>	<i>2.63%</i>	<i>10.43</i>
Camp Mt. McGregg	128	3	6	Minimum	4	3.13	1	0.78			

Exhibit D-DOCS Male HIV Rates and Infectious Disease Access-FY 2006-07

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Class</i>	<i>Hub Security</i>	<i>HIV Spec</i>	<i>Tot# Spec Apt</i>	<i>Totl Spec Rate</i>	<i># of IFD Apts</i>	<i>IFD Rate</i>	<i>HIV+ Pts</i>	<i>Rate HIV+</i>	<i>IFD per HIV+</i>
Coxsackie	978	1	6 Maximum	1	2,355	240.80	108	11.04	25	2.56%	4.32
Coxsackie RMU	56	1	6 Maximum		1,555	2776.79	64	114.29			
Great Meadow	1,681	1	6 Maximum		1,801	107.14	45	2.68	48	2.86%	0.94
Greene	1,756	1	6 Medium		1,999	113.84	106	6.04	33	1.88%	3.21
Hudson	506	2	6 Medium	1	688	135.97	50	9.88	13	2.57%	3.85
Moriah	200	3	6 Minimum		146	73.00	4	2.00			
Mt. McGregor	526	1	6 Medium	1	736	139.92	26	4.94	20	3.80%	1.30
Washington	1,037	1	6 Medium		1,381	133.17	101	9.74	20	1.93%	5.05
Hub 6 Totals	6,868				10,665	155.29	505	7.35	159	2.32%	3.18
Attica	2,204	1	7 Maximum		4,264	193.47	131	5.94	64	2.90%	2.05
Buffalo	109	2	7 Minimum		5	4.59	0	0.00			
Collins	1,165	1	7 Medium		1,274	109.36	46	3.95	25	2.15%	1.84
Gowanda	1,743	2	7 Medium		2,551	146.36	19	1.09	18	1.03%	1.06
Groveland	1,222	1	7 Medium		2,926	239.44	36	2.95	30	2.45%	1.20
Lakeview (male)	1,005	1	7 Minimum		591	58.81	17	1.69	9	0.90%	1.89
Livingston	871	1	7 Medium		1,430	164.18	19	2.18	13	1.49%	1.46
Orleans	996	1	7 Medium		2,610	262.05	71	7.13	27	2.71%	2.63
Rochester	51	3	7 Minimum						0	0.00%	
Wende	940	1	7 Maximum	1	5,444	579.15	72	7.66	25	2.66%	2.88
Wyoming	1,707	1	7 Medium		2,202	129.00	22	1.29	29	1.70%	0.76
Hub 7 Totals	12,013				23,297	193.93	433	3.60	240	2.00%	1.80

Exhibit D-DOCS Male HIV Rates and Infectious Disease Access-FY 2006-07

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Class</i>	<i>Hub Security</i>	<i>HIV Spec</i>	<i>Tot # Spec Apt</i>	<i>Totl Spec Rate</i>	<i># of IFD Apts</i>	<i>IFD Rate</i>	<i>HIV+ Pts</i>	<i>Rate HIV+</i>	<i>IFD per HIV+</i>
Auburn	1,767	1	8 Maximum		2,628	148.73	127	7.19	56	3.17%	2.27
Butler	172	3	8 Minimum		147	85.47	0	0.00	4	2.33%	0.00
Butler ASACTC	183	3	8 Medium		63	34.43	0	0.00			
Cayuga	1,016	1	8 Medium	1	1,830	180.12	49	4.82	23	2.26%	2.13
Elmira	1,779	1	8 Maximum		2,596	145.92	19	1.07	31	1.74%	0.61
Five Points	1,367	1	8 Maximum		3,203	234.31	4	0.29	25	1.83%	0.16
Monterey	177	3	8 Minimum		118	66.67	0	0.00	1	0.56%	0.00
Southport	813	1	8 Maximum		1,630	200.49	20	2.46	32	3.94%	0.63
Hub 8 Totals	7,274				12,215	167.93	219	3.01	172	2.36%	1.27
Arthur Kill	947	1	9 Medium		2,490	262.94	73	7.71	28	2.96%	2.61
Edgecombe	186	3	9 Minimum						2	1.08%	
Fulton	94	3	9 Minimum						3	3.19%	
Lincoln	151	3	9 Minimum						2	1.32%	
Queensboro	394	3	9 Minimum		142	36.04	8	2.03	16	4.06%	0.50
Sing Sing	1,737	1	9 Maximum		4,080	234.89	463	26.66	55	3.17%	8.42
Hub 9 Totals	3,509				6,712	191.28	544	15.50	106	3.02%	5.13
Willard DTC (male)	867	1	99 Medium	1	469	54.09	1	0.12	11	1.27%	0.09
Hub 99 Totals	867				469	54.09	1	0.12	11	1.27%	0.09
Department Totals	60,797				117,613	193.45	4,582	7.54	1,514	2.49%	3.03

IFD Rate - Rate of IFD Apts per total prison population

Exhibit E - DOCS Male Hepatitis C Rates and HCV Care by Hub - FY 2006-07

Prison	Pop	Med	Hub Secur-	GI	Rate	Liver	Rate	HCV+	HCV+	HCV	HCV	% Tx/	% Tx/	GI per	Liv Bx/		
2006 Class	2006 Class	ity	Care	GI	Biopsy	Liv Bx	Pis	%	Dis	HCV	Dis %	Tx	HCV+	Pop	HCV+	HCV+	
Georgetown	151	3	1	Min	2	1.32	0	0.00	15	9.93%	3	20.00%	0	0.00%	0.00%	0.13	0.00
Hale Creek	390	3	1	Med	7	1.79	4	1.03	39	10.00%	23	58.97%	1	2.56%	0.26%	0.18	0.10
Marcy	1,255	1	1	Med	39	3.11	33	2.63	127	10.12%	39	30.71%	12	9.45%	0.96%	0.31	0.26
Mid-State	1,503	1	1	Med	25	1.66	36	2.40	212	14.11%	94	44.34%	16	7.55%	1.06%	0.12	0.17
Mohawk	1,297	2	1	Med	20	1.54	41	3.16	136	10.49%	65	47.79%	5	3.68%	0.39%	0.15	0.30
Oneida	1,191	1	1	Med	52	4.37	21	1.76	96	8.06%	41	42.71%	3	3.13%	0.25%	0.54	0.22
Pharsalia	141	3	1	Min	5	3.55	0	0.00	11	7.80%	4	36.36%	0	0.00%	0.00%	0.45	0.00
Summit	173	3	1	Min	0	0.00	0	0.00	5	2.89%	5	100.00%	0	0.00%	0.00%	0.00	0.00
Walsh Medical	111	1	1	Max	49	44.14	3	2.70	25	22.52%	13	52.00%	1	4.00%	0.90%	1.96	0.12
Hub 1 Totals	6,212				199	3.20	138	2.22	666	10.72%	287	43.09%	38	5.71%	0.61%	0.30	0.21
Cape Vincent	866	1	2	Med	9	1.04	12	1.39	84	9.70%	19	22.62%	11	13.10%	1.27%	0.11	0.14
Gouverneur	1,021	1	2	Med	15	1.47	16	1.57	96	9.40%	34	35.42%	7	7.29%	0.69%	0.16	0.17
Ogdensburg	605	1	2	Med	2	0.33	16	2.64	77	12.73%	33	42.86%	5	6.49%	0.83%	0.03	0.21
Riverview	876	1	2	Med	11	1.26	14	1.60	78	8.90%	34	43.59%	9	11.54%	1.03%	0.14	0.18
Watertown	637	1	2	Med	16	2.51	6	0.94	60	9.42%	26	43.33%	0	0.00%	0.00%	0.27	0.10
Hub 2 Totals	4,005				53	1.32	64	1.60	395	9.86%	146	36.96%	32	8.10%	0.80%	0.13	0.16
Adirondack	552	1	3	Med	18	3.26	17	3.08	66	11.96%	9	13.64%	1	1.52%	0.18%	0.27	0.26
Altona	477	1	3	Med	43	9.01	16	3.35	57	11.95%	10	17.54%	1	1.75%	0.21%	0.75	0.28
Bare Hill	1,720	1	3	Med	28	1.63	8	0.47	177	10.29%	62	35.03%	3	1.69%	0.17%	0.16	0.05
Chateaugay	219	3	3	Med	7	3.20	18	8.22	29	13.24%	8	27.59%	0	0.00%	0.00%	0.24	0.62
Clinton	2,890	1	3	Max	257	8.89	38	1.31	231	7.99%	102	44.16%	6	2.60%	0.21%	1.11	0.16

Exhibit E - DOCS Male Hepatitis C Rates and HCV Care by Hub - FY 2006-07

Prison	Pop	Med	Hub Secur-	GI	Rate	Liver	Rate	HCV+	HCV+	HCV	HCV	% Tx/	% Tx/	GI per	Liv Bx/	
2006 Class			ity	Care	GI	Biopsy	Liv Bx	Pts	%	Dis	HCV	Tx	HCV+	Pop	HCV+	
Clinton Annex	1	3	Med	20	3											
Franklin	1,712	1	3	Med	65	3.80	0.47	184	10.75%	50	27.17%	7	3.80%	0.41%	0.35	0.04
Gabriel	165	3	3	Min	1	0.61	0.00	14	8.48%	5	35.71%	0	0.00%	0.00%	0.07	0.00
Lyon Mountain	135	3	3	Min	3	2.22	3.70	14	10.37%	7	50.00%	0	0.00%	0.00%	0.21	0.36
Upstate	1,162	1	3	Max	11	0.95	0.86	80	6.88%	30	37.50%	11	13.75%	0.95%	0.14	0.13
Hub 3 Totals	9,032			453	5.02	123	1.36	852	9.43%	283	33.22%	29	3.40%	0.32%	0.53	0.14
Eastern	1,175	1	4	Max	63	5.36	1.19	76	6.47%	31	40.79%	12	15.79%	1.02%	0.83	0.18
Mid-Orange	721	1	4	Med	48	6.66	1.53	68	9.43%	43	63.24%	8	11.76%	1.11%	0.71	0.16
Otisville	602	1	4	Med	39	6.48	0.66	58	9.63%	24	41.38%	2	3.45%	0.33%	0.67	0.07
Shawangunk	539	1	4	Max	80	14.84	1.30	50	9.28%	4	8.00%	0	0.00%	0.00%	1.60	0.14
Sullivan	746	1	4	Max	44	5.90	0.67	65	8.71%	38	58.46%	4	6.15%	0.54%	0.68	0.08
Ulster	746	1	4	Med	1	0.13	0.13	56	7.51%	22	39.29%	0	0.00%	0.00%	0.02	0.02
Wallkill	599	2	4	Med	59	9.85	0.83	54	9.02%	25	46.30%	1	1.85%	0.17%	1.09	0.09
Woodbourne	793	1	4	Med	39	4.92	0.88	98	12.36%	24	24.49%	7	7.14%	0.88%	0.40	0.07
Hub 4 Totals	5,921			373	6.30	54	0.91	525	8.87%	211	40.19%	34	6.48%	0.57%	0.71	0.10
Downstate	1,229	1	5	Max	17	1.38	0.16	82	6.67%	35	42.68%	1	1.22%	0.08%	0.21	0.02
Fishkill	1,718	1	5	Med	102	5.94	1.22	221	12.86%	95	42.99%	18	8.14%	1.05%	0.46	0.10
Fishkill RMU	29	1	5	Max	19	65.52	3.45									
Green Haven	2,149	1	5	Max	97	4.51	0.93	231	10.75%	113	48.92%	13	5.63%	0.60%	0.42	0.09
Hub 5 Totals	5,125			235	4.59	44	0.86	534	10.42%	243	45.51%	32	5.99%	0.62%	0.44	0.08
Camp Mt. McGreg	128	3	6	Min	2	1.56	4	3.13								

Exhibit E - DOCS Male Hepatitis C Rates and HCV Care by Hub - FY 2006-07

Prison	Pop	Med	Hub Secur-	GI	Rate	Liver	Rate	HCV+	HCV+	HCV	HCV	% Tx/	% Tx/	GI per	Liv Bx/		
2006 Class			ity	Care	GI	Biopsy	Liv Bx	Pis	%	Dis	Tx	HCV+	Pop	HCV+	HCV+		
Coxsackie	978	1	6	Max	151	15.44	10	1.02	87	8.90%	36	41.38%	2	2.30%	0.20%	1.74	0.11
Coxsackie RMU	56	1	6	Max	46	82.14	1	1.79									
Great Meadow	1,681	1	6	Max	77	4.58	6	0.36	148	8.80%	59	39.86%	5	3.38%	0.30%	0.52	0.04
Greene	1,756	1	6	Med	80	4.56	13	0.74	76	4.33%	34	44.74%	3	3.95%	0.17%	1.05	0.17
Hudson	506	2	6	Med	31	6.13	3	0.59	54	10.67%	19	35.19%	0	0.00%	0.00%	0.57	0.06
Moriah	200	3	6	Min	0	0.00	0	0.00	7	3.50%	5	71.43%	0	0.00%	0.00%	0.00	0.00
Mt. McGregor	526	1	6	Med	39	7.41	20	3.80	86	16.35%	33	38.37%	5	5.81%	0.95%	0.45	0.23
Washington	1,037	1	6	Med	45	4.34	12	1.16	75	7.23%	20	26.67%	3	4.00%	0.29%	0.60	0.16
Hub 6 Totals	6,868				471	6.86	69	1.00	533	7.76%	206	38.65%	18	3.38%	0.26%	0.88	0.13
Attica	2,204	1	7	Max	39	1.77	25	1.13	193	8.76%	68	35.23%	9	4.66%	0.41%	0.20	0.13
Buffalo	109	2	7	Min	0	0.00	0	0.00	5	4.59%	5	100.00%	1	20.00%	0.92%	0.00	0.00
Collins	1,165	1	7	Med	31	2.66	21	1.80	112	9.61%	37	33.04%	4	3.57%	0.34%	0.28	0.19
Gowanda	1,743	2	7	Med	22	1.26	23	1.32	115	6.60%	64	55.65%	3	2.61%	0.17%	0.19	0.20
Groveland	1,222	1	7	Med	98	8.02	51	4.17	147	12.03%	64	43.54%	1	0.68%	0.08%	0.67	0.35
Lakeview (male)	1,005	1	7	Min	3	0.30	10	1.00	30	2.99%	10	33.33%	1	3.33%	0.10%	0.10	0.33
Livingston	871	1	7	Med	57	6.54	24	2.76	77	8.84%	28	36.36%	7	9.09%	0.80%	0.74	0.31
Orleans	996	1	7	Med	65	6.53	34	3.41	73	7.33%	41	56.16%	4	5.48%	0.40%	0.89	0.47
Rochester	51	3	7	Min					2	3.92%	2	100.00%	0	0.00%	0.00%		
Wende	940	1	7	Max	69	7.34	20	2.13	91	9.68%	33	36.26%	2	2.20%	0.21%	0.76	0.22
Wyoming	1,707	1	7	Med	87	5.10	38	2.23	104	6.09%	86	82.69%	5	4.81%	0.29%	0.84	0.37
Hub 7 Totals	12,013				471	3.92	246	2.05	949	7.90%	438	46.15%	37	3.90%	0.31%	0.50	0.26

Exhibit E - DOCS Male Hepatitis C Rates and HCV Care by Hub - FY 2006-07

Prison	Pop	Med	Hub Secur-	GI	Rate	Liver	Rate	HCV+	HCV+	HCV	HCV	% Tx/	% Tx/	GI per	Liv Bx/			
2006 Class	1,767	1	8	Max	81	4.58	20	1.13	152	8.60%	63	41.45%	7	4.61%	0.40%	0.53	0.13	
	172	3	8	Min	2	1.16	0	0.00	27	15.70%	12	44.44%	0	0.00%	0.00%	0.07	0.00	
Butler ASACTC	183	3	8	Med	1	0.55	0	0.00										
Cayuga	1,016	1	8	Med	33	3.25	4	0.39	78	7.68%	21	26.92%	2	2.56%	0.20%	0.42	0.05	
Elmira	1,779	1	8	Max	15	0.84	16	0.90	156	8.77%	72	46.15%	7	4.49%	0.39%	0.10	0.10	
Five Points	1,367	1	8	Max	31	2.27	5	0.37	121	8.85%	39	32.23%	2	1.65%	0.15%	0.26	0.04	
Monterey	177	3	8	Min	0	0.00	0	0.00	4	2.26%	0	0.00%	0	0.00%	0.00%	0.00	0.00	
Southport	813	1	8	Max	7	0.86	21	2.58	79	9.72%	19	24.05%	7	8.86%	0.86%	0.09	0.27	
Hub 8 Totals	7,274				170	2.34	66	0.91	617	8.48%	226	36.63%	25	4.05%	0.34%	0.28	0.11	
Arthur Kill	947	1	9	Med	90	9.50	20	2.11	85	8.98%	50	58.82%	6	7.06%	0.63%	1.06	0.24	
Edgecombe	186	3	9	Min					8	4.30%	4	50.00%	0	0.00%	0.00%			
Fulton	94	3	9	Min					10	10.64%	8	80.00%	0	0.00%	0.00%			
Lincoln	151	3	9	Min					7	4.64%	3	42.86%	0	0.00%	0.00%			
Queensboro	394	3	9	Min	1	0.25	0	0.00	47	11.93%	18	38.30%	1	2.13%	0.25%	0.02	0.00	
Sing Sing	1,737	1	9	Max	121	6.97	32	1.84	160	9.21%	68	42.50%	17	10.63%	0.98%	0.76	0.20	
Hub 9 Totals	3,509				212	6.04	52	1.48	317	9.03%	151	47.63%	24	7.57%	0.68%	0.67	0.16	
Willard DTC (male)	867	1	99	Med	15	1.73	0	0.00	89	10.27%	32	35.96%	1	1.12%	0.12%	0.17	0.00	
Hub 99 Totals	867				15	1.73	0	0.00	89	10.27%	32	35.96%	1	1.12%	0.12%	0.17	0.00	
Department Totals	60,826				2,652	4.36	856	1.41	5,477	9.00%	2,223	40.59%	270	4.93%	0.44%	0.48	0.16	

Exhibit F - HCV Care at Male Class One Prisons by Treatment Rates - FY 2006-07

Prison	Pop 2006	Med Class	Hub Security	GI Care	Rate	Liver Biopsy	Rate	GI per Liv Bx	HCV+ HCV+	Liv Bx/ HCV+	HCV+ Pts %	HCV Dis %	HCV Tx %	HCV % Tx/ Pop			
Eastern	1,175	1	4	Max	63	5.36	14	1.19	0.83	0.18	76	6.47%	31	40.79%	12	1.02%	15.79%
Upstate	1,162	1	3	Max	11	0.95	10	0.86	0.14	0.13	80	6.88%	30	37.50%	11	0.95%	13.75%
Cape Vincent	866	1	2	Med	9	1.04	12	1.39	0.11	0.14	84	9.70%	19	22.62%	11	1.27%	13.10%
Mid-Orange	721	1	4	Med	48	6.66	11	1.53	0.71	0.16	68	9.43%	43	63.24%	8	1.11%	11.76%
Riverview	876	1	2	Med	11	1.26	14	1.60	0.14	0.18	78	8.90%	34	43.59%	9	1.03%	11.54%
Sing Sing	1,737	1	9	Max	121	6.97	32	1.84	0.76	0.20	160	9.21%	68	42.50%	17	0.98%	10.63%
Marcy	1,255	1	1	Med	39	3.11	33	2.63	0.31	0.26	127	10.12%	39	30.71%	12	0.96%	9.45%
Livingston	871	1	7	Med	57	6.54	24	2.76	0.74	0.31	77	8.84%	28	36.36%	7	0.80%	9.09%
Southport	813	1	8	Max	7	0.86	21	2.58	0.09	0.27	79	9.72%	19	24.05%	7	0.86%	8.86%
Fishkill	1,718	1	5	Med	102	5.94	21	1.22	0.46	0.10	221	12.86%	95	42.99%	18	1.05%	8.14%
Mid-State	1,503	1	1	Med	25	1.66	36	2.40	0.12	0.17	212	14.11%	94	44.34%	16	1.06%	7.55%
Gouverneur	1,021	1	2	Med	15	1.47	16	1.57	0.16	0.17	96	9.40%	34	35.42%	7	0.69%	7.29%
Woodbourne	793	1	4	Med	39	4.92	7	0.88	0.40	0.07	98	12.36%	24	24.49%	7	0.88%	7.14%
Arthur Kill	947	1	9	Med	90	9.50	20	2.11	1.06	0.24	85	8.98%	50	58.82%	6	0.63%	7.06%
Ogdensburg	605	1	2	Med	2	0.33	16	2.64	0.03	0.21	77	12.73%	33	42.86%	5	0.83%	6.49%
Sullivan	746	1	4	Max	44	5.90	5	0.67	0.68	0.08	65	8.71%	38	58.46%	4	0.54%	6.15%
Mt. McGregor	526	1	6	Med	39	7.41	20	3.80	0.45	0.23	86	16.35%	33	38.37%	5	0.95%	5.81%
Green Haven	2,149	1	5	Max	97	4.51	20	0.93	0.42	0.09	231	10.75%	113	48.92%	13	0.60%	5.63%
Orleans	996	1	7	Med	65	6.53	34	3.41	0.89	0.47	73	7.33%	41	56.16%	4	0.40%	5.48%
Wyoming	1,707	1	7	Med	87	5.10	38	2.23	0.84	0.37	104	6.09%	86	82.69%	5	0.29%	4.81%
Aftica	2,204	1	7	Max	39	1.77	25	1.13	0.20	0.13	193	8.76%	68	35.23%	9	0.41%	4.66%

Exhibit F - HCV Care at Male Class One Prisons by Treatment Rates - FY 2006-07

Prison	Pop	Med	Hub	Security	GI	Rate	Liver	Rate	GI per	Liv Bx/	HCV+	HCV	% Tx/	HCV	% Tx/		
2006	Class				Care	GI	Biopsy	Liv Bx	HCV+	HCV+	Pts	Dis	% Tx	Dis	% Tx		
Auburn	1,767	1	8	Max	81	4.58	20	1.13	0.53	0.13	152	8.60%	63	41.45%	7	0.40%	4.61%
Elmira	1,779	1	8	Max	15	0.84	16	0.90	0.10	0.10	156	8.77%	72	46.15%	7	0.39%	4.49%
Walsh Medical	111	1	1	Max	49	44.14	3	2.70	1.96	0.12	25	22.52%	13	52.00%	1	0.90%	4.00%
Washington	1,037	1	6	Med	45	4.34	12	1.16	0.60	0.16	75	7.23%	20	26.67%	3	0.29%	4.00%
Greene	1,756	1	6	Med	80	4.56	13	0.74	1.05	0.17	76	4.33%	34	44.74%	3	0.17%	3.95%
Franklin	1,712	1	3	Med	65	3.80	8	0.47	0.35	0.04	184	10.75%	50	27.17%	7	0.41%	3.80%
Collins	1,165	1	7	Med	31	2.66	21	1.80	0.28	0.19	112	9.61%	37	33.04%	4	0.34%	3.57%
Ottsville	602	1	4	Med	39	6.48	4	0.66	0.67	0.07	58	9.63%	24	41.38%	2	0.33%	3.45%
Great Meadow	1,681	1	6	Max	77	4.58	6	0.36	0.52	0.04	148	8.80%	59	39.86%	5	0.30%	3.38%
Lakeview (male)	1,005	1	7	Min	3	0.30	10	1.00	0.10	0.33	30	2.99%	10	33.33%	1	0.10%	3.33%
Oneida	1,191	1	1	Med	52	4.37	21	1.76	0.54	0.22	96	8.06%	41	42.71%	3	0.25%	3.13%
Clinton	2,890	1	3	Max	257	8.89	38	1.31	1.11	0.16	231	7.99%	102	44.16%	6	0.21%	2.60%
Cayuga	1,016	1	8	Med	33	3.25	4	0.39	0.42	0.05	78	7.68%	21	26.92%	2	0.20%	2.56%
Coxsackie	978	1	6	Max	151	15.44	10	1.02	1.74	0.11	87	8.90%	36	41.38%	2	0.20%	2.30%
Wende	940	1	7	Max	69	7.34	20	2.13	0.76	0.22	91	9.68%	33	36.26%	2	0.21%	2.20%
Altona	477	1	3	Med	43	9.01	16	3.35	0.75	0.28	57	11.95%	10	17.54%	1	0.21%	1.75%
Bare Hill	1,720	1	3	Med	28	1.63	8	0.47	0.16	0.05	177	10.29%	62	35.03%	3	0.17%	1.69%
Five Points	1,367	1	8	Max	31	2.27	5	0.37	0.26	0.04	121	8.85%	39	32.23%	2	0.15%	1.65%
Adirondack	552	1	3	Med	18	3.26	17	3.08	0.27	0.26	66	11.96%	9	13.64%	1	0.18%	1.52%
Downstate	1,229	1	5	Max	17	1.38	2	0.16	0.21	0.02	82	6.67%	35	42.68%	1	0.08%	1.22%
Willard DTC (male)	867	1	99	Med	15	1.73	0	0.00	0.17	0.00	89	10.27%	32	35.96%	1	0.12%	1.12%

Exhibit F - HCV Care at Male Class One Prisons by Treatment Rates - FY 2006-07

Prison	Pop 2006	Med Class	Hub Security	GI Care	Rate GI	Liver Biopsy	Rate Liv Bx	GI per HCV+	Liv Bx/ HCV+	Pts %	HCV+ HCV	Dis %	HCV Tx	% Tx/ HCV+
Groveland	1,222	1	7 Med	98	8.02	51	4.17	0.67	0.35	147	12.03%	64	43.54%	1 0.08%
Ulster	746	1	4 Med	1	0.13	1	0.13	0.02	0.02	56	7.51%	22	39.29%	0 0.00%
Shawangunk	539	1	4 Max	80	14.84	7	1.30	1.60	0.14	50	9.28%	4	8.00%	0 0.00%
Watertown	637	1	2 Med	16	2.51	6	0.94	0.27	0.10	60	9.42%	26	43.33%	0 0.00%
Department Totals	53,377			2,404	4.50	748	1.40	0.49	0.15	4,874	9.13%	1,938	39.76%	258 0.48%

Exhibit G - DOCS HIV Care at Female Prisons - FY 2005-06 and FY 2006-07

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Class</i>	<i>Hub</i>	<i>Security</i>	<i>HIV Spec</i>	<i>Tot# Spec Apt</i>	<i>Spec Rate</i>	<i>HIV+ Pts</i>	<i>Rate HIV+</i>	<i>2005 IFD</i>	<i>2006 IFD</i>	<i>Rate HIV+</i>	<i>IFD05/ HIV+</i>	<i>IFD06/ HIV+</i>
Beacon	228	5	Minimum	1,188	521.05	20	8.77%	108	123	53.95	5.40	6.15		
Bedford Hills	808	1	Maximum	7,054	873.02	39	4.83%	616	509	63.00	15.79	13.05		
Bedford Hills RMU	18	1	Maximum	529	2938.89	20		28	28	155.56				
Taconic	305	5	Medium	2,096	687.21	28	9.18%	209	210	68.85	7.46	7.50		
Hub Totals	1,359			10,867	799.63	87	6.40%	953	870	64.02	10.95	10.00		
Albion	1,150	7	Medium	1	5,442	473.22	58	5.04%	129	8	0.70	2.22	0.14	
Lakeview (female)	96	7	Minimum	81	84.38	2		3	3	3.13				
Hub Totals	1,246			5,523	443.26	58	4.65%	131	11	0.88	2.26	0.19		
Bayview	215	9	Medium	932	433.49	18	8.37%	7	39	18.14	0.39	2.17		
Hub Totals	215			932	433.49	18	8.37%	7	39	18.14	0.39	2.17		
Willard DTC female	51	99	Medium	67	131.37	0		0	0	0.00				
Hub Totals	51			67	131.37	0		0	0	0.00				
Department Totals	2,871			17,389	605.68	163	5.68%	1,091	920	32.04	6.69	5.64		

Exhibit H - DOCS Female Hepatitis C Rates and HCV Care - FY 2006-07

Prison	Pop 2006	Med Cls	Hub	Security	GI Care	Rate	Liver Biopsy	Rate Liv Bx	HCV Pts	HCV+ %	HCV Dis	HCV Dis %	HCV Tx	% Tx/ HCV+	% Tx/ Pop	GI per HCV+	Liv Bx/ HCV+
Beacon	228	3	5	Min	17	7.46	5	2.19	32	14.04%	8	25.00%	0	0.00%	0.00%	0.53	0.16
Bedford Hills	808	1	5	Max	82	10.15	9	1.11	99	12.25%	25	25.25%	5	5.05%	0.62%	0.83	0.09
Bedford Hills RMU	18	1	5	Max	4	22.22	1	5.56									
Taconic	305	2	5	Med	29	9.51	5	1.64	51	16.72%	6	11.76%	0	0.00%	0.00%	0.57	0.10
Hub 5 Totals	1,359				132	9.71	20	1.47	182	13.39%	39	21.43%	5	2.75%	0.37%	0.73	0.11
Albion	1,150	1	7	Med	51	4.43	28	2.43	196	17.04%	38	19.39%	10	5.10%	0.87%	0.26	0.14
Lakeview (female)	96	1	7	Min	0	0.00	0	0.00									
Hub 7 Totals	1,246				51	4.09	28	2.25	196	15.73%	38	19.39%	10	5.10%	0.80%	0.26	0.14
Bayview	215	1	9	Med	24	11.16	5	2.33	29	13.49%	3	10.34%	0	0.00%	0.00%	0.83	0.17
Hub 9 Totals	215				24	11.16	5	2.33	29	13.49%	3	10.34%	0	0.00%	0.00%	0.83	0.17
Willard DTC female	51	1	99	Med	3	5.88	0	0.00									
Hub 99 Totals	51				3	5.88	0	0.00									
Department Totals	2,871				210	7.31	53	1.85	407	14.18%	80	19.66%	15	3.69%	0.52%	0.52	0.13

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 1)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub Security</i>	<i>Tot #Spec</i>	<i>Rate Spec</i>	<i>Cardiology</i>	<i>Rate Card</i>	<i>Dermatology</i>	<i>Rate Derm</i>	
Georgetown	151	3	1	Minimum	144	95.36	1	0.66	6	3.97
Hale Creek	390	3	1	Medium	242	62.05	4	1.03	1	0.26
Marcy	1,255	1	1	Medium	1,312	104.54	22	1.75	12	0.96
Mid-State	1,503	1	1	Medium	2,233	148.57	28	1.86	35	2.33
Mohawk	1,297	2	1	Medium	2,549	196.53	26	2.00	45	3.47
Oneida	1,191	1	1	Medium	2,193	184.13	32	2.69	36	3.02
Pharsalia	141	3	1	Minimum	178	126.24	2	1.42	9	6.38
Summit	173	3	1	Minimum	116	67.05	0	0.00	0	0.00
Walsh Medical	111	1	1	Maximum	2,121	1910.81	26	23.42	27	24.32
<i>Hub 1 Totals</i>	6,212				11,088	178.49	141	2.27	171	2.75
Cape Vincent	866	1	2	Medium	884	102.08	4	0.46	14	1.62
Gouverneur	1,021	1	2	Medium	1,160	113.61	9	0.88	32	3.13
Ogdensburg	605	1	2	Medium	644	106.45	5	0.83	2	0.33
Riverview	876	1	2	Medium	940	107.31	6	0.68	32	3.65
Watertown	637	1	2	Medium	980	153.85	11	1.73	24	3.77
<i>Hub 2 Totals</i>	4,005				4,608	115.06	35	0.87	104	2.60
Adirondack	552	1	3	Medium	1,167	211.41	5	0.91	21	3.80
Altona	477	1	3	Medium	904	189.52	3	0.63	9	1.89
Bare Hill	1,720	1	3	Medium	2,106	122.44	11	0.64	16	0.93
Chateaugay	219	3	3	Medium	442	201.83	2	0.91	3	1.37
Clinton	2,890	1	3	Maximum	5,308	183.67	103	3.56	26	0.90
Clinton Annex		1	3	Medium	957		11		6	

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 1)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub Security</i>	<i>Tot #Spec</i>	<i>Rate Spec</i>	<i>Cardiology</i>	<i>Rate Card</i>	<i>Dermatology</i>	<i>Rate Derm</i>
Franklin	1,712	1	3 Medium	3,646	212.97	19	1.11	21	1.23
Gabriel	165	3	3 Minimum	293	177.58	0	0.00	6	3.64
Lyon Mountain	135	3	3 Minimum	230	170.37	0	0.00	1	0.74
Upstate	1,162	1	3 Maximum	2,533	217.99	0	0.00	16	1.38
Hub 3 Totals	9,032			17,586	194.71	154	1.71	125	1.38
Eastern	1,175	1	4 Maximum	3,203	272.60	30	2.55	34	2.89
Mid-Orange	721	1	4 Medium	2,409	334.12	55	7.63	93	12.90
Otisville	602	1	4 Medium	1,062	176.41	18	2.99	27	4.49
Shawangunk	539	1	4 Maximum	1,764	327.27	27	5.01	29	5.38
Sullivan	746	1	4 Maximum	1,992	267.02	16	2.14	12	1.61
Ulster	746	1	4 Medium	101	13.54	1	0.13	1	0.13
Wallkill	599	2	4 Medium	763	127.38	12	2.00	9	1.50
Woodbourne	793	1	4 Medium	2,574	324.59	52	6.56	37	4.67
Hub 4 Totals	5,921			13,868	234.22	211	3.56	242	4.09
Downstate	1,229	1	5 Maximum	1,668	135.72	11	0.90	30	2.44
Fishkill	1,718	1	5 Medium	6,918	402.68	146	8.50	261	15.19
Fishkill RMU	29	1	5 Maximum	864	2979.31	21	72.41	27	93.10
Green Haven	2,149	1	5 Maximum	7,655	356.21	31	1.44	138	6.42
Hub 5 Totals	5,125			17,105	333.76	209	4.08	456	8.90
Camp Mt. McGregor	128	3	6 Minimum	4	3.13	0	0.00	0	0.00
Coxsackie	978	1	6 Maximum	2,355	240.80	36	3.68	61	6.24
Coxsackie RMU	56	1	6 Maximum	1,555	2776.79	56	100.00	17	30.36

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 1)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub Security</i>	<i>Tot #Spec</i>	<i>Rate Spec</i>	<i>Cardiology</i>	<i>Rate Card</i>	<i>Dermatology</i>	<i>Rate Derm</i>
Great Meadow	1,681	1	6 Maximum	1,801	107.14	33	1.96	14	0.83
Greene	1,756	1	6 Medium	1,999	113.84	42	2.39	27	1.54
Hudson	506	2	6 Medium	688	135.97	17	3.36	20	3.95
Moriah	200	3	6 Minimum	146	73.00	0	0.00	4	2.00
Mt. McGregor	526	1	6 Medium	736	139.92	4	0.76	18	3.42
Washington	1,037	1	6 Medium	1,381	133.17	10	0.96	35	3.38
Hub 6 Totals	6,868			10,665	155.29	198	2.88	196	2.85
Attica	2,204	1	7 Maximum	4,264	193.47	23	1.04	50	2.27
Buffalo	109	2	7 Minimum	5	4.59	0	0.00	0	0.00
Collins	1,165	1	7 Medium	1,274	109.36	7	0.60	36	3.09
Gowanda	1,743	2	7 Medium	2,551	146.36	22	1.26	21	1.20
Groveland	1,222	1	7 Medium	2,926	239.44	46	3.76	25	2.05
Lakeview (male)	1,005	1	7 Minimum	591	58.81	0	0.00	10	1.00
Livingston	871	1	7 Medium	1,430	164.18	9	1.03	34	3.90
Orleans	996	1	7 Medium	2,610	262.05	40	4.02	51	5.12
Rochester	51	3	7 Minimum						
Wende	940	1	7 Maximum	5,444	579.15	45	4.79	107	11.38
Wyoming	1,707	1	7 Medium	2,202	129.00	14	0.82	20	1.17
Hub 7 Totals	12,013			23,297	193.93	206	1.71	354	2.95
Auburn	1,767	1	8 Maximum	2,628	148.73	39	2.21	50	2.83
Butler	172	3	8 Minimum	147	85.47	0	0.00	5	2.91
Butler ASACTC	183	3	8 Medium	63	34.43	1	0.55	2	1.09

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 1)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub Security</i>	<i>Tot #Spec</i>	<i>Rate Spec</i>	<i>Cardiology</i>	<i>Rate Card</i>	<i>Dermatology</i>	<i>Rate Derm</i>
Cayuga	1,016	1	8 Medium	1,830	180.12	69	6.79	42	4.13
Elmira	1,779	1	8 Maximum	2,596	145.92	24	1.35	23	1.29
Five Points	1,367	1	8 Maximum	3,203	234.31	12	0.88	37	2.71
Monterey	177	3	8 Minimum	118	66.67	0	0.00	0	0.00
Southport	813	1	8 Maximum	1,630	200.49	5	0.62	6	0.74
Hub 8 Totals	7,274			12,215	167.93	150	2.06	165	2.27
Arthur Kill	947	1	9 Medium	2,490	262.94	53	5.60	32	3.38
Edgecombe	186	3	9 Minimum						
Fulton	94	3	9 Minimum						
Lincoln	151	3	9 Minimum						
Queensboro	394	3	9 Minimum	142	36.04	2	0.51	3	0.76
Sing Sing	1,737	1	9 Maximum	4,080	234.89	66	3.80	56	3.22
Hub 9 Totals	3,509			6,712	191.28	121	3.45	91	2.59
Willard DTC (male)	867	1	99 Medium	469	54.09	4	0.46	6	0.69
Hub 99 Totals	867			469	54.09	4	0.46	6	0.69
Department Totals	60,826			117,613	193.36	1,429	2.35	1,910	3.14

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 2)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub Gastroent.</i>	<i>Rate GI</i>	<i>Inf. Dis.</i>	<i>Rate IFD</i>	<i>Liver Bx</i>	<i>Rate LvBx</i>	<i>Nephrology</i>	<i>Rate Neph</i>
Georgetown	151	3	1	2	1.32	1	0.66	0	0.00	0
Hale Creek	390	3	1	7	1.79	3	0.77	4	1.03	5
Marcy	1,255	1	1	39	3.11	9	0.72	33	2.63	2
Mid-State	1,503	1	1	25	1.66	2	0.13	36	2.40	20
Mohawk	1,297	2	1	20	1.54	10	0.77	41	3.16	16
Oneida	1,191	1	1	52	4.37	64	5.37	21	1.76	37
Pharsalia	141	3	1	5	3.55	0	0.00	0	0.00	3
Summit	173	3	1	0	0.00	0	0.00	0	0.00	0
Walsh Medical	111	1	1	49	44.14	100	90.09	3	2.70	15
Hub Totals	6,212			199	3.20	189	3.04	138	2.22	98
Cape Vincent	866	1	2	9	1.04	0	0.00	12	1.39	0
Gouverneur	1,021	1	2	15	1.47	10	0.98	16	1.57	2
Ogdensburg	605	1	2	2	0.33	3	0.50	16	2.64	1
Riverview	876	1	2	11	1.26	4	0.46	14	1.60	0
Watertown	637	1	2	16	2.51	14	2.20	6	0.94	4
Hub Totals	4,005			53	1.32	31	0.77	64	1.60	7
Adirondack	552	1	3	18	3.26	79	14.31	17	3.08	17
Altona	477	1	3	43	9.01	39	8.18	16	3.35	7
Bare Hill	1,720	1	3	28	1.63	145	8.43	8	0.47	16
Chateaugay	219	3	3	7	3.20	3	1.37	18	8.22	2
Clinton	2,890	1	3	257	8.89	262	9.07	38	1.31	23

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 2)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub Gastroent.</i>	<i>Rate GI</i>	<i>Inf. Dis.</i>	<i>Rate IFD</i>	<i>Liver Bx</i>	<i>Rate LvBx</i>	<i>Nephrology</i>	<i>Rate Neph</i>
Clinton Annex		1	3	20	76		3		2	
Franklin	1,712	1	3	65	94	5.49	8	0.47	10	0.58
Gabriel	165	3	3	1	5	3.03	0	0.00	1	0.61
Lyon Mountain	135	3	3	3	16	11.85	5	3.70	2	1.48
Upstate	1,162	1	3	11	94	8.09	10	0.86	6	0.52
Hub Totals	9,032			453	813	9.00	123	1.36	86	0.95
Eastern	1,175	1	4	63	80	6.81	14	1.19	12	1.02
Mid-Orange	721	1	4	48	107	14.84	11	1.53	23	3.19
Otisville	602	1	4	39	14	2.33	4	0.66	18	2.99
Shawangunk	539	1	4	80	52	9.65	7	1.30	13	2.41
Sullivan	746	1	4	44	63	8.45	5	0.67	10	1.34
Ulster	746	1	4	1	0	0.00	1	0.13	5	0.67
Wallkill	599	2	4	59	48	8.01	5	0.83	3	0.50
Woodbourne	793	1	4	39	85	10.72	7	0.88	20	2.52
Hub Totals	5,921			373	449	7.58	54	0.91	104	1.76
Downstate	1,229	1	5	17	33	2.69	2	0.16	0	0.00
Fishkill	1,718	1	5	102	635	36.96	21	1.22	122	7.10
Fishkill RMU	29	1	5	19	38	131.03	1	3.45	11	37.93
Green Haven	2,149	1	5	97	692	32.20	20	0.93	43	2.00
Hub Totals	5,125			235	1,398	27.28	44	0.86	176	3.43
Camp Mt. McGregor	128	3	6	2	1	0.78	4	3.13	0	0.00

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 2)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub</i>	<i>Gastroent.</i>	<i>Rate GI</i>	<i>Inf. Dis.</i>	<i>Rate IFD</i>	<i>Liver Bx</i>	<i>Rate LvBx</i>	<i>Nephrology</i>	<i>Rate Neph</i>
Coxsackie	978	1	6	151	15.44	108	11.04	10	1.02	12	1.23
Coxsackie RMU	56	1	6	46	82.14	64	114.29	1	1.79	20	35.71
Great Meadow	1,681	1	6	77	4.58	45	2.68	6	0.36	6	0.36
Greene	1,756	1	6	80	4.56	106	6.04	13	0.74	13	0.74
Hudson	506	2	6	31	6.13	50	9.88	3	0.59	3	0.59
Moriah	200	3	6	0	0.00	4	2.00	0	0.00	2	1.00
Mt. McGregor	526	1	6	39	7.41	26	4.94	20	3.80	3	0.57
Washington	1,037	1	6	45	4.34	101	9.74	12	1.16	9	0.87
Hub Totals	6,868			471	6.86	505	7.35	69	1.00	68	0.99
Attica	2,204	1	7	39	1.77	131	5.94	25	1.13	17	0.77
Buffalo	109	2	7	0	0.00	0	0.00	0	0.00	0	0.00
Collins	1,165	1	7	31	2.66	46	3.95	21	1.80	5	0.43
Gowanda	1,743	2	7	22	1.26	19	1.09	23	1.32	6	0.34
Groveland	1,222	1	7	98	8.02	36	2.95	51	4.17	11	0.90
Lakeview (male)	1,005	1	7	3	0.30	17	1.69	10	1.00	0	0.00
Livingston	871	1	7	57	6.54	19	2.18	24	2.76	10	1.15
Orleans	996	1	7	65	6.53	71	7.13	34	3.41	0	0.00
Rochester	51	3	7								
Wende	940	1	7	69	7.34	72	7.66	20	2.13	25	2.66
Wyoming	1,707	1	7	87	5.10	22	1.29	38	2.23	12	0.70
Hub Totals	12,013			471	3.92	433	3.60	246	2.05	86	0.72

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 2)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub Gastroent.</i>	<i>Rate GI</i>	<i>Inf. Dis.</i>	<i>Rate IFD</i>	<i>Liver Bx</i>	<i>Rate LvBx</i>	<i>Nephrology</i>	<i>Rate Neph</i>
Auburn	1,767	1	8	81	4.58	127	7.19	1.13	20	0.51
Butler	172	3	8	2	1.16	0	0.00	0.00	0	0.00
Butler ASACTC	183	3	8	1	0.55	0	0.00	0.00	0	0.00
Cayuga	1,016	1	8	33	3.25	49	4.82	0.39	4	0.49
Elmira	1,779	1	8	15	0.84	19	1.07	0.90	16	0.17
Five Points	1,367	1	8	31	2.27	4	0.29	0.37	5	0.29
Monterey	177	3	8	0	0.00	0	0.00	0.00	0	0.00
Southport	813	1	8	7	0.86	20	2.46	2.58	21	0.00
<i>Hub Totals</i>	<i>7,274</i>			<i>170</i>	<i>2.34</i>	<i>219</i>	<i>3.01</i>	<i>0.91</i>	<i>66</i>	<i>0.29</i>
Arthur Kill	947	1	9	90	9.50	73	7.71	2.11	20	0.00
Edgecombe	186	3	9							
Fulton	94	3	9							
Lincoln	151	3	9							
Queensboro	394	3	9	1	0.25	8	2.03	0.00	0	0.00
Sing Sing	1,737	1	9	121	6.97	463	26.66	1.84	32	1.09
<i>Hub Totals</i>	<i>3,509</i>			<i>212</i>	<i>6.04</i>	<i>544</i>	<i>15.50</i>	<i>1.48</i>	<i>52</i>	<i>0.54</i>
Willard DTC (male)	867	1	99	15	1.73	1	0.12	0.00	0	0.00
<i>Hub Totals</i>	<i>867</i>			<i>15</i>	<i>1.73</i>	<i>1</i>	<i>0.12</i>	<i>0.00</i>	<i>0</i>	<i>0.00</i>
<i>Department Totals</i>	<i>60,826</i>			<i>2,652</i>	<i>4.36</i>	<i>4,582</i>	<i>7.53</i>	<i>1.41</i>	<i>856</i>	<i>1.09</i>

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 3)

<i>Prison</i>	<i>Pop</i>	<i>2006</i>	<i>Med Cl</i>	<i>Hub</i>	<i>Neurology</i>	<i>Rate</i>	<i>Neuro</i>	<i>Ophthal.</i>	<i>Rate</i>	<i>Ophth</i>	<i>Orthopedics</i>	<i>Rate</i>	<i>Ortho</i>	<i>Urology</i>	<i>Rate</i>	<i>Uro</i>
Georgetown	151	3	1	1	2	1.32	14	9.27	18	11.92	1	0.66				
Hale Creek	390	3	1	1	1	0.26	24	6.15	4	1.03	5	1.28				
Marey	1,255	1	1	1	23	1.83	110	8.76	87	6.93	33	2.63				
Mid-State	1,503	1	1	1	46	3.06	158	10.51	138	9.18	64	4.26				
Mohawk	1,297	2	1	1	27	2.08	164	12.64	204	15.73	66	5.09				
Oneida	1,191	1	1	1	22	1.85	135	11.34	127	10.66	73	6.13				
Pharsalia	141	3	1	1	2	1.42	11	7.80	22	15.60	4	2.84				
Summit	173	3	1	1	0	0.00	10	5.78	0	0.00	0	0.00				
Walsh Medical	111	1	1	1	41	36.94	72	64.86	35	31.53	24	21.62				
Totals for Hub 1	6,212	1	6,212	164	2.64	698	11.24	635	10.22	270	4.35					
Cape Vincent	866	1	2	2	5	0.58	97	11.20	85	9.82	26	3.00				
Gouverneur	1,021	1	2	2	5	0.49	154	15.08	94	9.21	29	2.84				
Ogdensburg	605	1	2	2	8	1.32	127	20.99	13	2.15	8	1.32				
Riverview	876	1	2	2	10	1.14	135	15.41	104	11.87	7	0.80				
Watertown	637	1	2	2	9	1.41	121	19.00	85	13.34	15	2.35				
Totals for Hub 2	4,005	2	4,005	37	0.92	634	15.83	381	9.51	85	2.12					
Adirondack	552	1	3	3	17	3.08	67	12.14	67	12.14	13	2.36				
Altona	477	1	3	3	5	1.05	41	8.60	40	8.39	36	7.55				
Bare Hill	1,720	1	3	3	13	0.76	205	11.92	174	10.12	31	1.80				
Chateaugay	219	3	3	3	0	0.00	19	8.68	19	8.68	10	4.57				
Clinton	2,890	1	3	3	36	1.25	325	11.25	215	7.44	103	3.56				
Clinton Annex		1	3	3	9		54		34		15					

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 3)

<i>Prison</i>	<i>Pop</i>	<i>Med Cl</i>	<i>Hub</i>	<i>Neurology</i>	<i>Rate</i>	<i>Neuro</i>	<i>Ophthal.</i>	<i>Rate</i>	<i>Ophth</i>	<i>Orthopedics</i>	<i>Rate</i>	<i>Ortho</i>	<i>Urology</i>	<i>Rate</i>	<i>Uro</i>
Franklin	1,712	1	3	11	0.64	298	17.41	272	15.89	78	4.56				
Gabriel	165	3	3	0	0.00	37	22.42	18	10.91	9	5.45				
Lyon Mountain	135	3	3	0	0.00	17	12.59	14	10.37	3	2.22				
Upstate	1,162	1	3	18	1.55	105	9.04	232	19.97	42	3.61				
Totals for Hub	3	9,032	3	109	1.21	1,168	12.93	1,085	12.01	340	3.76				
Eastern	1,175	1	4	33	2.81	122	10.38	173	14.72	101	8.60				
Mid-Orange	721	1	4	22	3.05	85	11.79	108	14.98	76	10.54				
Otisville	602	1	4	1	0.17	64	10.63	41	6.81	39	6.48				
Shawangunk	539	1	4	12	2.23	80	14.84	136	25.23	37	6.86				
Sullivan	746	1	4	8	1.07	78	10.46	84	11.26	59	7.91				
Ulster	746	1	4	1	0.13	4	0.54	8	1.07	2	0.27				
Wallkill	599	2	4	8	1.34	37	6.18	39	6.51	13	2.17				
Woodbourne	793	1	4	22	2.77	116	14.63	184	23.20	79	9.96				
Totals for Hub	4	5,921	4	107	1.81	586	9.90	773	13.06	406	6.86				
Downstate	1,229	1	5	14	1.14	47	3.82	50	4.07	30	2.44				
Fishkill	1,718	1	5	104	6.05	204	11.87	412	23.98	124	7.22				
Fishkill RMU	29	1	5	22	75.86	18	62.07	34	117.24	22	75.86				
Green Haven	2,149	1	5	36	1.68	212	9.87	273	12.70	124	5.77				
Totals for Hub	5	5,125	5	176	3.43	481	9.39	769	15.00	300	5.85				
Camp Mt. McGregor	128	3	6	0	0.00	4	3.13	2	1.56	0	0.00				
Coxsackie	978	1	6	32	3.27	101	10.33	69	7.06	106	10.84				
Coxsackie RMU	56	1	6	31	55.36	43	76.79	19	33.93	48	85.71				

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 3)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub</i>	<i>Neurology</i>	<i>Rate Neuro</i>	<i>Ophthal.</i>	<i>Rate Ophth</i>	<i>Orthopedics</i>	<i>Rate Ortho</i>	<i>Urology</i>	<i>Rate Uro</i>
Great Meadow	1,681	1	6	19	1.13	84	5.00	90	5.35	66	3.93
Greene	1,756	1	6	23	1.31	91	5.18	81	4.61	60	3.42
Hudson	506	2	6	4	0.79	48	9.49	20	3.95	36	7.11
Moriah	200	3	6	2	1.00	1	0.50	1	0.50	0	0.00
Mt. McGregor	526	1	6	1	0.19	58	11.03	33	6.27	20	3.80
Washington	1,037	1	6	18	1.74	85	8.20	69	6.65	51	4.92
Totals for Hub	6,868	6		130	1.89	515	7.50	384	5.59	387	5.63
Attica	2,204	1	7	28	1.27	208	9.44	259	11.75	64	2.90
Buffalo	109	2	7	0	0.00	1	0.92	0	0.00	1	0.92
Collins	1,165	1	7	5	0.43	66	5.67	89	7.64	57	4.89
Gowanda	1,743	2	7	14	0.80	104	5.97	144	8.26	36	2.07
Groveland	1,222	1	7	36	2.95	122	9.98	253	20.70	72	5.89
Lakeview (male)	1,005	1	7	3	0.30	34	3.38	23	2.29	13	1.29
Livingston	871	1	7	19	2.18	69	7.92	129	14.81	25	2.87
Orleans	996	1	7	33	3.31	70	7.03	187	18.78	69	6.93
Rochester	51	3	7								
Wende	940	1	7	76	8.09	244	25.96	236	25.11	80	8.51
Wyoming	1,707	1	7	9	0.53	148	8.67	169	9.90	59	3.46
Totals for Hub	12,013	7		223	1.86	1,066	8.87	1,489	12.39	476	3.96
Auburn	1,767	1	8	51	2.89	135	7.64	172	9.73	67	3.79
Butler	172	3	8	1	0.58	14	8.14	6	3.49	4	2.33
Butler ASACTC	183	3	8	0	0.00	3	1.64	5	2.73	2	1.09

Exhibit I - DOCS Specialty Care for Male Prisons - FY 2006-07 (Part 3)

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub</i>	<i>Neurology</i>	<i>Rate Neuro</i>	<i>Ophthal.</i>	<i>Rate Ophth</i>	<i>Orthopedics</i>	<i>Rate Ortho</i>	<i>Urology</i>	<i>Rate Uro</i>
Cayuga	1,016	1	8	40	3.94	91	8.96	126	12.40	44	4.33
Elmira	1,779	1	8	72	4.05	114	6.41	192	10.79	123	6.91
Five Points	1,367	1	8	47	3.44	96	7.02	139	10.17	65	4.75
Monterey	177	3	8	0	0.00	1	0.56	1	0.56	0	0.00
Southport	813	1	8	11	1.35	74	9.10	182	22.39	43	5.29
<i>Totals for Hub</i>	<i>8</i>	<i>7,274</i>		<i>222</i>	<i>3.05</i>	<i>528</i>	<i>7.26</i>	<i>823</i>	<i>11.31</i>	<i>348</i>	<i>4.78</i>
Arthur Kill	947	1	9	28	2.96	79	8.34	107	11.30	81	8.55
Edgecombe	186	3	9								
Fulton	94	3	9								
Lincoln	151	3	9								
Queensboro	394	3	9	0	0.00	5	1.27	24	6.09	3	0.76
Sing Sing	1,737	1	9	17	0.98	92	5.30	205	11.80	133	7.66
<i>Totals for Hub</i>	<i>9</i>	<i>3,509</i>		<i>45</i>	<i>1.28</i>	<i>176</i>	<i>5.02</i>	<i>336</i>	<i>9.58</i>	<i>217</i>	<i>6.18</i>
Willard DTC (male)	867	1	99	2	0.23	28	3.23	27	3.11	17	1.96
<i>Totals for Hub</i>	<i>99</i>	<i>867</i>		<i>2</i>	<i>0.23</i>	<i>28</i>	<i>3.23</i>	<i>27</i>	<i>3.11</i>	<i>17</i>	<i>1.96</i>
<i>Totals</i>	<i>60,826</i>			<i>1,215</i>	<i>2.00</i>	<i>5,880</i>	<i>9.67</i>	<i>6,702</i>	<i>11.02</i>	<i>2,846</i>	<i>4.68</i>

Exhibit J - DOCS Specialty Care Utilization Rates at Male Prisons - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate All Spec	Card	Derm	Gastro	IFD	Liv Bx	Neph	Neuro	Ophtha	Ortho	Rate Urol	
Georgetown	151	3	1	Min	95.36	0.66	3.97	1.32	0.66	0.00	0.00	1.32	9.27	11.92	0.00	0.66
Hale Creek	390	3	1	Med	49.3%	28.2%	126.5%	30.4%	8.8%	0.0%	0.0%	66.3%	95.9%	108.1%	0.0%	14.2%
Marcy	1,255	1	1	Med	62.05	1.03	0.26	1.79	0.77	1.03	1.28	0.26	6.15	1.03	0.26	1.28
Mid-State	1,503	1	1	Med	32.1%	43.6%	8.2%	41.1%	10.2%	72.8%	117.2%	12.8%	63.6%	9.3%	0.5%	27.4%
Mohawk	1,297	2	1	Med	104.54	1.75	0.96	3.11	0.72	2.63	0.16	1.83	8.76	6.93	18.49	2.63
Oneida	1,191	1	1	Med	54.0%	74.6%	30.4%	71.2%	9.5%	186.8%	14.6%	91.7%	90.6%	62.9%	38.4%	56.2%
Pharsalia	141	3	1	Min	148.57	1.86	2.33	1.66	0.13	2.40	1.33	3.06	10.51	9.18	40.25	4.26
Summit	173	3	1	Min	76.8%	79.3%	74.1%	38.1%	1.8%	170.1%	121.7%	153.1%	108.7%	83.3%	83.7%	91.0%
Walsh Medical	111	1	1	Max	196.53	2.00	3.47	1.54	0.77	3.16	1.23	2.08	12.64	15.73	68.08	5.09
Totals for Hub	6,212	1			101.6%	85.3%	110.4%	35.4%	10.2%	224.5%	112.8%	104.2%	130.7%	142.7%	141.5%	108.7%
Cape Vincent	866	1	2	Med	184.13	2.69	3.02	4.37	5.37	1.76	3.11	1.85	11.34	10.66	35.94	6.13
					95.2%	114.3%	96.2%	100.1%	71.3%	125.2%	284.0%	92.4%	117.2%	96.7%	74.7%	131.0%
					126.24	1.42	6.38	3.55	0.00	0.00	2.13	1.42	7.80	15.60	0.71	2.84
					65.3%	60.3%	203.2%	81.3%	0.0%	0.0%	194.5%	71.0%	80.7%	141.5%	1.5%	60.6%
					67.05	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.78	0.00	0.00	0.00
					34.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	59.8%	0.0%	0.0%	0.0%
					1910.81	23.42	24.32	44.14	90.09	2.70	13.51	36.94	64.86	31.53	676.58	21.62
					987.7%	996.6%	774.3%	1012.0%	1195.4%	192.0%	1235.5%	1848.2%	670.7%	286.0%	1406.5%	462.0%
					178.49	2.27	2.75	3.20	3.04	2.22	1.58	2.64	11.24	10.22	46.70	4.35
					92.3%	96.6%	87.6%	73.4%	40.4%	157.8%	144.2%	132.1%	116.2%	92.7%	97.1%	92.9%
					102.08	0.46	1.62	1.04	0.00	1.39	0.00	0.58	11.20	9.82	14.43	3.00
					52.8%	19.7%	51.5%	23.8%	0.0%	98.4%	0.0%	28.9%	115.8%	89.0%	30.0%	64.2%

Exhibit J - DOCS Specialty Care Utilization Rates at Male Prisons - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate All Spec	Card	Derm	Gastro	IFD	Liv Bx	Neph	Neuro	Ophtha	Ortho	Rate Urol	
Gouverneur	1,021	1	2	Med	113.61	0.88	3.13	1.47	0.98	1.57	0.20	0.49	15.08	9.21	12.83	2.84
Ogdensburg	605	1	2	Med	58.7%	37.5%	99.8%	33.7%	13.0%	111.3%	17.9%	24.5%	156.0%	83.5%	26.7%	60.7%
Riverview	876	1	2	Med	106.45	0.83	0.33	0.33	0.50	2.64	0.17	1.32	20.99	2.15	5.12	1.32
Watertown	637	1	2	Med	55.0%	35.2%	10.5%	7.6%	6.6%	187.8%	15.1%	66.2%	217.0%	19.5%	10.7%	28.3%
Totals for Hub	2	4,005			107.31	0.68	3.65	1.26	0.46	1.60	0.00	1.14	15.41	11.87	17.12	0.80
Adirondack	552	1	3	Med	55.5%	29.1%	116.3%	28.8%	6.1%	113.5%	0.0%	57.1%	159.3%	107.7%	35.6%	17.1%
Altona	477	1	3	Med	153.85	1.73	3.77	2.51	2.20	0.94	0.63	1.41	19.00	13.34	13.50	2.35
Bare Hill	1,720	1	3	Med	79.5%	73.5%	119.9%	57.6%	29.2%	66.9%	57.4%	70.7%	196.4%	121.0%	28.1%	50.3%
Chateaugay	219	3	3	Med	115.06	0.87	2.60	1.32	0.77	1.60	0.17	0.92	15.83	9.51	13.06	2.12
Clinton	2,890	1	3	Max	59.5%	37.2%	82.7%	30.3%	10.3%	113.5%	16.0%	46.2%	163.7%	86.3%	27.1%	45.4%
Clinton Annex		1	3	Med	211.41	0.91	3.80	3.26	14.31	3.08	3.08	3.08	12.14	12.14	61.96	2.36

Exhibit J - DOCS Specialty Care Utilization Rates at Male Prisons - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate All Spec	Card	Derm	Gastro	IFD	Liv Bx	Neph	Neuro	Ophtha	Ortho	Rate Urol	
Franklin	1,712	1	3	Med	212.97	1.11	1.23	3.80	5.49	0.47	0.58	0.64	17.41	15.89	62.62	4.56
Gabriel	165	3	3	Min	110.1%	47.2%	39.0%	87.0%	72.9%	33.2%	53.4%	32.2%	180.0%	144.1%	130.2%	97.4%
Lyon Mountain	135	3	3	Min	177.58	0.00	3.64	0.61	3.03	0.00	0.61	0.00	22.42	10.91	52.12	5.45
Upstate	1,162	1	3	Max	91.8%	0.0%	115.7%	13.9%	40.2%	0.0%	55.4%	0.0%	231.9%	99.0%	108.4%	116.6%
Totals for Hub	3	9,032	3		170.37	0.00	0.74	2.22	11.85	3.70	1.48	0.00	12.59	10.37	40.74	2.22
Eastern	1,175	1	4	Max	88.1%	0.0%	23.6%	50.9%	157.3%	263.0%	135.4%	0.0%	130.2%	94.1%	84.7%	47.5%
Mid-Orange	721	1	4	Med	217.99	0.00	1.38	0.95	8.09	0.86	0.52	1.55	9.04	19.97	100.86	3.61
Ottsville	602	1	4	Med	112.7%	0.0%	43.8%	21.7%	107.3%	61.1%	47.2%	77.5%	93.4%	181.1%	209.7%	77.2%
Shawangunk	539	1	4	Max	194.71	1.71	1.38	5.02	9.00	1.36	0.95	1.21	12.93	12.01	59.88	3.76
Sullivan	746	1	4	Max	100.6%	72.5%	44.1%	115.0%	119.4%	96.7%	87.1%	60.4%	133.7%	109.0%	124.5%	80.4%
Ulster	746	1	4	Med	272.60	2.55	2.89	5.36	6.81	1.19	1.02	2.81	10.38	14.72	82.55	8.60
					140.9%	108.6%	92.1%	122.9%	90.3%	84.6%	93.4%	140.5%	107.4%	133.6%	171.6%	183.7%
					334.12	7.63	12.90	6.66	14.84	1.53	3.19	3.05	11.79	14.98	94.17	10.54
					172.7%	324.6%	410.6%	152.6%	196.9%	108.4%	291.6%	152.7%	121.9%	135.9%	195.8%	225.3%
					176.41	2.99	4.49	6.48	2.33	0.66	2.99	0.17	10.63	6.81	22.92	6.48
					91.2%	127.2%	142.8%	148.5%	30.9%	47.2%	273.4%	8.3%	109.9%	61.8%	47.7%	138.4%
					327.27	5.01	5.38	14.84	9.65	1.30	2.41	2.23	14.84	25.23	90.72	6.86
					169.2%	213.1%	171.3%	340.3%	128.0%	92.2%	220.5%	111.4%	153.5%	228.9%	188.6%	146.7%
					267.02	2.14	1.61	5.90	8.45	0.67	1.34	1.07	10.46	11.26	89.28	7.91
					138.0%	91.3%	51.2%	135.2%	112.1%	47.6%	122.6%	53.7%	108.1%	102.1%	185.6%	169.0%
					13.54	0.13	0.13	0.13	0.00	0.13	0.67	0.13	0.54	1.07	0.00	0.27
					7.0%	5.7%	4.3%	3.1%	0.0%	9.5%	61.3%	6.7%	5.5%	9.7%	0.0%	5.7%

Exhibit J - DOCS Specialty Care Utilization Rates at Male Prisons - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate All Spec	Card	Derm	Gastro	IFD	Liv Bx	Neph	Neuro	Ophtha	Ortho	Rate Urol	Rate PT
Walkill	599	2	4	Med	127.38	2.00	1.50	9.85	8.01	0.83	0.50	1.34	6.18	6.51	21.37	2.17
Woodbourne	793	1	4	Med	65.8%	85.2%	47.8%	225.8%	106.3%	59.3%	45.8%	66.8%	63.9%	59.1%	44.4%	46.4%
<i>Totals for Hub</i>	4	5,921			324.59	6.56	4.67	4.92	10.72	0.88	2.52	2.77	14.63	23.20	61.79	9.96
<i>Totals for Hub</i>	4	5,921			167.8%	279.0%	148.5%	112.7%	142.2%	62.7%	230.6%	138.8%	151.2%	210.5%	128.5%	212.9%
<i>Totals for Hub</i>	4	5,921			234.22	3.56	4.09	6.30	7.58	0.91	1.76	1.81	9.90	13.06	60.12	6.86
Downstate	1,229	1	5	Max	121.1%	151.6%	130.1%	144.4%	100.6%	64.8%	160.6%	90.4%	102.3%	118.4%	125.0%	146.5%
Fishkill	1,689	1	5	Med	135.72	0.90	2.44	1.38	2.69	0.16	0.00	1.14	3.82	4.07	4.88	2.44
Fishkill RMU	29	1	5	Max	70.2%	38.1%	77.7%	31.7%	35.6%	11.6%	0.0%	57.0%	39.5%	36.9%	10.1%	52.2%
Green Haven	2,149	1	5	Max	409.59	8.64	15.45	6.04	37.60	1.24	7.22	6.16	12.08	24.39	88.87	7.34
<i>Totals for Hub</i>	5	5,096			211.7%	367.8%	491.9%	138.4%	498.8%	88.3%	660.4%	308.1%	124.9%	221.3%	184.7%	156.9%
<i>Totals for Hub</i>	5	5,096			2979.31	72.41	93.10	65.52	131.03	3.45	37.93	75.86	62.07	117.24	510.34	75.86
<i>Totals for Hub</i>	5	5,096			1540.1%	3080.9%	2963.6%	1502.0%	1738.6%	244.9%	3467.8%	3796.0%	641.8%	1063.5%	1060.9%	1621.2%
<i>Totals for Hub</i>	5	5,096			356.21	1.44	6.42	4.51	32.20	0.93	2.00	1.68	9.87	12.70	119.22	5.77
<i>Totals for Hub</i>	5	5,096			184.1%	61.4%	204.4%	103.5%	427.3%	66.1%	182.9%	83.8%	102.0%	115.2%	247.8%	123.3%
<i>Totals for Hub</i>	5	5,096			335.66	4.10	8.95	4.61	27.43	0.86	3.45	3.45	9.44	15.09	83.81	5.89
<i>Totals for Hub</i>	5	5,096			173.5%	174.5%	284.8%	105.7%	364.0%	61.3%	315.8%	172.8%	97.6%	136.9%	174.2%	125.8%
Camp Mt. McGregor	128	3	6	Min	3.13	0.00	0.00	1.56	0.78	3.13	0.00	0.00	3.13	1.56	0.00	0.00
Coxsackie	978	1	6	Max	1.6%	0.0%	0.0%	35.8%	10.4%	221.9%	0.0%	0.0%	32.3%	14.2%	0.0%	0.0%
Coxsackie RMU	56	1	6	Max	240.80	3.68	6.24	15.44	11.04	1.02	1.23	3.27	10.33	7.06	52.97	10.84
<i>Totals for Hub</i>	5	5,096			124.5%	156.6%	198.5%	354.0%	146.5%	72.6%	112.2%	163.7%	106.8%	64.0%	110.1%	231.6%
<i>Totals for Hub</i>	5	5,096			2776.79	100.00	30.36	82.14	114.29	1.79	35.71	55.36	76.79	33.93	905.36	85.71
<i>Totals for Hub</i>	5	5,096			1435.4%	4254.6%	966.3%	1883.1%	1516.4%	126.8%	3265.2%	2769.9%	793.9%	307.8%	1882.1%	1831.7%

Exhibit J - DOCS Specialty Care Utilization Rates at Male Prisons - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate All Spec	Card	Derm	Gastro	IFD	Liv Bx	Neph	Neuro	Ophtha	Ortho	Rate Urol	
Great Meadow	1,681	1	6	Max	107.14	1.96	0.83	4.58	2.68	0.36	0.36	1.13	5.00	5.35	16.36	3.93
Greene	1,756	1	6	Med	55.4%	83.5%	26.5%	105.0%	35.5%	25.4%	32.6%	56.6%	51.7%	48.6%	34.0%	83.9%
Hudson	506	2	6	Med	113.84	2.39	1.54	4.56	6.04	0.74	0.74	1.31	5.18	4.61	11.39	3.42
Moriah	200	3	6	Min	58.8%	101.8%	48.9%	104.4%	80.1%	52.6%	67.7%	65.5%	53.6%	41.8%	23.7%	73.0%
Mt. McGregor	526	1	6	Med	135.97	3.36	3.95	6.13	9.88	0.59	0.59	0.79	9.49	3.95	20.95	7.11
Washington	1,037	1	6	Med	70.3%	142.9%	125.8%	140.4%	131.1%	42.1%	54.2%	39.6%	98.1%	35.9%	43.5%	152.0%
Totals for Hub	6,868	6			73.00	0.00	2.00	0.00	2.00	0.00	1.00	1.00	0.50	0.50	0.00	0.00
Attica	2,204	1	7	Max	37.7%	0.0%	63.7%	0.0%	26.5%	0.0%	91.4%	50.0%	5.2%	4.5%	0.0%	0.0%
Buffalo	109	2	7	Min	139.92	0.76	3.42	7.41	4.94	3.80	0.57	0.19	11.03	6.27	13.50	3.80
Collins	1,165	1	7	Med	72.3%	32.4%	108.9%	170.0%	65.6%	270.0%	52.1%	9.5%	114.0%	56.9%	28.1%	81.3%
Gowanda	1,743	2	7	Med	133.17	0.96	3.38	4.34	9.74	1.16	0.87	1.74	8.20	6.65	17.55	4.92
					68.8%	41.0%	107.4%	99.5%	129.2%	82.2%	79.3%	86.9%	84.8%	60.4%	36.5%	105.1%
					155.29	2.88	2.85	6.86	7.35	1.00	0.99	1.89	7.50	5.59	27.07	5.63
					80.3%	122.7%	90.8%	157.2%	97.6%	71.4%	90.5%	94.7%	77.5%	50.7%	56.3%	120.4%
					193.47	1.04	2.27	1.77	5.94	1.13	0.77	1.27	9.44	11.75	65.29	2.90
					100.0%	44.4%	72.2%	40.6%	78.9%	80.6%	70.5%	63.6%	97.6%	106.6%	135.7%	62.1%
					4.59	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.92	0.00	0.00	0.92
					2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	9.5%	0.0%	0.0%	19.6%
					109.36	0.60	3.09	2.66	3.95	1.80	0.43	0.43	5.67	7.64	11.24	4.89
					56.5%	25.6%	98.4%	61.0%	52.4%	128.0%	39.2%	21.5%	58.6%	69.3%	23.4%	104.6%
					146.36	1.26	1.20	1.26	1.09	1.32	0.34	0.80	5.97	8.26	36.83	2.07
					75.7%	53.7%	38.4%	28.9%	14.5%	93.7%	31.5%	40.2%	61.7%	74.9%	76.6%	44.1%

Exhibit J - DOCS Specialty Care Utilization Rates at Male Prisons - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate All Spec	Card	Derm	Gastro	IFD	Liv Bx	Neph	Neuro	Ophtha	Ortho	Rate	Rate PT	Urol
Groveland	1,222	1	7	Med	239.44	3.76	2.05	8.02	2.95	4.17	0.90	2.95	9.98	20.70	50.25	5.89	
Lakeview (male)	1,005	1	7	Min	123.8%	160.2%	65.1%	183.8%	39.1%	296.4%	82.3%	147.4%	103.2%	187.8%	104.5%	125.9%	
Livingston	871	1	7	Med	58.81	0.00	1.00	0.30	1.69	1.00	0.00	0.30	3.38	2.29	3.08	1.29	
Orleans	996	1	7	Med	30.4%	0.0%	31.7%	6.8%	22.4%	70.7%	0.0%	14.9%	35.0%	20.8%	6.4%	27.6%	
Rochester	51	3	7	Min	164.18	1.03	3.90	6.54	2.18	2.76	1.15	2.18	7.92	14.81	28.36	2.87	
Wende	940	1	7	Max	84.9%	44.0%	124.3%	150.0%	28.9%	195.7%	105.0%	109.2%	81.9%	134.4%	59.0%	61.3%	
Wyoming	1,707	1	7	Med	262.05	4.02	5.12	6.53	7.13	3.41	0.00	3.31	7.03	18.78	42.37	6.93	
Totals for Hub	7				135.5%	170.9%	163.0%	149.6%	94.6%	242.4%	0.0%	165.8%	72.7%	170.3%	88.1%	148.0%	
Auburn	1,767	1	8	Max	579.15	4.79	11.38	7.34	7.66	2.13	2.66	8.09	25.96	25.11	192.45	8.51	
Butler	172	3	8	Min	299.4%	203.7%	362.3%	168.3%	101.6%	151.1%	243.1%	404.6%	268.4%	227.8%	400.1%	181.9%	
Butler ASACTC	183	3	8	Med	129.00	0.82	1.17	5.10	1.29	2.23	0.70	0.53	8.67	9.90	26.42	3.46	
					66.7%	34.9%	37.3%	116.8%	17.1%	158.1%	64.3%	26.4%	89.6%	89.8%	54.9%	73.9%	
					193.93	1.71	2.95	3.92	3.60	2.05	0.72	1.86	8.87	12.39	48.16	3.96	
					100.2%	73.0%	93.8%	89.9%	47.8%	145.4%	65.4%	92.9%	91.8%	112.4%	100.1%	84.7%	
					148.73	2.21	2.83	4.58	7.19	1.13	0.51	2.89	7.64	9.73	39.05	3.79	
					76.9%	93.9%	90.1%	105.1%	95.4%	80.4%	46.6%	144.4%	79.0%	88.3%	81.2%	81.0%	
					85.47	0.00	2.91	1.16	0.00	0.00	0.00	0.58	8.14	3.49	5.81	2.33	
					44.2%	0.0%	92.5%	26.7%	0.0%	0.0%	0.0%	29.1%	84.2%	31.6%	12.1%	49.7%	
					34.43	0.55	1.09	0.55	0.00	0.00	0.00	0.00	1.64	2.73	0.55	1.09	
					17.8%	23.2%	34.8%	12.5%	0.0%	0.0%	0.0%	0.0%	17.0%	24.8%	1.1%	23.4%	

Exhibit J - DOCS Specialty Care Utilization Rates at Male Prisons - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate All Spec	Card	Derm	Gastro	IFD	Liv Bx	Neph	Neuro	Ophtha	Ortho	Rate PT Urol	Rate
Sing Sing	1,737	1	9	Max	234.89	3.80	3.22	6.97	26.66	1.84	1.09	0.98	5.30	11.80	55.04	7.66
Totals for Hub	9	3,509			121.4%	161.7%	102.6%	159.7%	353.7%	130.8%	100.0%	49.0%	54.8%	107.1%	114.4%	163.6%
					191.28	3.45	2.59	6.04	15.50	1.48	0.54	1.28	5.02	9.58	41.64	6.18
					98.9%	146.7%	82.5%	138.5%	205.7%	105.2%	49.5%	64.2%	51.9%	86.9%	86.6%	132.2%
Willard DTC (male)	867	1	99	Med	54.09	0.46	0.69	1.73	0.12	0.00	0.00	0.23	3.23	3.11	0.23	1.96
Totals for Hub	99	867			28.0%	19.6%	22.0%	39.7%	1.5%	0.0%	0.0%	11.5%	33.4%	28.3%	0.5%	41.9%
					54.09	0.46	0.69	1.73	0.12	0.00	0.00	0.23	3.23	3.11	0.23	1.96
					28.0%	19.6%	22.0%	39.7%	1.5%	0.0%	0.0%	11.5%	33.4%	28.3%	0.5%	41.9%
Department Totals	60,797				193.45	2.35	3.14	4.36	7.54	1.41	1.09	2.00	9.67	11.02	48.17	4.68

Exhibit K - Hub Specialty Care at Male Prisons - FY 2006-07

<i>Hub</i>	<i>Hub Name</i>	<i># Male Prisons</i>	<i>Male Pop 2006</i>	<i>Spec Care Rate</i>	<i>Cardio Rate</i>	<i>Derm Rate</i>	<i>Gastro Rate</i>	<i>IFD Rate</i>	<i>Liv Bx Rate</i>	<i>Nephro Rate</i>	<i>Neuro Rate</i>	<i>Ophthal Rate</i>	<i>Ortho Rate</i>	<i>PT Rate</i>	<i>Urol Rate</i>
1	Oneida	8	6,212	178.49	2.27	2.75	3.20	1.61	2.22	1.58	2.64	11.24	10.22	46.70	4.35
2	Watertown	5	4,005	115.06	0.87	2.60	1.32	0.77	1.60	0.17	0.92	15.83	9.51	13.06	2.12
3	Clinton	9	9,032	194.71	1.71	1.38	5.02	9.00	1.36	0.95	1.21	12.93	12.01	59.88	3.76
4	Sullivan	8	5,921	234.22	3.56	4.09	6.30	7.58	0.91	1.76	1.81	9.86	13.06	60.12	6.86
5	Green Haven	3	5,096	335.66	4.10	8.95	4.61	27.43	0.86	3.45	3.45	9.44	15.09	82.99	5.87
6	Great Meadow	8	6,868	155.29	2.88	2.85	6.86	7.35	1.00	0.99	1.89	7.50	5.59	27.07	5.63
7	Wende	11	12,013	193.93	1.71	2.95	3.92	3.60	2.05	0.72	1.86	8.87	12.39	48.16	3.96
8	Elmira	8	7,274	167.93	2.06	2.27	2.34	3.01	0.91	0.29	3.05	7.26	11.31	48.34	4.78
9	New York City	6	3,509	191.28	3.45	2.59	6.04	15.50	1.48	0.54	1.28	5.02	9.58	41.64	6.18
	TOTALS		59,930	195.47	2.38	3.18	4.40	7.50	1.43	1.11	2.02	9.76	11.14	48.80	4.72

EXHIBIT K

EXHIBIT K

Exhibit L - DOCS Specialty Care at Female Prisons - FY 2006-07

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Class</i>	<i>Hub Security</i>	<i>Tot # Spec</i>	<i>Rate Spec</i>	<i>Physical Therapy</i>	<i>Rate PT</i>	<i>Cardiology Card</i>	<i>Rate Card</i>	<i>Dermatology Derm</i>	<i>Rate Derm</i>
Albion	1,150	1	7 Medium	5,442	473.22	891	77.48	24	2.09	63	5.48
Bayview	215	1	9 Medium	932	433.49	89	41.40	9	4.19	21	9.77
Beacon	228	3	5 Minimum	1,188	521.05	227	99.56	3	1.32	33	14.47
Bedford Hills	808	1	5 Maximum	7,583	938.49	1,698	210.15	69	8.54	206	25.50
Bedford Hills RMU	18	1	5 Maximum			277	1538.89	7	38.89	16	88.89
Lakeview (female)	96	1	7 Minimum	81	84.38	0	0.00	0	0.00	0	0.00
Taconic	305	2	5 Medium	2,096	687.21	218	71.48	26	8.52	29	9.51
Willard DTC female	51	1	99 Medium	67	131.37	0	0.00	0	0.00	0	0.00
<i>Totals</i>	2,871			17,389	605.68	3,400	118.43	138	4.81	368	12.82

EXHIBIT L

Exhibit L - DOCS Specialty Care at Female Prisons - FY 2006-07

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub</i>	<i>Gastroent.</i>	<i>Rate GI</i>	<i>Inf. Dis.</i>	<i>Rate IFD</i>	<i>Liver Bx</i>	<i>Rate LvBx</i>	<i>Nephrology</i>	<i>Rate Neph</i>
Albion	1,150	1	7	51	4.43	8	0.70	28	2.43	5	0.43
Bayview	215	1	9	24	11.16	39	18.14	5	2.33	0	0.00
Beacon	228	3	5	17	7.46	123	53.95	5	2.19	2	0.88
Bedford Hills	808	1	5	82	10.15	509	63.00	9	1.11	31	3.84
Bedford Hills RMU	18	1	5	4	22.22	28	155.56	1	5.56	2	11.11
Lakeview (female)	96	1	7	0	0.00	3	3.13	0	0.00	0	0.00
Taconic	305	2	5	29	9.51	210	68.85	5	1.64	9	2.95
Willard DTC female	51	1	99	3	5.88	0	0.00	0	0.00	0	0.00
<i>Totals</i>	2,871			210	7.31	920	32.04	53	1.85	49	1.71

EXHIBIT L

Exhibit L - DOCS Specialty Care Services for Female Prisons - FY 2006-07

<i>Prison</i>	<i>Pop 2006</i>	<i>Med Cl</i>	<i>Hub</i>	<i>Neurology</i>	<i>Rate Neuro</i>	<i>Ophthal.</i>	<i>Rate Ophth</i>	<i>Orthopedics</i>	<i>Rate Ortho</i>	<i>Urology</i>	<i>Rate Uro</i>
Albion	1,150	1	7	26	2.26	100	8.70	273	23.74	45	3.91
Bayview	215	1	9	20	9.30	14	6.51	28	13.02	7	3.26
Beacon	228	3	5	12	5.26	20	8.77	38	16.67	7	3.07
Bedford Hills	808	1	5	121	14.98	141	17.45	258	31.93	43	5.32
Bedford Hills RMU	18	1	5	6	33.33	6	33.33	9	50.00	4	22.22
Lakeview (female)	96	1	7	1	1.04	2	2.08	1	1.04	0	0.00
Taconic	305	2	5	33	10.82	20	6.56	61	20.00	18	5.90
Willard DTC female	51	1	99	2	3.92	7	13.73	3	5.88	0	0.00
<i>Totals</i>	2,871			221	7.70	310	10.80	671	23.37	124	4.32

Exhibit M - DOCS Female Specialty Care Utilization Rates - FY 2006-07

Prison	Pop 2006	Med Cl	Hub	Security	Rate Ttl Spec	Rate Card	Rate Derm	Rate Gastro	Rate IFD	Rate Liv Bx	Rate Neph	Rate Neuro	Rate Opth	Rate Ortho	Rate PT	Rate Urol
Willard DTC female	51	99	Med		131.37 21.7%	0.00 0.0%	0.00 0.0%	5.88 80.5%	0.00 0.0%	0.00 0.0%	0.00 0.0%	3.92 50.9%	13.73 127.1%	5.88 25.2%	0.00 0.0%	0.00 0.0%
Totals for Hub	99	51			131.37 21.7%	0.00 0.0%	0.00 0.0%	5.88 80.5%	0.00 0.0%	0.00 0.0%	0.00 0.0%	3.92 50.9%	13.73 127.1%	5.88 25.2%	0.00 0.0%	0.00 0.0%
Department Totals	2,871				605.68	4.81	12.82	7.31	32.04	1.85	1.71	7.70	10.80	23.37	118.43	4.32

Note: The percentages contained in the second line for each facility represents the percentage of the prison's utilization rate in comparison to the system-wide average utilization rate for women for each specialty care service.

Exhibit N - DOCS Specialty Care at CA Visited Prisons - FY 2006-07

<i>Prison</i>	<i>Pop</i>	<i>Med</i>	<i>Hub</i>	<i>Security</i>	<i>Rate All</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>	<i>Rate</i>
<i>2006</i>	<i>Cl</i>	<i>Cl</i>	<i>Cl</i>	<i>Spec</i>	<i>Card</i>	<i>Derm</i>	<i>Gastro</i>	<i>IFD</i>	<i>Liv Bx</i>	<i>Neph</i>	<i>Neuro</i>	<i>Ophth</i>	<i>Ortho</i>	<i>PT</i>	<i>Urol</i>	<i>PT</i>	<i>Urol</i>
Albion	1,150	1	7	Med	473.22	2.09	5.48	4.43	0.70	2.43	0.43	2.26	8.70	23.74	77.48	3.91	
Arthur Kill	947	1	9	Med	262.94	5.60	3.38	9.50	7.71	2.11	0.00	2.96	8.34	11.30	52.80	8.55	
Attica	2,204	1	7	Max	193.47	1.04	2.27	1.77	5.94	1.13	0.77	1.27	9.44	11.75	65.29	2.90	
Auburn	1,767	1	8	Max	148.73	2.21	2.83	4.58	7.19	1.13	0.51	2.89	7.64	9.73	39.05	3.79	
Bedford Hills	808	1	5	Max	938.49	8.54	25.50	10.15	63.00	1.11	3.84	14.98	17.45	31.93	210.15	5.32	
Clinton	2,890	1	3	Max	183.67	3.56	0.90	8.89	9.07	1.31	0.80	1.25	11.25	7.44	62.35	3.56	
Coxsackie	978	1	6	Max	240.80	3.68	6.24	15.44	11.04	1.02	1.23	3.27	10.33	7.06	52.97	10.84	
Eastern	1,175	1	4	Max	272.60	2.55	2.89	5.36	6.81	1.19	1.02	2.81	10.38	14.72	82.55	8.60	
Elmira	1,779	1	8	Max	145.92	1.35	1.29	0.84	1.07	0.90	0.17	4.05	6.41	10.79	24.68	6.91	
Fishkill	1,718	1	5	Med	402.68	8.50	15.19	5.94	36.96	1.22	7.10	6.05	11.87	23.98	87.37	7.22	
Gowanda	1,743	2	7	Med	146.36	1.26	1.20	1.26	1.09	1.32	0.34	0.80	5.97	8.26	36.83	2.07	
Great Meadow	1,681	1	6	Max	107.14	1.96	0.83	4.58	2.68	0.36	0.36	1.13	5.00	5.35	16.36	3.93	
Green Haven	2,149	1	5	Max	356.21	1.44	6.42	4.51	32.20	0.93	2.00	1.68	9.87	12.70	119.22	5.77	
Mid-Orange	721	1	4	Med	334.12	7.63	12.90	6.66	14.84	1.53	3.19	3.05	11.79	14.98	94.17	10.54	
Oneida	1,191	1	1	Med	184.13	2.69	3.02	4.37	5.37	1.76	3.11	1.85	11.34	10.66	35.94	6.13	
Sing Sing	1,737	1	9	Max	234.89	3.80	3.22	6.97	26.66	1.84	1.09	0.98	5.30	11.80	55.04	7.66	
Sullivan	746	1	4	Max	267.02	2.14	1.61	5.90	8.45	0.67	1.34	1.07	10.46	11.26	89.28	7.91	
Upstate	1,162	1	3	Max	217.99	0.00	1.38	0.95	8.09	0.86	0.52	1.55	9.04	19.97	100.86	3.61	
Wyoming	1,707	1	7	Med	129.00	0.82	1.17	5.10	1.29	2.23	0.70	0.53	8.67	9.90	26.42	3.46	
<i>Totals</i>	28,253				248.48	2.89	4.29	5.27	12.46	1.30	1.40	2.46	9.10	12.61	64.70	5.40	

EXHIBIT N