NYC HEALTH+ HOSPITALS

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Dear Members of the Board of Correction:

Correctional Health Services (CHS) appreciates the opportunity to review and comment on the draft rules proposed by the Board of Correction (BOC).

As the Board is aware, CHS has been reporting serious injuries to the Department of Correction (DOC) for years, for the purpose of supporting DOC's investigations into serious injury incidents. Last year, CHS and DOC worked together to develop a new protocol and form for jointly capturing and reporting serious injuries and investigations of same. The revised protocol and form were held in abeyance when BOC announced that it intended to undergo rulemaking.

CHS has ample experience with the categorization of serious injury. Given the range of clinical presentations of such injury, inter-observer variability in such categorization has been the historical norm. Serious injury has no accepted clinical definition and there is no clinical importance to the binary categorization of injury as either serious or non-serious (rather each injury is treated according to its individual clinical needs). For this reason, clinical staff cannot make such determinations based solely on their clinical training and expertise. Two clinicians would be expected to have their own arbitrary cutoff for what constitutes serious and thus, the board's category of serious injury as "an injury defined as serious by a physician" has led to significant confusion. To reduce inter-clinician variability in determining whether an injury is serious, CHS has developed its own structured criteria for categorizing an injury as serious. We believe this new definition will improve the accuracy and reliability of such determinations. CHS has agreed to train staff on appropriate categorization in an attempt to standardize this process. This will be an enormous undertaking, requiring the dedication of much clinical staff time to a fundamentally non-clinical purpose. Nonetheless, CHS proactively and willingly developed and is committed to implementing this new definition, mindful of the importance of this work to DOC and to the Board and the overall safety of the jail system.

However, CHS has several concerns regarding other aspects of the proposed Health Care Standards 3-08 and 3-16 which were raised with BOC staff as part of our conversations over the drafts. As these concerns were not resolved during those discussions, we now bring our concerns officially to the Board.

1) Forensic evaluation. Concerning Health Care Standard 3-08(b), CHS strongly feels that the language in 3-08(b) should be changed from "forensic" evaluation to evaluation "for non-medical purposes," the Board's original terminology. The term, "forensic" is insufficiently broad to shield CHS from conducting clinical evaluations for any reason other than medical treatment. The only exception should be our Forensic Psychiatric Evaluation Court Clinics, which we carefully separate from our treatment work.

2) Contact tracing. As to 3-08(c)(4), CHS is concerned that reporting this information to the Board is potentially confusing, given the responsibilities of NYC DOHMH to whom these cases must be

reported under law. DOHMH advises CHS or any other entity (including DOC and the Board) of measures to be taken to prevent and contain the spread of communicable disease in the event of potential exposure. The Board's intended use of this information should be made explicit, if it in fact regards such information to be actionable by the Board.

3) Non-serious injury type. The Board's proposed rule will require the same process applied to serious injury to be done for non-serious injury, which we regard as an impossible task given the almost infinite types of non-serious injuries that exist. Given the arbitrary categorization we would have to develop, and the difficult yet unenforceable training and implementation, CHS cannot implement such a process.

CHS' understanding is that the Board is interested in identifying if there are specific additional types of injury (other than those described in the nine categories of serious injury) that might be particularly frequent in the population. We could propose adding head blows and lacerations regardless of severity of injury, to the serious injury reporting system, but we believe that this non-serious injury typing provision should be struck as it is unmanageable.

4) Body location of non-serious injury. As to Health Care Standard 3-16(d) (2) (i) (j), CHS cannot identify body location in a structured way, as a dropdown pick list for such an item would become unwieldy. Further, many injuries involve multiple body parts. It would be more clinically sound for CHS to indicate location on the homunculus on the DOC injury form as we currently do, for DOC report as part of its investigatory findings. As such, we believe that this provision should be struck as it is unmanageable.

5) Self-harm. The determination that an injury sustained was a result of self-harm is a determination made in the course of clinical treatment, typically by the mental health service and after consideration of the patient's clinical and environmental situation. Because the joint reporting protocol necessarily begins with line-listings of individual patients who have had a serious injury, including self-harm in this rule about reporting and investigations of serious injury will necessarily and inappropriately reveal to DOC highly sensitive and potentially harmful protected health information. Most importantly, self-harm in a jail setting is too easily and quickly attributed to intentional, attention-seeking behavior and can lead to patient harm through associated stigma and reduced awareness of warning signs. As a strong predictor of suicide is a prior attempt, regardless of the lethality of that attempt, all self-harm is treated as a serious warning sign and managed very carefully by the mental health service. We have the strongest objections to a DOC investigative process around self-harm, which among other negative outcomes will disincentivize patients from engaging in honest therapeutic relationships with the mental health staff and could lead to patient harm.

The injury reporting process is a DOC-initiated investigatory process which prompts CHS documentation and clinical care. From a clinical standpoint, an injury encounter is not the point in CHS clinical workflow at which CHS would definitively identify an act of self-harm as a cause of injury. Important self-harm events can occur without injury and injury encounters may result in MH referrals regardless of whether self-harm is alleged or mentioned. CHS has implemented a successful program for tracking and addressing self-harm which should not be confused with the injury investigation process, and proposes to voluntarily provide the Board with a recurring report on self-harm, as CHS has voluntarily provided three monthly access reports to the Board for years. As such, we believe that this self-harm provision should be struck from this serious injury reporting and investigation rule, as it is damaging to patient well-being and contrary to sound and ethical clinical practice.

We are grateful to the Board for providing CHS this opportunity to share our concerns, which are rooted in a sincere determination to provide our patients with clinically sound and appropriate healthcare. Thank you for your time and consideration.

Respectfully,

Dr. Patricia Yang