2024

Utilization of Sick Call in New York City Jails

BOARD OF CORRECTION ANALYSIS OF CY2023 DATA

AUGUST 2024

NYC Board of Correction

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Letter from the Vice Chair

August 19, 2024

Dear Colleagues and Partners,

I am pleased to introduce this report on the utilization of sick call services in New York City's jails, a vital aspect of our correctional system that has been carefully analyzed by the Board of Correction. This report is a testament to our ongoing commitment to ensuring that all individuals in our custody receive the healthcare they need and deserve.

Having personally experienced the challenges of navigating multiple systems in New York City, I understand the critical importance of access to reliable healthcare, particularly within correctional settings. The quantitative findings presented in this report are not just numbers; they are deeply correlated with the lived experiences of those within our jails. These findings echo the voices of individuals who have often struggled to access the care they need, reinforcing the urgency of the changes we must make.

The recommendations provided are rooted in evidence and reflect our dedication to fostering a correctional environment that prioritizes the health and dignity of every individual. It is imperative that we take these recommendations seriously and work collaboratively across all sectors to implement the necessary changes. The well-being of those in our custody depends on our ability to act decisively and with compassion.

As we move forward, I trust that this report will serve as a valuable resource for policymakers, practitioners, and all stakeholders committed to advancing the standards of care in our correctional facilities. The New York City Board of Correction remains steadfast in its mission to advocate for humane and effective practices, and I am confident that the insights from this report will drive meaningful progress in our work.

Thank you for your ongoing support and dedication to this critical cause.

Sincerely,

Helen Skipper, Vice Chair
New York City Board of Correction

Executive Summary

Pursuant to §§626(c) and (h) of the New York City Charter and §3-02(c) of Title 40 of the Rules of the City of New York (RCNY), the New York City Board of Correction (Board or BOC) conducted a comprehensive analysis of the provision and timeliness of sick call in New York City jails between January 1 and December 31, 2023. This report evaluates the performance of the current sick call process and proposes actionable recommendations to enhance healthcare access for people in custody.

Key findings include:

1. **Provision of Sick Call:** Over a third of requests during calendar year (CY) 2023 resulted in people in custody (PIC) not being escorted to the clinic for their scheduled appointments.
2. **Timeliness**: Of all sick call requests that resulted in PIC being escorted to the clinic, less than half were within the required timeframe of one business day.

Based on these findings, BOC recommends the following:

1. The Department of Correction (DOC) should reduce its reliance on the Correctional Health Services (CHS) Health Triage Line (HTL) and re-establish their own sick call process. The new process should:
    a. **Include multiple, defined pathways for PIC to request sick call virtually or in person.** All requests should be documented in a DOC electronic database using an electronic form. For each sick call request, DOC should collect and store, at minimum, the name of the PIC requesting sick call, the book and case number associated with the PIC, and the date and time of the sick call request.
    b. **Implement a dashboard to enable real-time scheduling of sick call appointments with CHS**. Using data collected and stored in its electronic database, DOC should develop a dashboard to be shared with CHS to assist with scheduling sick call appointments. The dashboard should include, at minimum, the name of the PIC requesting sick call, the book and case number associated with the PIC, and the date and time of the request. PIC should be added to the list in the order in which they request sick call. The dashboard should also indicate which PIC will not be escorted to the clinic, so CHS can be aware of who to expect in the clinic.
    c. **Track reasons for non-production.** DOC should also track reasons for non-production in its electronic database. These reasons should align with the reporting requirements specified in Local Law 132 for the year 2019 (LL132/2019) such as court, family visits, programming, barbershop, or production refusal.
    d. **Facilitate real-time monitoring of timeliness.** For each sick call request, DOC should document the clinic arrival time in its electronic database. This information should also be added to the dashboard to make CHS aware of when PIC arrive in the clinic.
    e. **Track healthcare encounter outcomes**. For each sick call request, CHS should be able to use the dashboard to note the date and time PIC are seen. If PIC are not seen, the dashboard should prompt CHS to enter the reason why. These should be consistent with existing reporting to the Board and reflect instances where PIC refuse treatment, leave without being seen, or CHS reschedules their encounter.
    f. **Track monthly performance metrics.** At minimum, these metrics should include:
        i. The total number of PIC requesting sick call.

ii. The number and percentage of PIC produced to the clinic. For PIC not produced to the clinic, the number and percentage in each non-production category.
iii. The number and percentage of PIC seen by a healthcare provider. For PIC not seen, the number and percentage in each not-seen category.

2. DOC should aim to improve the provision and timeliness of sick call to at least 95% within the next six months.
3. DOC should evaluate PIC satisfaction with sick call services. As soon as feasible, DOC should implement patient satisfaction surveys. These should be made available to PIC through their tablets following a request for sick call and inquire whether their concerns were addressed.

The proposed recommendations aim to address inefficiencies and delays in the provision of care following a sick call request. By implementing these recommendations, the Board believes that DOC could significantly enhance the sick call process, ensuring timely and effective medical care for all PIC as mandated by RCNY §3-02(c).

Introduction

The New York City Board of Correction (Board or BOC) monitors compliance with minimum standards regarding the provision of sick call in New York City (NYC) jails pursuant to §§626(c) and (h) of the New York City Charter and §3-02(c) of Title 40 of the Rules of the City of New York (RCNY). The sick call process is intended to provide people in custody (PIC) with timely access to medical care for the assessment, diagnosis, and treatment of health-related concerns. In this report, the Board clarifies the definition of sick call and presents an assessment of the provision and timeliness of sick call between January 1 and December 31, 2023 (CY2023).

Background

In June 2015, the City announced that it would end its relationship with Corizon Inc. and transition healthcare for PIC to Correctional Health Services (CHS), a new division of NYC Health + Hospitals.[1] Shortly after assuming responsibility for healthcare delivery in the NYC jails on January 1, 2016, CHS acknowledged that improvements could be made to the sick call process.[2] During a joint presentation with the Department of Correction (DOC) to the Board on March 8, 2016, the two agencies indicated that they were collaboratively working to improve access to care.[3] Beginning in April 2016, the Board required CHS to produce a monthly report summarizing healthcare encounters by type and outcome overall and for each facility.[4]

In June 2017, following seven[5] public Board meetings on access to care, DOC and CHS presented the Board with an action plan aimed at addressing challenges in staffing, scheduling, and transportation.[6] This plan included two pilot initiatives, which were collaborative efforts between DOC and CHS: (1) the implementation of cohort housing to reduce the need for escorts; and (2) coordinated scheduling aimed at minimizing conflicts and overscheduling.[7]

In its May 2018 report on access to care, the Board updated the public on the status of these two initiatives. The first initiative, cohort housing, afforded PIC with similar health needs centralized medical, nursing, and sick call.[8] However, it was underutilized. At the time, CHS reported that only 15% of those identified as eligible were placed in cohort housing.[9] The second initiative, coordinated scheduling, was discontinued after DOC and CHS determined that conflicts between health appointments and programming do not occur frequently enough to be a barrier to care.[10] In this report, the Board made several recommendations to DOC and CHS that, if implemented, would have facilitated improved tracking and outcomes related to its Minimum Standards on Health and Mental Health Care.

In June 2019, the Board issued a second report on access to care. In this report, the Board noted limited coordination between DOC and CHS to identify and address barriers to care and highlighted discrepancies in

[1] NYC Mayor's Office, Health and Hospitals Corporation to Run City Correctional Health Service, New York City, New York, June 2015.
[2] DOC and CHS, Presentation to the Board of Correction, New York City, New York, March 2016.
[3] Ibid.
[4] NYC Board of Correction, Access to Health and Mental Health Care (July – December 2017), May 2018, p. 1.
[5] See NYC Board of Correction Meeting Minutes on February 9, 2016, March 8, 2016, June 14, 2016, September 13,2016, October 11, 2016, January 10, 2017, and February 14, 2017.
[6] NYC Board of Correction, Access to Health and Mental Health Care (July – December 2017), May 2018, p. 2.
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid.

DOC and CHS reporting on the number of completed sick call encounters.[11] For example, in March 2019, the Board found that CHS reported 10,423 completed sick call encounters while DOC reported 7,136 completed sick call encounters.[12] The Board cited independent DOC and CHS systems as a significant factor contributing to inconsistent reporting on access to care and encouraged greater collaboration between the two agencies.[13] On June 13, 2019, citing the work of the Board and community advocates, the NYC Council passed Local Law 132.[14] This legislation codified the Board's Minimum Standards related to sick call into law and amended the administrative code to require DOC to report on clinic production for sick call and other healthcare services.[15]

On March 2, 2020, following its migration to a new electronic health record, CHS amended its reporting to the Board on access to care. In their memo to the Board detailing revisions and updates to its reporting, CHS noted that the new electronic health record system would enable them to distinguish between direct (in-person) and indirect (administrative, not-in-person) services.[16] According to CHS, this update would reduce overcounting of patient encounters by allowing them to report only on direct, in-person encounters.[17] The memo also indicated that they updated the scheduled service outcome to align with the requirements of LL132/2019 to report on reasons for non-production.[18] This change was not implemented for unscheduled services such as sick call. Shortly after, in its presentation to the Board on March 10, 2020, CHS introduced a new service called "sick call triage" which transformed sick call into an indirect unscheduled or direct scheduled encounter.[19] Despite this change, CHS continued to report on sick call as an unscheduled service preventing monitoring of non-production trends.

Prior to the introduction of the "sick call triage" process, PIC would request sick call by adding their name and identification number to a sign-up sheet in the housing area. These PIC would then be escorted by DOC each non-holiday weekday to the CHS clinic. These were unscheduled, direct encounters. Under the new process proposed by CHS on March 10, 2020, sick call would become an indirect (not-in-person) unscheduled or direct (in-person) scheduled encounter. PIC would speak to CHS nurses directly about their healthcare needs by calling a dedicated number using their tablets or a phone in their housing area. CHS nurses would answer calls on non-holiday weekdays between 5am and 12pm. Outside of these hours and when a nurse does not pick up, PIC would be encouraged to leave a message. CHS nurses would then triage the call or message and determine if the concern can be addressed administratively (indirect, unscheduled), over the phone (indirect, unscheduled), or in person (direct, scheduled).[20] For PIC who need to be seen in person, CHS would provide DOC with a list on each non-holiday weekday and DOC would then escort those individuals to the clinic.[21] The DOC "Daily Sick Call"

[11] NYC Board of Correction, Access to Health and Mental Health Care (January - December 2018), June 2019, p. 5.
[12] Ibid.
[13] Ibid.
[14] NYC Council, Committee Report of the Justice Division, June 2019, pp. 3-5.
[15] Ibid.
[16] NYC H+H Correctional Health Services, Revisions to the Monthly CHS Access Report following Completion of Electronic Health Record System Migration, March 2020, p. 1.
[17] Ibid.
[18] Non-production refers to instances in which DOC did not escort PIC to medical appointments requested by CHS. Common reasons for non-production include court, family visits, programming, barbershop, production refusal, and walkouts.
[19] NYC H+H Correctional Health Services, Correctional Health Services Update, March 2020.
[20] Ibid.
[21] NYC H+H Correctional Health Services, Correctional Health Services Update: Patient Access to Clinical Care, October 2023.

Operations Order indicates that this update to the sick call process was implemented effective September 4, 2020.[22]

In June 2020, DOC issued its first monthly report on medical non-production pursuant to LL132/2019. This reporting summarizes non-production by reason and facility for all medical services. No tracking is done on non-production for the sick call process specifically. Similarly, the CHS access to healthcare report only reports the total number of sick call encounters completed. Combined, these reports paint an incomplete picture of the sick call process, preventing the holistic monitoring needed to ensure that PIC receive consistent, reliable access to care. To date, neither agency has updated its reporting despite recommendations from the Board to do so.[23]

On October 4, 2021, Brooklyn Defender Services, the Legal Aid Society, and the law firm Milbank sued the DOC for failing to provide PIC with access to medical care.[24] On December 3, 2021, the Bronx Civil Supreme Court found that DOC failed to provide PIC access to care and ordered that they do so immediately by providing access to sick call on weekdays within 24 hours of a request. In addition, the Court also required that DOC provide sufficient security to allow movement to and from the clinics.[25]

In response to this lawsuit, the Board requested an update from CHS on the sick call triage process. In its presentation to the Board on October 19, 2021, CHS noted a daily increase in call volume from approximately 150 calls per day to 350 calls per day between April 7, 2020 and September 15, 2021.[26] They also explained that they have renamed the process from "sick call triage" to "health triage" because CHS Nursing staff coordinate care for PIC among all disciplines (e.g., mental health, dental, substance use, pharmacy, etc.). Of triaged calls, CHS reported that 53% led to direct scheduled encounters for patients and 47% were addressed administratively (unscheduled, indirect).[27] It is unclear from these metrics whether the implementation of the Health Triage Line (HTL) increased or decreased access to care relative to the previous sick call process which required DOC to produce all PIC to clinics operated by CHS upon request.

Current Study

Following five[28] additional public Board meetings discussing access to care through the sick call process between February 2022 and January 2024, the Board requested data in March 2024 from DOC and CHS to independently determine compliance with its Minimum Standards related to the provision of sick call. In particular, the Board requested line-level data from both DOC and CHS on all PIC (1) requests for sick call; (2) arrivals to the clinic; and (3) encounters with healthcare personnel. In response to this request, DOC provided CY2023 data on all PIC phone calls to the CHS HTL and information on encounter outcomes as documented by CHS in their electronic health records. DOC was unable to provide data on clinic arrivals beyond what is recorded in paper-based clinic logbooks. CHS did not provide any data in response to this request.

In July 2024, the Board asked DOC and CHS to each provide their operational definitions of sick call. On July 10, DOC shared that "while the Department has multiple policies related to the sick call process (Ops Order 11-20,

[22] NYC Department of Correction, The Sick Call Process and Access to Care, January 2024.
[23] NYC Board of Correction, Access to Health and Mental Health Care (July – December 2017), May 2018, p. 2.
[24] Agnew versus NYC Department of Correction, 217 A.D.3d 490, (N.Y. App. Div. 2023).
[25] Ibid.
[26] NYC H+H Correctional Health Services, Correctional Health Services Update, October 2021.
[27] Ibid.
[28] See NYC Board of Correction Meeting Minutes on February 8, 2022, September 8, 2023, October 17, 2023, November 14, 2023, and January 10, 2024.

Directive 3800, and the PIC Handbook), there is no operational definition outlined in these policies." On July 23, CHS responded that it "doesn't have an operational definition of sick call, which is a DOC-driven process." CHS also noted in previous discussions with the Board that the CHS HTL should not be considered part of the DOC-led sick call process. Given these differing perspectives, the Board seeks to clarify the definition of sick call in this report to ensure that its performance can be more effectively and uniformly measured.

Sick Call Definition

In its Minimum Standards, the Board defines "sick call" as an encounter between a PIC and health care personnel for the purpose of assessing and/or treating a medical complaint.[29] The Minimum Standards further specify that sick call is to be provided daily, Monday through Friday, in every facility and housing area operated by DOC.[30] Additionally, the Minimum Standards require that PIC be escorted by DOC staff for care at facility clinics operated by the Correctional Health Authority within twenty-four hours of a request.[31]

In July 2024, the Board conducted a survey of PIC to understand how they define sick call and what their experience has been with the process. The survey was administered using a semi-structured interview format as detailed in Appendix A. Between July 9 and July 23, the Board interviewed 50 PIC, who were randomly selected proportional to the population distribution across facilities as of June 1, 2024 (Table 1). Prior to the interviews, all participants provided their consent to speak with the Board as detailed in Appendix B. The interview questions explored how PIC define the sick call process, their methods for accessing it, their experiences with the process, their overall satisfaction, and suggestions for improvement.

Table 1: Sampling Methodology for Surveys with PIC

Facility	Census on June 1, 2024	PIC surveyed
EMTC	1,452 (23.1%)	12 (24.0%)
GRVC	973 (15.5%)	8 (16.0%)
NIC	265 (4.2%)	2 (4.0%)
OBCC	1,382 (22.0%)	11 (22.0%)
RESH	146 (2.3%)	1 (2.0%)
RMSC	382 (6.1%)	3 (6.0%)
RNDC	1,029 (16.4%)	8 (16.0%)
WF	658 (10.5%)	5 (10.0%)
Total	**6,287 (100.0%)**	**50 (100.0%)**

The Board's survey of 50 PIC revealed a range of insights into their experiences with the sick call process. PIC generally use "sick call" to address new medical issues (n=44; 88.0%), including emergencies (n=36, 72.0%) and medication requests (n=33; 66.0%) (Table 2).

[29] NYC Board of Correction, Health Care Minimum Standards Chapter 3 (eff. May 15, 1991).
[30] Ibid.
[31] Ibid.

Table 2: Purpose of Sick Call	Overall (N=50)
What do you believe sick call is primarily for?[32]	
Get care for a new medical issue	44 (88.0%)
Emergency medical issues	36 (72.0%)
Medication requests	33 (66.0%)
Routine health check ups	20 (40.0%)
Other	
Dental	10 (20.0%)
Mental Health	7 (14.0%)
Glasses	2 (4.0%)
Specialty	2 (4.0%)

Most respondents accessed sick call services by calling the CHS HTL (n=44; 88.0%) though some mentioned other methods like speaking directly to a correctional officer (n=7; 14.0%) or filling out a request form (n=2; 4.0%) (Table 3).

Table 3: Requesting Sick Call	Overall (N=50)
How do you typically (most frequently) access sick call services in your current facility?[33]	
Calling the Health Triage Line or #614	44 (88.0%)
By speaking directly to a correctional officer	7 (14.0%)
Writing a request or filling out a form	2 (4.0%)
Via a healthcare professional during another medical interaction	0 (0.0%)
Other	4 (8.0%)

According to the "Daily Sick Call" Operations Order from September 4, 2020, DOC uses the CHS HTL to provide PIC with access to sick call. Survey results support this, with most PIC reporting that they use the CHS HTL to request sick call. The function of the CHS HTL – addressing concerns administratively over the phone or by scheduling appointments with healthcare personnel at CHS-operated clinics – aligns with Board's definition of sick call in in its Minimum Standards, which is an encounter between a PIC and health care personnel for the purpose of assessing and/or treating a medical complaint. Therefore, the Board will also refer to calls to the CHS HTL as sick call requests.

Methods

The Board conducted a retrospective analysis of the data received from DOC to assess the provision and timeliness of sick call between January 1 and December 31, 2023. The specific objectives were to understand the:

Primary

[32] Respondents were permitted to select multiple options; therefore, the percentages may exceed 100%.
[33] See previous footnote.

- Provision of appointments for healthcare services following a sick call request as required by RCNY §3-02(c)
- Timeliness of being seen for healthcare services following a sick call request within one business day as required by RCNY §3-02(c)

Secondary

- Describe the sick call process
- Describe requestor profiles (e.g., demographics and incarceration characteristics)

Data Sources

This analysis required data from three sources: (1) PIC phone calls to the CHS HTL; (2) information on the outcome of scheduled healthcare encounters for sick call as documented by CHS in their electronic health records[34]; and (3) DOC incarceration-level information available in the Board's data warehouse.

Data Matching

Using individual- and incarceration-level identifiers, the Board matched all requests for sick call to healthcare encounter outcomes using a full outer join and deduplicated the data to one sick call request per PIC per day.[35] Where there were multiple sick call requests through the CHS HTL[36] on a given day by the same PIC, requests for appointments were retained over those to speak to CHS Nursing regarding medications, dental appointments, glasses, COVID-19 vaccinations, or other reasons. For PIC with multiple appointment requests on the same day, the earliest was retained. As PIC can have multiple requests for sick call and multiple healthcare encounters during the timeframe, the Board identified and retained the healthcare encounters closest to each request for sick call.[37] Requests with no associated encounter outcomes were also retained. Similarly, encounter outcomes with no associated requests were also retained. Where there were multiple healthcare encounter outcomes documented for the same sick call request, the following order determined which would be retained: seen, incomplete visit, left without being seen, refused, CHS rescheduled, and not produced.

As neither the phone call nor healthcare encounter data contained demographic information, the Board extracted DOC incarceration-level admission dates, racial/ethnic group, biological sex, birthdates, and binary

[34] Between January 1, 2023, and September 30, 2023, CHS documented sick call encounters in which PIC were seen by healthcare personnel at their clinics using the "MED - Sick Call Visit" or "NU - Sick Call Visit" forms. Starting October 1, 2023, CHS shifted to documenting these encounters using the "MED - Referred Visit" or "NU - Referred Visit" forms. In its reporting to the Board on access to care, CHS also updated the category from "Sick Call Visits" to "Referred Visits." CHS notes that "Referred" encounters result from referrals from various sources, including but not limited to the CHS Health Triage Line, CHS Patient Relations, other CHS staff, or DOC's sick call process.

[35] Fuzzy matching was employed because data on sick call requests exist separately from data on healthcare encounters. As such, there is no request-level identifier in either dataset that links a request for sick call to a healthcare encounter.

[36] There were 6,126 documented healthcare encounters for sick call that did not originate through the CHS HTL. These sick call requests could have been made through CHS patient relations, CHS staff, or DOC staff.

[37] This method ensures that each sick call request is matched with the earliest occurring healthcare encounter documented for the individual- and incarceration-level identifier.

health condition flags (mental health needs[38], self-identified substance use[39], and heat sensitivity[40]) from its data warehouse. This information was then matched to each PIC request for sick call using individual and incarceration-level identifiers. Once matched, the Board used the incarceration-level admission and birth dates to determine PIC length of stay and age at the time of each sick call request.

Data Analysis

The Board used the matched data of sick call requests and healthcare encounters for the analysis timeframe to determine compliance with RCNY §3-02(c) concerning the provision of sick call and timeliness of healthcare encounters following a request.

To measure the provision of sick call, the Board determined how many PIC were produced by DOC following a sick call request. To understand the timeliness of these healthcare encounters, the Board created a function that would count the number of business days between a request for sick call and the date of the scheduled encounter. The function excluded weekends and City holidays[41] such as New Year's Day, Martin Luther King Jr.'s Day, President's Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Columbus Day, Election Day, Veteran's Day, Thanksgiving Day, and Christmas Day. The Board then used this function to determine the timeliness of healthcare encounters within one business day of a sick call request.

Aligned with its secondary goals to better understand the sick call process and requestor profile, the Board developed a flow chart describing key steps and summarized requests by race/ethnicity, biological sex, age, and indicators within DOC data which may suggest health conditions.

Results

Between January 1 and December 31, 2023, there were 95,547 requests for sick call. During CY2023, the monthly volume of sick call requests ranged from 7,390 to 8,807 (Figure 1). On average, there were 7,962 sick call requests per month with the median being 7,938.

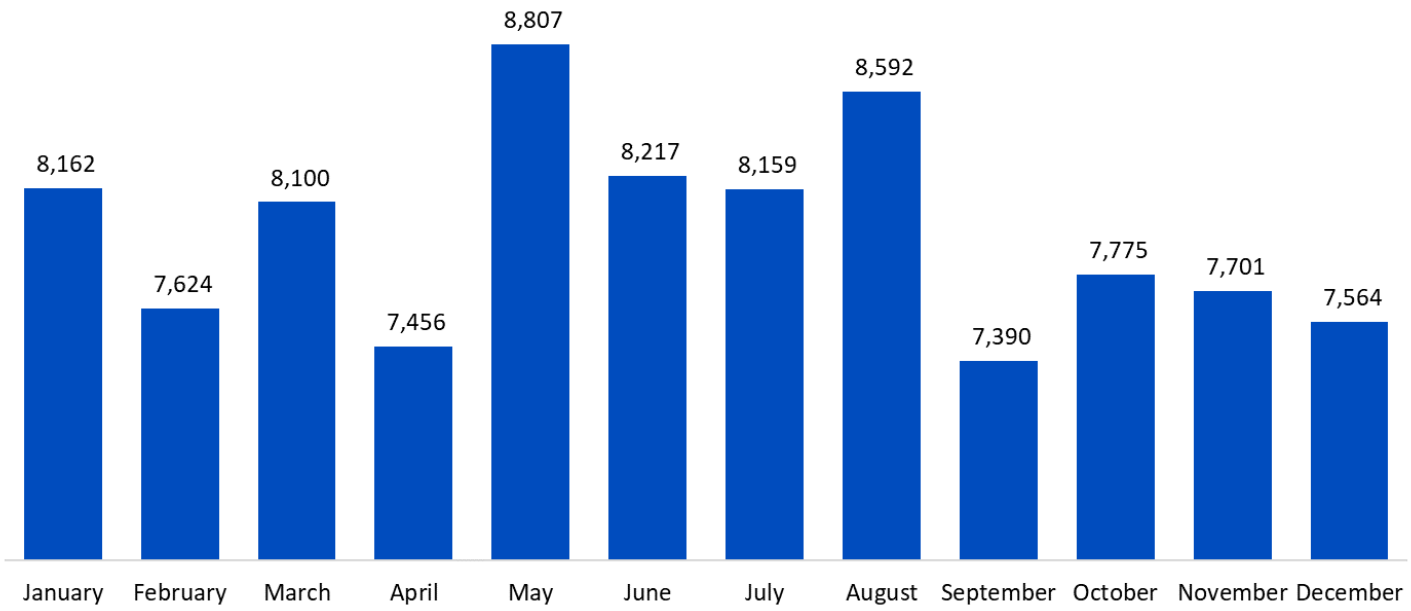
[38] Based on the" M" designation flag. Pursuant to a settlement in *Brad H. v. City of New York,* PIC are designed "M" if, during one incarceration event, they have engaged with the mental health service at least three times, have been prescribed certain classes of medication, or have otherwise been assessed by CHS or the Health Authority as needing further mental health treatment. For more information, see §RCNY 6-03 (b)(12).

[39] PIC who self-disclosed using drugs or alcohol at time of admission to DOC custody.

[40] PIC who are clinically designated as heat sensitive by CHS.

[41] In 2023, these holidays were on the following dates: 1/2, 1/16, 2/20, 5/29, 6/19, 7/4, 9/4, 10/9, 11/7, 11/10, 11/23, 12/25.

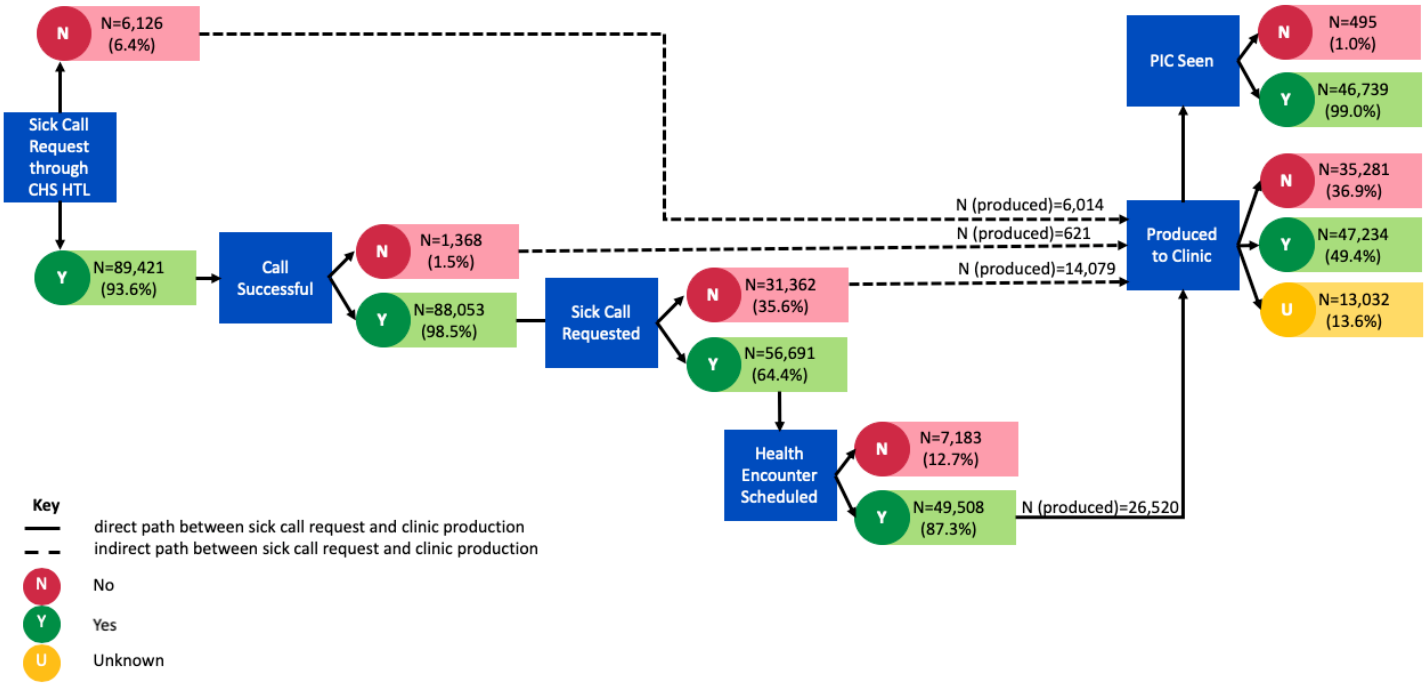
Figure 1: Monthly Sick Call Requests (N=95,547)



Sick Call Process

Of 95,547 sick call requests, 89,421 (93.6%) were made through the CHS HTL and 6,126 (6.4%) originated through some other means such as CHS Patient Relations, CHS Staff, or DOC Staff (Figure 2).

Figure 2: Sick Call Flow Chart for CY23 (N=95,547)



For the 6,126 (6.4%) sick call requests that did not originate through the CHS HTL there was no information in the data shared with the Board on how or when these requests were made. Similarly, for the 89,421 (93.6%) sick call requests through the CHS HTL, the Board identified several indirect pathways that were not well documented in the data and that appear to have led to PIC being escorted to the clinic. For example, calls to the

CHS HTL were not successful for 1,368 (1.5%) of all 89,421 requests through this route. Yet, 621 (45.4%) of these unsuccessful calls still resulted in DOC escorting PIC to the clinic. In 31,362 (35.6%) of all 88,053 sick call requests successfully placed through the CHS HTL, PIC did not request an appointment with a healthcare provider.[42] Despite this, 14,079 (44.0%) of these interactions resulted in DOC producing PIC to the clinic. This could be the result of triaging efforts by CHS Nursing to ensure PIC receive the care they need regardless of whether they request an appointment. However, the data does not indicate which sick call requests to the CHS HTL were addressed by CHS Nursing administratively (indirect, unscheduled) versus through an encounter with a healthcare provider (direct, scheduled).

In July 2024, the Board requested additional information from CHS on how calls are triaged. In response, CHS provided statistics, originally shared during their April 2024 testimony to the NYC Council, indicating that of 48,622 calls received through the CHS HTL, 30,458 (62.6%) resulted in an order for an appointment being placed and 18,164 (37.4%) were handled administratively. When the Board followed up to inquire why nearly 40,000 calls were not reflected in their data, CHS clarified that their records only include "every intelligible, identifiable call noted in the patient chart." This suggests that the system-generated log of all calls to the CHS HTL provided by DOC and used in this report may be more comprehensive than the CHS medical records, as some calls to the HTL may not have been documented by CHS clinical staff.

Provision & Timeliness of Sick Call

Overall, 47,234 (49.4%) of 95,547 PIC requests for sick call during CY2023 resulted in DOC escorting or producing PIC to clinics operated by CHS (Table 4). PIC were not escorted or produced to clinics operated by CHS for their scheduled appointments for 35,281 (36.9%) of all sick call requests. Of all sick call requests, there are 13,032 (13.6%) in which no encounter outcomes were documented by CHS in their electronic health record. This could be because the calls were addressed administratively by CHS Nursing on the phone or because encounter outcomes for scheduled appointments were not documented by clinical staff.

Table 4: Production Outcomes	Overall (N=95,547)
Escorted/Produced to Clinic by DOC	
Yes	47,234 (49.4%)
No	35,281 (36.9%)
Missing	13,032 (13.6%)

Production was timely, occurring within one business day for 18,665 (39.5%) of the 47,234 clinic escorts (Table 5). According to RCNY §3-02(c), PIC should be seen within one business day of their request, which requires CHS to schedule appointments promptly and DOC to produce PIC to the clinic in a timely manner. However, due to the absence of a request-level identifier linking sick call requests to healthcare encounters, the Board's analysis used fuzzy matching, making it difficult to pinpoint whether delays are due to untimely scheduling by CHS or delays in DOC's escorting process. Despite this limitation, the data indicates that delays in production do exist. CHS healthcare providers saw PIC for 46,739 (99.0%) of the 47,234 requests where they were escorted to the clinic by DOC. The remaining 495 (1.0%) were not seen due to PIC declining services, leaving without being seen, or having their appointments rescheduled by CHS.

[42] Based on dual-tone multi-frequency (DTMF) data indicating the purpose of the PIC's call to the CHS HTL.

Table 5: DOC Production Timeliness & Healthcare Encounter Outcome	Overall (N=47,234)
Timeliness of DOC Production	
Timely	18,665 (39.5%)
Not Timely	22,555 (47.8%)
Missing	6,014 (12.7%)
Seen by CHS Healthcare Provider	
Yes	46,739 (99.0%)
No	495 (1.0%)

Requestor Profile

Of 95,547 requests for sick call, 77,089 (80.7%) were made by Non-Hispanic Black/African American or Hispanic PIC (Table 6). Male PIC made the majority, 80,475 (84.2%), of all requests. Age at time of request ranged from 18 to 94 years old with the mean age being 39 years and the median age being 37 years.

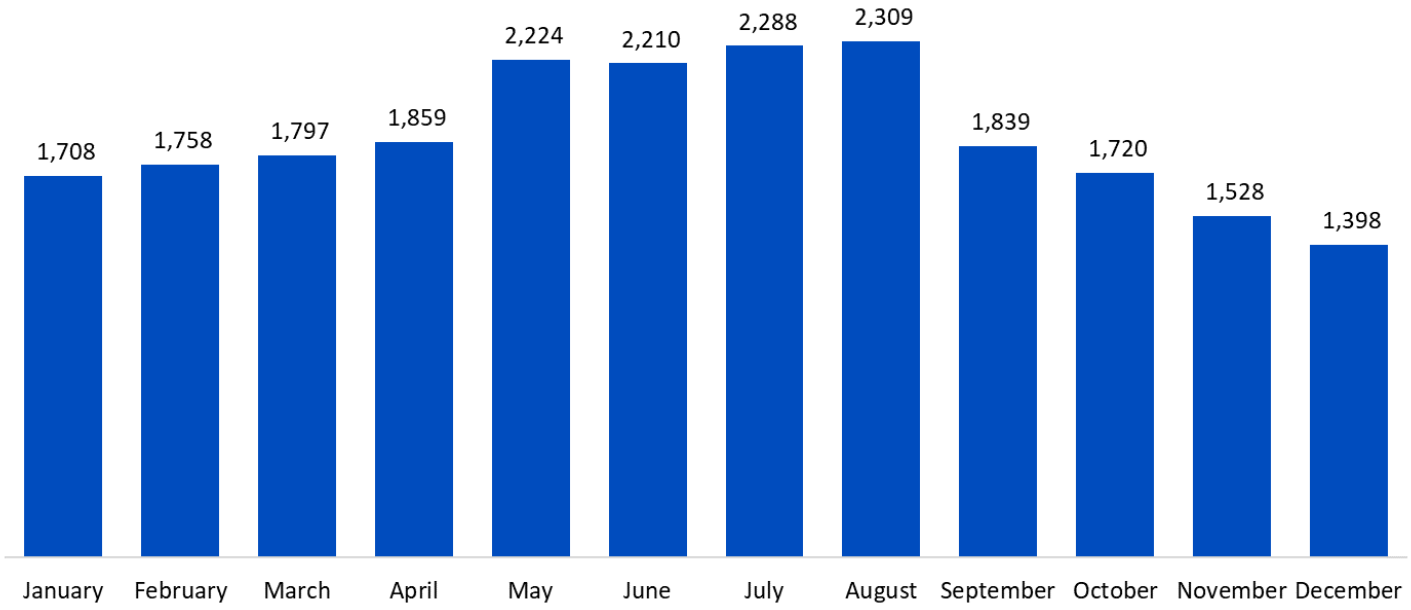
Table 6: Demographics	Overall (N=95,547)	Census[43] (N=6,102)
Race/Ethnicity		
Hispanic	26,582 (27.8%)	1,860 (30.5%)
NH American Indian or Alaska Native	210 (0.2%)	17 (0.3%)
NH Asian	2,029 (2.1%)	133 (2.2%)
NH Black or African American	50,507 (52.9%)	3,530 (57.8%)
NH Other	2,452 (2.6%)	186 (3.0%)
NH White	8,582 (9.0%)	354 (5.8%)
Missing	5,185 (5.4%)	22 (0.4%)
Biological Sex		
Female	9,960 (10.4%)	391 (6.4%)
Male	80,475 (84.2%)	5,693 (93.3%)
Missing	5,112 (5.4%)	18 (0.3%)
Age (at time of sick call request or date of census)		
Mean (SD)	38.6 (11.9)	35.8 (11.7)
Median [Min, Max]	37.0 [18.0, 94.0]	34.0 [18.0, 86.0]
Missing	4,830 (5.1%)	2 (0.0%)
Mental Health Needs		
No	38,050 (39.8%)	2,891 (47.4%)
Yes	52,705 (55.2%)	3,211 (52.6%)
Missing	4,792 (5.0%)	0 (0.0%)
Self-Identified Substance Use		

[43] Board analysis of DOC census data on June 29, 2023. Due to incomplete data, the Board is unable to compute average daily population for CY2023.

No	68,182 (71.4%)	4,874 (79.9%)
Yes	22,323 (23.4%)	1,228 (20.1%)
Missing	5,042 (5.3%)	0 (0.0%)
Heat Sensitive Condition		
No	68,028 (71.2%)	4,908 (80.4%)
Yes	22,638 (23.7%)	1,189 (19.5%)
Missing	4,881 (5.1%)	5 (0.1%)
Time Incarcerated (at time of sick call request or date of census)		
Mean (SD)	204 (300)	254 (326)
Median [Min, Max]	87.0 [0, 2180]	140.0 [0, 3,896]
Missing	4,796 (5.0%)	0 (0.0%)

The length of time PIC were incarcerated at the time of their request ranged from 87 to 2,180 days with the mean being 204 days and the median being 87 days. PIC designated as having a mental health need[44] made 52,705 (55.2%) of all requests for sick call. PIC who self-reported substance use[45] at admission made 22,323 (23.4%) of all requests for sick call. PIC clinically designated heat sensitive[46] made 22,638 (23.7%) of all requests with the monthly volume being higher during summer (Figure 3). There are minimal differences between proportions in the requestor profile and a mid-year daily census.[47]

Figure 3: Monthly Sick Call Requests by PIC with Heat Sensitive Conditions (N=22,638)



[44] See Footnote 38 for more information.
[45] See Footnote 39 for more information.
[46] See Footnote 40 for more information.
[47] See Footnote 43 for more information.

Conclusion

This analysis of sick call utilization in NYC jails for CY2023 reveals critical insights into the provision and timeliness of healthcare services for PIC. Despite efforts to improve access to medical care through the introduction of the CHS HTL, significant gaps remain in the process.

Key findings include:

1. **Provision of Sick Call:** Over a third of all sick call requests during CY2023 resulted in PIC not being escorted to the clinic for their scheduled appointment.
2. **Timeliness**: Of all sick call requests that resulted in PIC being escorted to the clinic, less than half were within one business day.

These findings were corroborated by a survey of 50 PIC conducted by the Board. The survey revealed several challenges, including difficulties scheduling appointments through the CHS HTL (n=15; 30.0%) and issues with being escorted by DOC to scheduled appointments (n=23; 46.0%). While some respondents expressed neutrality (n=10; 20.0%) or satisfaction (n=5; 10.0%), a majority reported general dissatisfaction (n=35; 70.0%) with sick call services. Suggestions for improvement focused on increased production (n=16; 32.0%), greater professionalism (n=13; 26.0%), and improved timeliness (n=9; 18.0%).

These findings suggest that while PIC are generally aware of the sick call process and how to access it, there remain significant concerns about the responsiveness and quality of services. Given these results, DOC must take substantial steps to improve the provision and timeliness of sick call.

Recommendations

The Board has the following recommendations to address the identified issues and improve the sick call process:

1. DOC should reduce its reliance on the CHS HTL and re-establish their own sick call process. The new process should:
    a. **Include multiple, defined pathways for PIC to request sick call virtually or in person.** All requests should be documented in a DOC electronic database using an electronic form. For each sick call request, DOC should collect and store, at minimum, the name of the PIC requesting sick call, the book and case number associated with the PIC, and the date and time of the sick call request.
    b. **Implement a dashboard to enable real-time scheduling of sick call appointments with CHS**. Using data collected and stored in its electronic database, DOC should develop a dashboard to be shared with CHS to assist with scheduling sick call appointments. The dashboard should include, at minimum, the name of the PIC requesting sick call, the book and case number associated with the PIC, and the date and time of the request. PIC should be added to the list in the order in which they request sick call. The dashboard should also indicate which PIC will not be escorted to the clinic, so CHS can be aware who to expect in the clinic.
    c. **Track reasons for non-production.** DOC should also track reasons for non-production in its electronic database. These reasons should align with the reporting requirements specified in Local Law 132 for the year 2019 (LL132/2019) such as court, family visits, programming, barbershop, or production refusal.

d. **Facilitate real-time monitoring of timeliness.** For each sick call request, DOC should document the clinic arrival time in its electronic database. This information should also be added to the dashboard to make CHS aware of when PIC arrive in the clinic.
e. **Track healthcare encounter outcomes**. For each sick call request, CHS should be able to use the dashboard to note the date and time PIC are seen. If PIC are not seen, the dashboard should prompt CHS to enter the reason why. These should be consistent with existing reporting to the Board and reflect instances where PIC refuse treatment, leave without being seen, or CHS reschedules their encounter.
f. **Track monthly performance metrics.** At minimum, these metrics should include:
    i. The total number of PIC requesting sick call.
    ii. The number and percentage of PIC produced to the clinic. For PIC not produced to the clinic, the number and percentage in each non-production category.
    iii. The number and percentage of PIC seen by a healthcare provider. For PIC not seen, the number and percentage in each not-seen category.

2. DOC should aim to improve the provision and timeliness of sick call to at least 95% within the next six months.
3. DOC should evaluate PIC satisfaction with sick call services. As soon as feasible, DOC should implement patient satisfaction surveys. These should be made available to PIC through their tablets following a request for sick call and inquire whether their concerns were addressed.

By implementing these recommendations, the Board believes that DOC could significantly enhance the sick call process, ensuring timely and effective medical care for all PIC as mandated by RCNY §3-02(c).

References

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Appendix A

Interview Guide for PIC on the Sick Call Process

1. In your own words, what does “sick call” mean to you?

2. What do you believe sick call is primarily for (select all that apply)
    a. Emergency medical issues
    b. Get care for a new medical issue
    c. Routine health check ups
    d. Medication requests
    e. Other (please specify)_____

3. How do you typically (most frequently) access sick call services in your current facility?
    a. By speaking directly to a correctional officer
    b. Calling the Health Triage Line or #614
    c. Writing a request or filling out a form
    d. Via a healthcare professional during another medical interaction
    e. Other (please specify)_____

4. Please describe any difficulties you have experienced when trying to access sick call services.

5. How satisfied are you with the sick call services?
    a. 1 (Very Dissatisfied)
    b. 2 (Dissatisfied)
    c. 3 (Neutral)
    d. 4 (Satisfied)
    e. 5 (Very Satisfied)

6. What would you do to improve the sick call process?

Appendix B

Informed Consent

Summary and Purpose of the Project:

The New York City Board of Correction is currently reviewing the Sick Call process for Persons in Custody. We are reviewing both the data and mechanisms of the Sick Call process from different avenues that includes, Persons in Custody, Correctional Health Services, and the Department of Correction. In order to do this, Board Staff are collecting and analyzing both qualitative and quantitative data. Through an upcoming report, the Board hopes to improve the sick call process throughout Rikers Island.

Potential Benefits of Participating:

Help the Board of Correction understand the current issues and mechanisms of sick call and help the Board make recommendations to both Correctional Health Services and the Department of Correction to improve the mechanisms and successes of sick call.

Potential Risks of Participating:

There are no risks for participating.

Confidentiality:

There will be no identifying information reported publicly. All participants will be given a code (e.g., M01, F01, etc.) and the consent forms will be kept in a secure area of the Board of Correction's office.

Participant Rights:

Any participant has the right to stop participating at any time with no consequences or punishment for stopping. Participants are also able to request that an answer be "off the record." Participants also have the right and ability to ask Board staff as many questions as they wish during the interview.

Participant's Agreement:

I have read the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

_____ _____

Printed Name & Signature of Research Team Member Obtaining Consent Date

_____

Book and Case Number of the Research Participant *(if necessary)*

_____ _____

Printed Name & Signature of Monitoring Team Member Overhearing Consent Date