

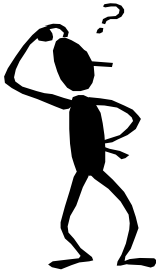
Impact of Crime and Violence on Illness and Health



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Definition of crime varies by time and by culture



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Examples:

- ⌘ Witchcraft
- ⌘ Polygamy
- ⌘ Seduction of a chaste woman
- ⌘ Prohibition of alcoholic beverages
- ⌘ Illicit drugs
- ⌘ Child abuse
- ⌘ Corporal punishment

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**IS VIOLENCE MORE
TOLERATED OR LESS
TOLERATED TODAY THAN
IN THE PAST?**

- ⌘ Media, e.g., movies
- ⌘ Against children, i.e. child abuse
- ⌘ Gun violence
- ⌘ Capital punishment

**Violence includes injury of
all types, intentional and
unintentional.**

- ⌘ Injuries are not Accidents

Reasons Crime has been higher than 40 years ago

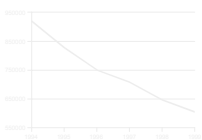
⌘ "Crime is a barometer of social disorganization"

⌘ Greater visibility "live and direct" TV copy

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New York State Index Crimes
1994-1999



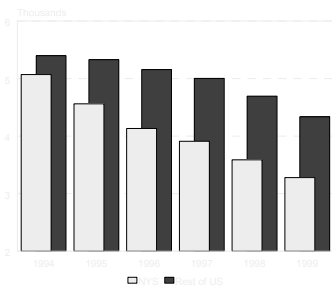
Source: Albany, New York: Department of Criminal Justice Services, January 2001. NY State

New York State Index Crimes
Down -35.2% from 1994 to 1999

New York State Violent Crimes
Down -38.8% from 1994 to 1999

- ! Murder down -63.5%
- ! Rape down -26.3%
- ! Robbery down -47.8%
- ! Aggravated Assault down -29.6%

Index Crime Rates 1994-1999
New York State and United States
Rate per 100,000 Population



Between 1994 and 1999

* The crime rate in New York State dropped -35.2%

* The crime rate in the rest of the United States dropped -19.7%

New York City Situation

- ⌘ The Mayor and police commissioner
- ⌘ Applied epidemiology
- ⌘ "Broken window theory"
- ⌘ "Beer and piss patrol"

Reasons II

- ⌘ Demographic changes
- ⌘ Change in drug of choice
- ⌘ "Mature" drug market
- ⌘ Statistics exclude drug crimes

Who is at greatest risk of being personally impacted by crime and violence

- ⌘ Perpetrator (NYS Prisons)
- ⌘ Women Offenders
- ⌘ Victim

Historical penalties for with crime and violence

- ⌘ Trend in philosophy
- ⌘ Trend to longer terms



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Problems with work programs

- ⌘ Competition with business
- ⌘ Maintain facilities or marketable skill?

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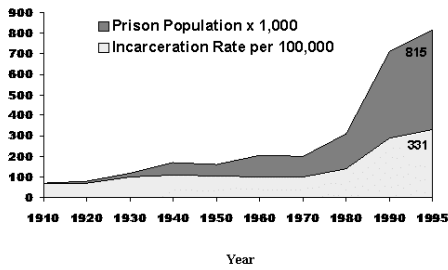
Shock Incarceration

- ⌘ Disciplined life
- ⌘ Build self-respect

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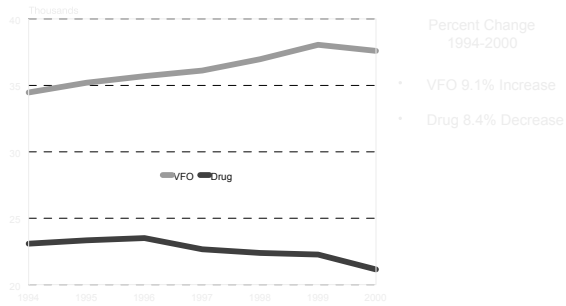
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Incarceration and Incarceration Rate in US Prisons

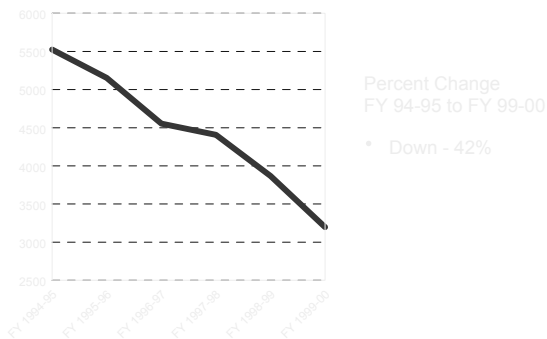


Source: NIJ, Bureau of Justice Statistics

NYS DOCS Under Custody Population



Arrests of Parolees for Violent/Coercive Crimes

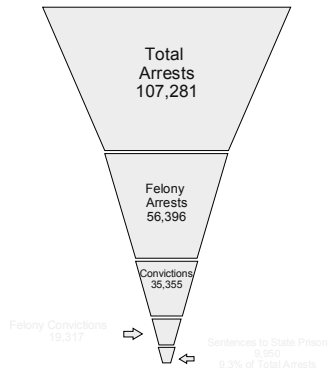


Why we deal with crime and violence in these ways?



- ⌘ Don't want crime to threaten us
- ⌘ We are angry and want retribution
- ⌘ Don't want to pay cost of punishing

Prosecution of Controlled Substances Arrests in New York State
PL 220 (1998 Arrests)



Prevention

- ⌘ of Crime
- ⌘ of Violence



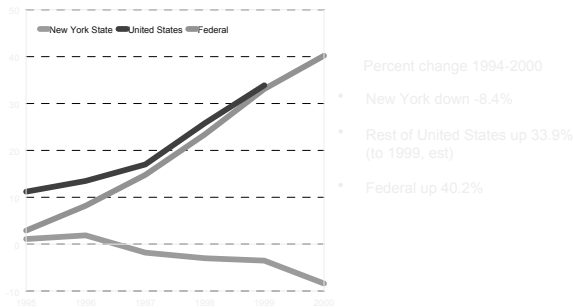
True Prevention requires



- ⌘ Avoid risk-taking
- ⌘ Help people know their value

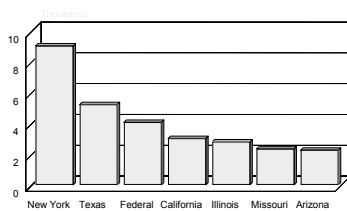
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Comparison of Drug Offender Inmates
Percent change from 1994
New York, Federal, and United States



- Nationally, New York State has the largest number of inmates in separate drug treatment units in correctional facilities
- The 9,027 New York State inmates housed in such units in 1999 represent 22% of all inmates in dedicated treatment units in prisons nationally

Inmates in Separate Drug Treatment Units in Prisons (1999)



Health problems of perpetrators

- ⌘ injuries
- ⌘ Infectious diseases
- ⌘ Dental problems
- ⌘ Psychiatric problems
- ⌘ Substance abuse problems

Health problems of victims

- ⌘ Injuries
- ⌘ Infectious diseases
- ⌘ Psychological injuries
- ⌘ Health hazard of work in facilities

Who has guaranteed access to health care in US?

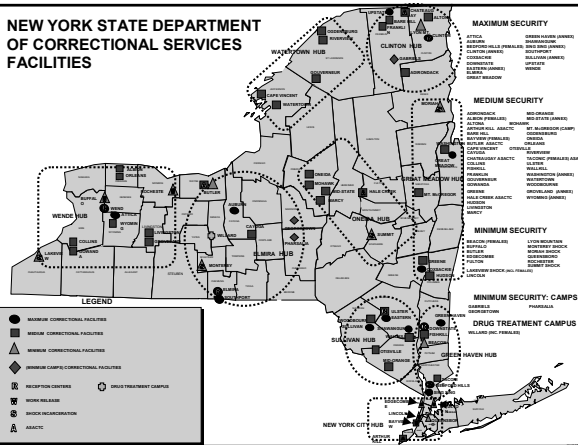
- ⌘ Active Duty Military
- ⌘ Native Americans
- ⌘ Service-connected Veterans
- ⌘ End Stage Renal Disease
- ⌘ Prisoners-- *the only class with constitutional guarantee*

WHY ARE PRISONERS INCLUDED IN THE LIST?

- ⌘ Custodial responsibility
- ⌘ The 8th Amendment
- ⌘ Denying necessary health care to those in custody is cruel and unusual punishment
- ⌘ Community standard of care



NEW YORK STATE DEPARTMENT OF CORRECTIONAL SERVICES FACILITIES



DESCRIPTION OF THE DOCS HEALTH CARE SYSTEM IN THE EARLY 1990'S.

- ⌘ 70 prisons housing 70,000
- ⌘ 4 reception sites
- ⌘ Frequent moves



Health care sites

- ⌘ Health presence in all facilities
- ⌘ Clinics
- ⌘ Infirmaries provide 24 hour supervised care
- ⌘ Acute hospitalization
- ⌘ Antiquated health facilities

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Health care Operations

- ⌘ Primary care by salaried employees
- ⌘ Referral to private specialists arranged by each facility
- ⌘ Use of outside hospitals arranged by each facility
- ⌘ Each medical trip COSTS and has security concerns

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Major disease issues:

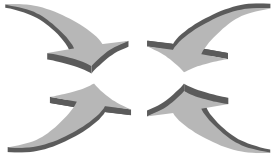
- ⌘ Approximately 16% of males HIV infected, 20% of females [Now 10% m and 18% f]
- ⌘ 23% had PPD+
- ⌘ 57% had drug history [now 55%]
- ⌘ 26% had history of alcohol abuse [now 40% test as alcoholic or possibly alcoholic]
- ⌘ Incredible dental neglect
- ⌘ Aging population
- ⌘ 26% women pregnant at reception

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Services provided per year:

- ⌘ 1 million primary care visits
- ⌘ 37,600 inpatient hospital days
- ⌘ 30,000 outpatient specialist encounters



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"Medical Call Out-Driven"

- ⌘ If an inmate wants to be seen, he/she drops a note asking to be seen by the nurse who will evaluate whether or not the condition requires a physician visit

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Unique features of correctional health care

- ⌘ Primary business is secure housing
- ⌘ Disruption, costs and security concerns of trips
- ⌘ Health of incoming prisoners
- ⌘ Health care as something to manipulate

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Analysis of the system

- ⌘ Guaranteed Access
- ⌘ Salaried primary care
- ⌘ Private fee-for-service specialists
- ⌘ Private hospitalization
- ⌘ Minimal utilization review due to local control of care arrangements

- ⌘ Movement within the system leads to lost records and delay of care
- ⌘ COSTS of medical trips
- ⌘ Need for chronic care and hospice

Qualities of the system that facilitate "MANAGED CARE"

- ⌘ Global budgeting
- ⌘ Universal coverage
- ⌘ Mandatory enrollment
- ⌘ Limited disenrollment
- ⌘ Limited patient choice
- ⌘ Ability to regulate usage

Decisions on Directions I: Retain primary care by employees

- ⌘ It is a control issue
- ⌘ And a union issue in a State with strong labor unions



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Implications:

- ⌘ Many hold-overs
- ⌘ Many work outside jobs and don't identify as part of the system
- ⌘ Many International Medical Graduates
- ⌘ Language/cultural barriers

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Response

- ⌘ Orientation for old as well as new employees
- ⌘ Clinical care guidelines
- ⌘ Future classes in medical Spanish

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Decisions on Directions II: Regional contracts for specialty care and acute hospitalization

⌘ The contracts are CAPITATED and RISK SHARING



Reasons for CSC

- ⌘ Guaranteed access to needed care
- ⌘ Cost control
- ⌘ Budgeting certainty
- ⌘ Ability to pay market rates
- ⌘ Utilization review

Note we do not use the term managed care

- ⌘ It means something different to each person
- ⌘ It is considered the major "evil" force in health care today
- ⌘ Invented a more precise term for our system, "coordinated specialty care."

Decisions on Directions III: Regionalize and Bring Care Inside

- ⌘ Specialty clinics in-house
- ⌘ Costs and security concerns



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Decisions on Directions IV: Construction

- ⌘ Rebuild Health Units
- ⌘ Building Regional Medical Units
- ⌘ Secure wards in hospitals [40% fewer hospital days used 1999 v. 1997]
- ⌘ Statewide contract for laboratory services
- ⌘ Central pharmacy with hub sub-pharmacies [129,000 Prescriptions by Central Pharmacy in '99]



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Decisions on Directions V: Computerize scheduling of consultations

- ⌘ Facilitate regional scheduling
- ⌘ Enable trip planning among nearby facilities



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Decisions on Directions VI: Adapting to schedule primary care

⌘ Aimed at changing from Medical Call
Out to Primary Care model.



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Decisions on Directions VII: Use tele-medicine

- ⌘ Cut medical trips (save cost and security concerns)
- ⌘ More ready access to care
- ⌘ More humane for sick
- ⌘ Serendipitous education by primary care providers



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Decisions on Directions VIII: Digitize medical records

- ⌘ Ready accessibility
- ⌘ Not lost during transfers
- ⌘ Compatible with feeder institutions
- ⌘ Legible records!
- ⌘ Information to manage
the system



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Decisions on Directions IX: Explore alternatives for the unique work release population, particularly in the City



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Privatize or not?

⌘A classical make/buy decision EXCEPT in our system the equation includes visibility and control, unions and political pressure.



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Decisions on Directions X: Use of Quality Management techniques

- ⌘Revisions of data collection and selected indicators
- ⌘Clinical treatment guidelines
- ⌘Patient Satisfaction Surveys
- ⌘Health Education Interest Survey



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Decisions on Directions XI: Increase use of Mid-level Practitioners

⌘ Situation demands relative independent practice



Decisions on Directions XII: Increase staff education

⌘ Use tele-health equipment
⌘ Satellite broadcast programs



Steps to Conversion I

⌘ Supportive Commissioner
⌘ Regional contracts
⌘ Indoctrination of staff
⌘ Monitor staff output

Health staff work for Superintendents

- ⌘ Health professionals involved in hiring
- ⌘ Health professionals involved in evaluating



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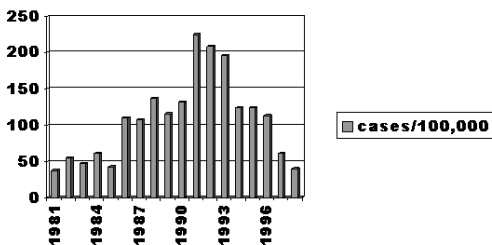
Steps to Conversion II

- ⌘ QM initiative
- ⌘ Digitizing records
- ⌘ Tightening Formulary
- ⌘ Health System research projects

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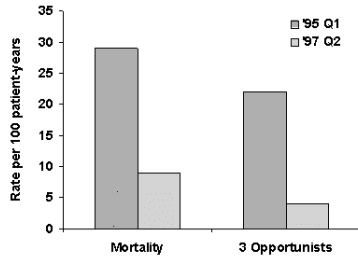
Tuberculosis Case Rates NYS Inmates 1981-98



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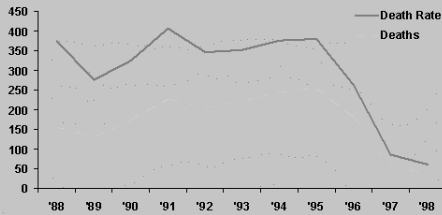
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Effect of Combination ART in Elite Clinics



Source: Fakilla, Delaney, Mocman, et al

Deaths in NY State Prisons



Source: NYS/DOR

Impact of Crime and Violence on Illness and Health
