

April 2018

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# A Question of Compassion:

Medical Parole in New York State

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Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and

community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, and staff.

## From the Director

Compassionate release laws enable those who are elderly, seriously ill, incapacitated—or some combination—to receive treatment in a community setting and in the company of loved ones. Research and common sense tell us that these are people who pose little if any risk to public safety. The need for such laws is now urgent. In recent years, the number of older adults in U.S. prisons has soared, even as the overall prison population has declined. With them, the elderly bring increasingly demanding health and end-of-life care needs.

But as we at the Vera Institute of Justice have reported, prisons make insufficient use of these laws and policies. The result? Too many people end up dying in prison, at great human cost and great cost to taxpayers.

The problem is not simply one of legislation. As the case study presented in this report shows, New York State has a relatively progressive compassionate release law, excluding only a few conviction offenses and allowing anyone to initiate an application on an incarcerated person's behalf. Yet even as the number of elderly people incarcerated in New York State prisons has increased, the number of requests for medical parole has decreased and the rate of approval for applications has stayed relatively stable.

Barriers and challenges exist at every step in the process. For many people, the application was started too late and took too long, and a notable number died before their applications could be resolved.

Complicating matters further, it can be extraordinarily difficult to find a community-based provider that is both able and willing to provide care to people who are granted medical parole.

Our study comes at a critical time for the many states faced with unprecedented numbers of elderly incarcerated people. Important lessons can be learned from New York State.

Our analyses suggest that New York's statute, as permissive as it is, still places too many limits on the state's ability to provide compassionate release. This, combined with the many challenges associated with the expedient approval of medical parole cases, creates a system in which twice as many applicants die in custody than are released.

In this report, Vera makes practical recommendations that can guide New York State, and many other states across the country, in making full use of their compassionate release laws. In providing for our sick, elderly, and dying incarcerated populations, we can and must do better.



Fred Patrick  
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# Introduction

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United States prisons have experienced massive growth in their older adult populations. From 1993 to 2013, the number of people age 55 and older in state prisons grew 400 percent, while the overall state prison population grew by 55 percent.<sup>1</sup> (National researchers consider people in prison who are age 55 to be older or geriatric because of the concept of “accelerated aging” for this population.<sup>2</sup>) This trend has major implications for the delivery of health care in prisons as departments of corrections are faced with the higher and more complex medical needs of the aging population—at great financial cost.<sup>3</sup> The aging of state prison populations portend more deaths of people in custody; nearly 3,500 people died in state prisons in 2014 and 59 percent of them were older adults.<sup>4</sup> This landscape demands a closer look at a legal process that is widely available and could help prevent prisons from turning into nursing homes and intensive care units: compassionate release. While varying by state, compassionate release (sometimes known as medical parole, medical release, or medical furlough) generally refers to policies and laws that share a basic structure: medical and correctional administrators, parole boards, the courts, or some combination thereof grant early discharge from prison to people on the basis of serious illness or age-related impairment.

These laws are premised on a humanitarian desire to allow people to spend their remaining days outside of prison in the company of their family and friends, as well as practical considerations of the high cost and minimal public safety value of incarcerating people who are old, gravely ill, or both.<sup>5</sup> Although compassionate release policies apply beyond older adults, the nexus between aging and infirmity and the continued growth of the elderly prison population make such policies increasingly important. Unfortunately, as the Vera Institute of Justice (Vera) and others have demonstrated, corrections departments sometimes struggle to make effective use of compassionate release.<sup>6</sup> This report presents findings and recommendations of Vera’s case study of one state that has made

considerable advances in its application of compassionate release laws, yet still faces challenges in making full use of the provision: New York.

New York has seen its overall prison population decline 31.5 percent since its peak in 1999—from 72,649 to 49,835 as of March 1, 2018—and has closed 14 prisons. But in its changing prison demographics, the state mirrors the national trend in the size and growth of its aging population.<sup>7</sup> Older adults represent a growing number and percentage of New York’s standing prison population *and* admissions. From 2008 to 2017, while the overall population in the state’s prisons decreased nearly 20 percent, the number of people age 55 and older increased 60 percent.<sup>8</sup> New York state prison admissions overall declined 18 percent from 2008 through 2016, but for people who were at least 55, admissions increased 62 percent.<sup>9</sup> Older adults now represent 11 percent of the population in the state prison system. As New York’s older adult prison population has grown, so have health care costs and related staffing challenges.<sup>10</sup>

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Vera conducted research and analysis of New York State’s compassionate release program through a partnership with New York’s Department of Corrections and Community Supervision (DOCCS), the agency that operates all of New York’s state prisons and supervises people on parole. The aim was to explore how DOCCS could make more effective use of the state’s compassionate release mechanism, as codified by the medical parole law that was enacted in 1992.

New York’s medical parole law is broadly written: few conviction types are categorically excluded; anyone can make a medical parole request, not only corrections staff; terminal *and* nonterminal illnesses are included and are not defined by a life-expectancy prognosis. The statute is thoughtfully and carefully implemented: DOCCS designates administrative nursing staff to oversee the program; has a detailed policy with time limits and clearly

defined roles and responsibilities; and keeps a database that follows and tracks people whose medical conditions do not initially meet the medical eligibility standards under the law. Still, twice as many medical parole applicants die in custody than are released. And that accounts only for those who apply; an unknown number of people who are never referred for medical parole die in custody because of conditions with prolonged and debilitating trajectories. The DOCCS internal guidelines and guidance about medical parole leave facility medical staff with significant discretion in submitting applications and determining patients' medical eligibility. Because the medical parole data does not distinguish between those who are ineligible based on their convictions and those who are medically ineligible, there is no way to know from the data collected whether the right candidates are being referred and which criteria limit the pool of eligible applicants. But even people who are referred, eligible, and granted release by the New York State Board of Parole face a formidable challenge in finding a community placement that can accommodate their medical and nursing needs. The reentry challenge is a persistent and critical one and, for corrections agencies, an issue that is hard to address. Although agencies can improve their internal capacity for locating placements and ensuring smooth transitions for people who are seriously ill, they cannot create community resources that do not exist.

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This study is timely. Governor Andrew Cuomo recently proposed legislation to expand New York's medical parole law to include geriatric release: early release on the basis of age-related infirmity.<sup>11</sup> As policymakers debate the merits of such legislation statewide and throughout the country, the findings and recommendations of this report may help them bridge the gap between policy goals and outcomes.

# Project Design

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The Vera Institute of Justice received funding from the New York State Health Foundation to conduct research about the use of medical parole statewide and identify opportunities to provide technical assistance to DOCCS. Vera conducted a variety of research activities to answer the following questions: How many people apply for and are granted medical parole and how do their cases progress through the system? What are the characteristics of medical parole referrals and of the people who are released? How are decisions made at key points in the process? What are the obstacles to and opportunities for a greater number of cases being granted medical parole? Vera also provided technical assistance to DOCCS by coordinating training for both DOCCS medical staff and members of the parole board about medical parole and issues related to aging and serious illness in prison.

Vera researchers analyzed two sources of data from DOCCS. First, to examine the number of requests and releases—and whether these have changed in recent years—Vera analyzed year-end reports prepared by DOCCS and provided for the years 2013 through 2017. These documents include the number of new medical parole requests, requests approved by the parole board, and medical parole releases. Second, Vera analyzed administrative data relating to all 251 requests made from January 1, 2013 through June 30, 2015. The data came from a database DOCCS maintains that tracks all medical parole requests, capturing the date of the request, eligibility, limited diagnostic information, board interview dates, and release decisions. Vera used this data to look at the demographics and release outcomes for people who went through the medical parole process and to determine how long it took for their cases to progress through the system.

Vera researchers also interviewed clinical and nurse administrators and key policy stakeholders about each step of the medical parole process, the roles of various actors in the process, and recent changes in policy. The researchers gathered additional information about clinicians' understanding and experience of medical parole applications through surveys of 103 medical practitioners who work in DOCCS prisons,



including physicians (65), nurse practitioners (22), physician assistants (13), and other medical staff (three). This was a self-administered, pen-and-paper survey that respondents completed at the medical staff training sessions, with a response rate of more than 90 percent.

After learning about the overall use of medical parole in New York, Vera set out to understand what happens when someone with serious medical needs is released on parole, what services are available for this population, and what barriers to care exist. To do this, Vera conducted an online survey of community care providers, including hospice care facilities, nursing homes, and home care providers. Surveys were distributed to administrators at 155 provider agencies throughout the state, and a total of 40 survey respondents (26 percent response rate) were recruited with the help of community partners in the field. Collectively, the responding agencies provide services in every county in the state.

As part of the technical assistance provided to DOCCS and the New York State Board of Parole, Vera coordinated a series of trainings in 2017 for DOCCS Health Services staff and for board members about the purpose and process of medical parole, as well as the issues central to it. The topics included hospice and palliative care, prognostication (the practice of predicting the trajectory of a condition, sometimes including life expectancy), advance care planning, and assessing patients' decision-making capacity. The trainings were developed by Dr. Brie Williams—an expert in geriatric and palliative care in corrections settings (and a coauthor of this report)—and delivered by Dr. Williams and a team of clinicians. More than 100 clinical staff, nine of the 16 parole board members at that time, and other staff from the board and DOCCS attended the trainings.

## The Challenge of New York's Aging and Infirm Prison Population

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**A**nthony Annucci, the acting commissioner of DOCCS, recently identified the large and growing population of older adults in New York's prisons as one of the principal health care challenges his agency faces.<sup>12</sup> That challenge is both a medical and fiscal one. Inflation-

adjusted per capita spending for health care in New York prisons increased 5 percent from fiscal year 2010 to fiscal year 2015—from \$6,701 to \$7,047.<sup>13</sup> Health care staffing is also a significant challenge for the department.<sup>14</sup>

### How New York’s medical parole law has changed over the years

The medical parole statute has undergone a number of substantive and procedural changes since its enactment in 1992:

**Conviction exclusions.** The original 1992 law excluded people convicted of first-degree murder, second-degree murder, first-degree manslaughter, sex offenses, or an attempt to commit any of those offenses.<sup>a</sup> But in 2009, these exclusions were divided into two groups. Only first-degree murder, and conspiracy and attempt to commit first-degree murder, are now categorically excluded. The remaining offenses—second-degree murder, first-degree manslaughter, sex offenses, or an attempt to commit any of those offenses—require people to serve at least half of their determinate sentence or half of their minimum indeterminate sentence before they are eligible for medical parole. As New York’s sentencing regime changed from indeterminate to a combination of determinate and indeterminate, the medical parole law ensured that people with determinate sentences would still be eligible for medical parole consideration.

**The physician’s role.** The medical assessment originally required a physician’s diagnosis to include an assessment of the person’s public safety risk. The 1994 amendment to the statute tethered the clinical role more closely to a medical assessment than to an assessment of risk to public safety, splitting the DOCCS process into two parts: the clinical staff’s medical evaluation, diagnosis, prognosis and functional assessment; and the commissioner’s office certification of the patient’s eligibility.<sup>b</sup>

**Types of medical conditions.** The original law covered only those who were suffering from terminal conditions. In 2009, legislators added a provision that allowed for medical parole of people suffering from “significant and debilitating” nonterminal illness.<sup>c</sup>

**Functional criteria.** The medical evaluation outlined in the 1994 amendment required a functional assessment that focuses on patients’ ability to ambulate and care for

themselves. In 2009, the functional criteria were revised. Language about self-care was revised to describe the ability to “perform significant activities of daily living,” and ambulation and performing significant activities of daily living became disjunctive rather than conjunctive—that is, the law now uses either/or criteria. The statement now required of a physician is “whether the inmate is so debilitated or incapacitated as to be severely restricted in his or her ability to self-ambulate or to perform significant activities of daily living.”<sup>d</sup>

**Form of incapacitation.** The definition of incapacitation was revised in 2009 to include cognitive incapacitation. This change allowed people with cognitive impairments such as dementia to be considered for medical parole.

**The length of medical parole terms.** In 1994, the length of the medical term was extended from a renewable four-month to a renewable six-month term.<sup>e</sup>

**Time limits in the process.** The 2009 amendment required DOCCS to send cases it certifies to the parole board within seven days of receiving a diagnosis.

**Forms of compassionate release.** The original medical parole law in 1992 focused only on people who had not yet reached their parole eligibility date. In 1994, the parole board allowed a change in medical condition as an avenue for accelerated reconsideration of release for people who were eligible for parole but had been denied.<sup>f</sup> In April 2015, “commissioner’s discretion” was instituted for those with terminal illnesses serving sentences for nonviolent offenses, allowing people to be released with the consent of the board chair without undergoing a board interview or the other steps in the board review process.<sup>g</sup>

<sup>a</sup> N.Y. Exec. L. § 259-r (1992).

<sup>b</sup> N.Y. Exec. L. § 259-r(2)(a) (1994).

<sup>c</sup> N.Y. Exec. L. § 259-s (2009).

<sup>d</sup> *Ibid.*, § 259-r-(2)(a) (2009).

<sup>e</sup> N.Y. Exec. L. § 259-r(2)(a) (1994).

<sup>f</sup> N.Y. State Division of Parole, Policy and Procedures Manual Item 8355.00, Full Board Case Review, 1994.

<sup>g</sup> N.Y. Exec. L. §§ 259-r(10) and (11) (2015).

DOCCS struggles to fill full-time health professional positions and, as of fiscal year 2015, had only 35.9 full-time health professional employees per 1,000 people in custody, below the national state median of 40.1.<sup>15</sup> In New York, that ratio is much lower than in the correctional medical departments of New Jersey (46.5), Connecticut (48.6), and Massachusetts (60.2). As of October 2017, the DOCCS nursing staff had a 20 percent vacancy rate.<sup>16</sup> These personnel issues are particularly worrisome as the state prison population ages, because older people require more health and nursing care. The need for more care also translates into more spending: estimates of the cost of incarcerating older adults typically range from three to nine times the cost of incarcerating younger people, principally due to increased health care costs and needs.<sup>17</sup> Not surprisingly, the costs have added up: the DOCCS health services budget increased nearly 20 percent from FY 2012 to FY 2018—more than the overall DOCCS budget growth of 9.2 percent—while the overall state prison population declined 9.1 percent.

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Although medical parole is an important strategy to respond to the needs of older people incarcerated in New York prisons, the compassionate release law originated in response to the AIDS crisis of the early 1990s. At that time, the state had the nation's highest rate of HIV infection among people in prison.<sup>18</sup> As New York instituted compassionate release, the Department of Correctional Services (what DOCCS was called before it merged with the Division of Parole in 2011, which in turn became the Board of Parole) expanded its capacity to manage and treat people who were seriously ill. In 1991, a year before the medical parole law was passed, the department opened its first Regional Medical Unit (RMU).<sup>19</sup> Regional Medical Units provide skilled nursing and long-term care to patients in New York State prisons. DOCCS now has more than 350 RMU beds throughout the state.<sup>20</sup> Most people in the RMUs are elderly and, of the 144 deaths in DOCCS prisons in 2016, 40 percent occurred in RMUs.<sup>21</sup> DOCCS also created a specialized unit for advanced dementia patients at the

## The three types of compassionate release in New York State

This paper uses the term “compassionate release” to refer to three different yet intersecting forms of release

The first, and most commonly used, is **medical parole**. First enacted in 1992 and since revised with expanded criteria, this type of release allows eligible people to be considered for parole on the basis of their medical condition before they would otherwise be eligible. It applies to indeterminate and determinate sentences. Medical parole is codified in New York’s Executive Law, Sections 259-r and 259-s, and governed by DOCCS Directive No. 4304, which spell out eligibility on the basis of a person’s conviction, sentence, and medical condition, and the public safety considerations to be undertaken.<sup>a</sup>

The second type of release is granted through a **parole board case review for extraordinary medical circumstances**. This allows people who have completed their minimum sentence and have been denied parole release to be reconsidered by the Board of Parole before their next parole review date, based on

a change in their medical condition. The medical certification process is the same as for medical parole. It succeeds a prior means of processing such cases—known as full board case review—and is detailed in DOCCS Directive No. 4044.<sup>b</sup>

The third form of compassionate release is medical parole at the discretion of the commissioner of DOCCS. This is referred to as “**commissioner’s discretion**.” It was added to the medical parole statute in 2015 and applies only to people who are terminally ill and serving a sentence for nonviolent offenses.<sup>c</sup> It provides an expedited process, bypassing the notification requirements for typical parole board review and allowing release based on the commissioner’s recommendation and the agreement of the parole board chair—without requiring an interview. The board retains the right to conduct further review, at the discretion of the chair or her designee, including an interview.

<sup>a</sup> N.Y. Department of Corrections and Community Supervision, Medical Parole, Directive 4304, <https://perma.cc/P7HL-8Q38>.

<sup>b</sup> N.Y. Department of Corrections and Community Supervision, Medical Parole, Directive 4044, <https://perma.cc/LF87-4YLX>.

<sup>c</sup> N.Y. Exec. L. §§ 259-r(10)-(11) (2018), <https://perma.cc/MQ49-NGWL>. There is no new DOCCS directive covering this new release mechanism; the most recent directive is from 2014.

Fishkill Correctional Facility RMU, known as the Unit for the Cognitively Impaired. This means that at the same time state legislators enacted a compassionate release law in the early 1990s, DOCCS also increased its internal capacity to care for older adults and others who are seriously and chronically ill.

## New York’s Medical Parole Law and the DOCCS Directive

The current law gives the parole board the authority to release people on medical parole who are certified by DOCCS as “suffering from a terminal condition disease or syndrome” or “a permanent non-terminal condition, disease or syndrome,” and “to be so debilitated or incapacitated as to create a reasonable probability that he or she is physically or cognitively incapable of presenting any danger to society.”<sup>22</sup>

(For details about exclusions and eligibility, see “How New York’s medical parole law has changed over the years” at page 10.)

- › **DOCCS certification:** The process and standards for “certification”—the process by which DOCCS approves an application to be considered by the parole board—are outlined in the statute and an accompanying DOCCS directive.<sup>23</sup> DOCCS has a multipart process to certify a medical parole application to the parole board, with three key steps:
- › **The initial request:** A request for medical parole may be initiated by DOCCS staff (uniform or medical), someone incarcerated in a DOCCS facility, or someone acting on behalf of the incarcerated person, such as a family member or lawyer. The DOCCS directive on this is more expansive than the statute. (The statute specifies that the request may be made by the commissioner, an incarcerated person, or the incarcerated person’s relative, spouse, or attorney.) DOCCS has assigned a nurse from the department’s Health Services division to be the medical parole coordinator. The coordinator works directly with the deputy commissioner/ chief medical officer to manage the review and certification process. If the request comes from someone outside of DOCCS, the coordinator contacts the facility to inquire about the person’s medical condition and eligibility for medical parole. The coordinator also reviews the admissions of DOCCS patients to outside hospitals and contacts the DOCCS facility medical staff to inquire about the appropriateness of submitting a medical parole application.
- › **The medical evaluation:** The facility’s clinical staff perform a medical evaluation and make a diagnosis and prognosis, including a description of the patient’s physical or cognitive capacity, as well as discharge needs, such as whether the patient needs skilled nursing care, acute care, or hospice care. The application consists of a comprehensive medical summary completed by the treating physicians and/or nurses, and a patient review instrument that assesses the individual’s care and placement needs and is completed by a nurse. If the facility health staff determine that the individual is *not* eligible, the case does not proceed further, but the medical parole coordinator enters it into the medical parole database for review and tracking. If the clinical staff determine that the person is medically eligible, the evaluation goes to the DOCCS deputy commissioner for health services, who is also the department’s chief medical officer (CMO).

- › **Review, recommendation, and certification:** During this part of the process, the CMO reviews the medical evaluation and accompanying documents to determine whether to certify that “the inmate is suffering from such terminal condition, disease or syndrome and that the inmate is so debilitated or incapacitated as to create a reasonable probability that he or she is physically and cognitively incapable of presenting any danger to society.”<sup>24</sup> The CMO’s review is thus a medical assessment and a public safety assessment. If the CMO finds that the person is eligible, the case goes to the commissioner to decide whether to certify the application and send it to the board for consideration or, if eligible, grant release as a case of commissioner’s discretion.

**The parole board decision.** The law sets the parameters of the board’s decisions about medical parole. In the case of terminal illness, the board shall grant medical parole if, in consideration of the person’s medical condition, “there is a reasonable probability that the inmate, if released, will live and remain at liberty without violating the law, and that such release is not incompatible with the welfare of society and will not so deprecate the seriousness of the crime as to undermine respect for the law.”<sup>25</sup> The board must provide notice to the district attorney, defense counsel, and sentencing court that the person is being considered for medical parole and afford them 15 days to provide a comment. The board makes no decision before the 15-day period expires.

For medical parole of someone who has a nonterminal illness, the board’s decision is governed by the same general standard as for people who are terminally ill.<sup>26</sup> This section then lists factors to consider when granting medical parole for people with nonterminal conditions:

- › the nature of the crime;
- › the applicant’s criminal history;
- › the person’s disciplinary record and program participation in prison;
- › the person’s scheduled parole eligibility date;
- › the person’s age now and at the time of the crime;
- › the recommendations of the sentencing court, the district attorney, and the victim or victim’s representative;
- › the nature of the person’s medical condition and how much care the individual requires; and
- › any other relevant factors.<sup>27</sup>

The notification procedure for medical parole of people who have nonterminal conditions is different from the procedure for those with terminal conditions. In addition to the sentencing court, the district attorney, and defense counsel, subsection 259-s(1)(c) requires notifying the victim or victim's representative and expands the comment period from 15 days to 30 days.

### New York State's law in context

New York's law has a number of notable features:

- > It does not define terminal illness on the basis of a timed prognosis (such as a life expectancy of six to 12 months), acknowledging that prognosis is an inexact science and that physicians are more likely to overestimate than underestimate life expectancy.<sup>a</sup>
- > The statute does not consider only physical impairment for eligibility, but includes cognitive impairment.
- > It does not limit eligible medical conditions to terminal illness, but also considers people who are severely debilitated and incapacitated, putting the focus on function rather than diagnosis.
- > The law's categorical exclusions are narrower than those of other states, and the law includes people serving determinate sentences.<sup>b</sup>
- > The process can be initiated by someone other than the applicant, who may be too debilitated or impaired to do so, and the process does not require the individual under consideration to complete any paperwork. A written request for review from a third party is sufficient to request medical parole.<sup>c</sup>

<sup>a</sup> See Nicholas A. Christakis and Elizabeth B. Lamont, "Extent and Determinants of Error in Doctors' Prognoses in Terminally Ill Patients: Prospective Cohort Study," *BMJ* 320, no. 7233 (2000), 469-72, <https://perma.cc/7UKY-S3MR>. This study of 343 doctors who provided survival estimates for 468 terminally ill patients at the time of hospice referral found that 63 percent were overoptimistic. Also see Brie Williams, Alex Rothman, and Cyrus Ahalt, "For Seriously Ill Prisoners, Consider Evidence-Based Compassionate Release Policies," *Health Affairs Blog*, February 6, 2017, <https://perma.cc/UR5G-5HWY>.

<sup>b</sup> These exclusions are in contrast with those in Maryland, where applicants for medical parole must be parole-eligible per Maryland SB 1005 (2016), and in Alabama, where sex offenses are categorically excluded per Alabama Code § 14-14-17 (2017).

<sup>c</sup> This process is in contrast with the one in Arkansas, which allows only the Department of Correction to initiate the application process per SB 750 (2011), § 75, amending Ark. Code § 12-29-404.

## How Medical Parole Works in Practice

Vera conducted a number of research activities—including administrative data analysis, surveys, and interviews—to better understand how compassionate release works in New York State. The results of this study suggest that a broad, permissive statute is not enough to ensure that people with serious illnesses and incapacitating medical conditions are successfully identified, processed, and released in a timely manner. As discussed below, effective use of the law can

be impeded at many points in the progression of a case. Vera studied these to identify opportunities for increasing the statute's impact. First, the report presents data on the number of people considered for and granted compassionate release, the points of case attrition, and common characteristics of referrals. This is followed by a description of the stages at which clinicians, administrators, and parole board members consider a case, and the discretion which they are afforded. The next section describes the challenges and opportunities people encounter when they are granted release, as department staff try to secure community-based care for medical parolees. (See "Community placement" at page 27.) Finally, the recommendations section suggests modifications to policy and practice that could help increase the use of compassionate release as a viable mechanism to alleviate the suffering of people in the state's prisons, allowing more people access to the care they need in the community. (See "Recommendations" at page 34.)

## How many people are granted medical parole?

DOCCS provided Vera with end-of-year reports on the number of medical parole cases processed from 2013 through 2017. During this period, DOCCS received 476 new requests; 84 people were granted compassionate release and 72 people were released to the community. In those five years, 143 medical parole applicants died in custody. This means that two people died for each person who was released.<sup>28</sup> (See Figure 1 at page 19.)

The rate of successful releases to the community (15 percent of requests) during the five-year period studied is consistent with the overall use of compassionate release in New York since its inception in 1992.<sup>29</sup> From June of that year through December 2017, DOCCS received 3,266 requests. A total of 460 cases—14 percent of all requests—resulted in compassionate release. At the same time, 1,112 cases (34 percent of all requests) ended with the death of applicants who were still in custody.<sup>30</sup> As the DOCCS population has aged, however, there has not been an increase in new requests. The number of people age 55 and older incarcerated in DOCCS facilities grew 23 percent from 2013 to 2017. During that same period, the number of new medical parole requests declined 25 percent, from 115 in 2013 to 86 in 2017. It is not easy to determine whether the decrease in medical parole requests and releases is part of a longer trend or just annual fluctuation in otherwise small numbers. This also points to a fundamental challenge in assessing the efficacy of the medical parole directive: it is difficult to quantify the total eligible population throughout the prison



system and to track changes in this population over time. This is because the detailed nature of the eligibility criteria makes it hard to identify qualified candidates accurately through data alone.

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The results of this study suggest that a broad, permissive statute is not enough to ensure that people with serious illnesses and incapacitating medical conditions are successfully identified, processed, and released in a timely manner.

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Researchers have sometimes used overall prison deaths as a proxy measure for people who might have been eligible for medical parole, but since 2014 DOCCS has not produced publicly available mortality data that distinguishes deaths resulting from a terminal (and diagnosed) illness—and not from violence or an unpredictable event such as a heart attack.<sup>31</sup> What's more, the medical parole statute does not limit eligibility to people who have terminal illnesses, but also considers those with significant, permanent nonterminal illnesses who are severely incapacitated. People with these conditions would be difficult to identify through data alone. Diagnostic information of the type that researchers might query in a database would not necessarily identify the stage or severity of a person's illness or condition; having an early-stage or manageable form of cancer, for example, may not make someone eligible for medical parole.

## How do cases progress through the system?

Few requests for medical parole make it as far as release. Vera took a closer look at the data to determine how far cases make it through the process. The data spanning 2013–2017 show that cases drop off at each stage. As Figure 1 on page 19, illustrates, the point of greatest attrition was early in the process: in 50 percent of cases, applicants did not make it past the first

assessment. Whether this was due to medical or statutory ineligibility is not discernible from the data. The large drop-off in cases may be a result of New York State's inclusive referral policy; requests for medical parole can be made by laypeople who are unfamiliar with the medical, criminal offense, or sentence conditions that determine eligibility. For this reason, it is perhaps more appropriate to measure successful medical parole releases as a proportion of all cases that were deemed medically and statutorily eligible, as indicated by their submission to the chief medical officer.<sup>32</sup> By this metric, 35 percent of eligible people (84 out of 240) were eventually approved for release and 30 percent of eligible people (72 out of 240) were released.

The CMO approved two-thirds of the cases submitted to him for review. These cases were then forwarded to the parole board, so its members could interview the eligible applicants. Not all cases made it that far, however, either because people died before their cases were heard, were released on regular (nonmedical) parole, or completed their sentences (likely a small number of applicants). During the years 2013 through 2017, the board granted compassionate release in 67 percent of the cases they heard—a high approval rate as compared to other forms of parole. For example, in 2015, the board had an overall parole grant approval rate of 23 percent.<sup>33</sup>

## Who is referred—and who is released?

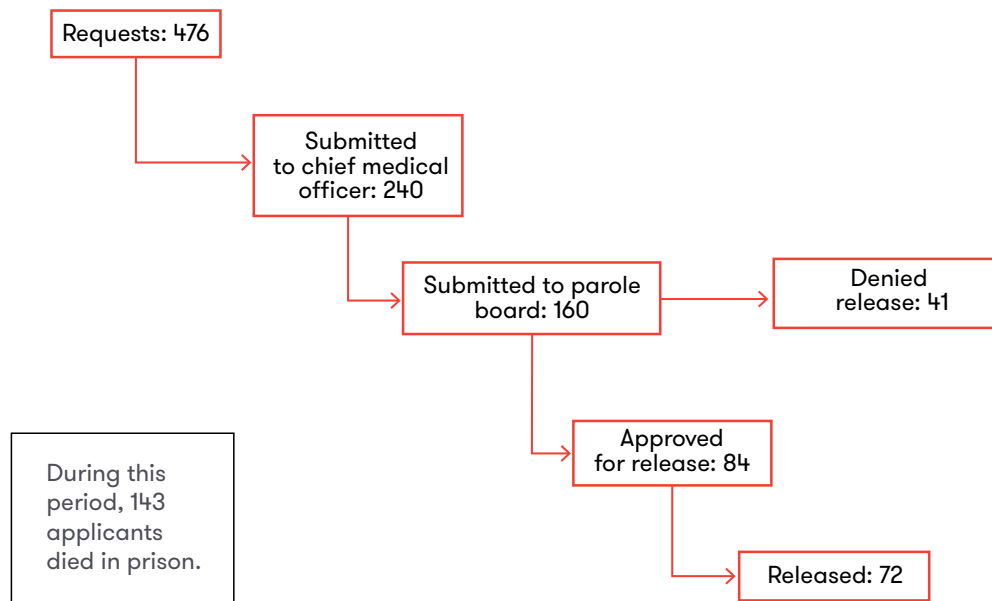
In addition to the case-outcome data described, Vera received more detailed case-level information for medical parole requests made from 2013 through 2015. This data included demographics, limited diagnostic information, and case-level outcomes. Vera analyzed these cases to describe the characteristics of people typically referred to medical parole. This data set also included dates of requests, parole hearings, and releases, allowing Vera to assess how long it took for cases to be resolved.

Data was drawn from an internal database DOCCS uses to track medical parole applications and, for people found to be ineligible or inappropriate for consideration, to assist in monitoring their cases so that they can be advanced should their condition or eligibility change. As is often the case with administrative data, the database is used for day-to-day operations and is not well suited to retrospective research activities. This limited the analyses Vera was able to perform. Specific concerns about the validity or completeness of the data are described where relevant below.

In analyzing case-level information from the 2013–2015 administrative

data, Vera removed cases that were initiated in the final six months of 2015, given that many of them might not have resolved during the period studied. The final sample included 251 requests for medical parole. Of these cases, the data shows 53 people (21 percent of the sample) as having had a parole interview through the medical parole process. Overall, 36 people (14 percent of the sample) were granted compassionate release (either through medical parole or full board case review), 30 of whom (12 percent) were identified as having been released. The remaining six people died in custody.

**Figure 1**  
**Department of Corrections and Community Supervision case outcomes for compassionate release applicants, 2013-2017**



Source: New York State DOCCS Compassionate Release Monthly Reports, end of year 2013-2017. Note that the 72 people granted compassionate release include those who left prison through medical parole, full board case review, and commissioner's discretion; seven applicants were approved for release by the commissioner's discretion, an option that went into effect in April 2015. The chief medical officer is a deputy commissioner of DOCCS who leads its Health Services division.

## Case demographics

Vera analyzed demographic and medical information for the 251 referrals to produce a more detailed picture of who was considered for compassionate release and who was approved.

**Age:** Medical parole requests were made more frequently for older incarcerated people. A total of 53 percent (133) of initial medical parole requests and 44 percent (16) of those approved were made for incarcerated people age 55 and older. As noted earlier, even as New York State’s prison population has declined in recent years, the number of incarcerated older adults has increased—and this has been true for both new commitments and the daily population.

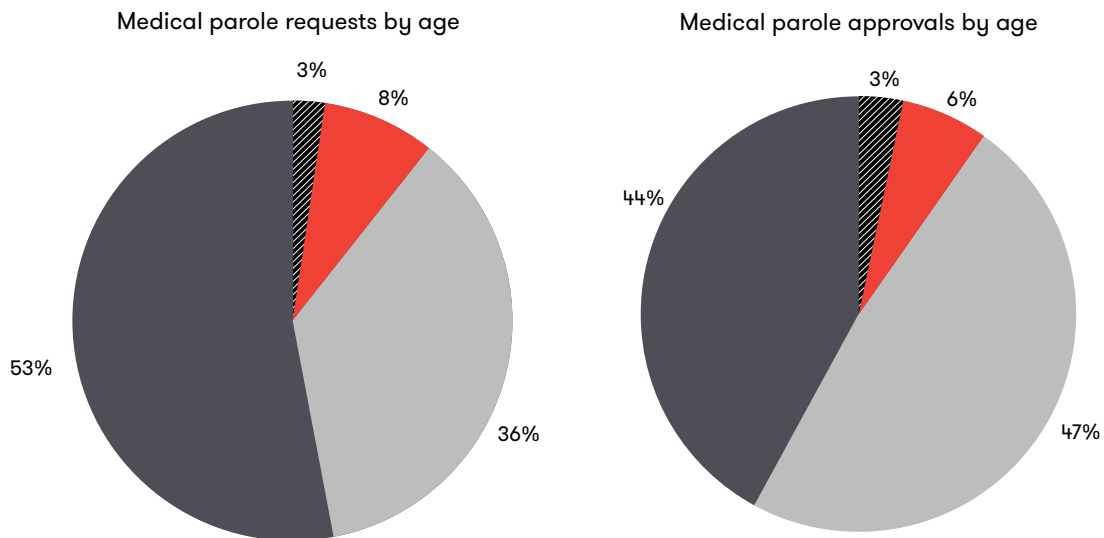
**Gender:** A breakdown of medical parole applicants by gender resembles the prison population broadly. Incarcerated men accounted for 93 percent of requests and 94 percent of those granted medical parole; in 2014 the New York State prison population was 97 percent male.<sup>34</sup>

**Race and ethnicity:** Racially and ethnically, medical parole applicants diverged noticeably from the prison population as a whole. White people accounted for 40 percent of initial applications in Vera’s sample, but only 24 percent of the prison population in 2014. Conversely, black people made up 49 percent of the prison population and 41 percent of applications.<sup>35</sup> This racial disparity may partly be a function of shifting demographics; the most recent period for which systemwide data is available for age

Figure 2

**Department of Corrections and Community Supervision medical parole requests and approvals, by age**

▨ Ages 18-24    ■ Ages 25-39    ■ Ages 40-54    ■ Ages 55+



Source: New York State DOCCS data from January 2013 through June 2015; analysis conducted by Vera. Requests by age: n = 251; approvals by age: n = 36.

disaggregated by race shows that a greater proportion of those age 55 or older were white (34 percent). As noted, people in this age group were most likely to submit a request for medical parole or have one submitted on their behalf.

**Table 1**  
**New York State prison population age 55+ and medical parole requests, by race and ethnicity**

	<b>DOCCS prison population ages 55+ (2012)</b>		<b>DOCCS medical parole requests (January 2013–June 2015)</b>	
White	1513	34%	101	40%
Black	1858	42%	103	41%
Latino	976	22%	21	8%
Other	86	2%	23	9%
Unknown	22	1%	3	1%

Sources: The data for 2012 is from DOCCS *Inmate Mortality Report, 2009-2012*; the data for January 2013 through June 2015 is DOCCS administrative data that Vera analyzed. For more information, see *Inmate Mortality Report: 2009-2012* (Albany, NY: DOCCS, 2013), <https://perma.cc/45BF-9JBB>.

The greatest disparity was among Latinos, who accounted for 22 percent of the population age 55 and older, but only 8 percent of medical parole requests. It is not possible to determine whether this is a result of the difference in time periods for the two sets of data, a result of the imperfect recording of people’s racial and ethnic identities using the categories in the DOCCS data system, or a reflection of a more systemic issue.

## Medical conditions

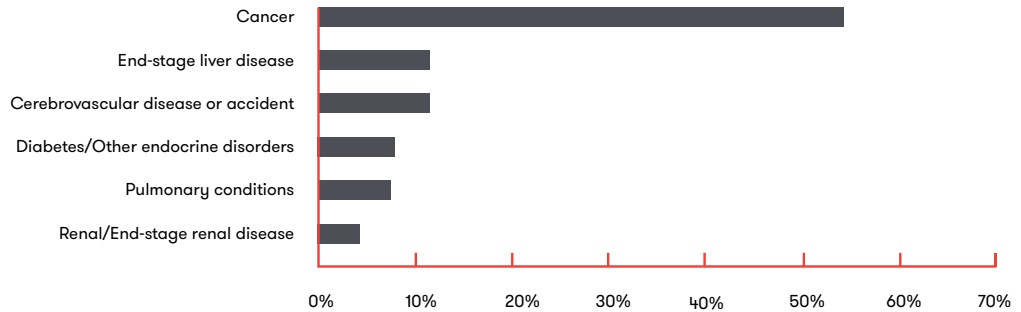
When assessing a request for medical parole, staff refer directly to the patient’s medical records, which are separate from the medical parole database that was provided to Vera. The diagnostic information available in the medical parole database is incomplete and limited. Twenty-two percent of the medical parole requests for which Vera obtained data did not include any medical information. Referrals initiated by non-medical professionals may include inaccurate diagnostic information. The findings illustrated in Figures 3 and 4, below, should therefore be interpreted with caution.

Figures 3 and 4 show the six most common conditions for cases for which this information was available (76 percent of medical parole requests and 78 percent of approved cases).<sup>36</sup>

If accurate, the data would suggest that various forms of cancer accounted for just less than one-third of initial medical parole requests and

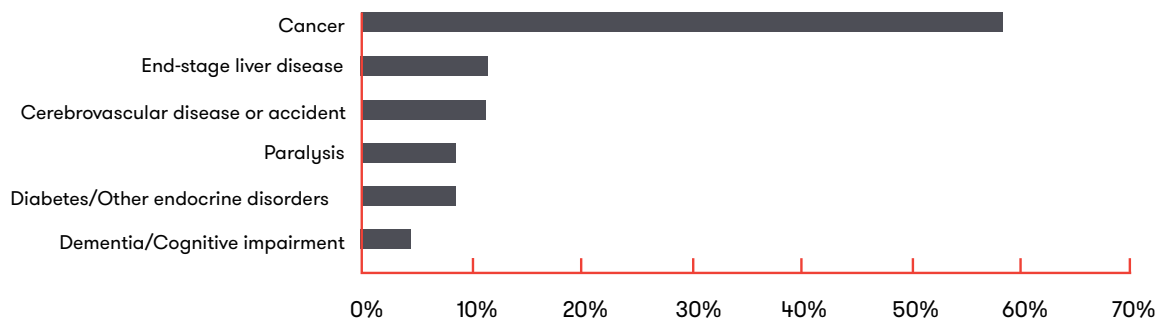
58 percent of people who were successfully granted medical parole. Of the six requests for medical parole involving a diagnosis of dementia/cognitive impairment, one release was granted. Of the four applications made on the basis of paralysis, two parole approvals were granted.

**Figure 3**  
**DOCCS medical parole requests: Most common conditions, January 2013-June 2015**



Source: New York State DOCCS data from January 2013 through June 2015; data on medical conditions was available for 190 of 251 cases.

**Figure 4**  
**DOCCS medical parole approvals: Most common conditions, January 2013-June 2015**



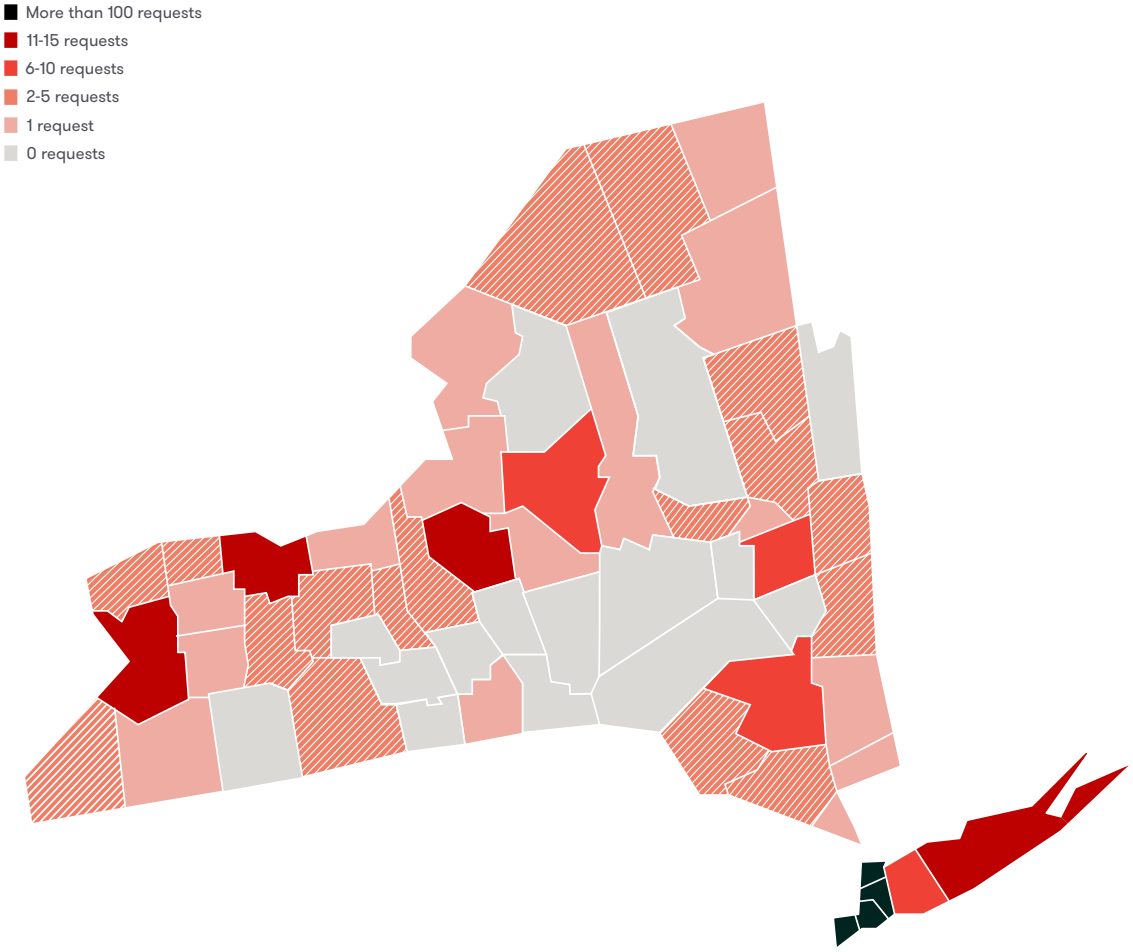
Source: New York State DOCCS data from January 2013 through June 2015; data on medical conditions was available for 27 of 36 cases.

## County of commitment

Vera also looked at the county of commitment for medical parole applicants, as these are the counties to which people will likely return if released. (County of commitment means the county where people were convicted and is often but not necessarily where they resided.) As discussed later in this paper, however, not all counties are able to provide the same level of access to medical and residential services that applicants may need.

Applications for medical parole were concentrated among people who came from the five boroughs of New York City and four counties nearby. Figure 5, below, shows that 43 percent of requests (n = 109) came from someone whose county of commitment was in New York City. The next greatest number was for Suffolk County (13). This mirrors the geographical composition of the state prison population as of January 1, 2016: 43 percent of people had New York City counties (Bronx, Kings, New York, Queens, and Richmond) as their county of commitment and 11 percent were from the New York City suburbs (Nassau, Rockland, Suffolk, and Westchester counties).<sup>37</sup>

**Figure 5**  
**Number of medical parole requests by county of commitment**



## Deaths prior to release

Of the 251 people who requested medical parole in Vera's sample, 59 of them—24 percent of cases—died in custody within the study's time frame. Vera did not receive case-level data beyond 2015; the rate may be higher if more members of the sample have died since then. Even so, this is nearly double the number of people who were successfully released via the medical parole process (30 people).

Of those 59 people, 30 of them (51 percent) were assessed as eligible for medical parole consideration. Another 16 people were deemed not medically eligible, and 13 cases had missing data. (It is not clear from the data whether these people died before an assessment could be conducted.) Six of the 59 people were granted medical parole but died before they could be released.

The profiles of the 59 people who died in custody are informative when thinking about the use of medical parole and the potential need for other release mechanisms. The majority of those deaths (75 percent) were of people who were age 55 or older and the remaining 25 percent were people ages 40 to 54. Among those people who died in custody, 46 percent (27 people) are identified in the data as having had some form of cancer, while another seven people (12 percent) suffered from end-stage liver disease. There was often only a short time between the request for medical parole and the applicants' deaths, suggesting that for release to have been possible their cases would need to have been identified and submitted sooner than they were. Although the average time between first request and death was just shorter than seven months, 37 percent of the deaths occurred within one month of a medical parole request and nearly 50 percent within two months of a request.

In Vera's sample, six applicants who were granted medical parole died before they could be released from custody. These people died within one month of their parole interview; this dramatically highlights the tight time constraints that discharge planners face, and the need for early identification of cases and speedy case processing.

## How long do cases take?

The average time it took a case in Vera's sample to progress from initial request to parole board interview was 3.7 months. There was great variation in this, however, with the longest case taking more than two years.<sup>38</sup> It is possible that in protracted cases, some requests were initially found to be ineligible for parole consideration but were deemed eligible at



a later date, perhaps due to a change in people's medical condition.

Because dates are not recorded for the early milestones in the medical parole database (including the first medical assessment and the chief medical officer's review), the data does not make clear which of the stages early in the application process took the longest. Interviews with senior DOCCS staff suggest that the chief medical officer typically grants approval expediently. But neither the statute nor the accompanying DOCCS directive set time parameters for physician's medical evaluation (if one is requested and/or initiated by someone other than the facility clinical staff), although the statute does set a seven-day time limit for DOCCS to submit cases to the parole board once the DOCCS Albany headquarters (referred to as "Central Office") receives a medical evaluation.

As cases are prepared for parole board review, however, several administrative hurdles must be cleared (such as the comment period for the district attorney, the sentencing court, the defense counsel, and any registered victims). The most recent data published by DOCCS shows that for all cases from 1992 through 2014, an average of 23 business days elapsed between the parole board receiving a case and the interview—eight business days beyond the statutory comment period of 15 days. For the 30 people granted medical parole who returned to the community, their release happened relatively quickly—in an average of 0.4 months.

## What happens at key decision points?

Although New York's compassionate release statute is broad relative to states that have numerous conviction exclusions, in practice few people are considered and many fewer are released. This section of the report examines the strengths and weaknesses at the three principal DOCCS decision points: medical staff review and evaluation at the facility; CMO certification and commissioner approval; and review by the parole board.

### Clinical staff and the medical parole request

Submitting a medical parole request is the first step in the process, and DOCCS staff or others can initiate it. The fact that someone from outside DOCCS can make a request—be it a family member, friend, or lawyer—is a principal strength of the referral mechanism. But as the people most familiar with patients' medical conditions, it is the DOCCS clinical staff

who must be leaders in this process. Although DOCCS physicians exercise a lot of discretion in deciding whether to initiate a request for medical parole and in assessing medical eligibility standards, as it stands there is reluctance among facility clinicians to do so, based on the survey responses from medical staff who attended training.

Indeed, it was clear from survey responses that some clinicians feel conflicted about their role in initiating the process and the sense and burden of responsibility it imposed. Among survey respondents (63 percent of whom were physicians; the remainder were mostly nurse practitioners and physician assistants), 28.2 percent believed they were treating at least one eligible patient they had not yet referred. They identified time constraints (52 percent of responses) and lack of administrative support (43 percent of responses) as the primary barriers to changing how they would approach compassionate release and care for the population under consideration. Discussions and interviews with DOCCS clinical staff revealed a lack of clarity about how compassionate release fits into the department's patient care mission, how to navigate the medical parole application process, and the critical role of physicians in early identification of potential applicants.

Consequently, too many requests are made too late. As mentioned above, in the 2013–2015 case data Vera reviewed, among the 59 people who died in custody, more than a third died just weeks after the medical parole request was initiated.

## Chief medical officer certification and commissioner approval

In the last stage of DOCCS review, the chief medical officer receives a medical parole application, reviews it and, if he determines that the person is eligible, sends it to the commissioner. The review done by the CMO and the commissioner at Central Office is both a medical assessment—a chart review based on the application paperwork—and an assessment of risk to public safety, based on the person's medical condition, DOCCS records, and general criminal history. Both the statute and the directive assign the responsibility of a public safety assessment to two actors: DOCCS and the parole board. The risk review done by Central Office, however, is likely duplicative of the public safety assessment the board conducts, but without the benefit of the COMPAS risk instrument the board uses—an algorithmic tool that helps assess a person's likelihood of reoffending.<sup>39</sup> For cases approved to go before the board, the CMO prepares a summary of people's medical information so that board members will understand

the applicants' condition, but this is not required under the DOCCS directive and may not be done in every case.

## Parole board review

The board grants medical parole to two-thirds (68 percent in Vera's sample of cases) of the certified medical parole and full-board case review applications received from DOCCS, a higher rate than the board's overall parole grant rate of 25 percent.<sup>40</sup> This suggests that the board has some confidence in DOCCS's recommendations, but still exercises its independent decision-making authority. One weakness in the board review process is how protracted it is. The statute requires a comment period of 15 days for applicants with a terminal illness and 30 days for those with a nonterminal illness. (Under the statute, the board must notify the sentencing court, the district attorney and defense counsel. The DOCCS directive requires referral of all cases to the Office of the Victim Assistance for victim notification.) The comment periods dictate the speed of the process in part, but that is not likely the only cause of delays. The parole board does not have the resources or capacity to interpret medical information, and neither the statute nor the directive requires a summary of medical conditions that is accessible to nonmedical professionals. The data does not show the length of time for each stage of the medical parole process—or between those stages—but Vera's interviews with policy stakeholders confirmed that the board's review is the stage at which the process typically slows down.

## Community Placement

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For people who progress through the medical parole process and are granted release, one significant hurdle remains—securing placement and transitioning to the appropriate level of medical care in the community. This is a crucial step in effecting access to quality health care for this often overlooked and underserved population. But as New York and other correctional systems report, the transition from prison to a community service provider can pose significant challenges, despite the low risk the patients pose to the public.<sup>41</sup> If appropriate residential or community-based care cannot be secured for people on parole who have

significant health needs, they may remain in prison until such care can be found, prolonging their incarceration.

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The transition from prison to a community service provider can pose significant challenges, despite the low risk the patients pose to the public.

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Successful release from prison for this population entails more than securing services or a bed in a residential nursing home. The American Geriatrics Society describes “transitional care” as the coordination and continuity of health care when patients are transferred between different levels of care in the same service setting or across different service settings.<sup>42</sup> Collaboration among corrections-based staff and community service providers can help address and alleviate the uncertainty that often exists when someone is discharged from one institution and admitted to another. It is an ongoing process that involves multiple actors and service systems. The effectiveness of transitional care determines whether passage from prison to the community will be reasonably smooth, timely, and cost-efficient—or uneven, uncomfortable, lengthy, and expensive.

The New York State DOCCS has designated staff to meet this challenge. The department’s RMUs have discharge planning teams that create transition plans and find care in the community for people who will soon be released directly from their units. Incarcerated people in the general prison population (and not in the RMU) who have two or more chronic conditions—or one significant condition such as HIV/AIDS or a serious mental illness—are released with the help of the Discharge Planning Unit (DPU). The unit comprises four senior utilization review nurses who cover the state.

## Conditions of a smooth transition

To better understand the challenges and opportunities faced in releasing people who have substantial health care needs, Vera surveyed a sample of 40 administrators from agencies in New York State that provide community-based care about their policies and experiences in admitting people directly from prison. The responses to these surveys, in combination with interviews Vera conducted with DPU staff and DOCCS administrators, demonstrate how the transition of care is especially problematic in states with large prison populations, such as New York, where a sizable number of people are serving long sentences for violent or sex offenses.

### What makes a good transition plan?

Assessment and planning for care transition (sometimes referred to as discharge planning) includes finding and linking the patient to housing, health, legal, and social services, including Medicare and/or Medicaid benefits.<sup>a</sup> An effective transition plan should identify what tasks need to be done, by whom, and when, as the person goes from prison to the community. The care transition teams in a facility and the community should monitor and evaluate the plan. Examples of tasks in the plan include securing benefits, completing paperwork and, for nursing home placement, completing the federally required Patient Review Instrument and Pre-Admission Screening and Resident Review.<sup>b</sup>

Ideally, transitional care involves communication among the key stakeholders to help enable a smooth transfer; this typically means the individual, family members (or assigned

surrogates or guardians), corrections staff, the parole officer, and community service providers.

To help facilitate smooth care transitions, the family and/or community service provider should see the person in transition before release. The community service provider would also benefit from contacting family members or the parole officer to begin the collaboration, including setting up a visit to the home or facility—or having them join the agency’s interdisciplinary team meetings.<sup>c</sup> While trying to secure a placement, correctional staff and family members may also need to advocate for the patient with community service providers. One central advocacy point is often helping providers understand that the individual in need of placement is a person with a need of and right to care and to avoid stigmatizing labels such as “ex-offender” or “prisoner.”<sup>d</sup>

- <sup>a</sup> See Tina Maschi, Suzanne Marmo, and Junghee Han, “Palliative Care in Prison: A Content Analysis of the Literature,” *International Journal of Prisoner Health* 10, no. 3 (2014), 172-97, [www.emeraldinsight.com/doi/abs/10.1108/IJPH-05-2013-0024](http://www.emeraldinsight.com/doi/abs/10.1108/IJPH-05-2013-0024); Tina Maschi, Deborah Viola, and Fei Sun, “The High Cost of the International Aging Prisoner Crisis: Well-Being as the Common Denominator for Action,” *Gerontologist* 53, no. 4 (2013), 543-54, <https://www.ncbi.nlm.nih.gov/pubmed/23042691>; and Brie Williams and Rita Abalde, “Growing Older: Challenges of Prison and Reentry for the Aging Population,” in *Public Health Behind Bars: From Prisons to Communities*, edited by Robert Greifinger (New York: Springer, 2007).
- <sup>b</sup> See the Patient Review Instrument at <https://perma.cc/SF8C-3CZR>; and the Preadmission Screening and Resident Review (PASRR) at <https://perma.cc/DLW3-KJSE>. For more information on the PASRR, see <https://perma.cc/4LDX-F62L>.
- <sup>c</sup> An ideal interdisciplinary team meeting typically includes all of the professionals who have a role in a patient’s care. In the case of people released from prison with serious medical conditions, this would include a medical doctor, nurse, social worker, parole officer, and other professionals who might provide care or counsel, such as a lawyer. When family members have a key role in the transition from prison to the community, their participation in team meetings might also be warranted.
- <sup>d</sup> See generally Kavita Patel, Amy Boutwell, Bradley Brockmann, and Josiah Rich, “Integrating Correctional and Community Health Care for Formerly Incarcerated People who are Eligible for Medicaid” *Health Affairs* 33, no. 3 (2014), 468-73.

The next sections present five common considerations that influence how smooth the transition of care will be for aging and seriously ill people going from prison to the community.

## Value conflicts: Health care vs. crime and punishment

People released from prison with significant medical needs are seen to inhabit two salient roles—“patient” and “ex-offender”—which, together, can elicit a conflict in values for service providers. As a result, the stigma associated with being formerly incarcerated, as well as concerns about public safety, may impede providers in realizing their duty to care.<sup>43</sup> When such conflicts are codified in providers’ policies as criteria for exclusion, it leads to even greater barriers in the medical parole process.

This was borne out in Vera’s survey of community service providers: a number of respondents, including those representing skilled nursing homes, reported that they had policies that deny placement to people based on their criminal history. Among responding agencies, 40 percent indicated that they had policies prohibiting them from accepting people convicted of sex offenses; 24 percent were prohibited from accepting people with a history of arson; and 20 percent said they could not accept people convicted of violent offenses. This has serious consequences for release planning. DPU staff members reported particular hardship in placing people convicted of those crimes with programs that provide appropriate care, regardless of the risk an individual posed to the community.

That is because community providers often have blanket exclusions for people with felony convictions or particular felony convictions. But even service providers that do not have restrictive policies may still struggle because other barriers exist, such as laws prohibiting the placement of people convicted of certain types of sex offenses within close proximity to a school or playground.

If people are barred placement based on their offense history, those who have been granted compassionate release may linger and die in prison. Six New York State prisons operate Residential Treatment Facilities (RTFs), where people can be placed pending their acceptance into a community-based care home. But although people held in RTFs are technically no longer serving their sentence, the units are staffed by corrections officers and, DOCCSS staff reported, the patients held there may still feel imprisoned.

## The discharge planning process

For people who are granted compassionate release, especially those with a terminal illness, every day counts. As Vera’s data analysis showed, people who died after being granted medical parole but before being released did

so in a relatively short period of time; in Vera's sample, they all died in less than one month.

One significant barrier to a speedy release can be the new care provider's intake requirements, especially because incarcerated people do not always have easy access to the documents that organizations require. Vera's survey of community-based providers asked whether the respondents' organization required any specific documentation to admit someone. Just more than one-third (37 percent) reported requiring proof of income, 40 percent require state identification, more than half (56 percent) require proof of insurance, and two-thirds (67 percent) require a Social Security number.

Securing these documents and meeting other requirements can delay a person's placement and therefore delay release from prison. Importantly, services are rarely provided free and a means to meet the costs must be secured. And though a small number (six) of respondents to Vera's survey reported that they do not charge clients for services, 50 percent reported accepting Medicaid, 38 percent accepted Medicare, 28 percent accepted private insurance, and a quarter accepted Veterans Administration benefits. Reinstating benefits or insurance to people being released from prison is therefore an important hurdle to clear. In New York State, dedicated Medicaid clerks based in the Transitional Services unit at DOCCS process Medicaid applications and prioritize people who have serious medical conditions and are approaching release.

Even with all of these bureaucratic imperatives satisfied, a timely release for people requiring a high level of care happens only if a bed is found at an appropriate program. As described, people's criminal history may exclude them from certain placements; this is particularly problematic for people being released in some upstate New York counties that have a much lower density of care providers than the counties in and around New York City. Staff at the DPU reported that finding beds was especially problematic in rural areas. Vera's survey illustrated this problem; respondents who reported that their agencies can serve people with criminal convictions were disproportionately located in New York City and surrounding counties.

To meet these challenges, it is vital that discharge planners have as much time as possible before a person's release to identify and coordinate services. In New York State, DPU staff receive lists of all people who are due to leave prison and have two or more chronic conditions (or one significant medical or mental health issue) 90 days before their release, so that they can create detailed discharge plans. For people seeking medical parole, however, their release date is uncertain and depends on the parole board's decision. This introduces other challenges. Waiting until parole is

granted is likely to be too late for a thorough discharge-planning process, especially for people in the late stages of a terminal illness. Beginning the process before the parole hearing, however, may require that discharge planners find a bed in a residential care facility that the provider can hold for the patient without knowing if or when the individual will be released from prison. This further narrows an already limited range of options.

## Coordinated discharge-planning capacity

Another condition that helps enable a smooth transition to community care is the presence of a formal discharge planning unit at the correctional institution the person is leaving. Ideally, this unit should consist of a specialized interdisciplinary team of staff that can address the complex health and social service needs of people granted medical parole.

As mentioned, in DOCCS a number of people work to meet these needs: the staff involved include a medical parole coordinator, discharge planning teams at each RMU, and the four nurses and one social worker at the DPU. And although these staff have had a substantial positive impact on the quality and number of transitions made to the community, DOCCS administrators and staff who spoke with Vera stated that more discharge planners are needed. When Vera interviewed DPU staff in December 2017, they reported that the unit had handled approximately 6,700 referrals since it was established in January 2016—a substantial volume for a small team. The need for assistance is likely much greater than this; the unit does not typically provide discharge planning for people who do not have two chronic illnesses or one major one, but who would still benefit from a more formal discharge plan.

Transitional care management also requires resources at receiving agencies. The extent to which community service providers have the specialized staff needed for effective collaboration with DOCCS varies. People released from prison often need assistance in addressing their complex health, mental health, social, cultural, financial, spiritual, and legal needs. In Vera's survey of New York State care providers, slightly more than half of responding agencies reported having specialized staff (such as clinical social workers, registered nurses, or physicians). Less than half of the respondents reported having psychiatrists, counselors, nurse practitioners, or physical therapists. Less than one-third reported having home health aides, lawyers, geriatricians, or clergy. This transition will go more smoothly if people have access to specialized staff.



## Communication and collaboration

Not only should discharging and receiving agencies have specialized staff overseeing a person's case plan, but their staffs should communicate and collaborate during the process, particularly if prison systems need service providers to hold a bed or ensure that any medical equipment needed is available, such as a wheelchair or oxygen. According to Vera's survey results, only a small number—15 of the 40 responding organizations—said they had received applications in the past 12 months for someone who was leaving prison; 12 reported having received more than five such applications during the year. Thirteen of the 15 respondents said that at least one application came directly from DOCCS staff, though agencies reported that they also received referrals from family members, social workers, advocates, lawyers, and other community service providers. Seven organizations reported having contact with DOCCS staff during the application process, with the remaining organizations being unsure as to whether such communication had taken place.

Respondents were mixed in their level of satisfaction with the communication and process of transferring someone from DOCCS custody to their care. Of the 12 responding agencies, four reported being dissatisfied with the level of collaboration between DOCCS and their agency during the application process, four were undecided, and four reported being satisfied. They were similarly split in their attitudes about the coordination of the transfer of care. To improve the process, organizations noted the need for increased communication between DOCCS and their organization.

The level of family involvement and preparedness can also affect the ease of a transition. Family members can be important actors in the success of a case; in Vera's survey, among the organizations that said they had received clients directly from prison facilities, 40 percent reported that the initial referral for services had come from a client's family member.

# Recommendations

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New York's experience reflects the challenges many states face with respect to compassionate release when their policies are not producing the desired outcomes.<sup>44</sup> What is notable about New York is that the barriers lie less in the limited scope of the policy (though there is room for improvement, as discussed below) than in implementation. The primary focus should be to ensure that compassionate release is carried out more effectively. New York State could improve outcomes by acting on the following recommendations for more effective implementation and for legislative changes.

## Nonlegislative changes

**Initiate new requests for medical parole at earlier stages in people's illness** by providing more direction and training to medical staff about when to submit medical parole applications, along with automatic triggers for submissions of such applications; informing families and lawyers about how they can initiate a medical parole request; and informing facility clinical staff about the medical parole database.

- › **Create automatic triggers for medical parole applications.** For example, an admission to the Unit for the Cognitively Impaired or a diagnosis of certain cancers could automatically prompt staff to submit a medical parole application for the person and/or to notify the medical parole coordinator to track the individual in the medical parole database. Even if people are not medically or statutorily eligible at the time of the first request, if the database flags them for potential future eligibility, a system would monitor them from that point on. All people in RMUs should be tracked for eligibility according to their sentence and medical condition.

- › **Provide clear and direct guidance and training to medical staff.** Make sure facility clinical staff understand that early referral for medical parole is considered good practice and that leadership encourages it. If Central Office administrators want medical staff to err on the side of applying too early in the course of someone's illness (perhaps while the individual is too healthy to qualify), they should communicate that expectation clearly to staff. Another example is the common misperception that a person who resides in a prison's general population (as opposed to a Regional Medical Unit, an infirmary, or an outside hospital) is not eligible. Vera heard from a number of DOCCS clinicians that some staff assume that people who can still manage in the general population are presumptively ineligible. This type of misinformation may have a negative impact on the clinical staff's willingness to pursue medical parole. Staff should also be trained on the policy and on geriatrics and palliative care broadly. Despite the fact that 74 percent of the surveyed medical staff provided care to older patients at least once a day, one-third said they believed they had not received enough training in geriatrics or palliative care.
- › **Guide medical staff through the process.** Comments provided in surveys with clinicians who attended the trainings Vera organized made it clear that they feel overburdened with work and see medical parole as an onerous process. In light of this, DOCCS should critically examine the medical parole process and how it is administered. There should be direct communication between clinical staff and Central Office on this subject.
- › **Inform families and lawyers that they can initiate requests.** Ensure that family members and lawyers know they can initiate requests for medical parole, a topic that is not even mentioned in the state's inmate handbook.<sup>45</sup> People should be able to find information on the DOCCS website about how to make such a request.
- › **Inform clinicians about the medical parole database.** The DOCCS medical parole database provides the capacity to track people as their illness progresses, so that their cases can be advanced as soon as they are medically and statutorily eligible. Although the database is used and maintained by DOCCS Health Services staff at Central Office and not by clinicians at the facility level, the tracking and monitoring they do should encourage facility

clinicians to initiate requests for medical parole in the early stages of a serious illness, even if the patient is not yet debilitated enough to qualify. The existence and utility of the medical parole database, however, is not common knowledge among DOCCS clinicians. As part of its efforts to improve communication and direction vis-à-vis facility medical staff, DOCCS should make sure that clinicians understand how the database operates and the benefits of referring potential applicants as early as possible.

**Understand and reduce the barriers to more medical parole requests** through improved data collection capacity, to allow DOCCS to know more about who is making these requests and the impact of the medical and conviction criteria for eligibility; and through increased accountability.

- › **Improve data collection.** Anyone can initiate medical parole requests, which are logged into the medical parole database. This database is an excellent resource for DOCCS and provides the ability to track and follow up on referred individuals whose condition might not initially be severe enough to qualify for medical parole. Other states should consider developing such an internal tool to track and monitor people's medical conditions. But New York's database could be improved so that it can be better used for systemwide quality improvement, research, and analysis. In the early phases of a case, the medical parole database does not currently distinguish between people who are not eligible because of their sentence from those whom facility clinical staff decline to recommend because they are not medically eligible. As a result, it is impossible to know what impact the statutory exclusions have on the law's effectiveness.
- › **Ensure accountability in the early stages of the process.** The directive does not spell out what discretion facility medical staff have to respond to Central Office requests for medical parole applications. It also does not cover what documentation is sufficient when Central Office reaches out to facility medical staff to check on the status of someone being tracked in the database. Is an e-mail refusal enough? Must the facility clinical staff conduct a new examination? Can they respond based on a chart review? The directive does not speak to these details, which are important for ensuring the effectiveness of follow-up and tracking.

**Improve communication with the parole board by describing and documenting people's medical conditions in plain English.** The medical evaluation forms are designed for the review and comprehension of health care professionals, not the members of the parole board, who make release decisions. The DOCCS policy should require a narrative explanation of people's conditions using descriptive language about their functionality, their degree of impairment, their symptoms, what kinds of care they require, an assessment of their prognosis and likely trajectory, and recommendations about the kind of care and placement they will need in the community. This kind of information is shared with the parole board in some cases, but the practice is not institutionalized in the DOCCS directive.

- › **Engage families in the discharge planning process.** Coaching from correctional staff or community service providers can help prepare a family to welcome a loved one home or back to the community, as well as to navigate the individual's health, social service, legal, and other needs. DOCCS can draw on the commitment and interest of some families in planning and preparing for discharge through intentionally involving family members who want to participate. Vera recommends that the word “family” be understood expansively, to refer to loved ones and community members who will support people in their reentry—and not exclusively blood relatives.

## Legislative changes

**Clarify who should conduct the public safety/risk assessment.** The statute should clarify the discrete responsibilities of DOCCS and the parole board. As the law is written, DOCCS certification to the board is premised on what sounds like a DOCCS evaluation of the level of risk a person poses—whether someone is so debilitated that he or she is incapable of presenting a public safety risk.<sup>46</sup> That language does not make clear whether the DOCCS assessment should go beyond the medical evaluation, nor does it refer to the incapacity evaluation or a person's ability or likelihood of reoffending. The parole board, which incorporates a risk assessment instrument into its decision making, is likely more informed and in a better position to make that determination.

**Rethink the role that notification of victims and law enforcement plays.** Two aspects of the victim and law enforcement notification process

should be examined: the length of the comment period and the information provided to them.

- › Since New York's medical parole law was first enacted in 1992—years before e-mail and other technologies were in wide use—the comment period for law enforcement required by Section 259-r (about people with terminal conditions) has been 15 days. For people who have a nonterminal illness and are considered for medical parole under Section 259-s, the period is 30 days. Modern technology allows for much faster notification than in the past, and the comment period should reflect that. The notification period creates a 15- to 30-day window when the case cannot proceed. Although that may not sound like a long delay, every day matters for the population under consideration. New York legislators should consider shortening the comment period or allowing cases to proceed once there has been confirmation about whether victims and law enforcement wish to weigh in.
- › Policymakers should consider whether to include information about medical parole—and what information—in such notifications. Even though medical privacy laws limit the sharing of such information, victims and law enforcement should be informed of the medical parole context—specifically, which eligibility requirements the person under consideration has met. Without knowing the context for medical parole eligibility, the notification does not convey the information victims and law enforcement might want to know about someone's risk to the community and the punitive value (or relative lack thereof) of continuing to incarcerate them.

**Prohibit blanket exclusion policies for people with felony convictions in community health care settings.** A pressing challenge for DOCCS is access to community providers that can care for people who are debilitated enough to meet the standard for compassionate release, a problem that DOCCS staff report has gotten worse in recent years. The state health department has the authority under Article 28 of the Public Health Law to prohibit such discriminatory exclusions.<sup>47</sup> Nondiscrimination for Article 28 health facilities would at least allow people seeking placement to be assessed individually for the potential risk they pose. All residential health care facilities must obviously protect their staff and vulnerable residents, but blanket felony-conviction exclusion policies are not sensible in light of the urgent need for placement and the ability of community providers to make individualized assessments.

# Conclusion

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This report shows how compassionate release is about much more than statutory design. **Although New York has a broad, well-designed law, few people are granted compassionate release and twice as many applicants die in custody than are released.** And while DOCCS and the parole board have given significant strategic attention to this issue, dedicating resources to manage and advance medical parole candidates, the state's use of compassionate release often does not achieve the law's objectives: to allow people to die outside of prison among their loved ones; to shift the burden of care for those who pose little to no risk to public safety to the more cost-efficient health care system in community settings; and to allow people with debilitating conditions to receive treatment in a setting more appropriate than prison. But without better information about who does not progress through the medical parole process and why—whether people are deemed ineligible because of medical or conviction-based criteria—it is difficult to know precisely which policies, practices, or statutory changes would improve outcomes. As policymakers debate Governor Cuomo's recent proposal for geriatric parole, they should keep two important lessons in mind. First, DOCCS needs to conduct systematic tracking and data collection to answer those questions. Second, the discretion that clinical staff have in the medical parole process is often a source of conflict and pressure, underscoring the need for clear direction from DOCCS leaders.

Policymakers' role in this discussion must also address a persistent challenge: where people will go once they are granted medical parole. This issue should be front and center in the debate ahead. But responsibility also lies with the community, to welcome and care for seriously ill and dying people who are returning after serving time in prison. Unless community-based providers accept the obligation to care for formerly incarcerated people and the public supports the easing of restrictions on such placements, the potential value of compassionate release will never be fully realized.

## Acknowledgments

The authors are very grateful for the support of the New York Health Foundation's Special Projects Fund and particularly Brian Byrd, Jessie Kavanagh, and Victoria Casani for their guidance in this project. Our special thanks to DOCCS deputy commissioner and chief medical officer Dr. Carl Koenigsmann and Board of Parole chairwoman Tina Stamford, who generously devoted their time to talking with and guiding Vera staff in our research. We are also grateful to all the DOCCS staff who spent time in research interviews and follow-up discussions related to medical parole. We wish to thank current and former Vera staff who contributed to this project, including Vedan Anthony-North, Ashley Demyan, Chelsea Davis, and Stephanie Pottinger. Jack Beck's previous work on this subject was an invaluable source of historical context and his insights into the current landscape also contributed to our understanding of the issue. Drs. Rachael Bedard and Jonathan Giftos helped lead and manage the training sessions and Lynn Cortella provided valued contributions to the research activities. The Vera internal review team, Chris Henrichson, Fred Patrick, Mary Crowley, Jim Parsons, and Ram Subramanian, gave us very helpful feedback. Our thanks to Jules Verdone who tirelessly edited this report, to Gloria Mendoza who designed it, and to Cindy Reed and Khusbu Bhakta for editorial support.

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### Suggested Citation

Rebecca Silber, Léon Digard, Tina Maschi, Brie Williams, and Jessi LaChance.  
*A Question of Compassion: Medical Parole in New York State*. New York: Vera Institute of Justice, 2018.



## Endnotes

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- 28 This rate is almost identical to that which was observed in New York State in the late 1990s. Beck presents data showing that in 1997 and 1998, one release was granted for every 2.23 medical parole applicants who died in custody. Beck, 1999, 217.
- 29 There is an unknown but likely small margin of error for the 15 percent success rate and other outcome rates calculated using this data. Outcomes—including parole decisions and releases—may relate to cases that were initiated prior to 2013, involving people who would therefore not be included in the count of “new requests.” Similarly, some cases may have been resolved after 2017; these would therefore be counted among the new requests, but they would be missing from the outcome count in Vera’s research.
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- 36 Vera researchers aggregated diagnostic information into broad categories, in consultation with Vera’s research partner, the geriatric and palliative care physician Brie Williams. The data contained some obvious errors, however—such as entries of medical

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