U.S. Department of Justice

United States Attorney's Office
Eastern District of New York

271 Cadman Plaza East
Brooklyn, New York 11201

January 10, 2017

By Hand and ECF

Honorable Kiyo A. Matsumoto
United States District Judge
Eastern District of New York
225 Cadman Plaza East
Brooklyn, New York 11201

Re: *United States of America v. City of New York (Kings County Hospital Center)*
Civil Action No. CV-10-0060 (KAM)

Dear Judge Matsumoto:

The United States respectfully submits this letter, with the approval of the parties to this action, to summarize the report of the expert compliance assessment team from its most recent tour of Kings County Hospital Center's Behavioral Health Service (the BHS). The report details the level of the BHS's compliance with the Consent Judgment entered in this action on January 7, 2010. The report is attached to this letter, which is being hand-delivered to the Court because of its size.

We are pleased to inform the Court that, as described below, the BHS has achieved and maintained substantial compliance with the Consent Judgment for the past year. Accordingly, the parties request that the Court issue an order closing this case.[1]

It has been seven years since the parties signed the Consent Judgment. The United States' subject matter experts agree that, since then, the BHS has greatly improved the quality of care and treatment and effectively addresses the critical needs of the vulnerable, seriously mentally ill population in the socio-economic catchment area served by the BHS. In many respects, the BHS has surpassed the requirements of the Consent Judgment and become a model acute care psychiatric facility. Below, we summarize the improvements in care and treatment in each section of the United States' Consent Judgment.

A. Protection From Harm

When we commenced this action, one of the most glaring deficiencies was the BHS' failure to properly identify and address patient aggression. The frequency of violence, suicide and self-harm

[1] The plaintiffs' attorneys in the related *Hirschfeld* action will be contemporaneously filing a letter concurring in the United States' request and seeking to have the Court close that case as well. The Consent Judgment in that action incorporates the United States' Consent Judgment by reference but also contains additional terms.

was alarming. The BHS did not identify patients at risk of such harmful behavior or take steps to prevent it. Hospital Police (discussed in section H. below) were posted on the units ostensibly to prevent violence, but their presence often made conditions worse. Officers often acted with unnecessary physical force.

Today, aggression on the units, while not completely eliminated, has greatly diminished. The BHS has developed clinical approaches to identify and address potential aggression and self-harm. Hospital Police are no longer present on the units. Instead, non-uniformed Behavioral Health Associates (BHAs), who have clinical training, are responsible for addressing potential violence and all staff have been trained in techniques to de-escalate agitated patients. The BHS has also developed an innovative peer counseling program, in which former patients at the BHS work with current patients. As a result of these changes, rates of suicide attempts and self-harm have dropped significantly. The BHS also has developed a comprehensive Quality Assurance/Performance Improvement system (discussed below) that readily and effectively addresses incidents, including aggression, when they occur, to identify root causes and develop and monitor corrective action.

In the past, the BHS used physical restraints to control and discipline patients. As a direct result of the reduction in aggression, the BHS' use of physical restraints also has dropped to record lows. One unit we visited on our trip in September had not used restraints since January. The BHS now uses restraints only when there is an immediate threat of harm to self or others that cannot be de-escalated. It carefully monitors and removes patients from restraints at the earliest possible time.

B. Mental Health Care

Treatment at the BHS has been revolutionized in the past seven years. No longer driven solely by psychiatrists' boilerplate assessments about what is best to control patients' behavior, treatment is interdisciplinary, individualized and focused on patients' needs and recovery goals. Upon admission to the psychiatric emergency room, or Comprehensive Psychiatric Emergency Program (CPEP), patients are quickly triaged to assess their current psychiatric condition and related issues such as intoxication, potential for harm to self or others and acute medical conditions. Assessments and diagnoses in the CPEP are clinically appropriate and thorough. Diagnoses and treatment, including medication regimens, are generally appropriate, timely, and refined over time as patients' conditions change.

As we noted in our reports to the Court over the past seven years, Treatment Planning has been a core concern. When we conducted our investigation in 2008 and 2009, patients with very different problems received identical treatment plans. The plans rarely supported discharge back to the community at the earliest possible time into the most integrated setting appropriate to patients' needs.

Although treatment plans remain somewhat uneven, the BHS has made significant improvements have been made in this area, particularly within the last year, Most treatment plans now are individualized, person centered and recovery oriented. Importantly, patients and, as appropriate, family members, not just clinical staff, are encouraged to and do have input into treatment plans. The BHS also has a well-developed program for psychosocial and therapeutic rehabilitation that allows patients to learn important coping skills. Exercise and physical activities

also are available as part of the overall treatment program.

Medication management has also changed substantially. The BHS has hired a dedicated psycho-pharmacist who ensures that the BHS engages in safe and effective pharmacological treatment. No longer does the BHS administer medications for their secondary sedative effects, *i.e.,* chemical restraint, a practice which caused patient harm and was a substitute for proper therapeutic interventions.

C. Behavioral Management

The BHS had almost no behavioral management program when we first visited the facility in 2007. Inappropriate behaviors were addressed with medication, physical restraints or close monitoring by staff on a 1:1 basis. As noted above, the BHS no longer uses chemical restraint and physical restraints are used much less frequently. In their place, the BHS has developed programs to help patients learn to control inappropriate behaviors. Central to this is the Behavioral Support Team, made up of clinical professionals who work with patients to help them address potentially problematic behaviors. The BHS also employs a neuropsychologist who helps to identify and adapt treatment and discharge plans for patients with cognitive impairments or learning problems.

D. Medical and Nursing Care

Many of the patients admitted to the CPEP or the inpatient units in the BHS have co-existing medical conditions, including diabetes, asthma and obesity. In the past, these conditions were often overlooked and their relationship and interaction with psychiatric disorders disregarded. Medical care at the BHS now is of the same quality and depth as psychiatric care. Every patient has a medical examination within twenty-four hours of admission, and physicians and nurses play a significant role in determining treatment and discharge plans.

In 2007, partly out of fear of patient violence, nurses minimized interactions with patients. Nurses now have become increasingly important in the lives of patients, embracing their role as front line caregivers. They also play an important role in treatment planning. Although nursing leadership still needs to continue to develop further, nursing practices have improved significantly over the last seven years.

One important note: the BHS faces significant challenges ensuring sufficient staffing levels, particularly in nursing and psychiatry. We have learned that, because of a shortage of psychiatrists and psychologists, nurse practitioners and psychologists are being assigned Unit Chief duties. This has not produced any specific concerns at this time, but the BHS must be vigilant to ensure that staff are not given responsibilities for which they are not qualified.

E. Quality Assurance and Performance Improvement

In order for any health care facility to identify its strengths and areas that need improvement, it must have strong data collection and analysis processes. Effective self-monitoring is the hallmark of good healthcare systems. In 2009, we found that the BHS's quality assurance and performance improvement programs were poorly organized and that it failed to analyze the data it did collect for

trends and underlying causes. In addition, the BHS lacked adequate procedures for investigating incidents, including those which caused serious injuries. Our consultants found that staff conducted little or no follow-up to determine the cause of an incident, its effect on the patient, or how similar incidents might be avoided in the future. As a result, patients continued to be exposed to actual and potential harm.

Today, the BHS has institutionalized a culture of continued performance improvement which permeates the entire system of care. Several committees meet regularly to review reports, analyze incidents and determine appropriate remedial action. Overall, the Quality Assurance and Performance Improvement processes at the BHS now help to identify and address deficiencies in care and treatment, thereby substantially reducing the possibility of future patient harm. The BHS must remain vigilant and continue to strengthen its ability to identify and act on trends that may reflect systemic improvement opportunities.

F. Fire and Life Safety

The physical environment and sanitation in the BHS are significantly improved from when we first visited in 2008. At that time, the BHS was in the "G" Building, an antiquated, unsanitary facility. In the "G" Building, linens and mattresses were stained, worn and torn. Patients' clothes were not washed or disinfected before being stored and in the CPEP, patients' clothes were stored on the floor. There were inadequate fire safety protocols. Hazardous materials, including medical waste, were not discarded consistent with generally accepted methods. Food was prepared in an unsanitary manner.

The BHS is now housed in the new "R" Building, which opened in late 2009. This new building is clean, light and airy, and provides patients with a more positive and therapeutic environment. Linens and laundry are kept clean, and patients' clothes are stored in closets. Medical waste is handled properly. Food is maintained in warming units until it is distributed in a comfortable dining room. Like much of the new BHS, the "R" Building is intended to help people recover and return to the community.

G. Discharge Planning

A critical aspect of any successful inpatient mental health treatment program is discharge planning. That is, from the moment a patient is admitted into the BHS, treatment and treatment planning should be focused on setting achievable goals to allow him or her to return to the community as soon as possible, and to successfully reintegrate and remain in the community. When we first visited the BHS in 2008, the BHS had virtually no discharge planning process at all. Treatment teams typically did not consider or integrate criteria for discharge into treatment planning. Consequently, many patients whose psychiatric conditions were stabilized remained hospitalized unnecessarily. The BHS, an acute care facility designed to expeditiously return individuals to the community, had an average inpatient length of stay of more than 30 days. Patients who were discharged were often sent back into the community without continuity of care or follow up by the BHS beyond ensuring that the individual reached his or her designated destination. As a result, individuals often were readmitted to the BHS within a few weeks of discharge.

Discharge planning is now robust and an integral part of treatment planning. Social workers, who are responsible for coordinating discharge plans, are important members of interdisciplinary treatment teams. The teams work to ensure that patients are discharged to an appropriate setting in the community, consistent with the community integration requirements of the Americans with Disabilities Act. Even in the face of shortages of appropriate community housing and services, the BHS has reached out to service providers and developed a network of contacts that facilitates quality community placements. The focus on community outreach has helped to make the BHS a focal point for community providers in the area.

The BHS has also created a Repeat Admission Review Committee (RARC) that assesses and attempts to address underlying reasons that particular individuals do not succeed in the community and are repeatedly re-admitted for treatment. It also has a Monitoring, Referral and Linkage (MRL) Unit that tracks discharged individuals up to 90 days, to ensure successful transitions back to the community.

H. Hospital Police

When we conducted our investigation in 2007 and 2008, the Hospital Police lacked a comprehensive, coherent set of policies that were effectively communicated to officers. Supervision and training of officers was inadequate, particularly when engaging mental health patients. KCHC also lacked a coherent and effective system for receiving, reviewing and investigating incidents and complaints against the Hospital Police. This resulted in inappropriate conduct by officers, including assaults on patients and handcuffing patients to beds and even radiators.

By July 2014, we determined that the Hospital Police had been substantially reformed. Hospital Police now perform only law enforcement duties. It has developed comprehensive policies and procedures that provide clear guidance for officer conduct. It is headed up by a retired NYPD supervisor and is professional and appropriately supervised. Hospital Police have no clinical role in the BHS. In fact, they have virtually no interaction with BHS patients, other than to monitor the entrances to the BHS and take crime reports on units when called upon by clinical staff.

I. Training and Policy Manuals and Accountability

In 2009, BHS policies were vague, accountability was not clear, and training for staff was virtually non-existent. Currently, the policies are well written and reviewed in a timely manner, and accountability is clear. BHS has developed competency based orientation programs for all employees, annual update trainings to ensure continued competency, and ongoing continuing education opportunities for all staff. Participation rates for all of these educational offerings are tracked to ensure that staff avail themselves of the training opportunities that are vital to support patient care improvements.

As set forth in more detail in the attached report, we find that the BHS has maintained substantial compliance over the past six-month period since we last wrote to the Court. Accordingly, pursuant to the terms of the Consent Judgment, we respectfully submit that this case should be closed. As always, the parties are available to the Court to answer any questions or address any concerns it may have.

Respectfully submitted,

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United States Attorney

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cc: All parties (by email and ECF)