

The Medical Crisis in California Prisons: A Cautionary Case Study

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In 2005 a federal judge found that “by all accounts, the California prison medical care system is broken beyond repair.” The medical care system alone, excluding dental and mental health, was costing well over a billion dollars annually with nearly 10,000 employees, and yet it was entirely makeshift, lacking the basic infrastructure elements introduced decades earlier in freeworld systems. In addition, there was “a culture of non-accountability and non-professionalism whereby ‘the acceptance of degrading and humiliating conditions [becomes] routine and permissible.’” Finally, the judge declared, “There is a single root cause of this crisis: an historical lack of leadership, planning, and vision by the State’s highest officials.” He then placed the medical care system in receivership.

The clinical leadership charged with transforming this morass adopted the “Quality Chasm” framework of the Institute of Medicine (IOM). In doing so, they tied the dysfunctions in prison to similar if less dramatic dysfunctions in freeworld American healthcare. The core IOM strategies were codified from successful improvement efforts that a number of healthcare organizations achieved during the 1990s, and they have acquired a *lingua franca* status that facilitates dissemination. Pertinent to this discussion, the IOM has explained the dynamics of complex adaptive systems and has championed transformational leadership, evidence-based management, error reporting within a culture of safety, relentless communication and training, and high-reliability organizations.

Getting to high reliability is a hard road in the best of worlds. California prisons have long suffered from deplorable processes and facilities and severe overcrowding. American jails and prisons serve as a *de facto* mental health system and face a growing challenge of complex illness among aging and impaired inmates. Sequencing decisions with the receivership, *i.e.*, what to do first and what to ignore, were often stark. The first priority focused on leadership and workforce. In one 12-month period, the receivership turned over 47% of physician positions and 35% of nursing positions. Other core challenges identified by the IOM, including information technology, care process redesign, development of effective teams and care coordination, and performance measurement, themselves depend on prerequisite infrastructure elements and demand exquisite attention to interdependency issues.

Improvements in workforce commitment and competence, well before facility enhancements, IT, and process redesign, yielded payoffs. All-cause mortality dropped 7% in 2007 and another 7% in 2008. The changes came with considerable personal costs among the workforce, however, entailing many departures and reassignments and widespread anxiety. The tasks shouldered by the physician peer review committee were often grim and controversial. Ironically, developing the capacity for significant bottom-up initiative can require prolonged top-down intervention and control. The leadership

introduced “just culture” concepts and practices, distinguishing knowing violations from human error, at-risk conduct, and reckless conduct. These concepts face particular resistance in healthcare but can mitigate organizational anxieties if given sustained leadership support.

Public bureaucracies operate within significant constraints in hiring, firing, procurement, and contracting, even under receivership. These constraints affected the speed—and ultimately, the existence—of many interventions. While pharmacy reform started early and proceeded apace, for instance, quality improvement, utilization management, and ancillary services received late and insufficient resources. Development of chronic care capacity got underway in 2008, garnered widespread support at ground level, progressed with speed and scope exceeding industry standards, then lost much of its momentum with the leadership losses of 2009.

Public and press support of the receivership waned over time, in part because of a targeted political attack that exploited the receivership’s building program, which was especially vulnerable in view of the state’s budgetary crisis. In addition, omnibus judicial interventions are inevitably personal. The first receiver’s mission and *modus operandi* was break-through change, but he ran into conflict with the judge in charge and was fired in early 2008. His replacement assumed a mission to close the receivership as soon as possible. In early 2009, a dozen executive leaders were forced out.

This case study raises multiple questions for discussion by high-reliability advocates, many of whom work in public systems that vary in performance from superb to horrid, subject to fluctuations over time, susceptible to neglect and attack. Effective and efficient healthcare requires infrastructure elements not yet in place in this system. Incipient changes may not succeed without their initial champions—and yet, some may.