

The California Plan: From Backwater to Mainstream

National Conference on Correctional Health Care
Atlanta, October 30, 2006

Terry Hill, MD
Chief Medical Officer
California Prison Receivership
www.cprinc.org

Agenda

- The California Prison Receivership
- San Quentin physical plant as metaphor for California prison health
- My argument (for discussion):
 - Correctional healthcare must participate in
 - Mainstream quality and safety initiatives
 - Centralized incident reporting
 - Standardized measurement
 - In order achieve and sustain progress in prison/
community health (and leverage resources)

Major California court cases re prison healthcare

<i>Coleman v. Wilson</i> 1992	Mental health care
<i>Shumate v. Wilson</i> 1996	Female inmates
<i>Clark v. Wilson</i> 1997	Inmates with developmental disabilities
<i>Armstrong v. Davis</i> 2000	Inmates with disabilities at parole hearings
<i>Plata v. Davis</i> 2001	Medical care
<i>Perez v. Tilton</i> 2005	Dental care

“By all accounts, the CA prison medical care system is broken beyond repair”

- “Unconscionable degree of suffering”
 - “On average, every 6-7 days one prisoner dies unnecessarily.”
- “No central office leadership in nursing”
- “Historically the CDCR would hire any doctor who had ‘a license, a pulse, and a pair of shoes’”
 - “Peer review ‘is either bogus or it’s not done at all’”
- “Data management... practically non-existent”
- “Medical records... either in a shambles or non-existent”
- “Pharmacy... in almost complete disarray”

U.S. District Court for the Northern District of California. Findings of Fact and Conclusions of Law Re Appointment of Receiver, *Plata v Schwarzenegger*, October 3, 2005

“Can’t do attitude... trained incapacity”

- “Decades of neglecting medical care”
- “A culture of non-accountability and non-professionalism whereby ‘the acceptance of degrading and humiliating conditions [becomes] routine and permissible’”
- “Historical lack of leadership, planning, and vision by the State’s highest officials”

Judge Thelton Henderson

U.S. District Court for the Northern District of California. Findings of Fact and Conclusions of Law Re Appointment of Receiver, Plata v Schwarzenegger, October 3, 2005

Powers and Authority of the Receiver, Robert Sillen

- “Hire, fire, suspend, supervise, promote, transfer, discipline and take all other personnel actions”
- “Create, abolish, or transfer positions”
- “Negotiate new contracts and renegotiate existing contracts, including with labor unions”
- “In the event... that the Receiver finds that a state law, regulation, contract, or other state action or inaction is clearly preventing the Receiver from developing or implementing a constitutionally adequate medical health care system..., the Receiver shall request the Court to waive the state or contractual requirement”

U.S. District Court for the Northern District of California. Order Appointing Receiver, Plata v Schwarzenegger, February 14, 2006

“The overwhelming majority of State employees... are also prisoners”

- “The present crisis was created by, and has been tolerated by, both the Executive and Legislative branches the State of the California.”
- “Furthermore, these problems have not been adequately addressed by the State’s control agencies”
 - e.g., the Departments of Finance, General Services, and Personnel Administration
- “The corrective action required... must, of necessity, involve the restructuring of not only of the CDCR, but also the operation and oversight of State of California control agencies.”

Robert Sillen

U.S. District Court for the Northern District of California. Receiver’s First BiMonthly Report, Plata v Schwarzenegger, July 5, 2006

San Quentin physical plant

as metaphor for California prison health

(Photo show goes here)

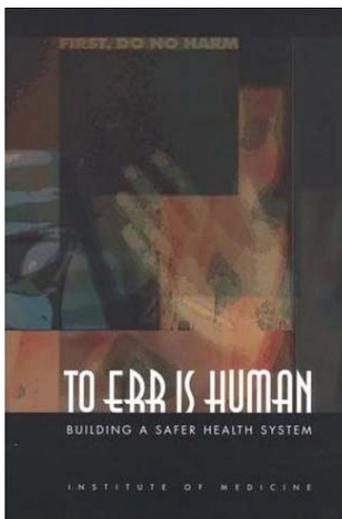
Argument

Correctional healthcare must participate in

- Mainstream quality and safety initiatives
- Centralized incident reporting
- Standardized measurement

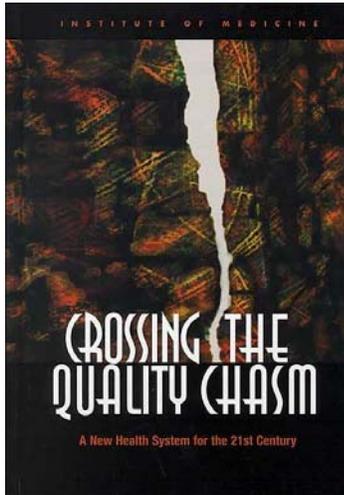
In order achieve and sustain progress in prison/community health (and leverage resources)

The Institute of Medicine, 1999



- Rate of adverse events in hospitals:
 - Colorado/Utah study: 2.9%
 - 8.8% fatal
 - New York study: 3.7%
 - 13.6% fatal
 - Over half were preventable
- 44,000 – 98,000 deaths/year by extrapolation

The Institute of Medicine, 2001



The American health care delivery system is in need of fundamental change ... not because of a failure of goodwill, knowledge, effort, or resources..., but because of fundamental shortcomings in the ways care is organized

IOM: Six aims for the 21st-century health system

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable

Crossing the Quality Chasm. 2001
www.nap.edu

I'm working hard already,

so how do I get
from 98,000
unnecessary
deaths, to



“the right care for every person every time”?

(Steve Jencks' new vision for
Centers for Medicare and Medicaid Services, 10/21/03)

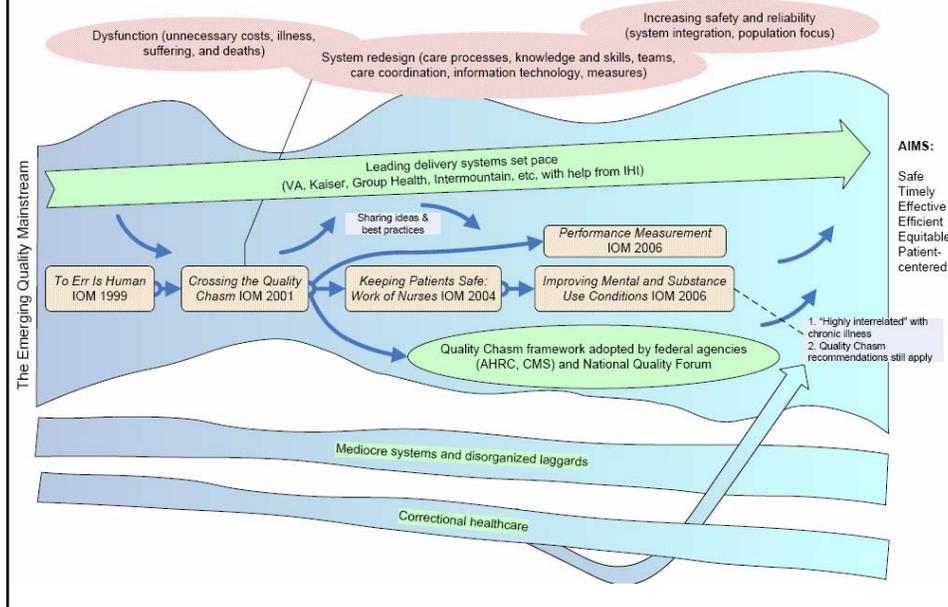
Answer: not by working harder in the same way.

IOM: Building organizational supports for change

- Redesign of care processes based on best practices
- Information technologies for clinical information and decision support
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, and settings over time
- Incorporation of performance and outcome measurements for improvement and accountability

Crossing the Quality Chasm. 2001

Correctional Health: Backwater to Mainstream



IOM: Simple rules lead to complex, innovative system behavior

1. Care based on continuous healing relationships
2. Customization based on patient needs and values
3. Patient as the source of control
4. Shared knowledge and free flow of information
5. Evidenced-based decision-making
6. Safety as system property
7. Need for transparency
8. Anticipation of needs
9. Continuous decrease in waste
10. Cooperation among clinicians

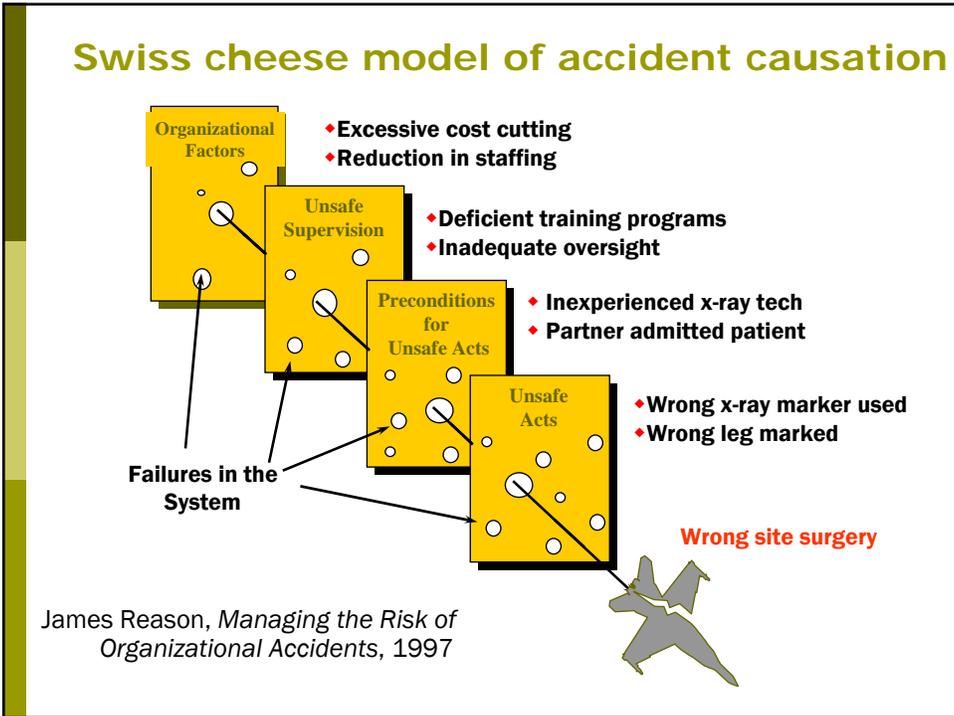
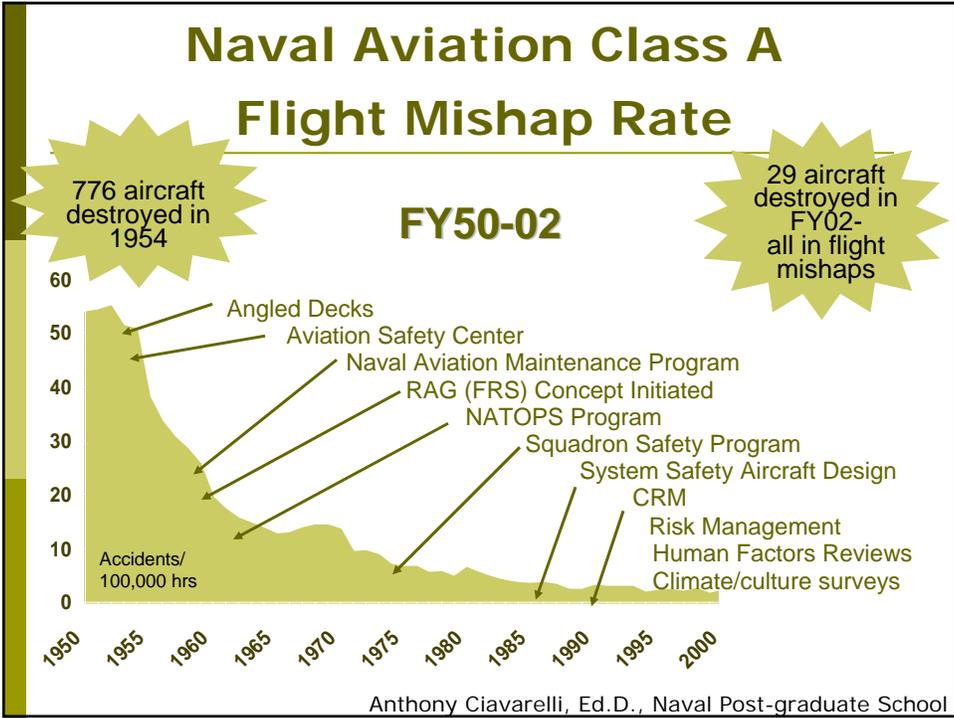
Crossing the Quality Chasm. 2001

Rule 6: Safety as a system property

- The biggest challenge:
 - Changing the culture
- Old rule:
 - Careful and competent professionals do not, or should not, make errors.
- New rule:
 - Threats to patient safety are the end result of complex causes such as faulty equipment; system design; and the interplay of human factors, including fatigue, limitations on memory, and distraction.

Safety is a system property

Errors are not causes.
Errors are consequences.



Hospitals are scarier than aircraft carriers

Sample survey questions (mirrored for aviators)	Aviators	ER, OR, ICU staff
Senior management provides adequate safety backups to catch possible human error during high-risk patient care.	2.7%	31.5%
Staff are provided with the necessary training to safely provide patient care.	2.2%	12.9%
Senior management has a clear picture of the risks associated with patient care.	2.0%	18.9%

Gaba DM et al.
Differences in Safety Climate Between Hospital Personnel and Naval Aviators,
www.highreliability.org

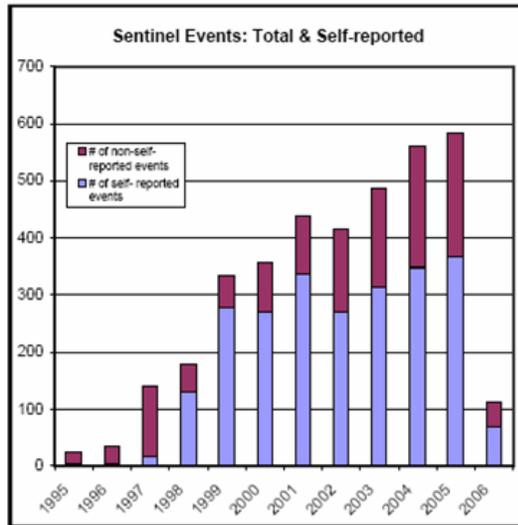
Healthcare: a high-hazard arena

“Just try to be a little more careful....”



www.baddesigns.com

JACHO logged 3661 sentinel events from 1995 to March 31, 2006



Outcomes:

- 73% death
- 10% loss of function
- 17% other

www.jointcommission.org

Settings of sentinel events in JCAHO database

General hospital	2475	67.6%
Psychiatric hospital	399	10.9%
Psych unit in general hospital	185	5.1%
Behavioral health facility	170	4.6%
Emergency department	139	3.8%
Long term care facility	114	3.1%
Ambulatory care	95	2.6%
Home care	75	2.0%
Clinical laboratory	6	0.2%
Health care network	2	0.1%
Office-based surgery	1	0.0%

Types of sentinel events in JCAHO database

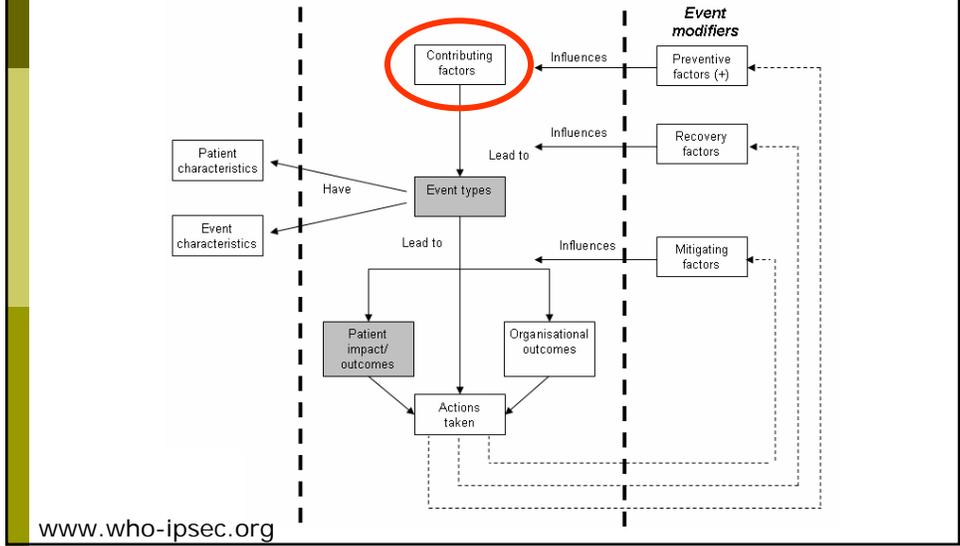
Patient suicide	483	13.2%
Wrong-site surgery	470	12.8%
Op/post-op complication	454	12.4%
Medication error	364	9.9%
Delay in treatment	276	7.5%
Patient fall	198	5.4%
Patient death/injury in restraints	143	3.9%
Assault/rape/homicide	124	3.4%
Perinatal death/loss of function	111	3.0%
Transfusion error	94	2.6%
Infection-related event	70	1.9%
Patient elopement	69	1.9%
Fire	66	1.8%
Anesthesia-related event	60	1.6%
Medical equipment-related	57	1.6%

Root causes of sentinel events 1995-2004

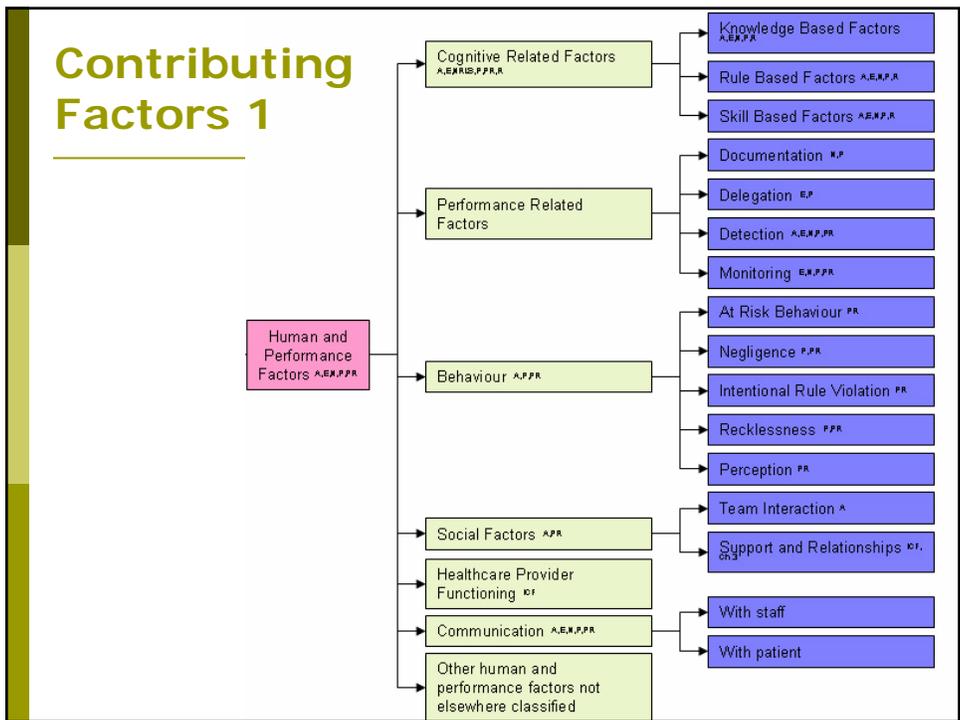


www.jointcommission.org

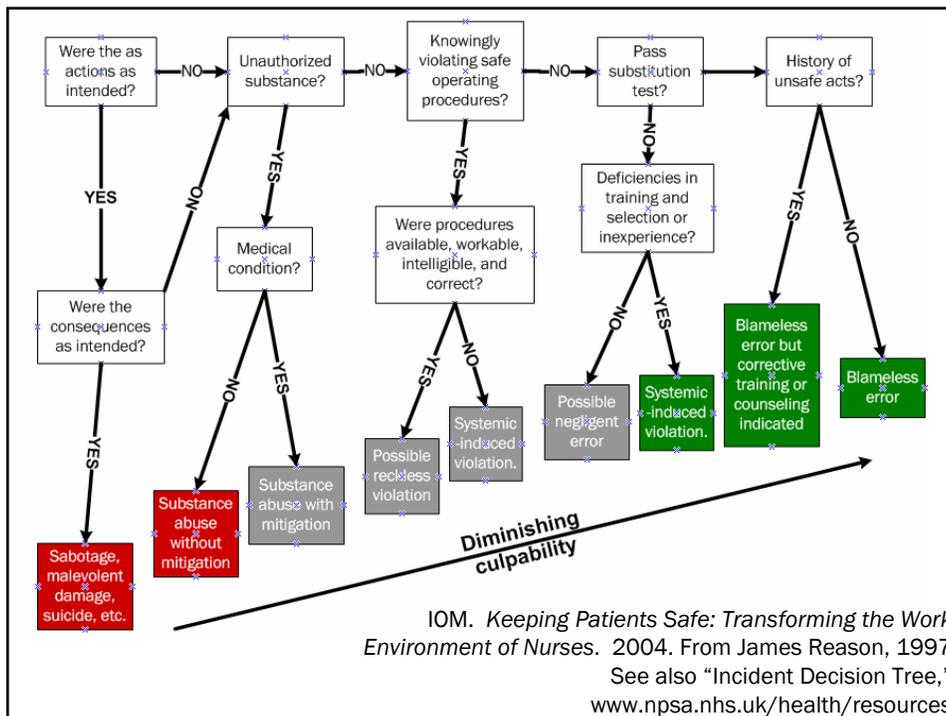
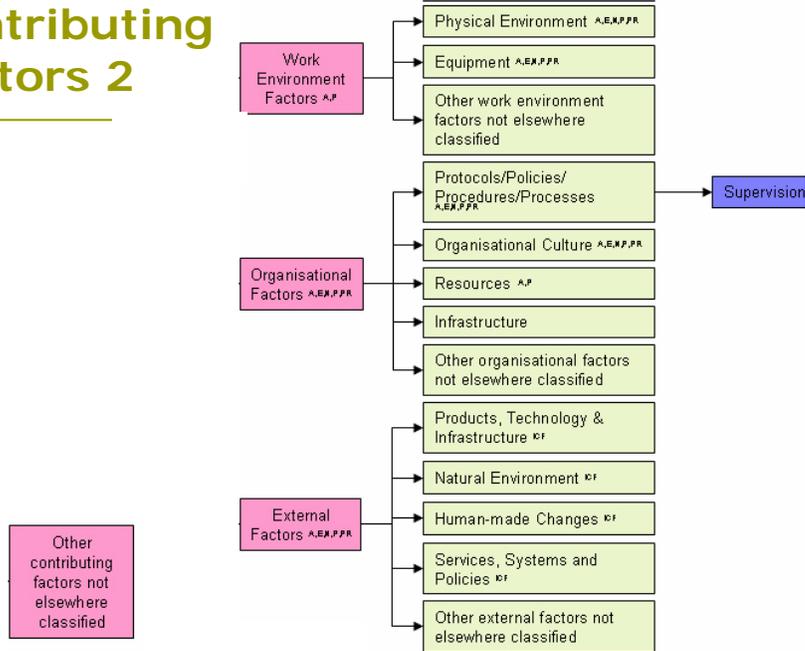
Bad outcome, so fire somebody? How to think about adverse events



Contributing Factors 1



Contributing Factors 2



Substitution test

Substitute the individual involved in the adverse event or near miss with another individual possessing comparable qualifications and experience.

Then ask the following question:

“In light of how events unfolded and were perceived by those involved in real time, is it likely that this new individual would have behaved any differently?”

The screenshot shows the Joint Commission website's Patient Safety Practices page. At the top, there is a navigation bar with links for ADVANCED SEARCH, CONTACT US, SITE MAP, CAREERS, NEWSROOM, and QUALITY CHECK. The Joint Commission logo is on the left, and a search bar is on the right. Below the navigation bar is a horizontal menu with tabs for HOME, ACCREDITATION PROGRAMS, CERTIFICATION PROGRAMS, STANDARDS, PATIENT SAFETY, SENTINEL EVENT, PUBLIC POLICY, PERFORMANCE MEASUREMENT, LIBRARY, and ABOUT US. The main content area features a blue header for "Patient Safety Practices" and a sub-header "PATIENT SAFETY PRACTICES (PSP) An online resource for improving patient safety". The text describes the resource as a new online tool for health care professionals and the public, providing 500 links to trusted patient safety websites. A link is provided to access the resource.

ADVANCED SEARCH | CONTACT US | SITE MAP | CAREERS | NEWSROOM | QUALITY CHECK

Setting the Standard for Quality in Health Care

SEARCH GO

HOME ACCREDITATION PROGRAMS CERTIFICATION PROGRAMS STANDARDS PATIENT SAFETY SENTINEL EVENT PUBLIC POLICY PERFORMANCE MEASUREMENT LIBRARY ABOUT US

Printer-Friendly

Home > Patient Safety > Patient Safety Practices

Patient Safety Practices

PATIENT SAFETY PRACTICES (PSP)
An online resource for improving patient safety

Patient Safety Practices is a new online resource for health care professionals and the public. Over 500 links to trusted patient safety websites are provided, with tips, tools and resources for addressing patient safety problems. The problem categories and topics have been culled from the Joint Commission's Sentinel Event Database. We are working to refine the categories and to add helpful resources.

The Patient Safety Practices is available on the Joint Commission International Center for Patient Safety Website.

[Click here to access Patient Safety Practices.](#)

"Do Not Use" List
Eisenberg Award
Infection Control
National Patient Safety Goals
Patient Safety Practices
Patient Safety Practices
Speak Up
Universal Protocol



Programs
Topics
Improvement
Leading System Improvement
Chronic Conditions
Critical Care
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End Stage Renal Disease
Flow
Health Professions Education
HIV/AIDS
Last Phase of Life
Medical-Surgical Care
Office Practices

[Download File](#)

SBAR Technique for Communication: A Situational Briefing Model

*Kaiser Permanente of Colorado
Evergreen, Colorado, USA*

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team about a patient's condition. SBAR is an easy-to-remember, concrete mechanism useful for framing any conversation, especially critical ones, requiring a clinician's immediate attention and action. It allows for an easy and focused way to set expectations for what will be communicated and how between members of the team, which is essential for developing teamwork and fostering a [culture of patient safety](#).

S	<p>Situation I am calling about <u><patient name and location></u>. The patient's code status is <u><code status></u>. The problem I am calling about is _____ I am afraid the patient is going to arrest.</p> <p>I have just assessed the patient personally: Vital signs are: Blood pressure _____/_____, Pulse _____, Respiration _____ and temperature _____</p> <p>I am concerned about the: Blood pressure because it is _____ over 200 or _____ less than 100 or 30 mmHg below usual Pulse because it is _____ over 140 or _____ less than 50 Respiration because it is _____ less than 5 or _____ over 40 Temperature because it is _____ less than 98 or _____ over 104</p>
B	<p>Background The patient's mental status is: Alert and oriented to person place and time. Confused and cooperative or non-cooperative Agitated or combative Lethargic but conversant and able to swallow Stuporous and not talking clearly and possibly not able to swallow Comatose. Eyes closed. Not responding to stimulation.</p> <p>The skin is: Warm and dry Pale Mottled Diaphoretic Extremities are cold Extremities are warm</p> <p>The patient _____ is not or _____ is on oxygen. The patient has been on _____ (l/min) or (%) oxygen for _____ minutes (hours) The oximeter is reading _____ % The oximeter does not detect a good pulse and is giving erratic readings.</p>
A	<p>Assessment This is what I think the problem is: <u><say what you think is the problem></u> The problem seems to be <u>cardiac infection neurologic respiratory</u> _____ I am not sure what the problem is but the patient is deteriorating The patient seems to be unstable and may get worse, we need to do something.</p>
R	<p>Recommendation I suggest or request that you <u><say what you would like to see done></u> transfer the patient to critical care come to see the patient at this time. Talk to the patient or family about code status. Ask the on-call family practice resident to see the patient now. Ask for a consultant to see the patient now.</p> <p>Are any tests needed: Do you need any tests like CXR, ABG, EKG, CBC, or BMP? Others?</p> <p>If a change in treatment is ordered then ask: How often do you want vital signs? How long to you expect this problem will last? If the patient does not get better when would you want us to call again?</p>

Measurement?



You can't fatten a cow by weighing it, but you can't manage what you don't measure

The Institute of Medicine, 2006



- “Some progress has been made toward reducing gaps in quality and safety”
 - E.g., see annual AHRQ reports
 - But “racial and ethnic disparities are pervasive”
- The measurement system
 - “Substantial scientifically grounded gains... have already been made”
- Measurement is foundation for:
 - Accountability
 - Quality improvement
 - Population health
- “Providers should be encouraged to invest in electronic health records if they have not already done so”

United States Department of Health & Human Services



AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care www.ahrq.gov

What's New Browse Información en español

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Measuring Healthcare Quality

- [2004 Proposed Measure Sets](#)
- [National Healthcare Disparities Report](#)
- [National Healthcare Quality Report](#)
- [AHRQ Quality Indicators](#)

2004 Proposed Measure Sets

[Selecting Measures to Highlight in the 2004 NHQR and NHQR](#)

National Healthcare Disparities Report

2005 [Report / Appendix, Newscast](#)
2004 [Highlights / Full Report](#)
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[Health Care Disparities in Rural Areas: Selected Findings from the 2004 National Healthcare Disparities Report](#)

National Healthcare Quality Report

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AHRQ Quality Indicators

[Development of the Next Generation of AHRQ Quality Indicators](#)
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NCOA HEDIS measures improve across almost all clinical indicators, all payers

Table 1. HEDIS Effectiveness of Care Measures
Select Commercial Averages, 2000 - 2004

Measure	2000	2001	2002	2003	2004
Beta-Blocker Treatment After a Heart Attack	89.4	92.5	93.5	94.3	96.2
Breast Cancer Screening	74.5	75.5	74.9	75.3	73.4
Childhood Immunization Status - Combo 1	66.8	68.1	68.5	74.4	76.4
Cholesterol Management - Control (LDL < 130)	53.4	59.3	61.4	65.1	68.0
Comprehensive Diabetes Care - Poor HbA1c Control*	42.5	36.9	33.9	32.0	30.7
Controlling High Blood Pressure	51.5	55.4	58.4	62.2	66.8

Table 2. HEDIS Effectiveness of Care Measures
Select Medicaid Averages, 2000 - 2004

Measure	2000	2001	2002	2003	2004
Beta-Blocker Treatment After a Heart Attack	82.9	87.9	90.1	83.5	84.8
Breast Cancer Screening	54.9	55.1	55.8	55.9	54.1
Childhood Immunization Status - Combo 1	56.4	58.9	57.7	62.0	65.4
Cholesterol Management - Control (LDL < 130)	28.2	34.5	36.7	39.0	40.7
Comprehensive Diabetes Care - Poor HbA1c Control*	54.9	48.3	48.2	48.6	48.6
Controlling High Blood Pressure	45.4	53.0	53.4	58.6	61.4

Mental health improvements have been more difficult.

The State of Health Care Quality 2005, NCOA

Health Care Quality in Prisons: A Comprehensive Matrix for Evaluation

Tamara T. Stone, PhD, Randee M. Kaiser, MS, CCHP,
and Annamarie Mantese, MPA

Journal of Correctional
Health Care
Volume 12 Number 2
April 2006 89-103
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10.1177/1078345806288948
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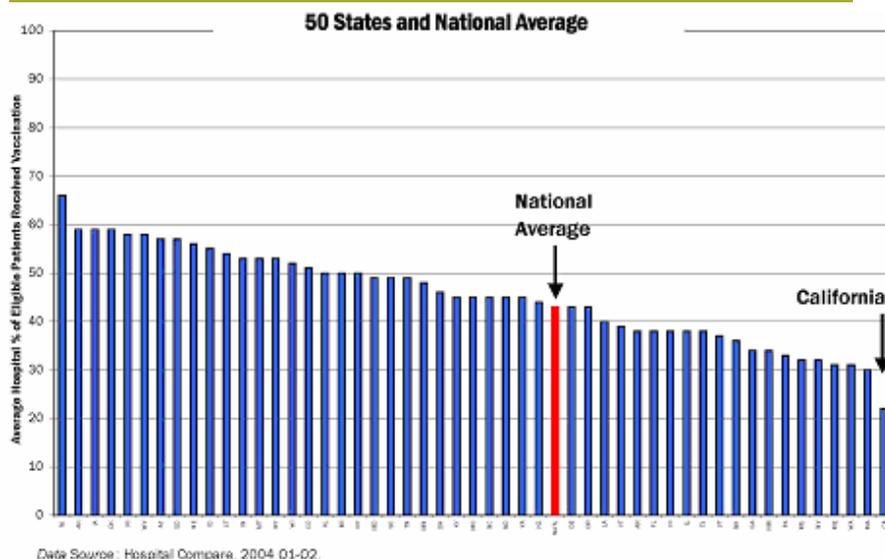
Health care organizations assess clinical processes and procedures to minimize errors, improve outcomes, and increase patient satisfaction. Many correctional facilities, however, are not able to fully engage in continuous quality improvement activities mainly because of a lack of current, relevant quality models and benchmarks to serve as a basis for evaluation. The Missouri Department of Corrections developed a quality indicator matrix based on information used by civilian health systems and collected benchmark data to systematically evaluate their services and identify evidence-based prevention and treatment processes to improve the delivery and management of specific health risk factors and diseases and conditions.

Missouri quality indicators

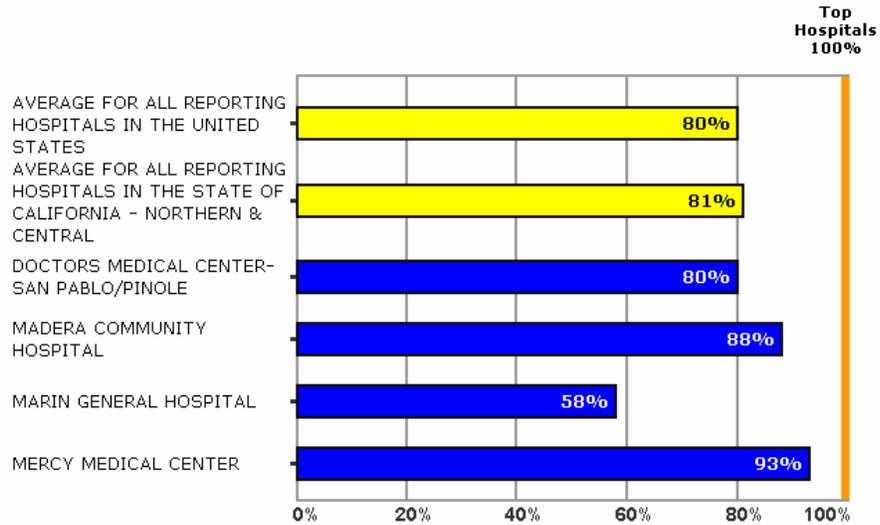
- For 2005, 40 indicators in 11 categories
 - Developed with assistance from NCQA, JCAHO, AHRQ, NCCHC, Healthy People 2010, et alia
- Results show improvements vs. drops compared with previous years
 - Often better than free-world benchmarks
- Vision includes dissemination of QI matrix to other states
 - Predicated on electronic health record system

Missouri Dept of Corrections, Health Services Quality Performance Report Phase VII, May 1, 2006

Variation example: hospital pneumococcal vaccination rates



Sample measure from Hospital Compare: % heart failure patients given ACE inhibitor or ARB



Hospital Compare: heart failure performance for 4 hospitals

	Top US hospitals	CA average	Doctor's San Pablo	Madera	Marin General	Mercy Merced
ACE inhibitor or ARB for LVSD	100%	81%	80%	88%	58%	98%
Assessment of left ventricular function	98%	83%	88%	60%	91%	80%
Discharge instructions	88%	47%	44%	2%	48%	75%
Smoking cessation advice/counseling	100%	71%	80%	100%	27%	94%

Note sizable gaps between top hospitals (top 10%) and averages

www.hospitalcompare.hhs.gov

IOM: Building organizational supports for change

- ❑ Redesign of care processes based on best practices
- ❑ Information technologies for clinical information and decision support
- ❑ Knowledge and skills management
- ❑ Development of effective teams
- ❑ Coordination of care across patient conditions, services, and settings over time
- ❑ Incorporation of performance and outcome measurements for improvement and accountability

Crossing the Quality Chasm. 2001

Progress is at hand, e.g., spread of proven interventions

100,000 Lives Campaign

- Rapid response teams (great for RN recruiting)
- Medication reconciliation
- Acute MI care
- Timely perioperative antibiotics
- "Central line bundles"
- "Ventilator bundles"



Map of > 300 participating hospitals

Based on data submitted,
122,300 lives were saved
from December 2004 to June 2006

www.ihl.org

This ain't "cookbook"

- Creativity is inherent in complex systems
- Simple rules generate complex, surprising effects via:
 - Variation
 - So we should encourage innovation
 - "Pruning" the resulting evolutionary tree
 - Do small tests of change, e.g., rapid-cycle plan-do-study-act
- "It's more helpful to think like a farmer than an engineer or architect in designing a health care system."

IOM: *Crossing the Quality Chasm*. 2001

Non-Linear Thinking

"Specifically, I would suggest that the effective organization is garrulous, clumsy, superstitious, hypocritical, monstrous, octopoid, wandering, and grouchy."

Karl Weick

On Re-Punctuating the Problem
in *New Perspectives on Organizational Effectiveness*,
1977

Correctional Health: Backwater to Mainstream

