Mailman School of Public Health
Case Consortium @ Columbia
Columbia University

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Community Savings, or Community Threat? California Policy for Ill and Elderly Inmates

For decades, a time bomb had been ticking in the country's prisons. Inmates convicted in the 1980s for a host of crimes from drug dealing to murder had been getting older—and sicker. National estimates put the number of inmates over age 55 at some 125,000 in 2011, with tens of thousands more right behind them. Meanwhile, spending on prisoners had increased 660 percent in 25 years (1982----2006), driven in large part by health care costs. One prisoner needing dialysis three times a week could cost $250,000 a year; for the seriously ill in outside hospitals, expenses could reach nearly $2 million a year, thanks in part to regulations that required two or three guards for each patient, even the comatose.

In California, prisoner numbers had escalated after passage of the "three strikes" mandatory sentencing law in 1994. By mid----2011, the number of elderly (age 55+) inmates in California jails had reached an all----time high of nearly 14,100. Moreover, the California prison healthcare system had been so inadequate that in 2006, after losing a court case, the entire network was placed under the care of a court----appointed receiver. The newly----configured California Correctional Health Care Services (CCHCS) would be administered separately from the California Department of Corrections and Rehabilitation (CDCR). The receiver's mandate was to make prison healthcare fair, competent and cost effective. For its first four years, the receivership concentrated on the first two; with some successes in place, it turned to costs.

In 2010, Receiver Clark Kelso spearheaded a successful legislative campaign to lessen the financial burden of prison healthcare on the state budget. So----called medical parole—which came into force in early 2011—offered an alternative to an existing, but rarely used, "compassionate release" program to move permanently medically incapacitated patients out of the costly corrections environment and into community----based care facilities where no guards would be required. Kelso hoped the new law would mean significant savings to taxpayers in a state facing crushing budget deficits.

Kelso asked Dr. Ricki Barnett, his director for utilization management, to identify prisoners eligible for medical parole. To qualify, prison doctors had to vouch that the inmate was non---functional—able to live only with significant assistance, and by

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implication unable to re----offend. Importantly, most prison doctors deliberately refrained from knowing their patients' criminal records. Most of the candidates for medical parole came from the California Medical Facility (CMF), the state's prison for sick male inmates. It housed some 2,500 ailing men; of those, about 900 were over 50.[1] By November 2011, Dr. Barnett and the CMF leadership team had identified 41 prisoners statewide for medical parole; 27 were released into the community.

In December 2011, a new case came to Dr. Barnett's attention. Carl Wade had been at CMF since 2003. He was on an oxygen machine fulltime, and suffered from heart and lung disease. His care, including hospitalizations, cost the system on average $200,000 a year. Barnett did not know his crime. But the court had turned him down for compassionate release. Wade was mentally alert; conceivably, he could mastermind a crime. It was impossible to predict how long he had left to live. Barnett and her medical team had to decide: should they support a request for Wade's medical parole, or not?

CA prison health

The state of California had followed a national trend toward more prisoners, and older prisoners. Nationwide, state and federal prisons in 2010 held over 1.5 million men and women. Of those, some 125,000 were over age 55—and the numbers were growing. In California, as of June 30, 2011, its 33 state prisons held 162,368 inmates. Those aged 55+ stood at 14,098, a 500 percent increase since 1990, compared to overall prison population growth of 85 percent.[2]

Not surprisingly, California's incarceration costs had risen sharply. One of the prime drivers was healthcare. For one thing, prisoners were not a healthy group to start with. Officials estimated prisoners' physical age at 10----15 years older than their chronological age, not just because of the stress of prison life but also due to substance abuse, poverty, poor healthcare before prison, and lack of health insurance. Inmates suffering from mental illness fared even worse, with a physical age some 15----20 years older.

Prisoners were not eligible for the federal Medicare or Medicaid health insurance programs. So the state paid all prisoner medical, dental, and mental health costs. In 2011, one----third of California's prison funding went to healthcare, including mental health and dental care. That translated into some $14,000 of the average annual $48,536 it cost to maintain a

[1] For California prison population numbers, see: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad1 111.pdf. For specifics on CMF, see: http://www.cphcs.ca.gov/docs/special/CCHCS_Dashboard_External.pdf

[2] Absolute numbers from "Fall 2011 Adult Population Projections, 2012-2017" *California Department of Corrections and Rehabilitation*, pp. 2, 35-36; percentages from "Old Behind Bars: The Aging Prison Population in the United States," *Human Rights Watch*, p. 22. See: http://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf

prisoner.[3] Of the $14,000, some $**10**,000 went to medical care, including infrastructure investment and administrative costs; the balance was for dental and mental healthcare.

For elderly inmates, those prices skyrocketed. Prisoners over 55 constituted only seven percent of inmates, but in 2011 they occupied fully 38 percent of the available "medical beds"— spaces in prison reserved for those who needed assistance with daily activities.[4] The most expensive inmate----patients were those who needed regular hospitalization or medical visits outside prison walls.

CDCR regulations required that an inmate leaving prison for dialysis, or a doctor's appointment, or to go into hospital, be accompanied at all times by custody officers— the number depended on the severity of the inmate's crime and the security risk s/he posed. It was not uncommon to see three officers for one criminal: one to sit outside the hospital room door and two to stand at the foot of the bed. This applied equally to prisoners in a coma or otherwise immobilized. After adding personnel costs, ambulance transportation, hospital board, doctor's fees and tests or treatment, the tab could run as high as $2 million a year.[5] By comparison, nursing homes cost an average $73,000.[6]

Receivership

No one was more aware of the rising California prison healthcare costs than Receiver Clark Kelso. The receiver's office had been created in 2006 in response to appalling conditions inside state prisons: prisoners could wait months to see a doctor, many were denied access to necessary medicines, and it was alleged that at least one a week died of preventable causes. Under the Eighth Amendment to the US constitution, which prohibits cruel and unusual punishment, prisoners had a right to adequate medical treatment. In 2002, the state settled a class----action lawsuit (Plata v. Davis/Schwarzenegger) that alleged "deliberate indifference" to prisoners' medical needs.[7] The settlement required CDCR to improve conditions substantially within several years.

But by 2005, there had been no credible progress; in fact, conditions had worsened. So the federal court overseeing the settlement intervened. US District Court Judge Thelton E. Henderson in October 2005 ruled CDCR in violation of the settlement order: the prison healthcare system, he wrote, was ""broken beyond repair"" and caused an ""unconscionable degree of suffering and death."" In February 2006, he appointed Robert Sillen as receiver. The receiver's mandate was to make prison medical care delivery fair, professional, and cost effective or, in the words of its mission statement, move it "from chaotic care that

[3] Cited in "Old Behind Bars," *HRW*, p.75.
[4] Ibid. p. 76.
[5] Some 21 patients met this cost threshold.
[6] Brie Williams et al, "Balancing Punishment and Compassion for Seriously Ill Prisoners," *Annals of Internal Medicine*, May 31, 2011.
[7] Another four lawsuits addressed other specifics, such as dental and mental health care.

is largely episodic and consists of often untimely and uninformed encounters between patients and clinicians" to "a system of proactive, planned, informed, patient----centered and professional care."[8] The receiver did not govern dental or mental health services, which was under federal oversight but controlled by CDCR.

Staff. Sillen turned his attention first to staff. There were about 300 people involved in running healthcare. The Receiver's Office absorbed most of them—and added to their numbers. There simply were not enough personnel, and many of those in the system performed poorly. Prison doctors, for one, were notoriously bad. Most were not board certified. Many had come to prison service after the California Medical Board offered them prison doctoring as an alternative to losing their licenses or other disciplinary action. There were also not enough medical staff: one prison had a single doctor for 7,000 patients. Nursing vacancies ranged from 50 to 80 percent.

Sillen put $6 million into a serious recruiting effort. He doubled doctor salaries that had been capped at $135,000 a year, meaning the job now paid slightly more than the average for community doctors. He also required board certification or a review of competence. Results were swift: some 85 percent of existing doctors retired or resigned. The average physician's age dropped to 51 from nearly 70, a third were women, and over 90 percent were board----certified But Sillen, despite these notable achievements, proved overly abrasive. His reforms were expensive, and his deteriorating relationship with the legislature threatened the receivership's success.

Kelso in charge

So in January 2008, Judge Henderson replaced Sillen with J. Clark Kelso, a law professor (and former clerk to then----9th Circuit Appeals Court Judge Anthony Kennedy) who had overhauled some of the state's largest systems, including insurance and information technology. "This was the most broken of the things that I've been involved with," comments Kelso.[9]

Kelso took the job for three reasons. One was legal: he hoped to prove the current Supreme Court wrong in its reluctance to give district courts the authority to require government to carry out legally----mandated reforms. A second was personal: he admired Judge Henderson, who was nearing retirement, and wanted to help him reform prison healthcare. But most important, Kelso felt he could do the job. He says:

> I'd have real power and independence to come up with a plan, have [Henderson] approve it, and implement the thing, without too

[8] Mission statement from California Correctional Health Care Services website (revised March 2011).

[9] Lundberg's interview with Clark Kelso on December 1, 2011, in Sacramento, CA. All further quotes from Kelso, unless otherwise attributed, are from this interview.

> much interference from political forces. So I thought I could be successful at it.

System changes. Kelso's goal was to put in place a sustainable system that would thrive and survive after the receivership went out of business—hopefully by 2014—and control of prison healthcare reverted to the state. To do that he needed to change not only the culture, but the organizational structure. One problem was that corrections personnel—notably the warden— remained in charge of each prison, including healthcare. Corrections officers historically had a single priority: security. Increasingly, this was at odds with the physician priority to provide compassionate care. Each prison already had a chief medical officer (CMO), but the CMO reported to the warden. The Receiver's Office public affairs officer, Nancy Kincaid, notes:

> The wardens were so entrenched in their culture, and custody didn't understand healthcare, usually didn't agree… Their focus is putting all their resources towards security and safety. [Kelso] said we need management that knows healthcare.[10]

The solution was to create a new position within each prison of chief executive officer, or CEO. The CEO was the prison's senior healthcare official, charged with managing its resource needs from staff to administrative support, procurement and technology. The CEO had authority equal to the warden, but reported directly to Kelso. Eventually, CCHCS created and filled 25 CEO positions (to restrain costs, a few oversaw two prisons). The CEOs came from a medical management background. The arrangement was challenging, concedes Kelso.

> It's been an often difficult thing to manage. Organizationally, it's a little awkward… when they've got a bunch of employees who don't report to the warden.

In November 2010, Kelso brought in Dr. Steven Tharratt as statewide medical executive to coordinate all medical services across the state's 33 prisons. Kelso also successfully sued the State Personnel Board to transfer physician review from the board—which knew nothing about medicine—to a panel of three independent physicians. CCHCS had also instituted educational programs for physicians, along with a pilot program at the University of California----San Diego to bring medical students and residents into prison medical facilities.

Kelso also updated information technology. Many prisons still kept paper records; some of the older doctors had no idea how to use a computer. Installing IT for prisoners' health records was additionally complicated because it required special security measures

[10] Lundberg's interview with Nancy Kincaid on November 29, 2011, in Sacramento, CA. All further quotes from Kincaid, unless otherwise attributed, are from this interview.

to meet privacy requirements. But by 2010, CCHSC had outfitted every prison with fiber optic lines and installed some 10,000 computers statewide.

California Medical Facility

One of the chief beneficiaries of the receiver's reforms was the California Medical Facility (CMF) in Vacaville, just outside the state capital of Sacramento. California had ailing prisoners in each of its 33 state facilities, including two other prison hospitals. But a disproportionate number— the population hovered around 2,500 men—were sent to CMF. The prison, which resembled a large high school with long and impersonal corridors, had been built in 1955 to serve male prisoners. Like most California prisons, its physical plant was outdated, ill----suited for modern medicine and designed for a considerably smaller population.

Before the receiver took over, care at CMF had been substandard. When internist Dr. Joseph Bick arrived in 1992, he was the only board----certified doctor among the 15----20 staff physicians. "This place was just a mess," he recalls. "The physical plant was totally inadequate. People were seeing patients at cell fronts or converted cells that didn't have sinks." Prisoners' paper health records were stacked in towering piles on every surface in what was called the clinic.

But in one respect, CMF was fortunate. In 1988, a court consent decree (*Gates vs. Deukmejian*) mandated improvements at CMF to delivery of mental healthcare as well as treatment of HIV/AIDS patients. Bick's background was in HIV/AIDS, and in 1993 he became director of all the prison's HIV treatment programs (he was one of two chief medical officers in the prison). In that capacity, he oversaw the creation of a hospice unit for dying AIDS patients, designed a scheduling system for medical appointments, installed a computer database, and expedited reports of lab results. In 2005, Bick spearheaded construction of a modern clinic with up----to----date equipment, and individual offices for medical exams (windows allowed corrections officers to monitor doctor safety). For all its frustrations, Bick found his job rewarding. He says:

> I felt every single day like I was making a difference, even the days that were dreadful… I've not yet had a day where I haven't rolled out of bed and said, I want to get there. And it's not because it's easy, or that every day is successful.

With the creation of the Receiver's Office in 2006, matters improved even further. Old and incompetent staff were fired or left. Kelso hired Nate Elam as CEO. A statewide IT system gathered all prisoners' medical records in one database, and money was available for facility upgrades. CMF also had an assisted living facility (or outpatient housing unit) for incapacitated inmates. There were nurses 24 hours a day, and meals served on the ward. Inmates had help with all activities of daily living, from dressing to bathing or eating.

None of this came cheap, either at CMF or system----wide. By 2008, prison healthcare costs were closing in on $2 billion, in a state with a deficit of $16 billion. In late 2008, Receiver Kelso began to scrutinize spending. "Doctors were referring anybody with a toothache out to a hospital," he says only half in jest. "We needed to start doing things to reduce costs."

Find savings

There were several pieces of low----hanging fruit. One was pharmaceutical purchases. Each prison had traditionally ordered the prescription drugs it needed for its inmates. The system could save significantly on drugs if it purchased in bulk. So CCHCS set up a centralized drug----purchasing unit, and negotiated contracts with significant discounts for system----wide purchases.

Then there were services. In July 2008, Kelso created a new office—Utilization Management Services—to apply the principles of managed care to prison health services. He hired Dr. Ricki Barnett, an anesthesiologist with a specialty in pain management, to head the office. Barnett reported to the statewide medical executive in the Receiver's Office, Dr. Steven Tharratt (a pulmonary critical care physician).

Dr. Barnett had retired after a career as medical director for a variety of sizeable organizations, from a physicians group to an insurance company. As she sees it, her job is to "ensure that patients can access medically necessary services that are cost effective."[11] In other words, to do for the prison system what other medical consumers tried to do for themselves. She adds:

> The price of everything keeps going up and the bar that determines … constitutionally adequate care, i.e. care that is not deliberately indifferent and that meets the standard for minimally adequate medical care—that bar keeps going up… It's ironic that the better we get at [medicine], the less affordable it becomes and the more challenges we have getting everybody to be able to access it.

Barnett decided to look for a partner who could help bring down the cost of medical specialists. Eventually, CCHCS contracted with Health Net, a company that managed healthcare services nationwide. Instead of thousands of contracts with individual specialists, ambulance services, hospitals and so forth, the Receiver's Office had a single contract with Health Net. Savings ran to some $2 million a month. The result was a workforce and primary care model that resembled a health maintenance organization (HMO). "We

[11] Lundberg's interviews with Dr. Ricki Barnett on November 29, in Sacramento, CA, and by telephone on December 7, 2011. All further quotes from Dr. Barnett, unless otherwise attributed, are from these interviews.

benchmark ourselves now to these groups… We have to take on the trappings and the behavior of a health plan," says Tharratt.[12] CCHCS also expanded telemedicine: the use of technology to provide medical care, especially prescriptions, without the need for a face----to----face meeting.

But there was a small population within the prisons whose healthcare costs, even with utilization management, remained stubbornly high—the ailing elderly. Only three percent of prisoners were using 40 percent of the budget for external services. Maybe those three percent could be moved out of prison altogether.

Compassionate release. This idea was not new. In 1997, the California legislature had passed a law that provided for the "compassionate release" of some prisoners (those on death row or condemned to life without parole did not qualify). Inmates with a life expectancy of six months or less could have their sentences vacated (revoked). This allowed for transfer to a less expensive community healthcare setting. In 2007, the legislature enlarged eligibility to include those who were "permanently medically incapacitated." Primary care physicians were legally required to identify patients for compassionate release and begin their applications.

The application then went through multiple reviews. On the medical side, it went to the chief medical officer of the individual prison, to the deputy medical executive, to the statewide medical executive in the receiver's office. On the custody side, it went form the prison warden to the Division of Adult Institutions and then to the undersecretary for operations (all within CDCR), at which point the two streams—custody and medical—joined and went to the Board of Parole Hearings. If the board approved, the application went to the court that had originally sentenced the prisoner to jail. The court held a hearing, to which it invited victims and witnesses; the judge then approved release or not.

Challenges. There were several challenges to the use of compassionate release. For one, doctors found it difficult to predict with accuracy how long a patient had left to live. Cancer patients, for example, could die quickly or linger for months or even years. Second, the cost of maintaining prisoners released into the community fell to the family or, if the prisoner qualified, to local counties—with small healthcare budgets. This meant local authorities resisted taking on discharged inmates, while sentencing judges were well aware of the burden a compassionate release could create for counties.

Finally, after 2009 the compassionate release program was undermined by what might be called the "Lockerbie bomber syndrome." Scottish authorities in 2009 released a convicted airline bomber on the grounds of terminal cancer, yet 2½ years later he was still alive, in

[12] Lundberg's interview with Dr. Stephen Tharratt, on November 30, 2011, in Sacramento, CA. All further quotes from Tharratt, unless otherwise attributed, are from this interview.

Libya. It became considerably more difficult for California prisoners to win CR because of public dismay that they, like the Lockerbie bomber, might not die quickly.

As a result, only a small number of applications for compassionate release were approved. Between 1991 and 2010, courts rejected 70 percent of the 1,157 CR cases submitted in California.[13] From 2001 to 2010, 810 applicants died in prison; only 34 won compassionate release.[14] The Federal Bureau of Prisons also offered compassionate release to federal offenders. Its CR release rate was only slightly higher: in 2008, 399 inmates died in federal prisons, while 27 won approval for compassionate release.[15]

Receiver Kelso, in his search for savings, wondered if California might be ready for a program Texas had been using for 10 years—medical parole (MP). MP was a modification of compassionate release that answered its critics but benefited from its advantages. Texas was releasing 50----70 prisoners a year under MP. "They use it as a way of getting rid of their expensive inmates," says Kelso. It was worth a try.

Enter Medical Parole

In January 2010, Kelso brought Joyce Hayhoe, a career CDCR official, out of retirement as the Receivership's legislative director with the specific goal of creating "cost containment" legislation. Working with state Senator Mark Leno (D----San Francisco), Hayhoe drafted legislation proposing medical parole for medically incapacitated prisoners. While there was no age requirement, it was expected to apply primarily to older, sick inmates.

Senate Bill 1399, introduced in spring 2010, was deliberately written broadly to effect maximum savings. It proposed parole for any inmate suffering from a significant and permanent condition, disease or syndrome that left him debilitated or incapacitated. The Board of Parole Hearings, which would make the final call, would take into consideration the nature of the original crime. The wording gave the board the option to release non-----threatening white----collar or non---violent criminals who were sick, but not necessarily helpless.

Modified. But it was an election year and legislators were sensitive to any appearance of being soft on crime. To secure passage, Hayhoe had to modify the original language and restrict eligibility for MP to those "with a medical condition that rendered him or her

[13] Jack Dolan, "Despite medical parole law, hospitalized prisoners are costing CA taxpayers millions," *Los Angeles Times*, March 2, 2011.
[14] Kurt Streeter, "Amid ill and dying inmates, a search for redemption," *Los Angeles Times,* November 20, 2011.
[15] Williams et al, "Balancing Punishment," *Annals of Internal Medicine.*

permanently unable to perform activities of basic daily living and results in the prisoner requiring 24----hour care."[16] Notes Hayhoe:

> What we lost is the ability to reach into the prison system to get those people that are not permanently medically incapacitated, requiring 24---hour care. For instance, you've got a whole group of people now in prison that are 70 years old and above… They don't need to necessarily be in a skilled nursing facility, but they are definitely no longer a danger to society.[17]

A clause specified that, should the prisoner unexpectedly recover, he or she would be returned to prison. Moreover, a parole officer would visit the prisoner regularly as with any other parolee. CCHCS would also check in weekly on the parolee's health condition and approve in advance any changes to a treatment plan.

The state, not local communities, would bear the costs. The prison system still would save thousands on the care of MP inmates by paying a lower price for their stay in area nursing homes. If the patient qualified for Medicare or Medi----Cal (the state Medicaid program), that would kick in, too. In any case, CCHCS would avoid the exorbitant security and transport costs for these patients, which could quickly balloon to $2----4,000 a day per inmate.

The California Assembly passed the legislation by a party----line 44 Democrats----32 Republicans vote on August 30, 2010; the Senate voted its consent the next day, 22----15. The opposition charged that government was allowing cost savings to trump justice. Assemblyman Jim Nielson (R----Gerber), who had chaired the state parole board for nearly a decade, spoke for many opponents when he said:

> Anything related to the prison's population should not be predicated on costs but rather on justice, and this [law] tends to drive releases of inmates because of costs. That has a terrible, terrible impact on their victims, who have a right to believe justice will be done by a full sentence served.[18]

Governor Schwarzenegger signed it into law on September 28. In his signing statement, the governor highlighted the restrictions on medical parole: as with CR, no death row prisoners or lifers without parole were candidates; those released would not be a threat to

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[16] For a copy of the bill, see: http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_1351-1400/sb_1399_bill_20100928_chaptered.html

[17] Lundberg's interview with Joyce Hayhoe on November 29, 2011, in Sacramento, CA. All further quotes from Hayhoe, unless otherwise attributed, are from this interview.

[18] Marisa Lagos, "Potential medical parole cases fuel debate," *San Francisco Chronicle*, May 15, 2011. See: http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2011/05/14/MNO91JERPJ.DTL&ao=all

public safety; and if they improved, they could be returned to jail. He expressed his hope that the savings from money "wasted" on guarding incapacitated prisoners "in comas or in similar conditions" could go instead to public education and social needs.[19] The new law took effect in January 2011.

The path to medical parole was different from that for CR. An inmate, family member or prison doctor could initiate the application. It went next for approval to the prison's chief medical officer, and then to Utilization Management (Dr. Barnett). If she approved, Barnett forwarded it to the Board of Parole Hearings, which had to rule within 30 days. It was a shorter pathway than compassionate release, and Corrections did not like it. Recalls Hayhoe:

> The way the bill was written, they don't have control over the process. Our doctors make the decision on who gets considered for medical parole and the Board for Parole Hearings makes the decision on whether they're approved. In compassionate release, [CDCR] get to make recommendations.

CDCR insisted that MP could not be implemented without corresponding regulations— but months went by and no regulations were forthcoming. Both the Receiver's Office and supportive legislators tried in vain to hurry the process. But on March 2, the *Los Angeles Times* published an article on the delay in scheduling MP hearings.[20] New----elected Governor Jerry Brown demanded action. The next day, the *Times* reported that 10 hearings would be scheduled promptly.[21] The regulations were in place by May 2011.

In the meantime, Dr. Barnett had identified and concluded contracts with skilled nursing facilities throughout the state that would accept parole prisoners. She set in place a system for medical staff to consult weekly with the nursing homes about a parolee's treatment program. Her office reviewed requests for services from the skilled nursing facilities, with decisions based, she says, on "scientifically collected evidence" shown to genuinely help the patient. Barnett's office emphasized palliative care and, she explains, "a reasonable, more conservative approach to the crises that inevitably occur," thus avoiding expensive and futile medical interventions.

Census. Dr. Barnett kept a statewide list of inmates in hospital beds—both inside prisons and in community hospitals. If an inmate's condition changed to the point where s/he might qualify for MP, says Barnett, "we schedule a teleconference with the treating team and the chief medical executive and investigate." She adds:

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[19] "Calif. Gov. Schwarzenegger Issues Statement on Signing SB 1399," *California News Wire*, September 29, 2010.
[20] Dolan, "Despite medical parole law," *Los Angeles Times*.
[21] Jack Dolan, "10 hospitalized prisoners to get prompt hearings under medical parole law, receiver says," *Los Angeles Times*, March 3, 2011.

> We survey our organization regularly to try and pick patients up who may be able to save the state money by going through medical parole. It is our responsibility to identify medical parolee candidates.

There was *never* an intent, despite CDCR efforts to include it in the regulations, that inmates should apply first for compassionate release and then for medical parole. But Receiver Kelso concedes that, in some cases, that was happening nonetheless:

> Some people said you should only go to [medical parole] after you've tried compassionate release… From my perspective, that's nonsense… I don't have any reason to think that you have to go through one, fail that, and then you go through the other.

From the prisoner's perspective, some saw advantage to applying first for compassionate release, because CR vacated their sentences. Others may have felt they did not qualify for medical parole, or were unaware of the option. For whatever reason, Carl Wade decided to try for compassionate release.

The case of Carl Wade

Carl Wade, or California state prisoner E18321, was born on March 26, 1946. He had been at the California Medical Facility since July 2003, when an emphysema diagnosis qualified him for transfer. He lived in the hospital wing, in a cell with another 11 inmates. The floor was locked, although the cell door often stood open. A day room was nearby, and doctors could examine him in a room across the hall. Several violent and abusive prisoners lived on the same hall in single cells behind a second set of locked doors.

Wade's prison medical report described his condition as "severe obstructive pulmonary disease with chronic hypoxia complicated by cor pulmonale," requiring continuous oxygen therapy. Even when resting, or taking the few steps from his bed to a wheelchair, he was short of breath. He also had coronary artery disease with "associated ischemic cardiomyopathy and congestive heart failure with chronic angina."[22]

Wade, 65, had smoked for 42 years, and also worked in a furniture factory for a decade, "breathing all the sawdust and the different Formica dust… and then I worked construction, so I was around a lot of dust."[23] In prison, a cardiologist visited him onsite, but he had to see a pulmonologist in a community medical facility. "The care's real good here," says Wade. "They take you outside to the hospital all the time. See a lot of specialists." He had been hospitalized three times for procedures to insert stents, a pacemaker

[22] From Carl Wade "chrono" (i.e. medical summary and custody file) submitted with application for compassionate release, July 11, 2011.

[23] Lundberg's interview with Carl Wade, on November 30, 2011, in Vacaville, CA. All further quotes from Wade, unless otherwise attributed, are from this interview.

and a defibrillator. He also received treatment for pneumonia. Each time, he required ambulance transport for his oxygen needs, while two guards attended him at all times in the hospital.

Wade started the process of applying for compassionate release after his primary care physician suggested it. Both his pulmonologist and cardiologist at Queen of the Valley Medical Center in Napa, 30 miles from CMF, assessed Wade's life expectancy at less than six months. Wade's older sister, along with a daughter who lived with her, had agreed to take him in. Wade submitted his application on July 11, 2011.

CMO Dr. Bick, whose recommendation was needed for the CR application to progress, made a point of visiting Wade in person. Prison doctors deliberately did not know their patients' criminal histories for fear it might affect their medical judgment. "If I wanted to know, that information's available to me," says Bick. He could also infer, for example, that an inmate serving life without parole had probably killed someone. "But it's unusual that I know," he says.

> I generally have to go out of my way to know it… As a husband and father, I don't want on some level to be influenced in my decision about someone's life expectancy or how infirm they are.

In Wade, Dr. Bick saw a "permanently medically incapacitated" patient with severely diseased heart and lungs. But predicting Wade's likely date of death was "more challenging," he says. Wade had no cancer, no liver cirrhosis. "He's getting very careful medical care here. In some ways, we're probably extending his life expectancy," notes Bick. "Would I be astounded if Mr. Wade lived a year? No. Would I be astounded if tomorrow morning he didn't wake up? No." Bick calls Wade's case "a difficult decision" on medical grounds and one he took seriously.

> I think it matters on many levels. One, I think the program itself is important, and the integrity of the program… If I'm not discharging my responsibility with a certain sense of gravity, then I could impair the program. As chief medical executives go, I think I have a disproportionate ability to do that because of the role of this prison. People are being released throughout the state, but we have many of the sickest people and we have our hospice unit.

After weighing the information available, Dr. Bick signed off, forwarding the application first to the regional medical director (Dr. Alan Frueh), and thence to statewide Chief Medical Executive Dr. Tharratt.

Unlike Bick, Tharratt did know Wade's criminal record. He didn't look at it carefully, but recalls that he happened to see the file. Tharratt requested more tests for pulmonary

function, and an echocardiogram. Satisfied by the results, Tharratt says he was "comfortable" with a diagnosis of terminal medical illness for Wade, but adds "[i]f I was really splitting hairs, I would call him more permanently medically incapacitated."

> My understanding of Mr. Wade is he can still feed himself, he can transfer. He may need assistance in these kinds of things, but [not at the level of] someone who's in a persistent vegetative state who needs toileting, needs feeding, needs artificial everything, basically.

On the other hand, Wade's congestive heart failure was never "going to be fixed," never "something that's spontaneously going to resolve." On September 7, Tharratt signed off on Wade's form. It then went to the custody authorities, who also approved.

On October 18, the Board of Parole Hearings voted 10----1 to refer Wade's case to Lake County Superior Court, the court which had sentenced Wade originally.[24] On November 2, Judge Andrew Blum heard from witnesses, and two relatives of the victim testified that they would feel threatened if Wade were released. Judge Blum turned down the application for compassionate release. "In this court''s view," he said, "Mr. Wade is exactly where he belongs. He''s in custody and he should stay there."[25] The judge admonished the parole board for sending only a summary, instead of original medical reports, and for insufficient research into Wade's proposed post----release living situation with his sister, who was deaf.

Wade appealed the decision to the First District Court of Appeals. But in December 2011, his case came to the attention of Dr. Barnett; his medical condition put him in the MP pool.

Medical parole for Carl Wade?

By November 2011, Utilization Management had enjoyed modest success with medical parole. The office had identified some 40 candidates; 27 of those had won approval. None of the parolees had shown medical improvement.

The system seemed to work in balancing medical condition against threat to public safety. The first MP applicant, for example, was Steven Martinez, a 42----year----old rapist made quadriplegic in a prison fight. His medical care cost the state some $625,000 a year; he had been turned down twice for compassionate release. Dr. Barnett says she approved his MP application because he met the medical criterion of permanently medically incapacitated. But "I made sure to indicate on my application that he was awake, alert, oriented, high IQ, and capable of planning complex analytical thought," she says. "That's all I needed to write." In

[24] Lake County lay some 100 miles north of Vacaville in Lakeport, near Mendocino State Forest.
[25] Elizabeth Larson, "Judge Denies Compassionate Release to Man," *Lake County News*, November 2, 2011.

May 2011, the parole board denied him on the grounds that he was mentally alert and could carry out threats using others as proxies.[26]

Like her medical colleagues, Dr. Barnett does not want to know the criminal record of MP candidates; she did not know Martinez's history until the press described it in covering his MP application. "I will presume, and it's almost always the case… that if I knew about [the crimes], I would be horrified," she observes.

> And that's enough for me. I don't need to know whether it was murder, rape, kidnapping, mayhem. I know that this probably wasn't a nice person, and I would probably be appalled if I knew and it would cloud my judgment.

At the same time, Dr. Barnett recognized that in many cases "[t]he person who committed that crime no longer exists. There is a brain----damaged individual in front of you who no longer has any memory, any ability or any capacity to form intent. There's nothing inside anymore." Some incidents had only confirmed the need to keep re----accentuating that view. For example, a parole officer had discovered a brain----damaged parolee, with the cognitive abilities of a one----year----old, masturbating. The officer, apparently judging this as a risk to public safety, dispatched the patient to a guarded unit in a community hospital until the Board of Parole Hearings could revisit his medical parole. Comments Dr. Barnett:

> The parole officers who guard the patients are still programmed to react to behavior the way they would react to the same behavior in an able----bodied healthy person, with an intact brain and an intact body.

Dr. Bick at CMF believes that such a reaction is a reflection of society, not just the corrections culture. He recognizes that many of his patients have done terrible things. But, he adds, "I will say that I think just in the larger sense as a society, prisoners are stigmatized. Behaviors that come from someone who's not a prisoner or a former prisoner might be viewed one way, and someone who's a prisoner, it's another way."

Dr. Barnett received Wade's medical file in mid----December.[27] She knew he had been turned down for compassionate release, but was aware that courts had varying reasons to deny CR. She notes:

> The sentencing judges who oversee the compassionate release decision are aware of medical parole and aware that [the state] will front the expenses. They oftentimes decline to give the permanently medically

[26] Associated Press, "California Denies First Medical Parole," May 24, 2011. See: http://www.foxnews.com/us/2011/05/24/apnewsbreak-calif-denies-medical-parole/

[27] See Appendix 1 for an account of Carl Wade's crimes. Prison doctors did not know these details; this account is for the benefit of readers of this case study.

> incapacitated people compassionate release, saying 'Why don't you just apply for medical parole? That way, the county doesn't have to give up its limited funds to support you. The state and the CDCR will pay for it.'

Wade was due for ordinary parole on October 3, 2019. Barnett had to decide whether to put him on her list of candidates for medical parole. On the one hand, Wade's medical condition was terminal. On the other hand, his date of death was difficult to predict, and for now he was mentally alert. Did he fit the definition of permanently medically incapacitated? Could he re---offend? It was the first year for medical parole, and as Receiver Kelso recognized, mistakes could be costly. "Virtually everything we're doing is for the first time," he says.

> That's why we're paying a lot more attention to it… Since it's in its first year, we're trying to see if we can get it off the ground and not have some terrible thing happen that causes the legislature to kill it.

At $200,000 a year, Wade's care was clearly a drain on the public purse. But Dr. Barnett was of two minds. Should she put him on the list, or not? The decision, at first glance straightforward, involved so many considerations. She observes:

> On the one hand, you have public safety. On the other hand, you have common sense. You have the state taxpayers versus the county taxpayers. You have custody and medicine. You have the victims and the defense attorneys versus the public advocates. You have use of expensive resources everywhere. What is the best solution for all the stakeholders that creates the least amount of damage and harm?

APPENDIX 1

Carl Wade: Criminal History

NOTE: The California prison medical authorities did not know this history. It is provided here as a service to readers of the case study.

Witnesses testified that on June 6, 1986, at his home in Mendocino State Forest near Upper Lake, CA, Carl Wade—a woodcutter—shot to death John Karns, with whom he had been drinking heavily at a nearby bar. After murdering Karns and burying his body, which was discovered only 13 days later, Wade fled to Colorado. There, on November 9, 1987, he shot in the face another drinking buddy, William Wiler. Wiler suffered a broken jaw, crushed vertebrae, and brain damage. Arrested for shooting Wiler, Wade was sentenced to 16 years' imprisonment in Colorado.

Additionally, on June 5, 1989, he was convicted in Lake County Superior Court, CA, of the first----degree murder of Karns and sentenced to 32 years to life (a sentence meant to be served consecutively with Colorado's), then remanded by judge's order to the state of Colorado.

On May 20, 2000, the Lake County Superior Court committed Wade into the custody of the California Department of Corrections and Rehabilitation. Two prisons and three years later, on July 31, 2003, he was brought to the California Medical Facility in Vacaville. He was declared totally medically disabled on April 4, 2007. According to the custody file prepared on September 7, 2011, to accompany his application for compassionate release, Wade's "institutional adjustment is considered acceptable," and he had "remained disciplinary [sic] free during his term." Before his disabling, Wade had worked prison jobs as a clerk, receiving satisfactory to above average ratings from his supervisor.[28]

[28] Information from Larson, "Judge Denies Compassionate Release," and from CDCR memorandum from Timothy Baker, Chief of Investigations, to Board of Parole Hearings re. Carl Wade, E-18321, September 7, 2011.