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December 23, 2003

TO: Each Supervisor

FROM: Thomas L. Garthwaite, MD
Director and Chief Medical Officer

SUBJECT: REPORT OF THE TASK FORCE ON GRADUATE MEDICAL EDUCATION AT KING/DREW MEDICAL CENTER

On September 16, 2003, your Board instructed the Department of Health Services to establish a Task Force made up of academic experts from around the Country to review the academic mission of King/Drew Medical Center.

This group, chaired by former Surgeon General David Satcher was convened in November and met on several occasions in person at King/Drew Medical Center and by phone to review the strength and viability of the medical education programs at the facility. The group also included other academic and healthcare leaders from institutions across the Country, a list of whom is attached.

The Task Force paid particular attention to the role of Charles R. Drew University of Medicine and Science in the maintenance of accreditation of training programs, its responsibilities to oversee the academic programs at the facility, and its ability to recruit and retain qualified medical faculty.

Attached is the final report of the Task Force which outlines the charge established by your Board's motion, findings regarding these programs, and recommendations. Several of the recommendations pertain to Drew and these recommendations were discussed on December 18, 2003 with their Board of Trustees.

I intend to work closely with Drew University, as well as the UCLA School of Medicine, to implement the Task Force's recommendations. This will include a

complete reassessment of all the training programs and the renegotiation of the existing affiliation agreement. Please let me know if you have any questions.

TLG:ak

Attachments

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

Task Force on Graduate Medical Education

Los Angeles County Department of Health Services
Charles R. Drew University of Medicine and Science

Findings and Recommendations

The mission of the Charles R. Drew University of Medicine and Science is to conduct education and research in the context of community service in order to train physicians and allied health professionals to provide care with excellence and compassion, especially to underserved populations.

The Task Force wishes to emphasize the importance and continuing relevance of the mission of Charles R. Drew University of Medicine and Science (Drew) in training minority physicians who choose to provide care to underserved populations. This mission is enhanced through its partnership with LA County Department of Health Services (DHS), whose mission is to provide the medically indigent with appropriate access to health services at the community level. This partnership between Drew and DHS comes together in the King/Drew Medical Center (KDMC) where healthcare is provided and where clinical teaching occurs. KDMC's record of success in achieving its mission is not duplicated elsewhere and represents a critical contribution to Los Angeles County and the nation.

For each of the past 30 years, about 300 post-graduate physicians (interns and residents), 24 medical students, 250 allied health professionals, and 8,000 physicians in practice have received training at King/Drew Medical Center (KDMC). In a statewide survey of graduating resident physicians in California, Drew students were the most likely to plan to practice in an inner city. In addition, the Drew College of Allied Health graduate survey conducted each year revealed that 95-97% of its graduates serve low income, medically underserved, or minority communities. Other studies show that Drew trainees follow through on these plans. Using data from minority graduates from 1989 – 1999, 54% of KDMC graduates continued to practice in low-income and minority populations, as compared to 36% of UCLA minority graduates. It is clear that the graduate medical training programs at KDMC make a major contribution to the enormous healthcare needs (see Addendum III) of the population of Service Planning Area 6 (SPA 6) and other underserved areas by graduating physicians who wish to serve in these areas.

However, Drew's current method for carrying out this vital role is seriously threatened, by a variety of circumstances both outside and within the control of those involved. The University now sits at a crossroads. The Task Force hopes that the guidance offered herein will be the broad outline of a road map that will steer the organization to ever-greater accomplishments in this vital mission.

The KDMC, with the proper support and partnership with other DHS facilities, the University of California System, USC, and others, is uniquely suited to take on some of the nation's most significant challenges in medical services delivery and post-graduate medical education. These challenges include reducing disparities in health, implementing the new NIH road map for reducing the time it takes to turn new knowledge into tangible benefits for patient care, and the challenge of providing care and public health to a multicultural population. Such a partnership could develop a national model for multicultural public health and medical care and for the

elimination of disparities in health. Such a transformation must be combined with a commitment to a culture of accountability at KDMC in order to attract funding and to demonstrate successful outcomes in residency training and quality patient care.

Overall Recommendation:

It is imperative to preserve King/Drew Medical Center while significantly upgrading the culture of accountability and integrity of oversight of its teaching programs. An opportunity for partnership with the University of California and other programs within the Los Angeles County system exists that can allow KDMC to respond to national goals relating to eliminating disparities in health as set forth by Healthy People 2010. The quality of patient care must be paramount in all programs.

Specific Recommendations:

1) Partnership

There has been no working partnership between DHS (as represented by King hospital administration) and Drew in carrying out residency training programs at KDMC. When comparing KDMC to the LAC+USC and Harbor/UCLA Medical Centers, this lack of a working partnership was a major difference. Each of the other entities felt that they were working together to oversee their residency training programs.

Recommendations:

We recommend that the DHS Director, the Chair of the Drew Board, and the President of Drew must commit and sustain an effort to correct this absence of partnership and communication, including the use of consultants with a strong track record in this type of situation. In addition, Ombudsman roles should be considered for KDMC, DHS and Drew to foster a culture of accountability and meet aggressive timelines for advancing problems up the chain of command [see Addendum II].

2) Residency Programs

The survival of residency training at KDMC is threatened by the loss of accreditation of two programs, the proposed withdrawal of another program, the probationary status of others and the institution's "Unfavorable" status. Equally threatening to residency training at KDMC is the drop in patient census and the loss of confidence by the community in the quality of care delivered at KDMC. Low patient census makes it difficult to support residency programs. It is not possible to sustain 18 residency training programs with an inpatient census of just over 200. Likewise, the damage done to residents who will be unable to complete their training at KDMC is inestimable. This will make it very difficult to attract residents who have other choices for their training.

At the Drew Board of Trustees meeting on December 18, Dr. Gerald Levey (Dean of the School of Medicine and Provost for Health Sciences at UCLA) described an opportunity to construct a mutually beneficial model that would include linked partnerships with training programs at other County hospitals. However, he stressed that before any

structural changes in residency programs are made, fundamental changes at KDMC must occur – including the correction of hospital management issues, addressing the falling census, and creating centers of excellence among the County hospitals similar to those discussed in DHS planning documents. Dr. Levey said that UCLA could participate in collaborative and advisory roles to determine how these partnerships can happen.

Recommendations:

The Task Force recommends a major overhaul of residency training including the development of an alliance with the University of California system and/or USC to assure that all residents have access to an integrated system of training of the highest quality within the LA County hospital system while preserving the KDMC mission and assuring the highest quality of patient care. This alliance could offer increased research opportunities for all partners.

This major overhaul should include a critical review of every training program at KDMC. Programs that are not sustainable should be discontinued as independent programs before they receive unfavorable review by accrediting agencies. These programs could become satellites of other programs or affiliates with other residency programs.

The Task Force emphasizes the need for and supports the changes in infrastructure and leadership that are in process within the hospital.

3) **Board of Trustees**

The Board of Trustees of Drew has failed to hold the leadership and administration of Drew accountable for the quality of programs and the performance of Drew faculty relative to the quality of patient care, teaching and learning.

The Board has also failed to hold itself accountable as evidenced by the lack of demonstrated commitment to regularly infuse the Board with new ideas, the lack of substantive fund raising to assure the long-term viability of the University, and the failure to attract sufficient members who could contribute in the area of academic excellence.

Recommendations:

The Drew Board must commit to self-reformation and accountability including a system to assure the regular infusion of new members and the targeting of new members who can contribute most to the long-term viability of Drew, financially, academically, and in the delivery of quality patient care.

Partnership should be demonstrated by adding representatives recommended by the DHS and the University of California system as full members (not ex-officio) of the Board.

Over the next six months, with the assistance of consultants, take steps to strengthen the oversight of patient care, the quality of teaching and learning, and the long term financial stability of Drew.

4) **Leadership of Drew**

The leadership (President) of Drew has not been accountable to the Board in terms of regularly reporting and alerting the Board to issues that threaten the viability of the University and its relationship with the County and State. The major agenda items of any Board meeting should be the President's Report and with rare exception, the President should be there in person to present it and respond to Board inquiry about it.

The President of Drew has lost the confidence of many on the Board, the faculty, and the surrounding community, including the Community Advisory Board to the President.

The President and other leadership of Drew have allowed the evolution and continuation of the present crisis regarding residency training, and have not responded with the sense of urgency that the situation demands. Despite early promises, the President has not yet proposed any plan or response to the previous visit of the Task Force.

Recommendation:

> The leadership of the President at Drew is critical to a successful response to the present crisis, as well as issues that have evolved over time, and to the future needs of Drew. The task force recommends a positive leadership transition at Drew.

5) **Physician Practice Plan**

There is no evidence of a functional faculty practice plan at the KDMC despite many attempts to implement one. Such a plan, however, is critical to a system of accountability for full-time clinical faculty. Both UCLA and USC have faculty practice plans. These are expedited by the existence of private facilities in the areas close to the County hospitals where private patients are treated by faculty.

The SPA 6 region in which KDMC is located is a very poor, low socio-economic area and is not supportive of private practice. Thus, KDMC faculty often sees and admits patients outside SPA 6 without a faculty practice plan to assure accountability to Drew.

Recommendation:

> The Drew Board and administration must develop a KDMC faculty practice plan or other mechanism to enhance recruitment and retention of qualified faculty, enforce accountability, and ensure that the mission of KDMC and community health care needs are the priorities of Drew faculty.

6) **Multicultural Health**

Dramatic change has taken place in the community surrounding KDMC. SPA 6 has experienced a shift in population demographics from an 80% African-American population base in the 1970s to a greater than 60% Latino representation today. Even though the Task Force did not have extensive interaction with persons from the Latino

community, it was our observation that the Institution has not incorporated a cultural change to match its own current environment.

The Chair of the Task Force has had the opportunity to talk with the President of The California Endowment (TCE) concerning the findings and recommendations. These discussions focused on four potential areas with national implications for the development of a model of solutions:

The questions:

I) How do we maintain quality healthcare and quality teaching programs in public hospitals/facilities serving predominantly poor communities, particularly those with dramatically changing racial/ethnic demographics such as those in SPA 6?

II) What is the role of partnership between historically Black academic health centers and predominantly White academic health centers in cultural competency programs, multi-cultural programs and the elimination of disparities in health?

III) How can a partnership between a predominantly White research intensive institution and a predominantly Black low research-intensive institution function to implement the NIH road map that focuses on moving from discovery to delivery of the best medical findings and technology to communities?

IV) How do we create a culture of accountability in an environment where accountability has been very low and where there is an environment of poverty and often hopelessness similar to that found in some other major public hospitals?

The President of The California Endowment expressed interest on the part of TCE to support efforts to make major changes at KDMC, including support of a transitional management team and development of KDMC as a center of excellence for multi-cultural public health and medicine. However, TCE would need to be confident that there is a clear plan and firm commitment to change.

Recommendations:

The Task Force recommends that Drew and DHS work together to develop a comprehensive plan to establish a center of excellence in multicultural health accompanied by a strategy for assuring accountability for quality patient care and residency training.

Drew should initiate a planning process, in conjunction with the community, the County and the University of California, to develop a Center of Excellence in Multicultural Medicine and Public Health and for the Elimination of Disparities in Health among Different Racial and Ethnic Groups.

Addenda

Addendum I: Specific Board of Supervisors' Questions and Responses:

a. The County's responsibility and obligation as a teaching hospital and the implications for patient care delivery:

The County has two major responsibilities or obligations as a teaching hospital:

- To maintain an environment of excellence in patient care with all the necessary support systems.
- To develop and maintain, through partnership or otherwise, an optimal environment for teaching, learning and other scholarly activities in order to prepare physicians and others for the future.

While this is done through partnership, the relationship must be one in which the two entities are wedded in their commitment to excellence in patient care and teaching – speaking with one voice about the need for accountability of all involved.

b. Review models utilized in other teaching hospitals with accreditation problems.

Most teaching hospitals at some point in their development or history will have some accreditation challenges. Rarely, however, will a teaching hospital have the number of accreditation problems experienced by the KDMC.

Perhaps the model most relevant to the situation at KDMC is the Meharry-Vanderbilt Alliance. After years of separation, distrust and significant accreditation problems at Meharry Medical College (MMC), which had been excluded from publicly funded facilities for most of its history, the merger of Meharry Hubbard Hospital (private) and Nashville General Hospital (public) created a unique opportunity for partnership between Meharry and Vanderbilt. The Meharry Vanderbilt Alliance builds on the unique strengths of each institution to coordinate quality patient care, teaching/learning and research. Students and residents move easily between the two institutions as needs demand.

Although residencies are separate, each institution's programs are strengthened by the Alliance. If a specialty area is not in place at Meharry but is at Vanderbilt University Medical Center (VUMC), students/residents are able to plan rotations accordingly with faculty cooperation. Likewise, if MMC has an experience not found at VUMC, students and residents rotate accordingly with faculty cooperation. Joint research efforts are attracting funds and targeting disparities in health.

UCLA has collaborated with Drew in their undergraduate medical education program and as a result hundreds of underrepresented minority physicians have been educated. UCLA could not have done this without Drew, and vice versa. A similar collaboration at the residency level could protect the independence of Drew while enhancing its partnership with UCLA or similar institutions within or outside the University of California system.

c. Evaluation of the physician private practice plan arrangements that exist at King/Drew and the other County hospitals and how the King/Drew practice plan can be enhanced to improve the recruitment and retention of qualified medical staff to ensure that the community's health care needs are met.

[Please refer to Recommendation #5 above.]

d. The academic content and commitment to the training program by the faculty and the Medical School.

[Please refer to Recommendations #2 & #6 above.]

e. Evaluate ways to strengthen the recruitment and retention of strong clinical and academic faculty.

Improve the overall operations of the hospital and the medical school. Expand appointments for patient care, teaching, and research by developing a broader partnership with the University of California system and/or USC.

Addendum II: Ombudsman

Ombudsman roled could be established along with aggressive and strict deadlines for solving the problems that threaten the viability of the organization. Timelines would assure that management attention at the highest level is focused on solving major problems within a defined period of time and according to a defined protocol.

This concept has been used effectively by companies and governments needing communication mechanisms to assure that serious problems are addressed and resolved in a timely manner.

The benefits of such a system are obvious. The problem-solving process is expedited; expectations are clearly understood. Another benefit is documentation of patterns of problems in organizational structure.

A detailed example of such a mechanism is available on the DHS website (http://www.ladhs.org then go to Department Communications section and click on the link to Task Force on Graduate Medical Education at KDMC).

Addendum III: SPA 6 Characteristics

Rates of poverty and uninsurance among Los Angeles County residents are extremely high. Overall, 42% of residents live below 200% of the Federal Poverty Level (FPL), or under $37,000 per year for a family of four. Thirty one percent of adults ages 18-64 and 19% of children have no health insurance. However, rates vary widely across different areas of the County.

King/Drew Medical Center is located in the South Service Planning Area (SPA 6), which has the highest rate of poverty in the County, with nearly three-fourths (74%) of the population living below 200% FPL. SPA 6 also has the highest rates of uninsurance, with nearly half (47%) of non-elderly adults and 28% of children having no health insurance. Nearly one million (965,000) people live within a 5-mile radius of King/Drew. Of these, 65% are living below 200% FPL, and 39% are uninsured.