King/Drew Medical Center Workplan Implementation
Summary by Initiative

County of Los Angeles Department of Health Services

Update Through: 3/4/05

Initiative	Overall Progress Update
Governance	Board of Supervisors approved plan for Hospital Advisory Board (HAB) and identified the first 7 members. There are 6 to 8 additional members to be selected (3 for approval to the BOS 3/8 and the remaining on 3/22).
Management/Structure	All organizational structure changes have been implemented. Goals and objectives have been completed on all executive and senior managers.
Risk Management	The critical/sentinel event notification process is being overhauled over next 3 weeks to ensure that all staff understand and report events and issues are addressed within 24 hours.
Regulatory	A mock survey was completed resulting in a complete inventory of all deficiencies related to Joint Commission standards, CMS Conditions of Participation and Title 22 regulations. An action plan for each citation organized by accountable person was developed to bring the hospital into compliance with regulatory requirements. Responsibility for correcting each of the deficiencies has been assigned as well as timeframes for completion. Implementation of these corrective actions is ongoing and being closely managed. As processes are implemented to correct practices that have been inconsistent with regulatory or accreditation requirements, mock surveys will be conducted to confirm that the desired outcomes are being achieved. The Plan of Correction has been accepted by the Centers for Medicare and Medicaid Services (CMS) and a recent CMS survey in which the hospital was successful in having an Immediate Jeopardy and Notice of Termination rescinded. Education and coaching has been provided to middle management on how to critically assess the performance of systems and processes and in the development of credible plans of correction. An organized system to proactively manage regulatory readiness has been designed and implemented. A structure to support this system has been put in place and includes a Regulatory Readiness Committee with progress reporting to senior management and ultimately the HAB. Accountability for regulatory compliance has been established through the development of measurable goals and objectives for middle management. These performance measures will be used to determine individual manager's performance in bringing KDMC into compliance with regulatory requirements.
Performance and Quality Improvement	The quality management function was separated from the regulatory function to ensure appropriate focus. A new interim QM Director has started. By 3/31, roll out of QM/RM plan setting expectations to the staff, physicians, leadership and board that the ownership of quality resides in them, not in a department.
Infection Control	Revision to Infection Control surgical site surveillance part of IC Plan was approved at IC Meeting. Surgical Site surveillance data will begin to be available in March for the IC Meeting; surveillance is being benchmarked by NNIS data. IC dashboard for reports to the Patient Safety Committee has been developed. IC Performance Measures have been developed. IC Committee Membership has been revised and revisions accepted by IC Committee.
Budget	Developing a daily dashboard tool to monitor key financial and statistical activities for KDMC management. Developing a monthly reporting package for the HAB for rollout in April/May.
Productivity	Productivity system development in process with planned rollout in May. Lack of financial resources continue to be an issue.
Space Planning	All occupied and vacant space has been physically inventoried. The space committee has been reconfigured and functioning. Processes for prioritization of space requests has been identified. There are 4 critical space/construction needs: OP Pharmacy, OR, ER, and Psych. Initial plans for psych with cost estimates provided. Reviewed and approved by clinicians on 3/1. OR plans near final with cost estimates. OSHPD has given preliminary approval to proceed. State Licensing Board review on 3/9. Transition plan under review during construction period (again for OR). Two options under consideration for OP pharmacy. One is less likely to obtain state approval. ER in initial stages of evaluation.
Environment of Care	The EOC Committee is scheduled to review and approve the (7) EOC Annual Evaluations at the next meeting on 3/17/05.
Facilities Management	A 6-module training program has been developed to establish, document, and maintain the competency nurses, doctors, and other health care workers at KDMC in the operation of electronic patient care equipment. The training plan has been submitted to administrative executives for approval. The roll out has not been scheduled for implementation. Inservice training plan for electronic patient care equipment has been submitted but not approved.
Materials Management	Efforts in recruitment continue. The timetable for KDMC in the On Line Requisitioning process still being determined.
Contracted Services (Respiratory)	Follow-up QA of charts as a joint effort between RT and Nursing yielded moderate improvement. A new full-time manager for RT from Symphony started on 2/28/05. Continue efforts to ensure performance measures are met.
Contracted Services (Dietary)	Overall the action steps have been completed for each of the recommendations due and we are on target and do not anticipate any problems in finalizing the plans on time.

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Contracted Services (Security)	Overall the action steps have been completed on target and the work plan is on schedule.
Communications	Developing an overall communication plan to deal with all constituencies and stakeholders.
Case Management and Utilization	Departmental consolidation completed this week. Staffing issues among case managers affect overall ability of Department to execute on plans.
Capacity and Throughput	Bed flow for medical/surgical beds improved this week, but need for critical care and stepdown beds continues to create a problem for placement. Committees met this week to define preliminary admission criteria for critical care units and improve and streamline the communication necessary to place a critical care patient. Recruitment for Patient Placement Coordinator continues; this is a critical role to overall bed management.
Physical Therapy	Finalization and initiation of the implementation of the work plan.
Emergency Services	The Trauma Center closed March 1 with few issues. Secured area, redeployed employees, and all dated supplies and drugs were removed. Policy finalized to manage Trauma patients. February ED diversion was decreased by approximately 30% compared to January (528 hours to 367 hours).
Perioperative Services	Perioperative dashboard titled "Perioperative Compass" has been developed. Admission and discharge criteria for PAR has been drafted. Perioperative facility remodel was approved by OSHPD and is slated to begin 5/1/05. Initial planning has begun for the one day design session "Charting the Course for OSA and Ambulatory Procedure Center." Surgical volume consolidation modeling completed.
Med Admin - Clinical Programs and Medical Departments	Medical Admin staff has been reconfigured to include AMD position for Med Staff Affairs and UM & Clinical Programs. Goals and objectives have been developed for each position. Have mentored a number of Chairs to resolve physician HR issues.
Med Admin - Medical Staff Affairs	All medical administrative documents have been updated and approved at MEC (PSA) level. Bylaws and rules and regulations have been updated and are now compliant with CMS and JCAHO regulations and standards. Medical Staff and GME personnel have agreed on proctoring protocols and resident supervisory process. Working towards developing reporting process.
Med Admin - Quality, Performance Improvement, Utilization and Case Management	Medical Officer of the Day (MOD) have been identified and are currently in their respective positions. Dr. Rutherford is currently acting as interim MOD until 4/1/05. Realignment of CM, Social Services and Bed Mgmt has been completed. Consolidation of Quality, medical legal affairs and RM staff reporting to Interim Director of PI has been accomplished. Interim Director of PI is in place.
Med Admin - Administrative Issues / Medical Admin	Transitioned the role from the COO and is cataloging administrative support in medical departments to develop a plan for rational allocation.
Nursing Services - overall	Five new nursing directors in place: ED, Psychiatry, Emergency Department, Perioperative and Critical Care. Successful readiness through drilling and education for demonstration to CMS of management of assaultive behavior (Code 9). Active planning in process for a palliative/end of life program. Planned implementation of a newly designed skin program. New nurse recruiter in place - little significant progress of yet. There is visible improvement in overall morale. Decision was made for all clinical documentation including but not limited to nursing be redesigned in a rapid cycle process. Pre-work has been initiated.
Psychiatric Services - overall	Instituted weekly Psychiatric Services Management meetings to discuss issues that impact care delivery. Developed treatment models for PES and instituted weekly focus group meetings to discuss the treatment model on an ongoing basis. Instituted 7-day/week coverage for OT- Rec Therapy and Social Workers for all units, including PES; Developed a therapeutic milieu including consistent staff coverage on each unit, including PES, and established therapeutic groups being run by all disciplines. Instituted daily rounds on each unit, including PES; Hired OTR to work specifically on PES. Developed QA/QI plan with indicators to be monitored by each specific discipline and reported to the Psychiatric Management Team. Developed a plan through which environmental issues can be addressed through weekly walk rounds and a summary report. Held discussions with interim CNO and nursing leadership regarding options for closure of the nursing office in psychiatry. Development of a restraint usage education program is in process. Initiated a group to discuss psychiatry documentation issues and
Information Technology - overall	ANSOS and ORSOS upgrades may be delayed because of purchasing of hardware for those project. The Enterprise Pharmacy implementation sequence can not be negotiated at this time because there in no published go-live date and KDMC is still third in the implementation cycle. Also note, the recruitment of IT staff is very slow. The newly formed Technology Group is meeting to regularly to discus the Workplan and IT implications.
Health Information Management - overall	On 3/3/05 the first meeting of the OVERT (Deming management-empowering a working team). The transcription vender was notified that they were not meeting the terms of the contract, the average turn-around time decreased from 30 hours to 10 hours. Files keepers (the off-site contract agreed to supply free software that will access their records system.

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Human Resources - overall	The Human Resource Group is operational and meeting weekly. The performance evaluation and management process has been revised with focused efforts to complete performance reviews. A needs assessment has been completed with KDMC management and an educational plan to prioritize and address those needs is in development. The process to receive HR advice, consultation, and coaching to KDMC management on performance management and discipline was revised for easier access and more timely feedback to KDMC managers. Efforts were implemented to improve the recruiting process including: the PAR listing was updated to better communicate positions being actively recruited, single person accountability has improved the feedback to managers on the process. All KDMC HR policies and procedures have been reviewed and updated.T
Radiology	Implemented contracted radiology coverage as an interim strategy. Incorporating all imaging equipment into Medical Equipment Management Program (MEMP). A plan has been initiated to recruit Radiologists. Identified five issues that effect efficiency of radiologist report management resulting in expedition of signed reports and decrease in the amount of activity required to produce reports. Implementation in process.
Laboratory/Pathology	CAP resurvey in process. Conducted mock inspection of the laboratory specialties and wrote procedures to meet 2005 - 2006 regulatory requirements. Made additional progress with IT to print labels from Affinity. Implemented patient instructions and hand outs. Enhanced STAT service availability for outpatients and stopped patients from carrying their own blood specimens. Provided computer (Affinity) training to phlebotomy staff and nurse managers in various clinics. Initiated the use of planned orders with full transition scheduled for 3/14/05. Formed a physician Laboratory Advisory Committee. Assumed blood collection service for blood transfusion requests. Conducted additional Point of Care Testing (POCT) inservices for nurses in various shifts.
Pharmacy	All registry staff has completed new employee orientation, and 80% pharmacists completed competence assessment. Chapter 797 GAP analysis performed by onsite vendor analysis, and will require significant physical plant modifications. Planning for outpatient pharmacy relocation underway with request for expedited relocation. Working with nursing to revise P&P pertaining to Medication
Cardiology	Finalization and initiation of the implementation of the work plan.
Neuroscience	Finalization and initiation of the implementation of the work plan.
Ambulatory Services - overall	Initial workplan developed. Further revisions with KDMC leadership need to be made. Accountabilities for implementation need to be established.
Programs & Services - overall	Draft of the work steps completed. Accountabilities and responsibilities need to be established.