Scope of Responsibility

- *This report has been prepared by **Navigant Consulting, Inc. (NCI)**, solely for the use and benefit of **County of Los Angeles** hereinafter referred to as (Client), located in **Los Angeles California**, for consulting services (Services) pursuant to an agreement between **County of Los Angeles** and **NCI** dated October 28, 2004. The scope, process and timetable of NCI's work are identified in that agreement.*
- *NCI has used reasonable care to ensure the accuracy of the information provided in this report. However, the report relies on data and information received from or prepared by others. NCI has assumed the accuracy and completeness of such data and information and the accuracy of the analyses and conclusions contained in this report can be adversely affected if such data or information is not correct or complete.*
- *NCI cannot guarantee that any particular result will follow from any action taken or not taken on the basis of this report and its recommendations.*
- *NCI and its personnel do not provide legal or auditing advice nor do they provide appraisals or opinions of fair market value.*
- *Any legal commentary in this report should not be treated as a basis for taking any action and it should not be assumed that any tactics or strategy described in the report would necessarily be permitted under applicable laws. Before undertaking the implementation of any of the strategies or tactics discussed in the report, professional advice on the issues raised by these strategies or tactics should be sought, such as: qualified legal advice on such matters as antitrust, health care fraud and abuse and tax exemption issues; qualified medical advice on issues relating to clinical practice and patient treatment; and, other appropriate advice on issues such as accounting and taxation.*
- *The information, opinions and recommendations contained in this report have significance only within the context of the entire report. No parts of this report may be used or relied upon outside that context.*

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Section I – Introduction

Objectives

- The County of Los Angeles has entered into a Memorandum of Understanding (MOU) with the Centers for Medicare and Medicaid Services (CMS), which requires the engagement of an outside contractor to provide interim managerial support at King/Drew Medical Center (KDMC or Hospital), assess the major systems and operations of KDMC, and assist in the restructuring of KDMC's operations based on that assessment. Contractor will conduct a comprehensive assessment of all systems and operations at the Hospital which shall include a detailed action plan to address each of the deficiencies or inefficiencies identified. The assessment of the acute hospital is to be completed January 3, 2005. The assessment of the ambulatory enterprise and final review of programs and services is to be completed February 1, 2005.

Scope

- In addition to interim management services, the scope of this contract will include additional personnel to assist the interim managers with an assessment and concurrent implementation of services for improvements in the operations and delivery of health services throughout the hospital. The initial assessment will be completed within 60 days from the start of the contract. The assessment will be conducted through data analyses, interviews, observations, and use of the Contractor's proprietary best-practices database. The interim management team will be focused on the full-time responsibilities of running the hospital and its departments. For this reason they will need to be supplemented for the assessment by twelve specialists. The twelve specialists have extensive industry experience in Emergency Services, Perioperative Services, Boards, Governance and Organizational Structure, Nursing Training, Operations, Case Management, Quality and Regulatory, Funds Flow for physicians, Programs and Services and Finance. These are areas where there is not an interim manager provided under the agreement.
- For each areas specified herein, the Assessment Plan shall include a detailed description of the area assessed, specify any and all deficiencies, inefficiencies or other areas of concern identified by the Contractor, and the Contractor's analysis as to the cause for those deficiencies, inefficiencies or areas of concern.

Scope

- Additionally, the Assessment Plan shall prioritize the identified deficiencies, inefficiencies and areas of concern by identifying those critical to the functioning of the Hospital or to the assuring the Hospital's regulatory compliance. The Assessment Plan shall also include recommendations as to how to remedy each deficiency, inefficiency and area of concern including recommendations for staffing the remediation efforts, staffing costs, as well as an estimated timeline for implementation of the recommendations. In recommending staffing, Contractor shall recommend County staff who should be involved in implementing the recommendation and shall specify what, if any, Contractor staff, in addition to the interim management team, will be required to implement the recommendation.
- County and Contractor shall meet to discuss the Assessment Plan and its recommendations. Based on the Assessment Plan and these follow-up discussions, within 30 days of receipt of the Assessment Plan, County shall notify Contractor in writing as to which of the recommendations Contractor should implement and the agreed upon staffing for each recommendation.

Scope

- If upon review of County's determinations as to which recommendations will be implemented and the staffing as to those recommendations, Contractor believes that County's failure to support one or more of the recommendations jeopardizes the Contractor's ability to fulfill its obligations under this Agreement, Contractor shall have 10 days from receipt of the County's notice to notify County of its decision to terminate this Agreement pursuant to paragraph 8.45 of the Agreement. In such case, the parties shall immediately, and in good faith, attempt to resolve the issue. If, the issue cannot be resolved, Contractor may terminate the Agreement pursuant to paragraph 8.45 the Agreement.
- After issuance of the Assessment Plan, throughout the duration of the Agreement, Contractor shall issue periodic progress reports at intervals not to exceed 60 days, describing and evaluating all remedial actions taken by the Hospital and, where appropriate, recommending additions and other amendments to the Contractor's initial Assessment Plan. In instances where Contractor recommends additional implementation efforts or changes to the timelines initially agreed upon, County and Contractor shall meet to discuss these recommendations and their implementation and mutually agree upon any necessary revisions. Contractor shall not dedicate any additional staff to any implementation efforts until and unless Contractor receives prior written approval from County.

Scope

- Contractor shall provide all reports, simultaneously and unredacted, to the Board of Supervisors, CMS, and the California Department of Health Services. Contractor shall not include any specifically identifying patient or employee information in any of the reports.
- The Initial Assessment Plan shall evaluate and address all of the following:

A. General Operations/Organizational Structure (Governance, Management Structure and Organizational Effectiveness and Performance)

- Contractor shall provide an assessment of KDMC's governance, management structure, and overall organizational effectiveness, as well as an evaluation of the facility's clinical capability and quality and the sustainability of services under the current environment and provide recommendations for improvement in the following areas:
  - Effectiveness of hospital executive leadership and governance structure
  - Feasibility of establishing Center for Multicultural Health Care
  - Overall patient flow across the hospital, including bed utilization
  - Hospital's structure to determine actions necessary to ensure consistent operations that produce dependable, safe and high quality health care service throughout the Hospital

Scope

- Governance, leadership, competency of staff, including medical staff, nursing staff and all clinical health care professionals
- Labor-management issues
- Hospital's standard operating procedures and standard operating systems and allocation of resources
- Integrity of hospital's physical plant
- Hospital's compliance with licensing and accreditation requirements associated with management of personnel, including, but not limited to:
  - Maintenance of performance evaluations
  - Annual health screenings
  - Maintenance of licensure, registration, and certification.
  - Staffing Effectiveness and Variances
  - Reviewing personnel files to ensure currency and validity of all documentation
  - Integrating the Human Resources components into the Improving Organizational Performance (IOP)
- Management of communications with the public, media, and regulatory agencies.

Scope

B. Clinical Organization

- While the Contractor shall evaluate the management and structure of all clinical services at the hospital, particular attention is required in two clinical areas: the Emergency Department and Operating Rooms. The Contractor shall review and develop recommendations in the following areas:
  - Assess Emergency and Trauma Department operations and develop recommendations to reduce time spent on diversion, including:
    - Evaluate patient flow in Emergency and Trauma Department and admitting and discharge processes
    - Review processing of medication orders by Emergency and Trauma Department staff
    - Review physical layout and nurse and ancillary staffing of Emergency and Trauma Department
    - Assess and benchmark Emergency and Trauma Department physician staffing model to comparable hospitals
    - Identify ways to increase efficiency in the Emergency and Trauma Department and establish a sustained reduction in amount of time the hospital is on ambulance diversion
    - Recommend changes to reduce/eliminate Emergency Department "holding" patients through increased efficiencies and improved patient flow
    - Steps to eliminate barriers to the hospital's capacity to provide appropriate access to care

Scope

- Steps to improve patient throughput, reduce length of stay in the Emergency Department and increase capacity

– Evaluate and make recommendations to enhance the efficiency of the Operating Rooms, including:
  - Management and structure of Operating Rooms.
  - Scheduling of Operating Room time and productivity of physician and clinical staff
  - Management of the surgical suites, including staffing and materials management
  - Reduction of delays in care through increased efficiencies and improved patient flow in the Operating Rooms and Intensive Care Units
– In addition to the above areas of focus, the Assessment Plan shall also address:
  - Appropriateness and sustainability of current scope of services, including the breadth and depth of specialty and sub-specialty clinical services across the hospital
  - Provider productivity
  - Organization, management, and integration of ancillary services (e.g., Pharmacy, Laboratory, Radiology, Housekeeping, OT/PT, and Dietary)

Scope

C. Medical Administration

- The Assessment Plan shall review:
  - Management of physician services provided at the hospital
  - Physician accountability of time for dual clinical and academic responsibilities
  - The structure of physician management at the executive and clinical department levels
  - Medical Staff Office structure, staffing, and management to ensure that staff is properly trained and the necessary processes are in place
  - The Hospital's physician credentialing and privileging processes, including data collection, application processing, and documentation collection, and utilization of data to make privileging decisions
  - Physician policies and procedures to determine level of appropriateness and compliance with outside regulatory requirements, as well as determine whether medical staff are in compliance
  - Physician governance model, including assessment of Professional Staff Association structure
  - Physician productivity with recommendations for establishing clear measures of productivity and steps necessary to improve physician productivity
  - Physician supervision of medical residents

Scope

- Current peer review processes at both the hospital and department-specific levels; including identifying and training the staff that will collect, aggregate, report, and analyze date and involvement of department chairs and Medical Executive Committee in JCAHO compliance and implementation of peer review process
- Adequacy of medical staff policies and procedures
- Policies and procedures related to supervision of residents

D. Nursing Services

- The Assessment Plan shall evaluation of:
  - Progress of efforts to ensure nursing staff conduct basic patient assessments and reassessments, follow patient safety requirements, implement physician orders, communicate among team members, accurately document in medical records, and appropriately use nursing processes.
  - Nurse staffing levels and recruitment efforts throughout King/Drew Medical Center
  - Collaboration of nursing services with ancillary services, such as dietary and pharmacy to improve integration of delivery of care
  - Patient program for psychiatric emergency and inpatient services
  - Processes for skill verification and providing on-going competency training and education
  - Status of improvement activities and nursing operation reforms
  - Ongoing performance improvement activities
  - Ongoing implementation of nursing operation reforms

Scope

E. Regulatory

- The Assessment Plan shall include an assessment of the implementation and management of activities under the Plans of Correction currently filed with both CMS and JCAHO as well as assessment of Hospital's current compliance with all 23 Conditions of Participation for CMS and make recommendations to assure sustained compliance.

Outcomes

- **Deliverable 2.1** - By January 3, 2005, provide a comprehensive written Assessment Plan, addressing all of the above areas. The Assessment Plan shall include recommendations as to how to remedy each deficiency, inefficiency and area of concern and include recommendations for staffing the remediation efforts as well as an estimated time line for implementation of the recommendations. In recommending staffing, Contractor shall recommend County staff who should be involved in implementing the recommendation and shall specify what, if any, Contractor staff, in addition to the interim management team, will be required to implement the recommendation.
- **Deliverable 2.2** - Periodic progress reports at intervals not to exceed 60 days, describing and evaluating all remedial actions taken by the Hospital and, where appropriate, recommending additions and other amendments to the Contractor's initial Assessment Plan.
- **Deliverable 2.3** - Reduce the number of admitted patients awaiting a bed in the Emergency Department "holding area" (24 hour average). The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.

Outcomes

- **Deliverable 2.4** - Reduce by 50 percent the number of treated and released Emergency Department patients whose length of stay is greater than 250 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.5** - Reduce by 50 percent the number of admitted patients in the Emergency Department whose length of stay is more than 400 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.6** - Discharge 20 percent of all patients to be discharged each day by 11:00 a.m. and implement a plan for continuous measurement and improvement.
- **Deliverable 2.7** - Improve by 50 percent operating room utilization (by number of minutes of operating room use). The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.8** - Reduce by 50 percent the number of patients in the Post-Anesthesia Care Unit whose length of stay is greater than 120 minute. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.

Outcomes

- **Deliverable 2.9** - Reduce by 50 percent the number of Intensive Care Unit patients whose Post-Anesthesia Care Unit length of stay is greater than 225 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.10**- Reduce by 50 percent the number of non-Intensive Care Unit patients whose Post-Anesthesia Care Unit length of stay is greater than 90 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.11** - Increase by 25 percent physician reporting of adverse clinical events. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.12** – Develop and implement a plan to achieve and sustain/obtain reinstatement of full JCAHO Accreditation.
- **Deliverable 2.13** - By February 1, 2005, provide a detailed, written plan for the coordination of administrative and clinical services between Humphrey Comprehensive Health Center and King/Drew Medical Center, including timeframe for implementing the plan to assure that it is fully implemented and joint accreditation of all facilities in the Southwest Cluster (King/Drew Medical Center, Humphrey Comprehensive Health Center, and Dollarhide Health Center) is achieved no later than September 1, 2005.

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Kerry Ann Phaneuf	Assessment Support

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Meetings/ Interviews

- To develop a robust understanding of the issues, NCI met with the numerous Hospital, County, and University staff. NCI also met with community leaders. NCI used a multidisciplinary Steering Committee to review the deficiencies and recommendations for coordination, comprehensiveness and ability to execute.

Executive Summary

- This is the final report for the assessment conducted by NCI from November 1, 2004 through January 27, 2005.
- Despite the many deficiencies and corrective actions listed in the assessment, there are departments that substantially meet all regulatory requirements and provide quality patient care. During the course of NCI's assessment it was clear that strengths exist at King Drew Medical Center upon which to build. Strengths identified include, but are not limited to:
  - Employee and physician pride in the hospital;
  - Long-term employees' commitment and loyalty;
  - Support of the mission to provide comprehensive medical care to the community;
  - Medical school affiliation;
  - Diversity of the work force; and
  - Community support.
- The deficiencies and recommended changes are provided in detail in each section of the comprehensive assessment. Some key findings and recommendations are highlighted in this executive summary.

Executive Summary

Governance

- It is clear that the historical ***KDMC governance process has been ineffective in ensuring quality health care*** and resolving operational issues.
- The ***KDMC governance structure lacks independence*** and does not receive accurate and timely management reports. Further, there is an absence of management and physician leadership accountability, resulting in a failure to maintain high quality patient services.
- A governance structure should be created to overcome these obstacles. Such an ***oversight body must be empowered to make change and must remain independent from the political interference*** experienced in the past.
- While the ***long term solution*** of the creation of a ***health authority*** is being considered, an interim step is needed to immediately place KDMC under the governance of a more independent and knowledgeable board.
- The Board of Supervisors should ***immediately designate the KDMC Advisory Board as the entity responsible for oversight of KDMC***, including the responsibility to oversee the clinical and educational programs of KDMC, reporting to the Supervisors on at least a quarterly basis.
- The Board of Supervisors should ***delegate to the KDMC Advisory Board the authority to act as the governing body*** for all functions required in JCAHO, CMS & licensure regulations.

Executive Summary

Governance

- As soon as feasible, ***membership of the KDMC Advisory Board should be expanded and its responsibilities clearly delineated to enable it to fulfill its critical governance role*** on behalf of KDMC. The expanded membership of the Board should include:
  - Three (3) ex officio members with vote (Dean of Drew School of Medicine; President of the PSA; and Director of DHS)
  - The KDMC CEO as ex officio member, without vote
  - Three to seven (3-7) additional members who have demonstrated expertise and experience in finance, business, hospital or clinic management, health plan administration and/or health and public policy. The members so appointed should have a clear commitment to the provision of high quality health care to underserved populations.
  - The Advisory Board should also develop a process to insure participation and ongoing input from the communities served by KDMC.
  - Initial appointments to the Advisory Board should be for three-year terms. In its first year, the Advisory Board should develop a succession plan.

Executive Summary

Governance

- The ***KDMC Advisory Board should be responsible to review***, assess and make recommendations concerning, but not limited to, the following critical areas:
  - ***Quality of care***, patient safety, clinical outcomes, malpractice experience, patient satisfaction and compliance with regulatory and accreditation requirements
  - ***Medical staff credentialing***, peer review, privileging and reappointment processes
  - ***Affiliation Agreement*** terms and conditions to assure that involved parties clearly commit to the dual mission of patient care and teaching at KDMC and that expectations are clarified with respect to the scope of clinical and academic services to be provided; physician staffing levels, time allocations, and time reporting methodologies; and medical accountability for individual and collective physician performance related to the quality of medical services
  - ***Graduate medical education programs*** to include residency supervision, adherence to Residency Review Committee and ACGME program requirements, adequacy of clinical experience and opportunities to strengthen programs through collaboration with other academic medical centers and/or schools of medicine
  - ***Definition of programs and services*** consistent with available resources, community needs and KDMC's clinical and academic missions
  - Development of a ***Strategic Plan***, capital facilities plan, five-year financial plan and operating budget, including a requested appropriation from the Board of Supervisors to meet the current operating and capital needs of KDMC consistent with its mission and vision.

Executive Summary

Governance

- Development of an ***Information Technology Plan*** consistent with KDMC clinical and business strategy
- ***Financial performance*** consistent with annually approved operating budget and productivity standards, as well as expense reduction, clinical resource management and revenue cycle initiatives
- ***Oversight of hospital business practices,*** policies and procedures that influence the quality of care and/or impede efforts to provide care in the most cost effective manner possible
- ***Appointment of KDMC executives*** including recommendation of an individual to serve as the permanent KDMC chief executive officer (CEO).
- ***Human Resources*** with respect to recruitment and retention, market driven compensation and benefits, labor contract terms and conditions, employee training and orientation, supervisor/employee relations, management development, performance evaluations and workers' compensation experience
- Recommendations for ***specific relief from County policies and procedures*** which impede management's efforts to provide high quality, cost effective clinical services
- Oversight of the interim management and implementation services provided by NCI

Executive Summary

Management

- ***A new organizational structure is being recommended to reduce the span of control for the Director of Nursing, Chief Medical Officer and Administrative Director Quality Management/ Regulatory Programs. These positions have responsibility for significant changes which need to occur at a fast pace. The new structure will provide more senior oversight and support for staff.***
- Responsibilities of management are not clearly defined, consistent and predictable. The current management structure does not facilitate the decision-making process. Responsibility and authority for key decision making is not clear. Often times, the management team functions in a crisis mode, resulting from a lack of planning, direction and delayed decision making.
- Individual goals and objectives need to be established. Clear accountabilities, performance expectations and management needs to be instituted.
- There needs to be management training and development to promote critical situational analyses and decision making. There is a limited use of data analysis in decision making.
- Management is not always required to be fiscally responsible for their actions. There is little to no input into the budget process resulting in a lack of accountability and ownership. Setting productivity standards and measuring compliance with the standards are important to provide quality patient care. Fostering low productivity standards will increase the use of temporary staff and overtime. Both overtime and a large proportion of temporary/agency staff can have a negative impact on quality of patient care.

Executive Summary

Management

- There is currently no productivity monitoring system. ***Despite a decrease in discharges and adjusted discharges with a stable case mix index, paid FTEs have increased. Registry hours as a percent of productive hours has doubled. Management should receive training for productivity monitoring to better match staffing to patient needs and improve safety.***

	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04
Hours	Paid Hours		Productive Hours		OT Hours		Registry (Agency) Hours	
	411,455	4,746,196	333,931	3,897,575	Data to be Provided	Data to be provided	50,874	326,464
Volume	OP Adjustment Factor*		ALOS		AOB		ADC	
	1.36	1.36	6.28	6.77	229.1	275.1	169.0	202.9
Volume	Patient Days (Excluding Nbs)		Discharges (Excluding Nbs)		Adjusted Patient Days		Adjusted Discharges	
	5,070	74,269	807	10,966	6,872	100,673	1,094	14,865
Ratios	Non-Productive as a % of Paid Hrs		Overtime as a % of Productive Hrs		Registry (Agency) as a % of Productive Hrs		Paid FTEs	
	21.5%	19.2%			18.0%	9.1%	2,400	2,269
Indicators	Case Mix Index*		Paid FTEs per AOB		Paid Hrs per Adj Disch		NAVIGANT CONSULTING	
	1.1	1.1	10.48	8.25	376.1	319.3		

Source / Notes:

- OP Adjustment Factor is calculated based on FY02-03OSHPD report on KDMC. KDMC does not calculate OP Adjustment Factor due to its "all-inclusive" (per diem / per visit) billing practice.
- Paid Hours (therefore Paid FTEs), Productive Hours, and Registry (Agency) Hours exclude physicians, residents, and mid-level providers.
- Case Mix Index was provided by OSHPD, reflecting FY00-01 data.
- For sectios that indicate "Data to be provided", the data is unavailable as of December 2004.
- The blank sections will have the calculated indicators once all the data elements become available.

Executive Summary

Management

- There have not been regular “live” communications with staff. This includes formal staff meetings, rounds, management forums, etc. No formal staff/employee or medical staff newsletter currently exists that is distributed throughout the organization on a predictable schedule. ***The preferred method of communication is paycheck inserts.***
- There is a failure to integrate the regulatory compliance or quality process into an overall communications scheme both internally and externally. ***The organization is reactionary rather than proactive with respect to communicating with regulatory agencies. Regular communication with CMS, JCAHO and other regulatory bodies needs to occur going forward. Information on the organization’s performance on regulatory surveys has been closely held by senior management and has not been widely communicated to middle management and staff who are integral to the resolution of the issues.***

Executive Summary

Regulatory

- The organization has been surveyed and inspected by regulatory and accrediting bodies almost monthly over the past 12 months. Due to the volume of recent surveys and the subsequent submission of plans of correction to regulatory and accrediting agencies, the organization has been in a reactionary rather than proactive mode. The organization has committed to implementing volumes of corrective actions with CMS and JCAHO without accountability or tracking mechanisms. Previously-submitted JCAHO and CMS corrective action plans have not fully addressed the deficiencies.
- ***The leadership, committee structure and tracking system needs to be completely revamped. Due to the seriousness of the issues, a regulatory readiness committee is being recommended, This committee will need to meet at least weekly.*** The Administrative Director Regulatory Programs will report to the CEO. A program management function needs to be implemented to manage and track implementation progress for all plans of correction. Also, a process to share results regularly with managers, clinicians and staff needs to be developed.
- ***Executive oversight of the quality of care and compliance with regulatory accreditation requirements has been lacking by previous senior management and the Board. Issues and results will be reported at least monthly to the Medical Executive Committee and Board. The Board needs to be fully engaged and will receive regular updates and a dashboard of indicators on the organization's level of regulatory compliance.***

Executive Summary

Regulatory

- The ***regulatory compliance function and hospital departmental operations are divorced from one another***. Information does not flow into the regulatory compliance process from hospital operations. The department managers are not held accountable for regulatory compliance. There has been a failure to integrate the regulatory compliance process into hospital operations, risk management activities and performance improvement goals. Performance expectations, training and communications need to be implemented immediately. ***Quality of care is not built into the fundamental processes of taking "care" of patients.***
- There has been a ***lack of accountability of Medical Staff department chairs for individual and collective physician performance***. Medical staff chairs and division chiefs need coaching to assess individual physician performance and to initiate appropriate action. The ***focused use of external reviewers for quality and peer reviews is recommended.***

Executive Summary

Performance and Quality Improvement

- ***The program needs a major overhaul*** in order to be effective given the significant issues facing King Drew Medical Center. There is a lack of data aggregation, analysis and identification of opportunities for improvement. There is a lack of follow-through on implementing recommendations for improvement. ***There is a lack of communication throughout the organization***, including feedback on PI and patient safety issues (dead-ends with middle management).
- ***The Board needs to establish a Quality Oversight Committee.*** The hospital committee (Improving Organizational Performance, IOP) is too large (50 members) and should be reduced to 15 members. The IOP results are reported too infrequently to the Medical Executive Committee ***and Board (only quarterly). The IOP Committee needs to be prepared to meet at any time or frequency over the next six months based on the critical nature of the situation.*** Monthly reporting needs to be instituted. Data collection, trending and analysis are ineffective. The approach to scientific process for performance measurement needs to be developed. Some software needs to be purchased to support this endeavor.

Executive Summary

Performance and Quality Improvement

- The ***Nursing, Medical Staff, Risk Management and Hospital Performance and Quality Improvement programs are not integrated.*** Given the volume and magnitude of issues, there is a need for separate programs which operate in an integrated fashion. There is not a formal, functioning process for sentinel event reporting and root cause analysis. There is minimal reporting of medication errors by nursing staff. The organization cannot compute patient fall rates. The incident report process is manual and should be automated. The hospital needs to more accurately measure and track compliance with the National Patient Safety goals and measures.
- Limited peer review is occurring in all medical staff departments. However, the Medical Staff Peer Review process is not robust and does not systematically contribute to improving the quality of care. Medical staff peer review activities are not being recorded in the physician profile. ***The Medical Staff credentialing, privileging and reappointment process does not result in a comprehensive, objective assessment of individual practitioners' performance.*** The credentialing and peer review process need to be revised and integrated with the credentialing and privileging process.

Executive Summary

Performance and Quality Improvement

- The department has more than sufficient staff to accomplish the needed changes. Five of the six analysts have achieved Certified Professional in Healthcare Quality (CPHQ) status from the Healthcare Quality Certification Board of the National Association for Healthcare Quality (NAHQ). The Director role should be revised to separate Performance and Quality Improvement from Regulatory Compliance and staff reallocated to support the separated functions since there are too many improvements needed in both areas.
- ***Patient Satisfaction has not been measured since the first quarter of 2003.*** When it was measured, the tool a "home grown", self-administered questionnaire. Results were not benchmarked or routinely shared. A standardized tool administered by an outside agency should be implemented. Results should be routinely shared with departments and the Board Quality Oversight Committee. Analysis of opportunities for improvement and a corrective action plan should be instituted.

Executive Summary

Environment of Care

- ***The overall condition of the patient care areas is in need of structural and organizational improvement. The root cause of the issues identified above is management inattention to regulatory compliance, patient aesthetics and comfort, signage and general space adequacy. The safety related modifications need to occur immediately.***
- A tour of the Mental Health units indicates that there are potentially serious environmental safety issues in patient rooms, even in the remodeled rooms.
- A tour of the Surgery Suites indicates that there are potentially serious environmental safety issues in storage rooms, and the surgery suites. It is recommended to remodel the suites by closing three suites.
- The ***areas housing infants do not have any alarms or anti-abduction systems in place beyond local alarms on a few doors***. This needs to be addressed immediately.

Executive Summary

Capacity Management and Case Management

- The systems and processes for bed control, length of stay management, level of care determination, and discharge planning need significant improvement. Most measures are not collected or tracked. Policies and procedures are not developed to support improving throughput. There is a lack of interdisciplinary communication and support staff coordination to improve throughput.
- ***Medical direction and management of length of stay and level of care needs improvement and consistency. Interdisciplinary rounds need to be instituted on all units. A physician advisor for throughput management needs to be instituted.*** At a minimum the medical officer of the day needs to be consistent and focus on throughput. Individual physician performance needs to be collected and shared to improve clinical management of patients.
- Positions such as the admit nurse, case management and social work predominantly provide coverage five days a week. The admit nurse position needs to be expanded to provide seven day a week coverage and given overall responsibility for bed control.

Executive Summary

Emergency Services

- ***There are serious leadership issues including a lack of collaboration between the nursing and physician leaders and disciplines. ED physician practice is not consistent in managing patients. The physician and nursing staff were not able to agree upon the content for triage protocols or clinical pathways. ED physician behavior has been identified as an issue. Physicians have become complacent in their practice***. For example, the ED blue team physician is not always available and the ED physicians are reluctant to help with Blue Team patients who have been admitted to other physician teams.
- ***Night shift staff are sleeping during their shift, and staff on all shifts are known to disappear. Of the current KDMC RN staff (47), 7 had expired ACLS, 6 had expired PALS, 7 had expired BLS. Of the current NA staff (68), 6 had expired BLS. The current staff are 58% KDMC and 42% Travelers/county per diem. Traveler and agency RNs are required to be compliant with ACLS, PALS and BLS.***
- The ED was on diversion approximately 70% of the time during May through October. Based on the data, there is no relationship between diversion and ED volume. The ED average length of stay is 12 hours. 50% of the patients have a length of stay of 12 hours, 44% of the patients have a length of stay > 12 hours. There are numerous issues which adversely impact patient flow including: physicians identifying higher level of care than is needed; delays in transfer to inpatient floors or ICUs; delays in Neuro; failure to identify appropriate transfers to other facilities (Rehab)

Executive Summary

Emergency Services

- Addressing the ED deficiencies and implementing the recommendations is critical. The Nursing Management structure needs to be changed. All staff need to be compliant with CPR, ACLS and PALS immediately. An ED Joint Practice Group needs to be developed. There needs to be an ED Quality and Performance Measurement position to support data driven decision making. ED protocols and pre-printed orders for commonly seen complaints need to be developed and implemented for all ED physicians to follow. A mechanism for monitoring ED physician productivity needs to be developed. It is recommended that ED physicians and staff attend cultural sensitivity and patient satisfaction training.
- There are some environmental and equipment issues which need to be addressed. Patient privacy is violated in multiple ED areas, space is cramped without dedicated resuscitation bays or separated areas for pediatric patients and space modification is required. ***The ED has 26 monitors and lacks portable telemetry. Of those only six monitors are linked to the central monitoring station, and monitors frequently require biomed for repair.***

Executive Summary

Perioperative

- ***The governance structure for the perioperative service is ineffective. Committee attendance is variable; issue follow-up does not routinely occur; data analysis is poor; infection control is not routinely included.*** The committee membership, size, charge and reporting needs to be revised. A dashboard of key indicators needs to be developed and reported on monthly. Accountability for follow-up needs to be assigned and consequences for poor performance instituted.
- ***Data was not readily available despite the existence of an information system and two full-time data analysts.*** Once data was entered, it became clear that the operating rooms are unproductive. Operating suite utilization has been 26%. This only includes the main operating room suites. There are two additional suites in Trauma, two cystoscopy suites, three suites on the labor floor. On-time starts are 61%. Unfortunately the surgical team has not prepared the room prior to the patient entering. This results in long case times and potential harm to the patient. Currently the time from the patient entering the suite to time of incision is not recorded.
- ***Despite a backlog of cases, productivity remains significantly below standards. The current level of staffing could support approximately 6,500 additional cases annually.*** Anesthesia is currently mandating all patients, regardless of ASA classification, attend OSA clinic before surgery. This is an unnecessary bottleneck.

Executive Summary

Perioperative

- The high level of staffing poses risks for patients with too many people in the rooms, increased opportunities for contamination, and the use of agency staff. Staffing patterns show no less than three in-house teams on nights and weekends, with four rooms staffed during weekend days. Management has not been responsible for ensuring productivity.
- Several students, unsupervised for long periods of time were observed in all operating rooms. The OR Supervisor was unable to identify all of the programs represented by the students, the skill level of the students and the location of the program instructors.
- ***There were numerous patient safety violations including: basic OR principles not being followed such as sterile field maintenance and wearing masks; instrument, sponge and sharp counts inconsistently performed; site-verification not routinely checked or documented; and inconsistent instrument cleaning.***

Executive Summary

Perioperative

- ***Overall condition of the Operating Room area is sub-standard.*** There are Life Safety Code issues such as: storage in the exit corridor; SHRED bind over 32 gallons, roller latches on some corridor doors. One operating room has been converted to storage for both sterile and non-sterile items. In that suite the following environmentally issues were observed: floor tiles cracked; walls and baseboard damaged and with missing tiles; wood shelving delaminating and musty smelling; abandoned sink and utilities neither covered not removed; non-functional OR lights remain in place; broken ceiling tiles and fluorescent light tubes without covers. The need for physical site remediation and renovation is extensive. Given the excess capacity, it is recommended to close three suites and renovate them. Once these are open the remaining three suites can be renovated if the volume to fill them exists.
- ***Supply areas and operating rooms are packed with excessive inventory, yet key items, such as masks, are not readily available***. Orthopedic implants are provided by limitless vendors. All orthopedic supplies, including expensive implants, were in disarray with sterile mixed with non sterile items. The office for materials management staff in OR houses huge stack of invoices, requisitions, vendor books and other items that confound speedy resolution and problem solving.

Executive Summary

Medical

- ***The breadth of improvements needed and pace of change necessitate reducing the span of control for the Medical Director. The revised structure provides an additional Associate Medical Director responsible for UM and CRM. UM, CRM and Performance Improvement activities are aligned under the Medical Director to improve patient throughput and clinical management. It is also recommended to consolidate the oversight of surgical chairs under a single "super chief".*** The chairs should be better aligned with the administrator for their departments, and a lead administrator, reporting to the Medical Director, will facilitate administrative support for the clinical departments.
- ***ICU patient management needs improvement***. A single ICU director should be assigned for each ICU with clear accountability for the clinical oversight of the unit, reporting via their respective Department Chair to the Medical Director. An ***Intensivist coverage program for all ICU's should be developed and policy requiring Intensivist consultations for all ICU patients should be implemented***. It is also recommended to strongly consider implementation (perhaps on a contracted basis) of a remote ICU monitoring program to better ensure consistent high quality MD intensivist and RN coverage to supplement the on-site clinicians.

Executive Summary

Medical

- The credentialing process needs to be revised and all files need to be completely reviewed. There is no link for ensuring that peer review, risk management or quality information is included in credentialing reviews. Little profiling data is collected to support credentialing/privileging decisions. Privileging information is not routinely readily available so that nursing staff can access when scheduling procedures, or for proctoring (provisional staff) or supervision requirements (residents and AHPs). For employed physician and AHP staff, performance reviews and efficient progressive disciplinary processes, linked to credentialing as appropriate, are not clearly present. AHP credentialing/privileging processes and procedures parallel those for medical staff, though specific scope of service criteria need clarification by specialty (in process), and required physician supervision is not clearly monitored.
- ***The medical staff committees need to be restructured and re-invigorated.*** There are varying levels of attendance and productivity of committees. Committee recommendations need to be more practical and able to be implemented. Results need to be tracked.

Executive Summary

Medical

- ***It is critical for the Advisory Board and hospital to be able to hold the medical staff accountable for the clinical time and coverage that it is financially supporting. There are reports of clinical situations where physician oversight is needed but not available. Productivity is not systematically measured or reported or compared with external benchmarks.*** There are no productivity (or other) incentive programs. There is significant confusion and lack of rigor or accountability in defining the various components of physician work activity, and alignment with the components of compensation. Clinical time is, therefore, not accurately or consistently measured and/or accounted for. It is thus nearly impossible to match available clinical resource with demand to rationally plan clinical staffing complements.
- ***The sum of residency program requirements exceeds the clinical breadth of patients available at KDMC to successfully train the currently accepted residency complement for 2005. There needs to be a review of each residency program to determine if it should continue to stand alone, be integrated with another program or eliminated***. Joint programming pilots with UCLA and/or USC should be considered – Ophthalmology and Ortho might be good initial candidates. Program size needs to be defined based on the available clinical experiences. There needs to be an analysis of GME monies currently being expended to support residency programs and reconciliation with available funding from federal and other sources.

Executive Summary

Nursing

- ***A significant number of changes need to be instituted in the short term. To assist with implementing the improvements, provide closer supervision and support to nurse managers and staff the number of nursing directors need to be increased.***
- With the addition of traveling and agency nurses, staffing meets California standards. There are 112 agency nurses. ***Staffing is not well-managed***. The units are often over-staffed due to almost non-existent flexing and a set schedule which accommodates agency staff with contract requirements. Shift reports illustrate ratios varying 1:3 or 1:4 consistently on medical surgical units which require minimum ratio of 1:6. There is no float pool or resource/admissions nurses to aid in flexing staff, filling call-in vacancies or being available for a temporary increase in workload, such as higher than usual numbers of admissions, returns from OR, patient in crisis, etc.
- Recruitment and retention needs an increased focus for nurses. Currently, one recruiter is in place for the nursing department with one support staff person. This recruiter returned from retirement on a limited basis to meet the needs of the department. An experienced recruiter has just been hired to build the recruitment and retention efforts. A second recruiter and a support person is needed. A workforce plan needs to be developed and the recruitment plan adjusted accordingly. Staff should be involved in recruitment.
- ***There is no clearly articulated model of nursing care, leading to role confusion and performance issues.*** A "Care Partner" model of nursing care will be implemented which clearly defines the role of the RN as being responsible for patient care and the supervision of the LVN and CNA. LVNs and CNAs will be assigned to RNs, not patients. RN will administer all medications, assess patients, develop the plan of care, communicate/ collaborate with physicians.

Executive Summary

Nursing

- ***Clinical collaboration between nursing and most other disciplines is minimal.*** The relationship between medical staff and nursing is not cohesive or collaborative in nature. While there are some areas that work well together, overall the relationship is fragmented. Interviews and direct experience showed that nursing staff are unsure of the chain of command, do not have trust in having pages returned and as a result have developed alternative work-arounds. Relations between nursing and pharmacy are fragmented. Both areas work in silos when making changes to policies, procedures, etc. Perceived lack of available resources in physical therapy exists, with managers unable to relate if their specific unit has a Physical Therapy assigned. Orders for Physical Therapy are not encouraged due to perceived lack of available services.
- The care planning and clinical documentation system is outdated. Managers have been working on a revised system which is still outdated. Charting by exception needs to be fast-tracked. Standard forms are available from outside vendors which should be purchased to expedite the change process.

Executive Summary

Nursing

- There is no uniform or coordinated system for skill verifications and competencies tracking. Nursing Staffing, Nursing Education and Nursing Administration are presently tracking various items. There is no one owner of both licenses and competencies within the department. Currently, over 60 competencies are tracked using the ANSOS system. However, all of these are not currently updated due to a disjointed approach to documenting these competencies. Reports are not readily available to leadership and management regarding licensure and competency (ACLS, BLS) expiration dates. Clear documentation of competency expectations per unit does not exist. An annual skills and competency fair has not been done in the last one to two years, but the department reports former success with this approach.
- Skills verification and competencies records need to be organized in Nursing Staffing office under the Clinical Director, Administration position. Nurse managers need to be held accountable for timely completion of skills verification and competency training. The competencies need to be updated to match current patient needs An annual skills and competency fair needs to be held early in 2005 placing all units in an annual consistent schedule.
- ***There are a number of significant patient safety issues which need immediate remediation. These include Code Blue, Code Nine, DNR/ DNI, Patient Identifiers for Allergies/ Fall Risk and availability of translators.*** Additional safety issues were discussed in "Environment of Care". Another critical safety issue is the lack of portable telemetry transmitters on the Telemetry unit. Currently, the system uses hardwire only. This is not community standard for this population. For example, if a patient has bathroom privileges, he/she is removed off the cardiac monitor while in bathroom.

Executive Summary

Psychiatry

- The county facilities are the primary source for psychiatric care. ***A myriad of problems exist from clinical care to environment of care.*** Despite repeated citations for deficiencies, there has been very little improvement. A change in nursing leadership was made in mid-December. The prior Nurse manager was unable to grasp the seriousness of the situation. Deficiencies have not been proactively identified and resolution plans have not been implemented. Staff were not compliant with mandatory trainings. There continues to be a lack of therapeutic programming. The management of aggressive behavior and Code Nine was not modified to meet CMS and JCAHO standards. There is little interaction between patients and staff. Policies regarding restraints are not followed. Patients are not monitored in the room by staff but monitored from nurses' station on video.
- Training for managing aggressive patients needs to change from didactic to behavioral. The staff need to be provided a "pocket algorithm", participate in multidisciplinary training that is behavioral not didactic in nature.
- Currently therapies are available five days a week. A seven day a week mentality needs to be implemented for all therapies. Consistency of care needs to be provided by all disciplines.
- Skills and competency validation is done in orientation and evaluated annually in performance review. Staff use checklists and self assessments to document. For new procedures or skills, a Trainer will evaluate competency. ***Compliance is recorded at 100% which seems unbelievable after observing actual practice and preliminary interviews with staff. All staff need to be re-evaluated for competency.***

Executive Summary

Psychiatry

- ***The overall physical condition of the Mental Health area is sub-standard and subject to serious censure by any authority having jurisdiction that should inspect the area.*** Housing the types of patients described and observed requires a much higher degree risk minimized environment than currently exists even in so-called remodeled areas. Typical un-remodeled patient room issues include: electrical over-bed lights (mostly damaged) that should be removed; doors to closets are removable and that can be used as weapons; washrooms with numerous grab bars, faucet, exposed plumbing pipe, toilet tissue holder hazards; removable ceiling tiles should be solid ceiling; and electrical outlets on wall should be blanked over with tamperproof screws. In Ward "D" remodeled rooms the following problems exist: washrooms with plumbing piping and faucet handle hazards; mirror not recessed and removable from wall, doors to closets are removable and can be used as weapons; removable ceiling tiles should be solid ceiling; knobs on both bathroom and inside room doors; electrical outlets on wall should be blanked over w/ tamperproof screws. The restraint room is occupied as a patient room. The room should be available for restraint without removal of another resident. The access panel in the ceiling has loose edges. Other observations include: Ward "F" doors to ramp without security locks to prevent elopement; room 2075 without breakaway cubical curtain suspension; fire extinguishers should be kept inside nurse's stations; security magnets on some exterior doors impede on the required 6"-8" required egress height.; location of the nurse's station does not maximize the observational requirements of the patient area corridors. Sprinkler system is accessible by patients which can result in patient harm or flooding of the unit.

Executive Summary

Information Technology

- The Department of Health Services (DHS) has a very robust strategic application directions plan to provide information systems on an Enterprise level. Included in these plans are: Enterprise Pharmacy; Laboratory; Electronic Medical Record; Data Repository; Web services; Voice over IP; Document Imaging; and Unique Unified Patient Identifier. ***While the information technology plan is technically sound in direction, the specified timeframes for implementing new systems are too elongated (e.g., pharmacy, and Nursing Plan of Care module), especially given the critical issues that need to be addressed by MLKD. Many of these systems are needed immediately at MLKD, in particular the Pharmacy system.***
- The information systems plan is strategic in direction but details are lacking in the areas of:
  - An Organization and Human Resources Plan that identifies the number and experience required to fulfill the plan.
  - A Management Process Plan that identifies the ongoing planning process and project management process.
  - An Investment Plan that identifies the cost of hardware, software, supplies, and human resources required.
  - An Education and Training Plan that identifies the needs for educating the users, technicians, and management.
  - An Implementation Plan that identifies the precise timeframes that meet the organization's needs and objectives.

Executive Summary

Information Technology

- The expenditure level for KDMC on Information Technology equates to about 1.1% of the total operating budget. ***Based upon industry benchmarks a stand alone community hospital averages approximately 2.0% in operating expenses and multi-hospital integrated delivery systems average 3%. The IT staff should be appropriately aligned for Operations/implementation support and Customer Service respectively.*** Customer service scores are low. Information technology needs to be restructured, separating ongoing operations support from implementation and customer support.

Executive Summary

Human Resources

- The Human Resources Department (HR) at MLK/Drew MC has evolved from a hospital-based department to a county centralized service delivery model, maintaining limited on-site staff which provides transaction based services in personnel processing, training/orientation, performance management and return to work. ***Given the cultural transformation required, numerous performance management issues (300 cases), the significant recruitment needs (559 vacant positions, 26%), the number of late evaluations (92%), and significant lack of regulatory compliance a different HR model is needed now.*** A shared service model may work after the significant issues that exist are rectified.
- ***King Drew Medical Center needs an on-site Senior Human Resource leader and more site-specific staff. The current staffing levels are below industry standards.***
- HR management is the cornerstone to the clinical turnaround. Quickly managing performance problems to equitable and effective closure is critical. Reducing vacancies and hiring permanent staff will be important. Recruiting staff through competitive, innovative, & healthcare market-driven compensation and benefits while strengthening supervisory-employee work relationships must be addressed. Management development is critical.
- The data for personnel management is not easily available and HR performance measures must be established and maintained. A new HRIS system is under consideration but a long way from being implemented. In addition to a new HRIS system, the hospital needs an automated time and attendance system.

Executive Summary

Pharmacy

- ***Numerous issues exist in Pharmacy including the lack of full-time, dedicated management, a less than effective Pharmacy and Therapeutics Committee, extensive use of registry staff (35% inpatient staff and 100% outpatient staff are registry), and a plan to implement information systems that is too prolonged. Despite prior problems with drug diversion, there is still a need for improving drug security including installation of security cameras and changes in policies/ procedures.***
- Overall pharmacy areas are not optimally designed:
  - IV room is not compliant with USP Chapter 797 regulation;
  - Insufficient space resulting in clutter and medication errors;
  - Clinical Pharmacist work area is designed for two desks maximum (have 5 desks);
  - Medication procurement and storage areas not maximally secured;
  - OP Pharmacy designed for volumes of 200-300 scripts per day (average 850-900);
- ***Given the serious nature of the issues, all alternatives for improving quality, patient safety and service delivery including outsourcing should be evaluated***.

Executive Summary

Ambulatory

- The ***ambulatory care organization is fragmented***, with the nurse manager of KDMC reporting to the CNO, the interim ambulatory care administrator reporting to the COO, the Interim CEO of Hubert H. Humphrey Comprehensive Health Center (HHHCHC) reporting to the CEO.
- The ***availability of primary care services does not meet the community medical needs***.
- ***Most clinics use block scheduling resulting in excessive wait times for registration and being seen by a physician***. Block scheduling needs to be eliminated:
  - As an example, 4M had 63 patients scheduled for 12 noon with only one registration clerk. It took 2.5 hours to register all the patients.
  - There are lengthy wait times and patients line the hallways for hours without a place to sit.
  - Patients routinely fight in the clinical area because they are so overcrowded.
  - Patients are asked to reschedule appointments when the doctor does not get to them during the clinic session
  - There is a high no show rate with minimal strategy apparent for addressing.

Executive Summary

Ambulatory

- ***The ambulatory system is not patient-friendly:***
  - Patients have to jump through hundreds of hoops to get anything accomplished.
  - 3G patient medication refill requests require the patient to come to the clinic to pick it up. They do not mail prescriptions or call in refills.
  - Patient flow is driven by what is convenient to nurses and physicians, not what is convenient to patients.
  - Patients are not provided with a minimally acceptable level of service related to wait times, space and accommodations, privacy and resolution to problems by clinic staff.
  - Hispanic patients are often seen without appropriate interpreters.
- There are ***many facility and equipment issues in ambulatory***.
  - Physicians do not always have at least 2 exam rooms to see patients in.
  - Exam rooms are not always supplied with the appropriate medical supplies.
  - There is no systematic planning to match clinic service “supply” to patient demand.

Executive Summary

Ambulatory

- There are ***Human Resource issues***, for example:
  - It is felt that some physicians do not routinely spend 40 hour a week on site when they are considered full time.
  - The staffing needs of these clinics cannot be determined because there is no accurate data currently available to determine the staffing or activity level in ambulatory care.
  - There is a feeling of helplessness in dealing with Human Resource and personnel issues. Staff have been "cascaded" through the system. One department reports having three out of five employees transferred to that department as a result of performance issues in another department.
- KDMC ***policy on Supervision of Residents is incongruent with CMS guidelines***.

Executive Summary

Programs and Services

- The ***health status of the population in SPA 6, the KMDC service area, is seriously compromised, as indicated by the poorest ratings County-wide in a number of health indices and the presentation of many preventable conditions for hospital and tertiary level specialty care.*** While an assessment of the community based and primary care services are part of a subsequent report, it is clear that there is a current significant backlog in meeting current referrals for specialty care.
- ***Growth is recommended in the areas of Internal Medicine***, (especially in the specialty areas of cardiology, endocrinology, hematology/oncology as related to sickle disease), ENT, ophthalmology, orthopedics, OB/GYN, Pediatric subspecialties and basic dental services. Services that need to be maintained as key resources include geriatrics, nephrology, surgery, neuroscience, psychiatry and emergency medicine.
- A pediatric surgeon should be recruited to support higher levels of care in the NICU and PICU. In the meantime:
  - ***Downgrade NICU from Regional to Community NICU.***
  - Assess the severity of illness in the ***PICU*** to ***determine if it should be an intensive or intermediate care unit.***

Executive Summary

Programs and Services

- ***Restoration of a trauma*** capability could be considered after significant enhancement of essential organizational and service issues are met and reestablishment support requirements for surgical resident resources.
  - To manage a trauma center, ***the standard of care would typically include a surgical residency program with on site coverage 24/7.***
  - In addition, the level of trauma service is determined by the on site and on call availability and depth of surgical and surgical subspecialty capability as well as the depth and breadth of ancillary supports, e.g. ***immediately available angiography which is currently a challenge***.
  - Given the current regulatory situation, re-establishment of a surgical residency ***could not realistically occur before July, 2006, perhaps later.***
- While there is a County-wide need for additional operating room capacity***, there is a very significant need for a dedicated ambulatory surgical capability at KDMC***.
- There is clearly continued need for vast outreach in primary care medicine and dentistry that improves health status and interdicts development of tertiary level service needs.

Executive Summary

Culture

- ***Findings indicate that MLK/Drew has a culture of excuses and blaming.*** Involvement and participation, leader visibility and approachability, leaders leading by example, leadership development, planning and direction (the organization is reactive versus proactive), accountability, HR practices as they relate to service excellence, communication, cross-departmental teamwork and a consistent and well-deployed customer service focus in every department are all significant opportunities for improvement.
- Alignment, deployment and consistency of service and operational excellence practices will be critical in moving the organization forward. The recommended Service and Operational Excellence Implementation Plan is focused on five key areas. They are: Create and Maintain a Culture of Patient Safety and Employee Growth and Development; Select and Retain Outstanding Employees; Commit to Service and Quality Excellence; Continuously Develop Great Leaders and Hardwire Success through Systems of Accountability. Each of these areas includes leveraging current areas of strength as well as the introduction of new strategies and concepts. Working through the recommended Service Teams, MLK/Drew Medical Center will need to engage both leaders and employees in moving the organization forward following specific strategies recommended.

Executive Summary

Culture

- ***There needs to be a re-dedication to the stated mission and vision of King Drew Medical Center*** which are:
  - *Mission:* To provide quality , comprehensive medical care, that is accessible,
  - acceptable & adaptable to the needs of the community we serve.
  - *Vision:* An academic medical center of excellence that is caring, compassionate,
  - & competent, focusing on the needs of our culturally diverse community
  - as well as ways to continually improve our service.

- ***Values need to be developed and internalized.***

Executive Summary

Measurement and Monitoring

- A ***Results Management Office will be established to provide discipline and a structured tracking and measurement*** critical to successful implementation of the Implementation Plan.
- Each of the sections of the Implementation Plan identify ***Performance Measures*** to objectively measure progress toward performance targets.
- Each of the sections of the Implementation Plan have identified ***Recommendations*** and the identification of an responsible executive.
- Each Recommendation has a Workplan that was developed in collaboration with key KDMC Leadership. ***Workplans were finalized including action steps, accountabilities and due dates***.
- Three sub groups composed of select KDMC, DHS and LAC will meet regularly to support completion of the Action Steps:
  - Human Resources
  - Facilities and Equipment
  - Technology

Executive Summary

Measurement and Monitoring

- ***Status updates will be reviewed with KDMC Senior Staff every other week***. This group will provide the oversight and management of the plan.
- ***Status updates will be reported to the newly created KDMC Governing Board and the Board of Supervisors monthly*** and will include the following:
  - Overall status of progress by Section.
  - Measurement of Key Performance Measures.
  - Areas of performance variance and corrective action plans.
  - Identification of implementation

Executive Summary

Critical Success Factors

- Integrated, prioritized focused plan.
- Clear commitment to the success of the plan by DHS and Board of Supervisors.
- "Real" governance and "sleeves rolled up, visible" leadership.
- Involve CMS and the JCAHO as partners in the solution versus "finding fault". Get some reprieve from constant regulatory reviews.
- Create a central, dedicated function to monitor and course correct the plan.
- Disciplined execution of the plan with and "attention to detail mentality".
- Defined individual roles and accountability "deep" into KDMC.
- Revised and streamlined committees that are engaged.
- Sufficient, capable resources to enable success.
- Sufficient time to execute.
- "Blocking and tackling" management skills.
- KDMC based Human Resources management.
- Information systems that enables management and the improvement plan.
- True collaborative practice.
- Re-invigorated physician peer review process.
- Definition and commitment to the vision of KDMC and its' programs and services.
- Communication, communication, communication – inside and out.

Section II – General Operations / Organizational Structure

NAVIGANT CONSULTING

Section II – General Operations / Organizational Structure

1. Governance
   - Interviews
   - Prioritized Summary of Recommendations
   - Introduction

Governance > Interviews

• Hospital Administrators	Harbor-UCLA Medical Center Olive View-UCLA Medical Center
• T.Garthwaite, MD	Los Angeles County Dept. of Health Services (DHS)
• F. Leaf	Los Angeles County Dept. of Health Services (DHS)
• J. Wallace	Los Angeles County Dept. of Health Services (DHS)
• L. Kapur and Others	Los Angeles County Attorneys
• C. Hopper, MD	Chair, Steering Committee on the Future of King/Drew Medical Center (SCFKDMC)
• H. Flores, MD	Chair, KDMC Advisory Board (KDMCAB) and Member SCFKDMC
• M. Drake, MD	VP for Health Affairs, University of CA System, Member, KDMCAB and Member, SCFKDMC
• W. Myers, MD	Member, SCFKDMC
• S. Drew Ivey	Member, SCFKDMC
• Yolanda Vera	LA Health Collaborative

Governance > Prioritized Summary of Recommendations

Governance		
Intermediate	2.1.01	BOS should continue to explore the feasibility of creating a Health Authority to govern the entire County health system.
Urgent	2.1.02	BOS, DHS, KDMC and Drew University should publicly reaffirm their commitment to the joint goal of creating and sustaining a truly collaborative partnership in support of their common clinical and academic missions.
Urgent	2.1.03	BOS should immediately designate the KDMC Advisory Board as the entity responsible for oversight of KDMC, including the responsibility to oversee the clinical and educational programs of KDMC, reporting to the Supervisors on at least a quarterly basis.
Urgent	2.1.04	BOS should delegate to the KDMC Advisory Board the authority to act as the governing body for all functions required in JCAHO, CMS & licensure regulations.
Intermediate	2.1.05	The KDMC Advisory Board should develop a process to insure participation and ongoing input from the communities served by KDMC.
Short term	2.1.06	As soon as feasible, membership of the KDMC Advisory Board should be expanded and its responsibilities clearly delineated to enable it to fulfill its critical governance role on behalf of KDMC.
Short-term	2.1.07	The KDMC Advisory Board should meet at least monthly, and should receive its staff support from the office of the KDMC CEO.
Intermediate	2.1.08	The KDMC Advisory Board should be responsible to review, assess and make recommendations concerning, but not limited to, the critical areas identified in this report.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Governance > Prioritized Summary of Recommendations

Governance		
Short term	2.1.09	To discharge the articulated responsibilities, management must provide the KDMC Advisory Board timely and accurate clinical and financial information, including metrics to enable ongoing evaluation of KDMC's performance over time compared with best practice.
Urgent	2.1.10	Management must be charged with the clear responsibility to identify problems and to develop and implement plans to resolve deficiencies in a timely manner, with regular reports to the KDMC Advisory Board with respect to progress.
Urgent	2.1.11	The organizational reporting responsibility for the KDMC CFO should be moved back to the KDMC CEO in order to assure appropriate direction and management of financial controls, accounting and reporting.
Short-term	2.1.12	The KDMC Advisory Board should develop a committee structure that will enable it to effectively discharge its scope of responsibilities.
Intermediate	2.1.13	The KDMC Advisory Board should seek external expertise to assist in establishing a Board education and development program.
Short-term	2.1.14	County counsel should clarify Board legal issues including conflict of interest, public meeting requirements, confidentiality with respect to personnel issues and any related legal matters.

Governance > Introduction

- The cornerstone of a successful organization is the existence of a governing body and an oversight process that ensures effective and efficient management. In the post Enron era, board oversight of management and the organization's operations has been elevated to a new level of significance, with an emphasis on board of directors, management, and employee accountability and compliance with policies and procedures. Boards of directors are expected to validate the accuracy of information provided to them by management and to take aggressive, timely action to correct problems identified through their oversight efforts.
- In the hospital setting, corporate governance carries an additional level of responsibility. The hospital organization is one that provides health care services to patients who enter the doors of an institution and entrust their well being based on a confidence that the hospital and its employees will use their best efforts to provide appropriate, high quality patient care.
- Four critical factors for the successful oversight of an organization are:
  - Independence in decision-making.
  - Accurate and timely reporting.
  - Validation of reported information.
  - Empowerment to implement change.

Governance

Assessment

- It is with this perspective of corporate governance that Navigant Consulting, Inc (NCI) conducted its review of KDMC governance. As a precursor to identifying best practice for future corporate governance, NCI reviewed the historical and current oversight structure, reporting mechanisms, information exchange, and Los Angeles County Department of Health Services (DHS) policies and procedures. In addition, NCI reviewed legal, political, and operational factors that impacted oversight in the past and that are likely to influence governance in the future.
- The Los Angeles County Board of Supervisors (BOS) is the entity that is responsible for the oversight and governance of Los Angeles County (LAC) hospitals and has the ultimate responsibility for DHS. Currently, DHS appoints the CEO, Medical Director and other hospital administrators.
- Concurrent with the start of this project, the organizational reporting structure for the KDMC Chief Financial Officer (CFO) was moved from the KDMC CEO to the DHS CFO.
- BOS has delegated responsibilities similar to those of a typical hospital board of directors to DHS. Therefore, the DHS Medical Director, the DHS COO, and their senior reports are responsible for review of corporate governance documents submitted by each County hospital and are also responsible to regularly meet with management to discuss hospital operations.

Governance

Assessment

- NCI asked DHS personnel, County Legal Department representatives and hospital management to identify obstacles that they perceive undermined the historical governance of KDMC. The issues identified as most problematic included:
  - Civil service employment system.
  - Organized labor issues.
  - Drew Medical School issues.
  - Difficulty in attracting capable management personnel.
  - Inability to provide incentives for employee performance.
  - Employee performance, skills, and attitude.
  - “Politics”
- Although each of these issues had a critical impact on KDMC corporate governance and day-to-day operations, political interference appeared to be the most disruptive factor .
- According to DHS, KDMC management and employees have effectively used political intervention to influence both corporate governance and day-to-day operational decisions.

Governance

Assessment

- In recent years, BOS have requested and received several reports on alternative forms of governance and management of the County's health system. On December 13, 2001 a report was presented by the Chief Administrative Officer (CAO) on how BOS could implement reforms to provide DHS with more flexibility on budgetary, personnel and contracting matters. On September 1, 2002 BOS received a report from the CAO outlining an action plan and a three- to five-year timetable for converting to five alternative health governance models. On February 5, 2002 BOS received a report from an Ad Hoc Hearing Body on Governance suggesting that BOS undergo a process for enhancing revenue before considering governance changes.
- In May 2003 a report was prepared by the School of Policy, Planning & Development of the Keck School of Medicine, University of Southern California. The report, entitled "An Analysis of Alternative Governance for the Los Angeles County Department of Health Services," was funded through a grant from the John Randolph Haynes and Dora Haynes Foundation. The report contained a detailed analysis of current and potential governance models, and recommended new governance, specifically a health authority, "to help stabilize the County health care system, improve efficiency, and attract new revenue."

Governance

Assessment

- The LA Health Collaborative is currently embarking on a review of governance options for the entire DHS health system, with funding provided by the California Endowment. This study is expected to utilize the reports identified above, along with the recommendations included in this report, as it proceeds with work. NCI staff have offered to collaborate with the LA Health Collaborative in its efforts.
- There is an entity entitled "Governing Body" that has been convened by the Director of DHS and chaired by the KDMC CEO. Additional attendees of the monthly meeting include the COO of DHS, President of the Professional Staff Association (PSA), KDMC Medical Director, and other administrative and medical staff representatives from KDMC. These meetings appear to relate primarily to medical staff issues. There is insufficient detail in the reporting to this body of clinical outcomes and financial results, and metrics are not consistently defined for each reporting topic that would enable this entity to evaluate the hospital's reported performance as compared to expected, best practice performance levels. In addition, this body is not appropriately constituted to serve as a governing board.

Governance

Assessment

- There is a Joint Planning and Operations Council (JPOC) consisting of KDMC representatives: CEO, Medical Director, a chairman/chief of service and CFO; along with representatives of Drew University: President, Executive Vice President, Dean of the School of Medicine, CFO, and the Associate Dean for Graduate Medical Education This group is chaired by the Hospital's Medical Director, and meets monthly. It functions reasonably effectively as a communications forum for issues jointly affecting the hospital and the University, but does not serve in a governance role.
- A KDMC Advisory Board has been constituted with a charge to "accelerate the development and implementation of effective structural and operational reforms at KDMC." The Advisory Board is chaired by a community physician who is affiliated with White Memorial Medical Center. Its membership includes a former Surgeon General of the US, along with representatives of UCLA, USC, the UC System, and the Hospital Association of Southern CA. The DHS Director and representatives of NCI participated in the first two, primarily organizational, meetings of the Advisory Board. With clarified delegation of responsibility and expanded membership, this Board could form the basis of an effective governing body.

Governance

Assessment

- Provision of high quality patient care services at KDMC will only be assured if BOS, DHS, KDMC, and Drew University create and sustain a truly collaborative partnership in support of their common clinical and academic missions.
- The creation of a Health Authority is likely to require considerable time to evaluate, plan and execute. However, many of the recommendations contained in this report cannot be achieved without a strengthening of governance.

Governance

Deficiencies

- It is clear that the historical KDMC governance process has been ineffective in ensuring quality health care and resolving operational issues.
- The KDMC governance structure lacks independence and does not receive accurate and timely management reports. Further, there is an absence of management and physician leadership accountability, resulting in a failure to maintain high quality patient services.
- A governance structure should be created to overcome these obstacles. Such an oversight body must be empowered to make change and must remain independent from the political interference experienced in the past.
- While the long term solution of the creation of a health authority is being considered, an interim step is needed to immediately place KDMC under the governance of a more independent and knowledgeable Board.

Governance

Recommendations

2.1.01 BOS should continue to explore the feasibility of creating a Health Authority to govern the entire County health system..

2.1.02 BOS, DHS, KDMC and Drew University should publicly reaffirm their commitment to the joint goal of creating and sustaining a truly collaborative partnership in support of their common clinical and academic missions.

2.1.03 BOS should immediately designate the KDMC Advisory Board as the entity responsible for oversight of KDMC, including the responsibility to oversee the clinical and educational programs of KDMC, reporting to the Supervisors on at least a quarterly basis.

2.1.04 BOS should delegate to the KDMC Advisory Board the authority to act as the governing body for all functions required in JCAHO, CMS & licensure regulations.

2.1.05 The KDMC Advisory Board should develop a process to insure participation and ongoing input from the communities served by KDMC.

Governance

Recommendations

2.1.06 As soon as feasible, membership of the KDMC Advisory Board should be expanded and its responsibilities clearly delineated to enable it to fulfill its critical governance role on behalf of KDMC.

- Three ex officio members with vote (Dean of Drew School of Medicine, President of the PSA, and Director of DHS).
- The KDMC CEO as ex officio member, without vote.
- Three to seven additional members who have demonstrated expertise and experience in finance, business, hospital or clinic management, health plan administration, and/or health and public policy. The members so appointed should have a clear commitment to the provision of high quality health care to underserved populations.
- The Advisory Board should also develop a process to ensure participation and ongoing input from the communities served by KDMC.
- Initial appointments to the Advisory Board should be for three-year terms. In its first year, the Advisory Board should develop a succession plan.

2.1.07 The KDMC Advisory Board should meet at least monthly, and should receive its staff support from the office of the KDMC CEO.

Governance

Recommendations

2.1.08 The KDMC Advisory Board should be responsible to review, assess and make recommendations concerning, but not limited to, the critical areas identified in this report.

- Quality of care, patient safety, clinical outcomes, malpractice experience, patient satisfaction and compliance with regulatory and accreditation requirements.
- Medical staff credentialing, peer review, privileging and reappointment processes.
- Affiliation Agreement terms and conditions to ensure that involved parties clearly commit to the dual mission of patient care and teaching at KDMC and that expectations are clarified with respect to the scope of clinical and academic services to be provided; physician staffing levels, time allocations, and time reporting methodologies; and medical accountability for individual and collective physician performance related to the quality of medical services.
- Graduate medical education (GME) programs to include residency supervision, adherence to Residency Review Committee and ACGME program requirements, adequacy of clinical experience and opportunities to strengthen programs through collaboration with other academic medical centers and/or schools of medicine.
- Definition of programs and services consistent with available resources, community needs, and KDMC's clinical and academic missions.

Governance

Recommendations

2.1.08 The KDMC Advisory Board should be responsible to review, assess and make recommendations concerning, but not limited to, the critical areas identified in this report. (cont'd)

- Development of a Strategic Plan, capital facilities plan, five-year financial plan and operating budget, including a requested appropriation from BOS to meet the current operating and capital needs of KDMC consistent with its mission and vision.
- Development of an Information Technology Plan consistent with KDMC clinical and business strategy.
- Financial performance consistent with annually approved operating budget and productivity standards, as well as expense reduction, clinical resource management and revenue cycle initiatives.
- Oversight of hospital business practices, policies and procedures that influence the quality of care and/or impede efforts to provide care in the most cost effective manner possible
- Appointment of KDMC executives including recommendation of an individual to serve as the permanent KDMC chief executive officer (CEO).
- Human Resources (HR) with respect to recruitment and retention, market driven compensation and benefits, labor contract terms and conditions, employee training and orientation, supervisor/employee relations, management development, performance evaluations, and workers' compensation experience.

Governance

Recommendations

2.1.08 The KDMC Advisory Board should be responsible to review, assess and make recommendations concerning, but not limited to, the critical areas identified in this report. (cont'd)

- Recommendations for specific relief from County policies and procedures which impede management's efforts to provide high quality, cost effective clinical services.
- Oversight of the interim management and implementation services provided by NCI.

2.1.09 To discharge the articulated responsibilities, management must provide the KDMC Advisory Board timely and accurate clinical and financial information, including metrics to enable ongoing evaluation of KDMC's performance over time compared with best practice.

2.1.10 Management must be charged with the clear responsibility to identify problems and to develop and implement plans to resolve deficiencies in a timely manner, with regular reports to the KDMC Advisory Board with respect to progress.

2.1.11 The organizational reporting responsibility for the KDMC CFO should be moved back to the KDMC CEO in order to assure appropriate direction and management of financial controls, accounting and reporting.

Governance

Recommendations

2.1.12 The KDMC Advisory Board should develop a committee structure that will enable it to effectively discharge its scope of responsibilities.

2.1.13 The KDMC Advisory Board should seek external expertise to assist in establishing a Board education and development program.

2.1.14 County counsel should clarify Board legal issues including conflict of interest, public meeting requirements, confidentiality with respect to personnel issues and any related legal matters.

Section II – General Operations / Organizational Structure

2. Management/Structure
   - Interviews
   - Prioritized Summary of Recommendations
   - Organizational Structure
   - Communications

NAVIGANT CONSULTING

Management / Structure > Interviews

- Senior Management Team
- Department Directors
- Clinical Chairs
- DHS Communication Office

NAVIGANT CONSULTING

Management / Structure > Prioritized Summary of Recommendations

Management / Structure		
Urgent	2.2.01	Consolidate management positions and roles as appropriate, and re-align reporting relationships to promote improved decision-making and implementation along with ongoing oversight (see proposed organizational charts).
Urgent	2.2.02	Institute a process for identification of prioritized goals and objectives for individuals based on roles and corresponding responsibility and authority.
Short-term	2.2.03	Identify a disciplined performance management process ensuring ongoing objective feedback against established goals and objectives.
Urgent	2.2.04	Identify and institute an appropriate management meeting structure to enhance collaboration and cooperation among hospital departments.
Short-term	2.2.05	Identify appropriate vehicles to increase collaboration and problem solving across clinical services.
Short-term	2.2.06	Establish a disciplined consistent systems for effective meeting components, i.e., agenda development, minutes, data collection and analyses to support an effective decision-making process.
Urgent	2.2.07	Establish and monitor accountabilities by individual for day-to-day operational performance.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Management / Structure > Prioritized Summary of Recommendations

Communications		
Urgent	2.2.08	DHS to re-locate at a minimum one half-time position to support all communication efforts for the hospital. While on-site this position should report to the CEO/COO for setting priorities.
Short-term	2.2.09	Establish standards for presentation to ensure quality of presentation, clarity of message and content.
Short-term	2.2.10	Publish an employee/staff newsletter, at a minimum once a month, in a standardized format.
Short-term	2.2.11	Proactively manage media relations with the public as change occurs and positive results are documented. Enhance communications with the press, such as meeting with their editorial boards to foster beneficial relationships.
Urgent	2.2.12	Require department directors to meet on a regular basis with their staff members on all shifts to ensure proper flow of information.
Short-term	2.2.13	Develop a comprehensive communication plan. Identify key stakeholders/audiences, define messages and the type of media to be used.
Short-term	2.2.14	Increase visibility and accessibility of leadership/management and an open communication culture by instituting executive rounds and staff forums.
Short-term	2.2.15	Broadly disseminate information to staff in a format that it easy to follow and react to, especially when dealing with regulatory issues.

Management / Structure > Management/Organizational Structure

Assessment

- Organizational Structure:
  - The role of Interim Hospital Administrator for KDMC has been filled by an Interim CEO.
  - The CEO reports to the DHS Chief Operating Officer and has seven direct reports.
    - Medical Director
    - Chief Nursing Officer
    - Administrative Director, Quality Management/Regulatory Programs
    - Chief Operating Officer
    - Chief Financial Officer
    - Chief Information Officer
    - Administrator HHHCHC & Health
  - The COO has eight direct reports in the following areas:
    - Outpatient and Psychiatric Services
    - Emergency Services/Trauma
    - Medical Services
    - Hospital Social Services
    - Value Analysis Facilitator
    - Plant Management (currently filled with an interim position from the County)
    - Environmental Safety

Management / Structure > Management/Organizational Structure

Assessment

- Lack of a comprehensive strategic plan.
- Individuals do not have goals and objectives.
- There is not enforcement of a disciplined evaluation process.
- Responsibilities of management staff are not consistent or predictable.
- Current management structure does not facilitate an efficient/effective decision-making process.
- Responsibility and authority for making decisions is not always clear.
- Often times, the management team functions in a crisis mode; resulting from a lack of planning, direction, and delayed decision-making.
- Critical situational analyses and decision-making is not always evident.
- Managers are not required to be fiscally responsible for their departments.
- Managers have little or no input into the budget process resulting in a lack of accountability and ownership.
- Limited use of data analysis in decision-making.

Management / Structure > Management/Organizational Structure

Deficiencies

- There is no comprehensive strategic planning.
- Lack of overall responsibility and accountability by management for the decision-making process and routine operations.
- There is a failure to develop systems to gather, analyze, and apply basic industry-wide standards and data elements to the decision-making process; and in setting strategic goals for KDMC.

Management / Structure > Management/Organizational Structure

Recommendations

2.2.01 Consolidate management positions and roles as appropriate, and re-align reporting relationships to promote improved decision-making and implementation along with ongoing oversight (see proposed organizational charts).

2.2.02 Institute a process for identification of prioritized goals and objectives for individuals based on roles and corresponding responsibility and authority.

2.2.03 Identify a disciplined performance management process ensuring ongoing objective feedback against established goals and objectives.

2.2.04 Identify and institute an appropriate management meeting structure to enhance collaboration and cooperation among hospital departments.

2.2.05 Identify appropriate vehicles to increase collaboration and problem solving across clinical services.

2.2.06 Establish a disciplined consistent systems for effective meeting components i.e., agenda development, minutes, data collection and analyses to support an effective decision-making process.

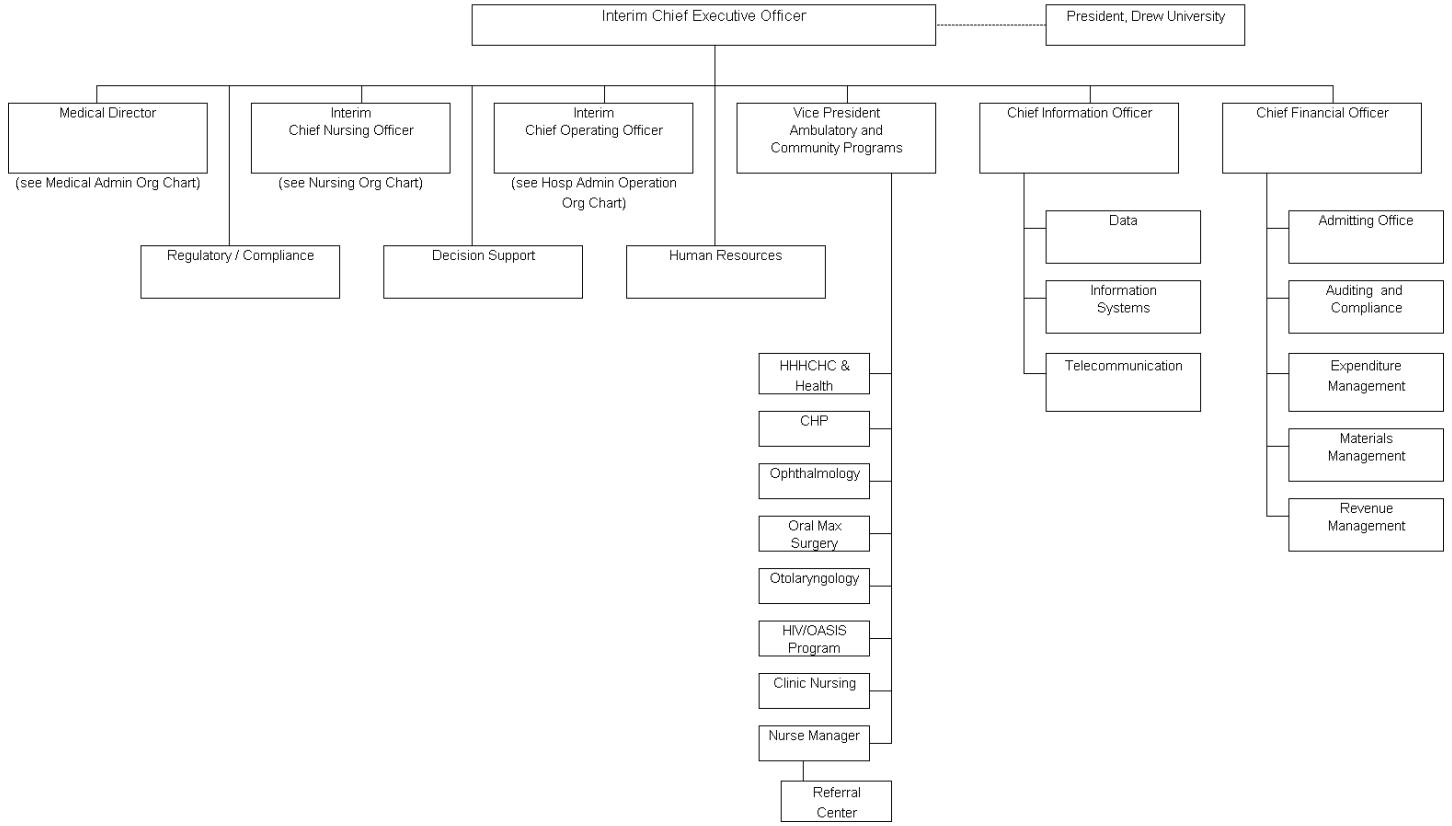
2.2.07 Establish and monitor accountabilities by individual for day-to-day operational performance.

Management / Structure > Organizational Structure

Proposed Organizational Chart: Hospital Administration

Draft 1/29/05

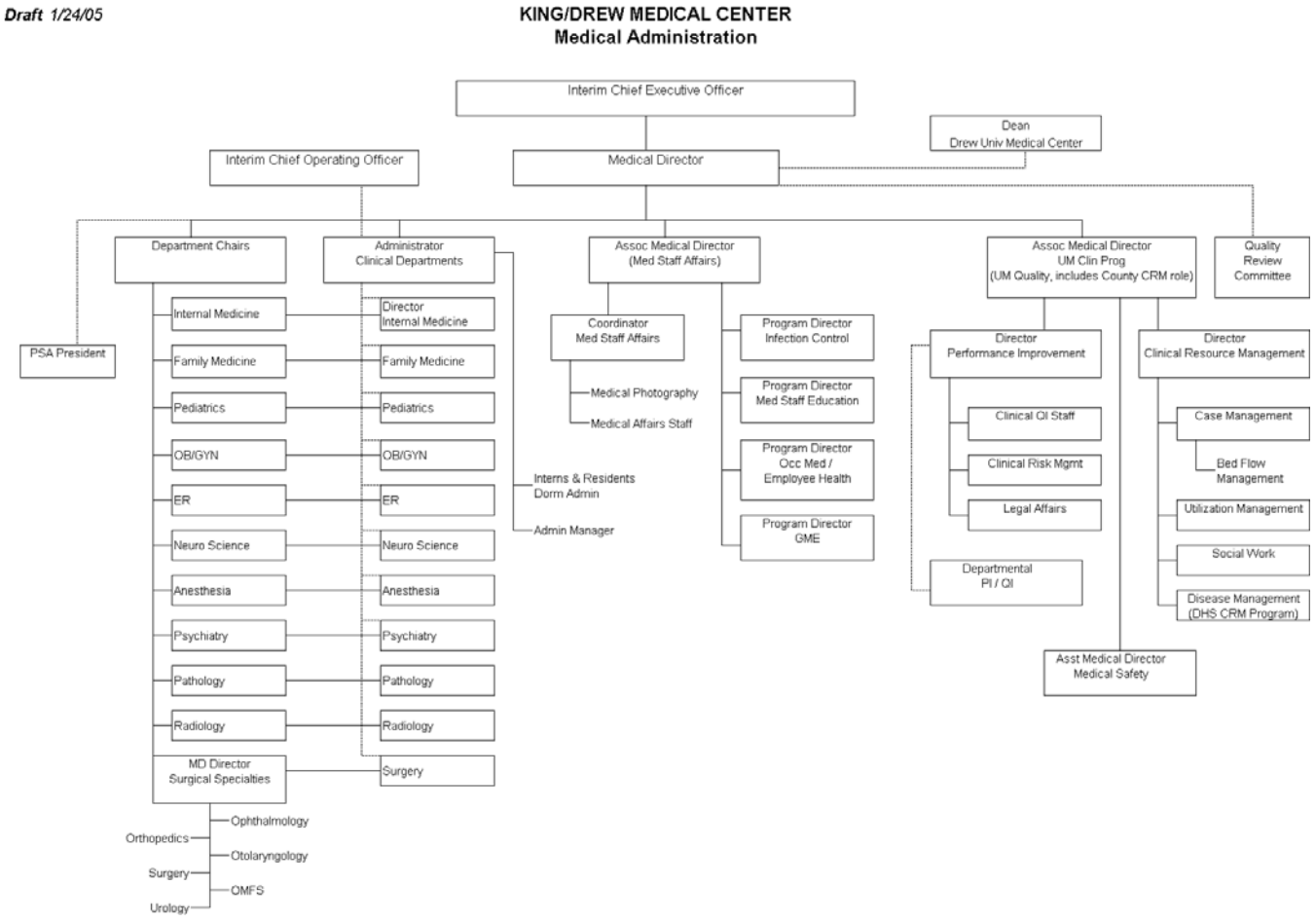
KING/DREW MEDICAL CENTER
Hospital Administration



NAVIGANT CONSULTING

Management / Structure > Organizational Structure

Proposed Organizational Chart: Medical Administration

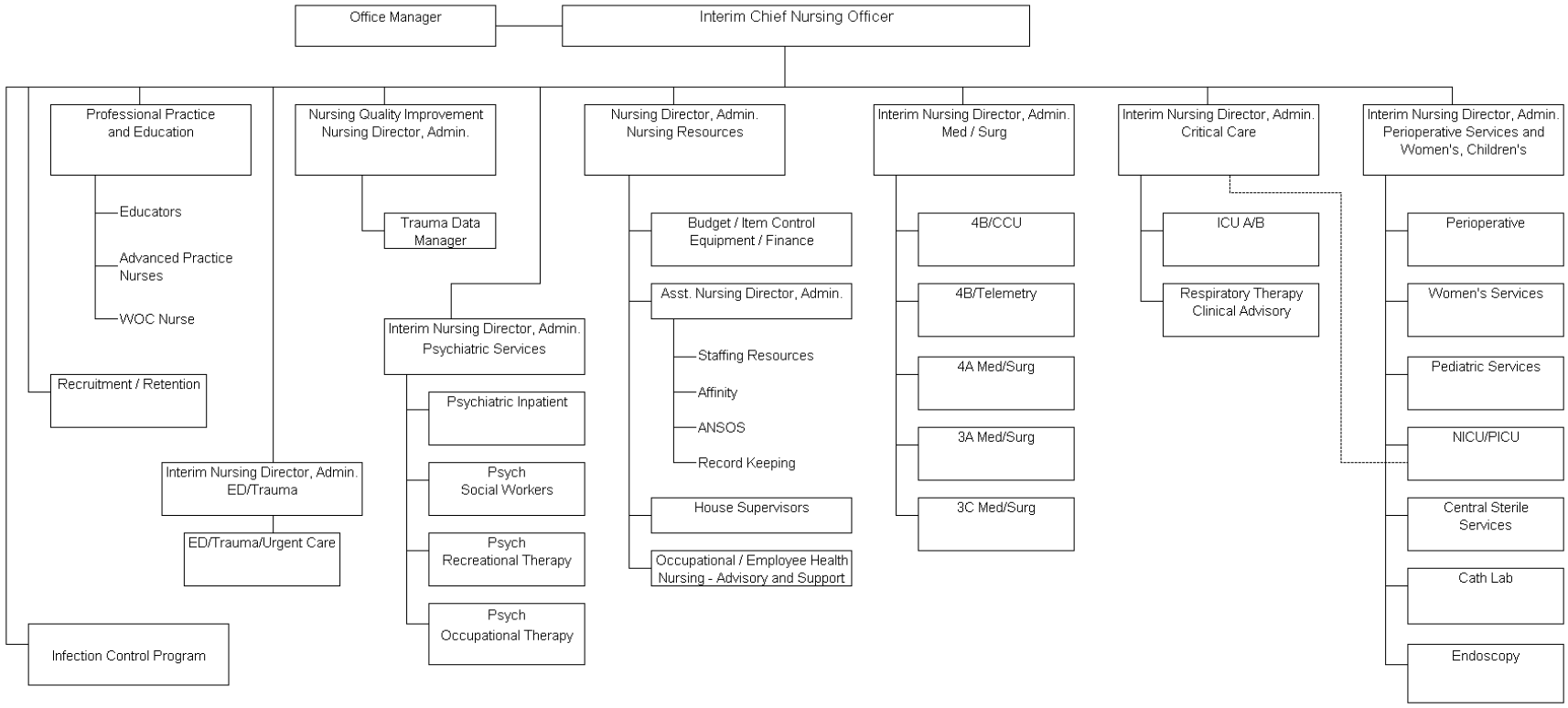


NAVIGANT CONSULTING

Proposed Organizational Chart: Nursing Service

Draft *12/21/04*

KING/DREW MEDICAL CENTER
Nursing Services



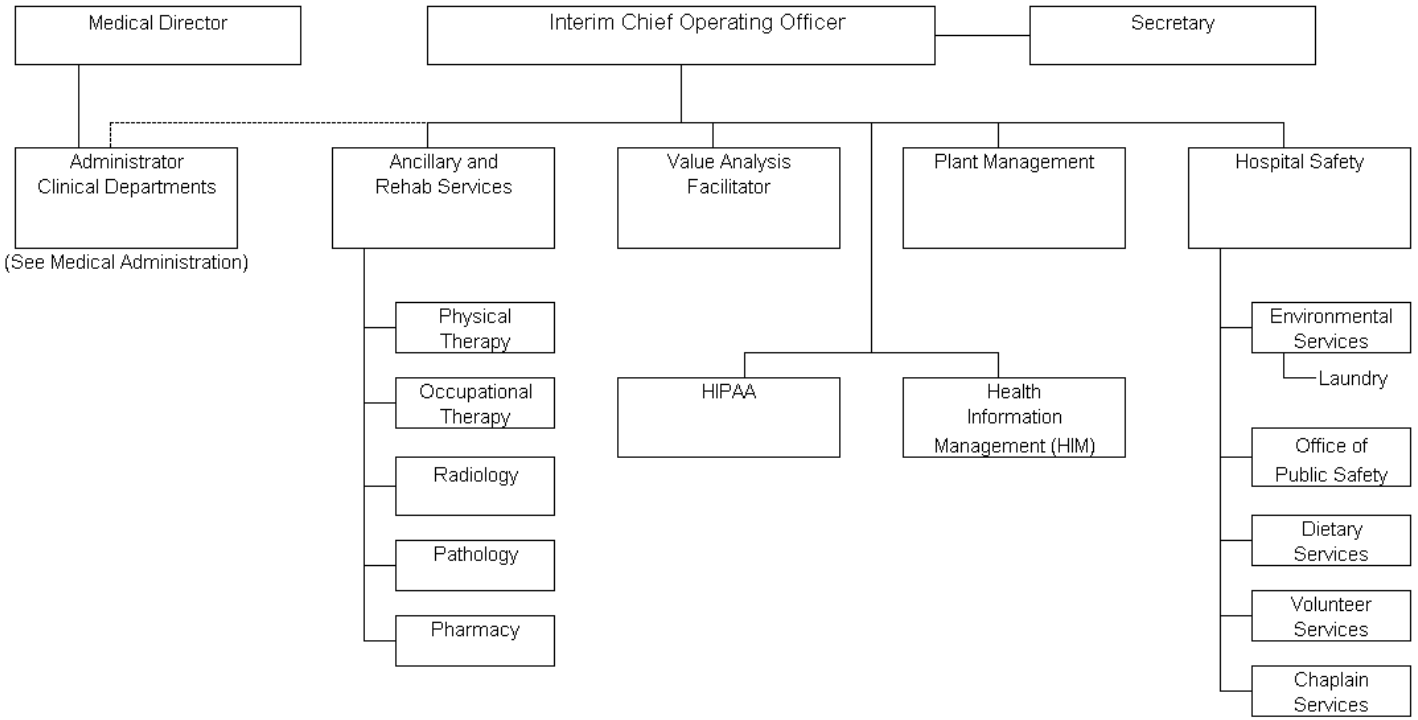
NAVIGANT CONSULTING

Management / Structure > Organizational Structure

Proposed Organizational Chart: Operations

Draft 1/29/05

KING/DREW MEDICAL CENTER
Hospital Administration Operations



NAVIGANT CONSULTING

Management / Structure > Communications

Assessment

- There is a DHS Director for Communications.
- There is no overall communication plan.
- Internal Communications:
  - There is a regular DHS-wide newsletter “Connections.” It is distributed with paychecks at the mid-month pay date with two poster size copies for posting in employee areas.
  - There is no facility specific newsletter. No resources are currently available but DHS could provide some support.
  - Forums or staff meetings are not consistently held.
  - Information on the organization’s performance on regulatory surveys has been closely held by senior management and has not been widely communicated to middle management and staff who are integral to the resolution of the issues.

Management / Structure > Communications

Assessment

- External Communications:
  - Communication with the public, when it does occur, is decentralized throughout the organization with individual departments either distributing flyers, posting notices or contacting community groups on an ad hoc basis.
  - There are no standards that have been established and distributed to ensure uniformity of presentation in regard to branding, content of message and means of appropriate distribution.
  - Media relations is perceived by many to operate in a reactive mode to negative coverage as opposed to being proactive in creating positive story-lines and getting good news out to the public through the media.
  - Media relations is currently centralized in the offices of DHS. Many have a limited understanding of how best to access and use this resource.
  - The organization is reactionary rather than proactive with respect to communicating with regulatory agencies.

Management / Structure > Communications

Deficiencies

- Failure to be proactive in communicating with the media, the public and employees, and a lack of clarity in message and mode of delivery.
- Lack of resources to ensure timely and consistent communication in support of organizational goals and needs, as in resolving regulatory issues and meeting the needs of those served.
- No comprehensive communication plan.
- Some DHS support resources but no local communication resources.

Management / Structure > Communications

Recommendations

2.2.08 DHS to re-locate at a minimum one half-time position to support all communication efforts for the hospital. While on-site this position should report to the CEO/COO for setting priorities.

2.2.09 Establish standards for presentation to ensure quality of presentation, clarity of message and content.

2.2.10 Publish an employee/staff newsletter, at a minimum once a month, in a standardized format.

2.2.11 Proactively manage media relations with the public as change occurs and positive results are documented. Enhance communications with the press, such as meeting with their editorial boards to foster beneficial relationships.

2.2.12 Require department directors to meet on a regular basis with their staff members on all shifts to ensure proper flow of information.

2.2.13 Develop a comprehensive communication plan. Identify key stakeholders/audiences, define messages and the type of media to be used.

2.2.14 Increase visibility and accessibility of leadership/management and an open communication culture by instituting executive rounds and staff forums.

2.2.15 Broadly disseminate information to staff in a format that it easy to follow and react to, especially when dealing with regulatory issues.

Management / Structure

Responsibility

- KDMC Senior Management Team
- DHS Leadership
- DHS Communication Office

Section II – General Operations / Organizational Structure

3. Risk Management
   - Interviews
   - Prioritized Summary of Recommendations

Risk Management > Interviews

• E. Bradley	Risk Manager
• C. Black, MD	Advisor to Medical Director
• P. Price	Chief Nursing Officer
• L. Knight, Ph.D.	Administrative Director, Quality Management/Regulatory Programs
• L. Sarff	Director, Quality Improvement Program, DHS
• R. Peeks, MD	Medical Director

Risk Management > Prioritized Summary of Recommendations

Risk Management		
Short-term	2.3.01	Review and revise the risk management process.
Long-term	2.3.02	Plan and present regular educational programs to clinical and administrative departments.
Urgent	2.3.03	Review and revise the incident reporting policies and procedures.
Short-term	2.3.04	Educate all health care providers on the complete hospital incident reporting procedures.
Short-term	2.3.05	Establish a procedure that ensures the Report of Incident Forms and other significant incidents are reviewed on an ongoing basis by appropriate departments and committees.
Short-term	2.3.06	Ensure and monitor that each service reviews and analyzes all reported incidents on an on going basis and reports trends and corrective actions.
Intermediate	2.3.07	Institute a program to improve relationships between patients and providers to learn techniques for increasing patient satisfaction.
Short-term	2.3.08	Ensure an effective, comprehensive informed consent process.
Short-term	2.3.09	Ensure all health care providers comply with federal, state and municipal rules and regulations.
Short-term	2.3.10	Review all confidentiality policies and procedures and ensure compliance.
Short-term	2.3.11	Ensure that all discussion of patient related information is conducted in appropriate locations.
Urgent	2.3.12	Review policies regarding patient related information and ensure compliance.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Risk Management > Prioritized Summary of Recommendations

Risk Management		
Short-term	2.3.13	Ensure meetings to discuss patients are conducted in appropriate locations and materials distributed should be collected and not left for members of the general public to find.
Short-term	2.3.14	Ensure all health care providers are familiar with patients' rights under state law and hospital policy and observe them at all times.
Short-term	2.3.15	Ensure that appropriate assistance is provided to patients including the use of an interpreter, to ensure that patients understand their rights.
Intermediate	2.3.16	Ensure appropriate policies and procedures are followed for patients to review and or obtain a copy of their medical record.
Intermediate	2.3.17	Identify a process for patients, or appropriate family members, to be informed promptly about unexpected and/or negative outcomes.
Short-term	2.3.18	Ensure that policies and procedures ion the use of restraints are followed and documented.
Short-term	2.3.19	Ensure that policies and procedures are followed when a patient refuses treatment including his/her voluntary decision to be prematurely discharged.
Intermediate	2.3.20	Develop key metrics for hospital performance and track on a monthly basis.
Intermediate	2.3.21	Implement the UHC database and standardize performance measures to benchmark performance.

Risk Management

Assessment

- There is a staff of two FTEs, consisting of a director, one professional attorney, and one clerical staff.
- The director and attorney report directly to the Chief Medical Officer (CMO).
- The scope of the risk management function primarily involves the management of medical liability cases.
- There is minimal emphasis on education and prevention. There is also minimal involvement in general liability management.
- The department interfaces with clinical departments, all services involved in quality reviews, medico-legal services, County counsel, and others.
- There is little automation of claims; although access to the organization's performance measurement system vendor, University Healthcare Consortium's (UHC) database is in process County-wide.
- The quality of the working relationships between the departments of Risk Management, Quality Management (QM), Nursing, Clinical Resource Management (CRM), and others is observed to be contentious.
- There is a formal incident-reporting process; but reports are inconsistently routed to risk management. In addition, while individual cases are reviewed, aggregate data is not developed or reviewed for trends or clusters.

Risk Management

Assessment

- There is no database to capture claims or incident reports; and no integration of information with quality, safety, credentialing, or privileging activities.
- The legal function consists primarily of interfacing with the malpractice administrator and orchestrating reviews to consider settlements.
- The risk manager reports incidents by location/unit and include all occurrence types.

Incident By Location Data: Incidents by Occurrence Type
Number/Volume of Occurrences

	January, 2004	February, 2004	March, 2004	April, 2004	May, 2004	June, 2004	July, 2004	August, 2004	September, 2004	October, 2004
Decubitus	12	19	17	12	11	10	8	6	9	12
Medication Event	14	11	78	24	15	10	25	22	12	10
Patient Fall	8	10	7	14	4	10	11	3	4	10
Delay in Treatment	10	12	6	17	14	10	5	5	1	2
IV Infiltrate	1	1	0	5	1	4	4	3	1	0
Treated/Discharged/Returned	1	1	0	0	0	1	0	1	0	0
Total # of Incidents (All Occurrence Types)	243	227	335	277	257	218	246	302	178	176

*The % Total Incidents for each occurrence type is the number of instances for that occurrence type over the total # of incidents (all occurrence types) as reported on the Incident by Location report).

Source: KDMC Incident by Location Reports (January, 2004 through October, 2004)
Provided by Elcedo Bradley (KDMC Risk Manager)

- A recent enhancement installed by UHC provides attending physician-specific data on performance of core measure activities. This feature will provide peer review data for the credentialing and privileging process.

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Risk Management

Deficiencies

- There is poor compliance with incident reporting of policies and procedures.
- There is little emphasis on education and risk prevention.
- There is little coordination among Risk Management and other departments involved in quality review, safety, or credentialing.
- Steps taken after an event occur are not integrated into a comprehensive prioritized plan.
- There are multiple reactive plans.
- The approach is not multi-disciplinary nor proactive.
- There is little automation to help organize data and recognize trends.
- There is almost no attention paid to issues of general liability.
- There is no mechanism to inform senior management of unanticipated events in a timely manner and to appropriately respond to these events.
- Executive staff and middle management staff are having difficulty in getting access to incident reports and aggregate data.

Risk Management

Recommendations

2.3.01 Review and revise the Risk Management process.

- The process should include a mechanism and correct situations or problems, which may give rise to events or incidents of potential liability for the hospital, its employees, physicians and other healthcare providers.

2.3.02 Plan and present regular educational programs to clinical and administrative departments, which includes:

- Orientation of new employees, including Medical Staff, residents and nurses.
- Continuing education in the form of in-service programs regarding medical-legal and risk management related subjects.
- Special seminars or conferences for target audiences in response to particular risk management problems.

2.3.03 Review and revise the incident reporting policies and procedures.

- Identify steps taken after an event or incident occurs to minimize the adverse impact, financial or otherwise, of the event or incident on the patient, the hospital and its staff. Include involvement and input from a number of the medical and administrative staff throughout the hospital.

2.3.04 Educate all healthcare providers on the complete hospital incident reporting procedures.

Risk Management

Recommendations

2.3.05 Establish a procedure that ensures the Report of Incident Forms and other significant incidents are reviewed on an ongoing basis by appropriate departments and committees. This review process allows for:

- Identification and documentation of trends within service(s) and those that cross over services, which might affect policies or procedures.
- Recognition and identification of hospital-wide programs to correct identified problems
- Assessment of conformance to required standards of practice and care.

2.3.06 Ensure and monitor that each service reviews and analyzes all reported incidents on an on going basis and reports trends and corrective actions.

2.3.07 Institute a program to improve relationships between patients and providers to learn techniques for increasing patient satisfaction.

2.3.08 Ensure an effective, comprehensive informed consent process.

Risk Management

Recommendations

2.3.09 Ensure all health care providers comply with federal, state and municipal rules and regulations, including:

- Preventing and reporting communicable diseases.
- Universal blood and body fluid precautions.
- Needlestick precautions.
- Proper medical waste disposal.

2.3.10 Review all confidentiality policies and procedures and ensure compliance.

2.3.11 Ensure that all discussion of patient related information is conducted in appropriate locations.

2.3.12 Review policies regarding patient related information and ensure compliance.

2.3.13 Ensure meetings to discuss patients are conducted in appropriate locations and materials distributed should be collected and not left for members of the general public to find.

2.3.14 Ensure all health care providers are familiar with patients' rights under state law and hospital policy and observe them at all times.

Risk Management

Recommendations

2.3.15 Ensure that appropriate assistance is provided to patients including the use of an interpreter, to ensure that patients understand their rights.

2.3.16 Ensure appropriate policies and procedures are followed for patients to review and or obtain a copy of their medical record.

2.3.17 Identify a process for patients, or appropriate family members, to be informed promptly about unexpected and/or negative outcomes.

2.3.18 Ensure that policies and procedures ion the use of restraints are followed and documented.

2.3.19 Ensure that policies and procedures are followed when a patient refuses treatment including his/her voluntary decision to be prematurely discharged.

2.3.20 Develop key metrics for hospital performance and track on a monthly basis.

2.3.21 Implement the UHC database and standardize performance measures to benchmark performance.

2.3.22 Provide instruction to staff on reportable errors. Create a non-punitive culture to encourage self-reporting.

Risk Management

Responsibility

- CEO
- Medical Director
- Risk Manager

Section II – General Operations/Organizational Structure

4. Regulatory
   - Interviews
   - Prioritized Summary of Recommendations
   - Compliance Profile
   - Structure, Leadership and Oversight
   - Process

Regulatory > Interviews

- L. Knight — Administrative Director, Quality Management/Regulatory Programs
- R. Peeks, MD — Medical Director
- P. Valenzuela — Lead Administrator, Ancillary & Rehab Services
- P. Price — Acting Chief Nursing Officer
- M. Lang — Interim Clinical Nursing Director
- P. Rodriguez — Nursing Quality Improvement
- E. Bradley — Risk Management Director
- V. Simpson — Risk Manager
- H. Jones — Director, Health Information Management
- M. McClure — Chief Information Officer
- S. Abrams — Nursing Finance
- L. Russeau — Patient Safety Officer
- M. Villaflor — Medical Staff Coordinator

- Six Performance Improvement Specialists from Quality Improvement

Regulatory > Prioritized Summary of Recommendations

Regulatory – Structure, Leadership and Oversight		
Urgent	2.4.01	Institute a regulatory readiness committee that meets weekly.
Urgent	2.4.02	Develop and aggressively implement a detailed action plan.
Urgent	2.4.03	Resurrect/reinvigorate JCAHO Functional Committees.
Short-term	2.4.04	Develop and provide a dashboard of the organization's level of regulatory compliance to the BOS.
Urgent	2.4.05	Ensure that future executive management is educated on regulatory responsibilities.
Urgent	2.4.06	Educate Medical Staff on their responsibilities related to regulatory compliance.
Urgent	2.4.07	Formalize executive patient safety walk rounds.
Short-term	2.4.08	Implement a Human Resource philosophy and policy that recognizes the difference between culpability and blamelessness. Change organizational culture.
Urgent	2.4.09	Coach medical staff division chiefs.
Urgent	2.4.10	Develop expectations and an accountability structure.
Urgent	2.4.11	Provide senior leadership with measures to assess the effectiveness of individuals responsible for the regulatory compliance program.
Urgent	2.4.12	Provide a senior consultant to coach Administrative Director, Quality Management/Regulatory Programs in effectively managing the regulatory compliance process.
Short-term	2.4.13	Provide staff with information related to the hospitals' philosophy regarding regulatory compliance.
Urgent	2.4.14	Develop and maintain a system to track all licensures/certifications/accreditations in a central repository.
Urgent	2.4.15	Revise the Regulatory compliance reporting structure.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Regulatory > Prioritized Summary of Recommendations

Regulatory – Process		
Urgent	2.4.16	Utilize PI Analysts to educate management staff on root cause analysis and strategies to perform objective, critical assessments of organizational performance.
Urgent	2.4.17	Disseminate the results of regulatory and accreditation surveys to middle management and staff with an assignment of responsibility for corrective actions.
Urgent	2.4.18	Coach management staff to develop substantive corrective actions that treat deficiencies with hard-wired approaches and at the root cause level rather than the symptoms.
Urgent	2.4.19	Structure a formal mechanism to follow-up on corrective actions and to track current status of planned improvements.
Short-term	2.4.20	Facilitate coordination and integration between all hospital-wide functions through the encouragement of teamwork and collaboration.
Short-term	2.4.21	Revise the hospital-wide staff orientation and ongoing education program.
Short-term	2.4.22	Implement a formal process to create, approve, disseminate, educate, and reinforce new or revised policies and procedures, and to assess staff compliance.
Short-term	2.4.23	Implement an effort to internally and publicly promote the organization's accomplishments and advances in improving the safety and quality of care.

Regulatory > Compliance Profile

Assessment

- KDMC's recent regulatory compliance history includes:
  - Preliminary denial of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation due to a series of surveys with marginal to poor outcomes dating back to February 12, 2004.
  - Loss of JCAHO accreditation is anticipated in mid to late January 2005.
  - Recent difficulty with Centers for Medicare and Medicaid Services (CMS) dates back to:
    - January 2004: Complaint Validation survey during which CMS removed JCAHO deemed status and placed KDMC under California Department of Health Services jurisdiction.
    - March 2004: Complaint investigation relating to medication errors. CMS found an immediate threat to patient safety and proceeded with immediate jeopardy termination.
- The organization has been surveyed and inspected by regulatory and accrediting bodies almost monthly over the past 12 months.
- Due to the volume of recent surveys and the subsequent submission of plans of correction to regulatory and accrediting agencies, the organization has been in a reactionary rather than proactive mode as it relates to regulatory preparedness and compliance.
- The organization has committed to implementing volumes of corrective actions with CMS and JCAHO without accountability or tracking mechanisms.

Regulatory > Compliance Profile

Assessment

- There is a pervasive belief that the organization is being “set up“ for closure through poor reviews by regulatory and accrediting agencies.
- The organization’s staff have assumed the role of victim with respect to regulatory agencies.
- Previously-submitted JCAHO and CMS corrective action plans have not fully addressed the deficiencies. The organization failed to implement, evaluate, re-assess and identify measures of success related to the performance of functions and processes that are necessary to continuously improve the quality of patient care.

Regulatory > Structure, Leadership and Oversight

Assessment

- Administrative Director, Quality Management/Regulatory Programs (Director) maintains oversight responsibility for the organization's regulatory compliance efforts and co-ordinates all of the hospital's regulatory activities.
- The Director has administrative responsibility for:
  - Regulatory compliance
  - Performance Improvement
  - Hospital policy and procedure development
  - Maintenance and distribution of hospital policies
- The Director administratively reports directly to the Chief Executive Officer.
- The Director's attention is spread over too many programs, resulting in a lack of focus on either performance improvement or regulatory compliance.
- The Director feels powerless to execute change and, as a result, has become less effective in her role.
- The Director has not been held accountable for driving improvements within the organization nor has she educated her superiors on the expectations they should set.

Regulatory > Structure, Leadership and Oversight

Assessment

- The Director is not effective under the current structure. If focused solely on performance improvement regulatory compliance, the Director is more likely to be effective. The structure of the regulatory compliance oversight process is as follows:
  - Compliance with JCAHO standards is assessed on an ongoing basis by JCAHO Functional Committees. Each of these multi-disciplinary committees is responsible for assessing compliance with an individual chapter of JCAHO standards (a function). Each committee meets monthly and identifies the nature of the organization's non-compliance.
  - The results of these committees' assessments are forwarded to the appropriate departments/staff who are tasked with developing and implementing a plan of correction.
  - These results are also reported to the Ancillary Performance Improvement Committee, which meets quarterly.
  - The results and recommendations are then forwarded to the hospital's Improving Organizational Performance (IOP) Committee, then to the Medical Executive Committee (MEC), and ultimately, BOS.

Regulatory > Structure, Leadership and Oversight

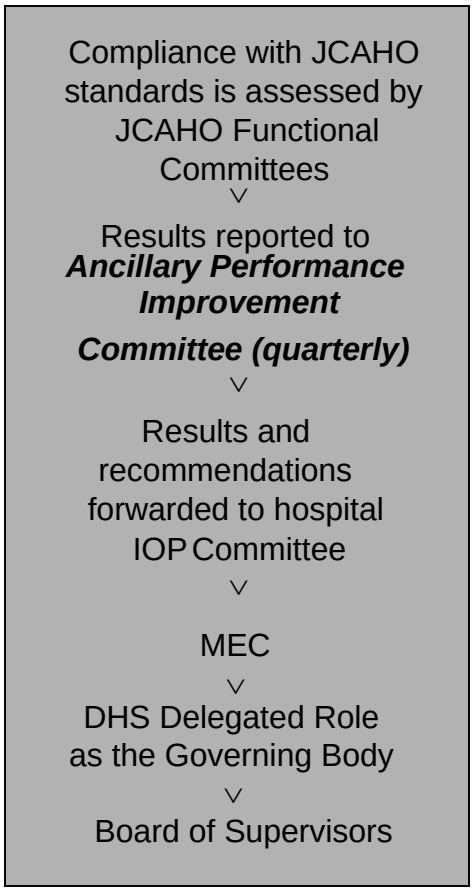
Assessment

- Until early 2004, the assessment results emanating from the JCAHO Functional Committees were reported to a Joint Commission Oversight and Assessment Committee rather than the Ancillary Performance Improvement Committee. This committee was disbanded by hospital leadership as its function was perceived to be redundant with that of the Ancillary Performance Improvement Committee.
- The agenda of the Ancillary Performance Improvement Committee is routinely overloaded with reports on individual performance improvement efforts, as well as reports from the JCAHO Functional Committees; resulting in lengthy meetings.
- The effectiveness of the JCAHO Functional Committees has diminished over the past few years due to the increased turnover of the staff who participate in these committees.
- The established structure calls for departments to provide quantitative feedback to the JCAHO Functional Committees on their success in implementing improvements and a trending of their performance in that area.
- The assessments of the JCAHO Functional Committees have not been acted upon due to weak leadership at the department manager level. Lack of follow-through in developing and implementing plans of correction was especially evident with the nurse managers and the Chief Nursing Officer (CNO).

Regulatory > Structure, Leadership and Oversight

Assessment

- Current regulatory compliance reporting structure.



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Regulatory > Structure, Leadership and Oversight

Assessment

- Previous senior management has provided minimal leadership to the organization's regulatory compliance efforts.
  - There has been little support and assistance by senior management for requests by the various committees to follow-up with departments on the status of implementing plans of correction.
  - Previous interim senior management has not been aggressive in holding middle management accountable for providing evidence of improvement or for compliance with regulatory and accreditation requirements.
  - Such efforts have been further hampered by frequent and significant turnover of organizational leadership at the senior level and the lack of stable, effective leadership within Nursing and other hospital departments.
- The regulatory compliance function and hospital departmental operations are divorced from one another.
  - Information does not flow into the regulatory compliance process from hospital operations.
  - The department managers are not held accountable for regulatory compliance.
- Medical staff chairs, though formally reporting through the hospital CMO, are held directly accountable by the Dean.

Regulatory > Structure, Leadership and Oversight

Assessment

- Though interested in clinical medicine and committed to providing quality care, the department chairs place greater emphasis on academic endeavors than on oversight of individual physician performance.
- An organizational culture exists that assigns blame to and rationalizes medical error rather than emphasizing error reduction and embracing a non-punitive environment.
  - The organization lacks a well-defined approach towards balancing individual accountability with system or process failures.
  - There has been little or no education of hospital staff on efforts to improve patient safety.
- Due to the volume of recent surveys and the subsequent submission of plans of correction, the organization has fallen into a defensive position with regulatory agencies and has not been proactive in assuring regulatory compliance.
- Responsibility for maintaining and tracking all of the organization's licenses, certifications, and accreditations has not been centralized.
- DHS has an Office of Quality Improvement (QI), which can provide minimal support in helping the organization achieve regulatory compliance.
  - In the past, staff from this office have lent an objective eye to help the organization assess its compliance with regulatory requirements.
  - This service is currently not being utilized by KDMC.

Regulatory > Structure, Leadership and Oversight

Deficiencies

- Ineffective oversight of clinical activities supporting compliance with regulatory requirements as evidenced by the impending loss of JCAHO Accreditation and requirement to enter into a memorandum of understanding (MOU) with CMS and continued failure to ensure the organization's continued compliance with regulatory requirements.
- Lack of coordination with Charles R. Drew School of Medicine and response to the recommendations, requirements and citations of their Graduate Medical Education residency review committees.
- Lack of oversight by previous senior management and the BOS of the quality of care and compliance with regulatory and accreditation requirements.
- Failure to integrate the regulatory compliance process into hospital operations and performance improvement goals.
- Lack of accountability of Medical Staff chairs for individual and collective physician performance.
- Failure to make patient safety and continuous quality improvement a priority in the eyes of hospital and Medical Staff.
- Reactive rather than proactive approach with respect to regulatory compliance.
- Lack of an organized system to assign responsibility for assuring compliance with all of the organization's licensure, certification, and accreditation requirements.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.01 Institute a Regulatory Readiness Committee that meets weekly.

- This committee will be chaired by the Chief Operating Officer and staffed by the Administrative Director, Quality Management/Regulatory Programs.
- Membership will include executive management, the Medical Staff, Nursing, Human Resources, and representatives of the Ancillary/Support IOP Committee.
- The Committee's charge would be to track the organization's progress in achieving compliance with regulatory requirements, prepare for regulatory surveys, and to hold individuals accountable for continuous compliance.
- Progress reports will be submitted to the IOP Committee monthly, with reports to the MEC also occurring monthly.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.02 Develop and aggressively implement a detailed action plan that identifies and resolves regulatory deficiencies identified by JCAHO, CMS, and NCI consultants. Resolution of deficiencies will address the systemic causes of non-compliance and include:

- Policy and procedure development.
- Staff education.
- Implementation of new and revised practices.
- Use of performance measures to gauge improvements.
- Daily tracking of progress in fulfilling the Action Plan with reporting to hospital's senior management on a weekly basis.

2.4.03 Resurrect/re-invigorate JCAHO Functional Committees (mock survey standards teams).

2.4.04 Develop and provide a dashboard of the organization's level of regulatory compliance to the BOS.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.05 Ensure that future executive management is educated on their responsibilities relative to regulatory compliance, performance improvement and healthcare safety through:

- Executive coaching.
- Education on regulatory requirements.
- Establishing and fulfilling accountabilities surrounding regulatory compliance.
- Providing a consistent flow of information on the organization's level of regulatory compliance.

2.4.06 Educate Medical Staff on their responsibilities related to regulatory compliance.

2.4.07 Formalize executive patient safety walk rounds, including a formal feedback mechanism to promote an organizational culture of safety.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.08 Implement a human resources philosophy and policy that recognizes the differences between individual culpability and blamelessness, such as that described by James Reason in Managing the Risks of Organizational Accidents (see attached algorithm page 72).

- Educate frontline managers who deal with errors and provide staff with feedback on efforts to reduce the risk of error.

2.4.09 Coach Medical Staff division chiefs to assess individual physician performance and to initiate appropriate action. Use external reviewers as appropriate.

2.4.10 Develop expectations and an accountability structure to hold middle management accountable for regulatory compliance, patient safety and performance improvement.

2.4.11 Provide senior leadership with measures to assess the effectiveness of individuals responsible for the regulatory compliance program.

- Identify qualities of an effective regulatory compliance process.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.12 Provide a senior consultant to coach Administrative Director, Quality Management/Regulatory Programs in effectively managing the regulatory compliance process.

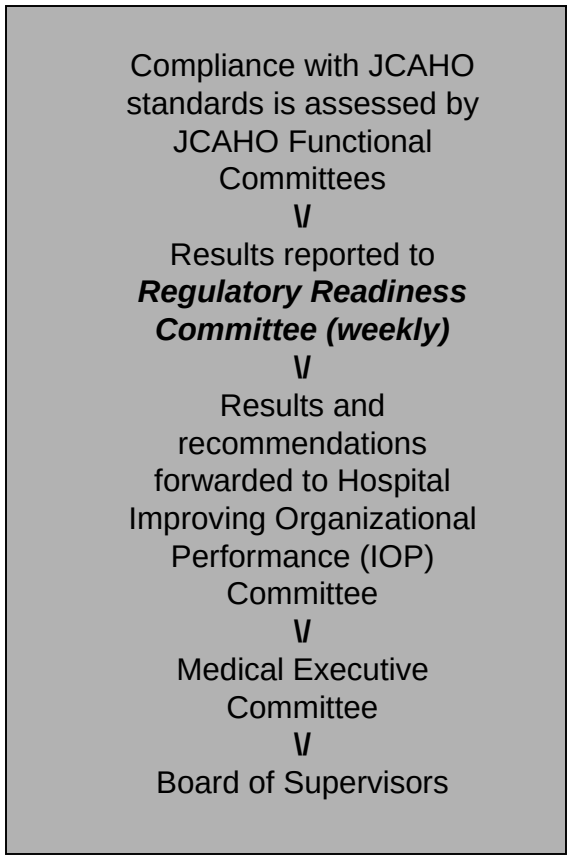
2.4.13 Provide staff with information and education related to the hospital's philosophy that regulatory compliance is a natural result of effective hospital operations and management and not a stand-alone activity.

2.4.14 Develop and maintain a system to track all licensures, certifications, accreditations in a central repository in the office of QI. Identify individuals responsible for compliance with each regulatory body.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.15 Revise the regulatory compliance reporting structure.



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Regulatory > Process

Assessment

- The organization's internal assessment of its performance has failed to identify and proactively respond to significant lapses in compliance with regulatory requirements.
- Information on the organization's performance on regulatory surveys has been closely held by senior management. Department management have not been involved in the development of the corrective action plan and have not had the opportunity to provide suggestions for process improvements.
- Development of superficial corrective actions with lack of follow-through on identified corrective actions and mechanism to track current status of planned improvements.
- Deterioration in the organization's ability to adhere to established policies, procedures, and systems.
- Ineffective hospital-wide staff orientation and ongoing education system.
- Lack of reports to BOS that capture pertinent quality/patient safety activities of the organization.
- Performance of the system's, processes and infrastructure that supports the organization's ability to satisfy regulatory and accreditation requirements has deteriorated over time.
- Attention to basic clinical practice and staff competence has declined over time.
- There is a public and professional perception that quality is poor and will not change.

Regulatory > Process

Deficiencies

- Lack of a critical self-assessment of organizational performance.
- Department management is not engaged in resolving deficiencies cited by regulatory agencies.
- The organization has not been successful in implementing correction action plans developed in response to regulatory and accreditation surveys.
- The effectiveness of the organization's performance improvement initiative and Infection Control effort has diminished over time.
- Lack of coordination and integration between hospital-wide functions; such as Infection Control, risk management, and performance improvement.

Regulatory > Process

Recommendations

2.4.16 Utilize PI Analysts to educate management staff on root cause analysis and strategies to perform objective, critical assessments of organizational performance.

2.4.17 Disseminate the results of regulatory and accreditation surveys to middle management and staff with an assignment of responsibility for corrective actions.

2.4.18 Coach management staff to develop substantive corrective actions that treat deficiencies with hard-wired approaches and at the root cause level rather than the symptoms.

2.4.19 Structure a formal mechanism to follow-up on corrective actions and to track current status of planned improvements.

2.4.20 Facilitate coordination and integration between all hospital-wide functions through the encouragement of teamwork and collaboration.

2.4.21 Revise the hospital-wide staff orientation and ongoing education program.

2.4.22 Implement a formal process to create, approve, disseminate, educate, and reinforce new or revised policies and procedures, and to assess staff compliance.

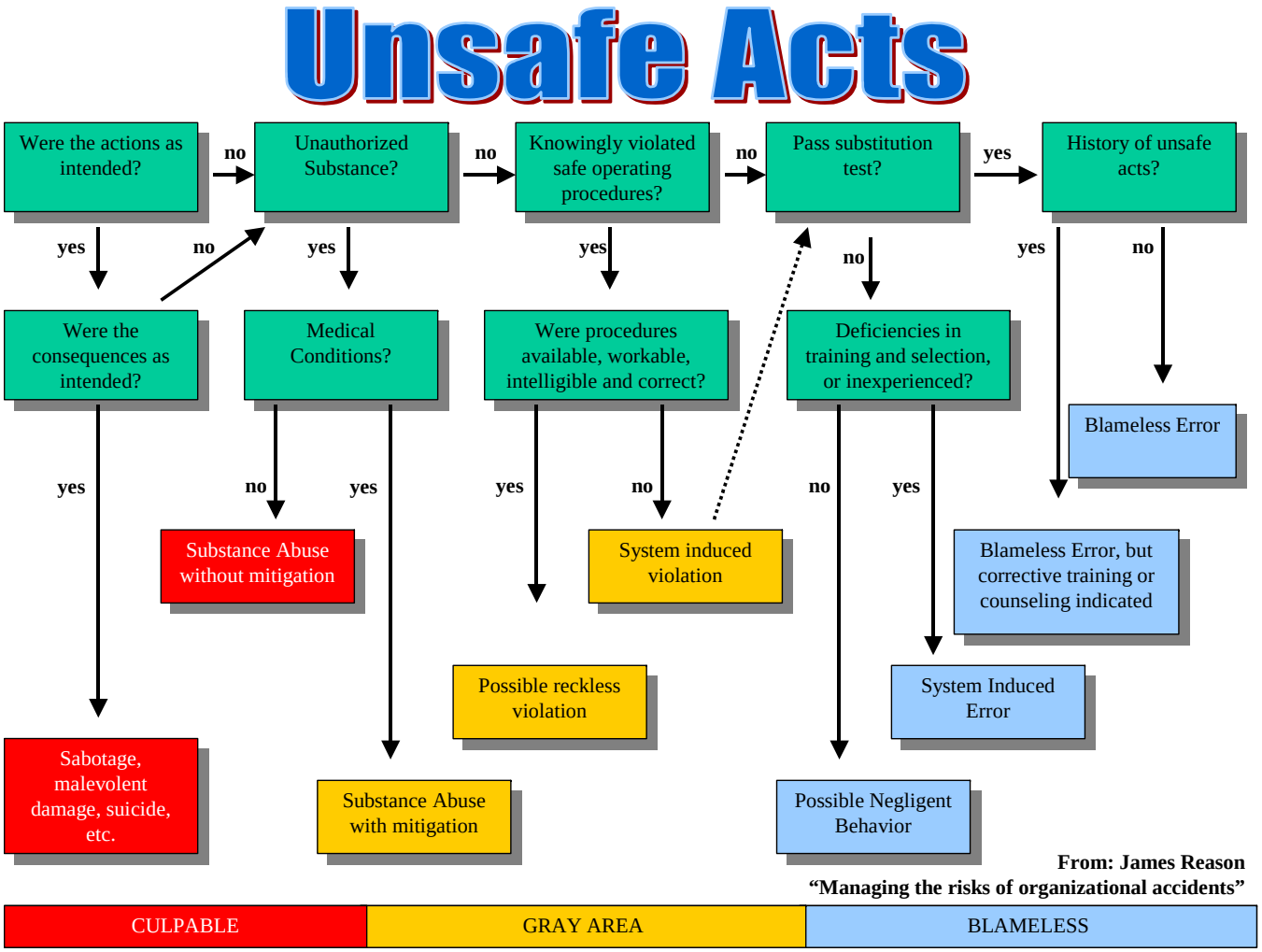
2.4.23 Implement an effort to internally and publicly promote the organization's accomplishments and advances in improving the safety and quality of care.

Regulatory

Responsibility

- CEO
- Administrative Director, Quality Management/Regulatory Programs

Regulatory > Managing the Risks of Organizational Accidents



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Section II – General Operations/Organizational Structure

5. Performance and Quality Improvement
   - Interviews
   - Prioritized Summary of Recommendations
   - Structure, Leadership and Oversight
   - Staffing and Process
   - Tools, Measurement and Technology
   - Patient Satisfaction

Performance and Quality Improvement > Interviews

• L. Knight	Administrative Director, Quality Management/Regulatory Programs
• R. Peeks, MD	Medical Director
• P. Valenzuela	Lead Administrator, Ancillary & Rehab Services
• P. Price	Acting Chief Nursing Officer
• M. Lang	Interim Clinical Nursing Director
• P. Rodriguez	Nursing Quality Improvement
• E. Bradley	Risk Management Director
• V. Simpson	Risk Manager
• H. Jones	Director, Health Information Management
• M. McClure	Chief Information Officer
• S. Abrams	Nursing Finance
• L. Russeau	Patient Safety Officer
• M. Villaflor	Medical Staff Coordinator
• M. Hernandez	Former COO
• F. Robinson	ITC / Nursing Administration

Performance and Quality Improvement > Interviews

- S. Mitchell — Staff / Nursing Administration
- C. Nalls — Ambulatory Care Administration
- J. Johnson — Staff / Ambulatory Administration
- C. Cahill — Materials Management / Olive View Medical Center

- Six Performance Improvement Specialists from Quality Improvement

Performance and Quality Improvement > Prioritized Summary of Recommendations

Performance and Quality Improvement – Structure, Leadership and Oversight		
Urgent	2.5.01	Develop a quality oversight committee of the Board.
Urgent	2.5.02	At a minimum, revise IOP Committee membership to a 15 member group that assesses departmental PI reports.
Short-term	2.5.03	Develop and educate IOP Committee members on their responsibilities and charge.
Short-term	2.5.04	Separate out administrative responsibility for Regulatory Compliance from PI, each with a unique manager.
Short-term	2.5.05	Appoint a member of the medical staff to fulfill the Medical Safety Officer role.
Short-term	2.5.06	Charge a physician and advanced practice nurse to oversee core measure activities.
Urgent	2.5.07	Establish a PI manager role to facilitate oversight of department functions.
Short-term	2.5.08	Ensure there is a functioning, formal process and forum for reporting of sentinel events and root cause analyses.
Short-term	2.5.09	Realign reporting relationships of PI Director and Risk Manager.
Short-term	2.5.10	Establish a mechanism for dissemination of information from the IOP Committee to appropriate departments.
Short-term	2.5.11	Revise the Performance Improvement Plan to include the missing issues.
Short-term	2.5.12	Educate directors and managers on their PI responsibilities.
Urgent	2.5.13	Review and update Hospital Plan for the provision of care and departmental scopes.
Staffing and Process		
Urgent	2.5.14	Restructure the hospital-wide IOP Committee is shown in this report.
Short-term	2.5.15	Educate department management and staff on essential PI tools and strategies.
Short-term	2.5.16	Define accountabilities with middle managers related to PI.
Short-term	2.5.17	Identify a clear charge to all PI teams and monitor their progress.
Short-term	2.5.18	Require each department to have PI as part of their department meeting discussion.
Short-term	2.5.19	Incorporate educator position into quality department or train PI specialists to educate hospital-wide staff on PI tools.
Short-term	2.5.20	Provide standardized education to all levels of staff on PI goals.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Performance and Quality Improvement > Prioritized Summary of Recommendations

Staffing and Process		
Urgent	2.5.21	Review and/or revise the policies on the National Safety goals.
Short-term	2.5.22	Develop Human Resource staffing measures.
Short-term	2.5.23	Develop oversight for an organized and systematic approach to performance measurement in Nursing.
Short-term	2.5.24	Pilot a new method of starting PI on a nursing unit to evaluate the process.
Short-term	2.5.25	Revise the PI model based on the pilot results and implement the model on all units.
Short-term	2.5.26	Assign Nursing department responsibility for data collection and analysis relative to restraint use.
Short-term	2.5.27	Establish regular meeting with Nursing and the newly-designated hospital PI coordinator to assure that nursing is measuring their performance on the appropriate indicators and that the data is being assessed and used to improve performance.
Short-term	2.5.28	Provide instruction to staff on reportable errors. Create a non-punitive culture to encourage self-reporting.
Short-term	2.5.29	Educate staff on their responsibilities related to organ procurement.
Short-term	2.5.30	Provide initial and ongoing staff education for performance improvement and medical safety activities.
Urgent	2.5.31	Identify all opportunities for a root cause analysis to the PI department in a timely manner (as soon as they happen).
Short-term	2.5.32	Hold division chiefs accountable for evaluating physician performance and making reappointment recommendations.
Urgent	2.5.33	Assign responsibility for processes that cross departmental boundaries and lack an identified owner.
Short-term	2.5.34	Provide administrative and data support to the peer review process.
Short-term	2.5.35	Evaluate the effectiveness of Medical Staff Department PI efforts.
Short-term	2.5.36	Conduct a formal review and mentor the process of all case reviews.
Short-term	2.5.37	Retrain and mentor medical staff chairs in the expectations and process to conduct effective peer review.

Performance and Quality Improvement > Prioritized Summary of Recommendations

Tools, Measurement and Technology		
Short-term	2.5.38	Mentor QI and PI analysts.
Short-term	2.5.39	Implement the use of standardized PI tools.
Short-term	2.5.40	Develop forms for the monthly reporting of data and easy reading of the data.
Short-term	2.5.41	Develop a measure for patient falls and establish a rate.
Short-term	2.5.42	Develop a daily multidisciplinary tool for compliance assessment and other JCAHO/CMS citations.
Short-term	2.5.43	Begin to track and trend risk management data.
Short-term	2.5.44	Develop a tool to measure reporting of all deaths within two-hour timeframe.
Short-term	2.5.45	Standardize the performance measurement process by implementing scientific methodology to develop measures.
Short-term	2.5.46	Implement a PI data analysis system.
Intermediate	2.5.47	Review departmental staffing to provide for a data analyst position within the existing staffing complement.
Urgent	2.5.48	Use Cactus computer program module in medical staff office for physician peer review.
Short-term	2.5.49	Investigate using Nursing Data Indicator Quality Program.
Short-term	2.5.50	Measure and track compliance to the National Patient Safety goals and measures.
Patient Satisfaction		
Short-term	2.5.51	Establish formal leadership responsibility along with logistics in result report distribution and follow-up process.
Intermediate	2.5.52	Investigate an opportunity to utilize an outside vendor to measure patient satisfaction.
Short-term	2.5.53	Investigate with DHS the use of a consistent vendor across all county facilities to facilitate peer hospital comparisons.
Short-term	2.5.54	Utilize the County-wide outpatient survey result available for individual hospitals.

Performance and Quality Improvement > Structure, Leadership and Oversight

Assessment

- Administrative Director, Quality Management/Regulatory Programs (Director) has administrative responsibility for:
  - Regulatory compliance.
  - Performance Improvement.
  - Hospital policy and procedure development.
  - Maintenance and distribution of hospital policies.
- The Director administratively reports directly to the Chief Executive Officer.
- The Director's attention is spread over too many programs, resulting in a lack of focus on performance improvement.
- Previous senior management did not support the regulatory program.
- The Director is overwhelmed with too many responsibilities under the current structure. If focused solely on performance improvement or regulatory compliance, the Director is more likely to be effective.

Performance and Quality Improvement > Structure, Leadership and Oversight

Assessment

- The medical safety officer role is currently being held by one of the performance improvement specialists.
  - The County is to appoint a medical safety officer for each of the County hospitals.
- Nursing has a separate function that went several months without reporting to the Performance Improvement Committee.
- Integration and coordination of risk management activities with performance improvement is not occurring.
- The performance improvement plan describes the scope, structure, objectives, methodology, and evaluation of the performance improvement process. While the plan addresses many essential elements, the priorities for the hospital are not clearly defined nor does the plan address the reduction of hospital errors.
- The hospital plan for the provision of care and department scopes of care were last revised and approved by the executive team in 2003.
- New performance improvement initiatives are established and assigned a strategic priority by the Hospital Performance Improvement Committee.
- Data is not being reported into the Performance Improvement Committees.

Performance and Quality Improvement > Structure, Leadership and Oversight

Assessment

- There is no mechanism to identify, inform senior management, and respond to unanticipated events.
- Executive staff and middle management staff are having difficulty in getting access to incident reports and aggregate data.
- The current structure of the hospital-wide IOP Committee is as follows:

Feature	Current Structure
Membership Size	28 members
Membership	All clinical areas (both Medical Staff and non-Medical Staff departments).
Attendance	All 28 members do not attend each monthly meeting. In addition to the core committee members, only representatives from the departments scheduled to report are in attendance.
Reporting	Departments report on the outcomes of their performance improvement efforts and on variances in practice on a rotating basis.
Information Flow	The results of the IOP Committee are presented to the MEC on a **quarterly** basis and subsequently to the Board.

Performance and Quality Improvement > Structure, Leadership and Oversight

Assessment

- A performance improvement analyst is assigned to assist those departments that are struggling with implementing a change.
- The organization's core measures are:
  - Community-Acquired Pneumonia
  - Acute Myocardial Infarction
  - Congestive Heart Failure
- The summary results of core measure data are reported to the MEC and the respective Medical Staff departments. No actions are taken in response to this data.

Performance and Quality Improvement > Structure, Leadership and Oversight

Deficiencies

- There is an absence of an effective, QI Board Committee to provide oversight of the hospital IOP Committee.
- Lack of effective, dedicated oversight and accountability of performance improvement program.
- Risk management, safety, and performance improvement activities are not well coordinated.
- Lack of oversight by Nursing staff for performance improvement indicators pertaining to Nursing.
- Oversight by the hospital-wide IOP Committee needs to be strengthened to hold individuals accountable for improvements.
- The hospital plan for the provision of care and department scopes of care are now considered outdated.

Performance and Quality Improvement > Structure, Leadership and Oversight

Recommendation

2.5.01 Develop a quality oversight committee of the Board.

2.5.02 At a minimum, revise IOP Committee membership to a 15 member group that assesses departmental PI reports.

2.5.03 Develop and educate IOP Committee members on their responsibilities and charge.

2.5.04 Separate out administrative responsibility for Regulatory Compliance from PI, each with a unique manager.

- Transition performance improvement activities to medical administration, with a director of performance improvement.
- Supporting quality management staff reporting to the Associate Medical Director for utilization management and clinical programs.

2.5.05 Appoint a member of the medical staff to fulfill the Medical Safety Officer role.

2.5.06 Charge a physician and advanced practice nurse to oversee core measure activities.

Performance and Quality Improvement > Structure, Leadership and Oversight

Recommendation

2.5.07 Establish a PI manager role to facilitate oversight of department functions.

2.5.08 Ensure there is a functioning, formal process and forum for reporting of sentinel events and root cause analyses.

2.5.09 Realign reporting relationships of PI Director and Risk Manager.

2.5.10 Establish a mechanism for dissemination of information from the IOP Committee to appropriate departments.

2.5.11 Revise the Performance Improvement Plan to include the missing issues.

2.5.12 Educate directors and managers on their PI responsibilities.

2.5.13 Review and update Hospital Plan for the provision of care and departmental scopes.

Performance and Quality Improvement > Staffing and Process

Assessment

- The quality management/regulatory programs' staff consists of:
  - One Director
  - Six performance improvement analysts
    - Five of the six analysts have achieved Certified Professional in Healthcare Quality (CPHQ) status from the Healthcare Quality Certification Board of the National Association for Healthcare Quality (NAHQ).
  - One Clerk
  - The analysts' responsibilities include:
    - Abstracting and reviewing clinical documentation for performance improvement studies.
    - Identifying cases for peer review.
    - Initiating and coordinating root cause analyses.
    - Providing education to hospital & house staff on Performance Improvement and Patient Safety
  - Each analyst is responsible for coordinating the performance improvement activities of at least one Medical Staff Department.
  - The analysts are generally competent at performing their activities.
  - By comparison with other 200-bed facilities, the quality management/regulatory programs is overstaffed.

Performance and Quality Improvement > Staffing and Process

Assessment

- Current Performance Improvement (PI) Process:
  - The organization uses the Focus PDCA performance improvement model to plan, design, measure, and improve patient care and processes.
  - The important key functions that are being monitored and evaluated are identified in each department.
  - Department heads/service chiefs are to assist their department staff in selecting key functions or services to be evaluated in departmental PI activities.
  - Additionally, key functions or services are to be identified for improvement in an interdisciplinary setting (e.g., Medical Staff Committees or task forces).
  - While priorities for organizational performance improvement activities are to be established collaboratively by organizational leadership, there is little evidence of such goal setting.
  - Data collection is to consists of selecting:
    - Data source(s)
    - Data collection method
    - Appropriateness of sampling
    - Time frame for data collection
    - Process for comparing the level of performance

Performance and Quality Improvement > Staffing and Process

Assessment

- Current PI Process: (cont)
  - Empirical data is to be collected to determine if:
    - Design specification of a new process was met.
    - Level of performance and stability of important existing processes.
    - Priorities for possible improvement of existing processes.
    - Actions to improve the performance pf processes.
    - Whether changes in the process resulted in improvement.
  - While data is collected and reported monthly on performance improvement initiatives, departments often table their report to the IOP committee. As a result, measures that were to be tracked were reported to the committee when specified.
  - For inter-disciplinary performance improvement efforts, the Performance Improvement Committee determines which department will coordinate the data collection.
  - There is little evidence that statistical quality control techniques and variation are used when appropriate.
  - Absolute levels of benchmarks that are based on appropriate standards are not consistently utilized in evaluating important, single-clinical events; or in identifying the level or patterns/trends in care or outcomes.

Performance and Quality Improvement > Staffing and Process

Assessment

- Current PI Process: (cont)
  - The following processes and clinical activities are not consistently used to measure and assessed when an undesirable variation in performance is detected:
    - Discrepancies or patterns of discrepancies between preoperative and postoperative diagnosis.
    - Transfusion reactions.
    - Adverse events, or patterns of adverse events during anesthesia use.
    - Behavior management processes and outcomes.
  - Opportunities to improve care or service identified through departmental monitoring are not consistently identified and addressed at departmental meetings, documented as such, and integrated into organizational PI activities.
  - Opportunities to improve care/service identified through interdisciplinary meetings are addressed and documented in committee meeting minutes.
  - The PI Committee reviews and prioritizes all such recommendations and makes the determination to assign a process action team to identify and implement actions to improve the process.
  - All information generated through this PI Process is reported through the monthly IOP Committee.

Performance and Quality Improvement > Staffing and Process

Assessment

- Current PI Process: (cont)
  - The results of PI efforts are not disseminated throughout the organization through:
    - Governing Body meeting minutes
    - MEC
    - Medical Staff Service/IOP Committee meetings
    - Story Boards
    - Process Action Team Committee minutes, process improvement team, department and services staff meetings
    - Management information bulletins
  - Actions taken are not assessed for effectiveness through continued monitoring.
  - The effectiveness of actions taken are not documented on the hospital-wide reporting tool and in appropriate departmental and committee meeting minutes.
  - The information is not shared throughout the organization.
  - Data is collected but not trended.
  - The validity of the data is suspect.

Performance and Quality Improvement > Staffing and Process

Assessment

- Outcomes, improvements and method to decrease adverse events are not occurring. There is a demonstrated lack of improvement noted with patient assessments:
  - Nutrition not being consistently assessed or referred to dietary.
  - Inconsistent pain assessment and reassessment.
  - Wound management not being carried out.
- Nursing indicators focused on patient outcomes for restraint use are lacking.
- The Nursing PI function reports through the hospital-wide PI Process.
- There is minimal reporting of medication errors by Nursing staff. Medication errors are most frequently identified and reported by the Pharmacy staff and reflect errors in ordering.
- The organization cannot compute a patient fall rate from available data.
- The hospital was cited for lack of compliance with the JCAHO patient safety goals.
- There is no tracking mechanism to measure and assure that deaths are reported to the organ procurement agency. However, a review of medical records from January to May 2004 found two cases, which had a potential for organ procurement, that were not referred to the organ procurement organization.

Performance and Quality Improvement > Staffing and Process

Assessment

- Staffing effectiveness measures have not been developed nor has data been analyzed for this purpose.
- The effectiveness of the Medical Staff performance improvement efforts is unknown.
- Root cause analyses needs to be enhanced to reflect a more thorough and credible process.
- Many root cause analyses have been conducted. It is unclear whether the actions identified to reduce risk have been implemented and whether the measures developed to determine the effectiveness of these actions are being utilized and reported. The events are not trended.
- There is not a scientific process for performance measurement. The frequency of data collection is not specified; there is a lack of data aggregation, analysis, and identification of opportunities for improvement.
- The hospital patient identifiers are conflicting. For adults, patient's name and medical record number is used. For pediatrics, patient's name and date of birth is used. Staff understanding of these identifiers contradicts that which is stated in policy.
- There are generic screen referrals. Each department has specific indicators to trigger a physician review. A review of Medical Staff meeting minutes reflects that peer review is occurring in all services.

Performance and Quality Improvement > Staffing and Process

Assessment

- The Medical Staff credentialing, privileging, and re-appointment process does not result in an objective assessment of individual practitioners' performance.
- An effective Medical Staff peer review process is not functional and does not contribute to improving the quality of care.
- Medical staff peer review activities are not being recorded in the physician profile.
- Data on core measures is not being well disseminated to staff.
- The results of performance improvement efforts, advances in patient safety, and the organization's priorities for improvement are not communicated by middle management to front-line staff.

Performance and Quality Improvement > Staffing and Process

Deficiencies

- The performance improvement program lacks substantial data rich/information poor.
- There is a lack of data aggregation, analysis, and identification of opportunities for improvement.
- There is a lack of follow-through on implementing recommendations for improvement.
- There is a lack of communication throughout the organization, including feedback on performance improvement and patient safety issues (dead-ends with middle management).
- The peer review process does not identify individual Medical Staff member performance issues, which are to be fed into the clinical privileging and re-appointment process.
- There is inadequate staff education for quality and medical safety activities.

Performance and Quality Improvement > Staffing and Process

Recommendations

2.5.14 Restructure the hospital-wide IOP Committee. See below:

Feature	Proposed Structure
Membership Size	15 members
Membership	Select Medical Staff, clinical, and administrative leaders.
Attendance	In addition to the IOP Committee members, only representatives of departments reporting that month attend.
Reporting	Same
Information Flow	The results of the IOP Committee are presented to the MEC on a **monthly** basis and subsequently to the Board.

Performance and Quality Improvement > Staffing and Process

Recommendations

2.5.15 Educate department management and staff on essential performance improvement tools and strategies including:

- How to measure performance.
- Aggregate and analyze data.
- Identify and implement opportunities for improvement.
- Measure performance to assess the effect of the improvement on outcomes.

2.5.16 Define accountabilities with middle managers related to performance improvement.

2.5.17 Identify a clear charge to all performance improvement teams and monitor their progress.

2.5.18 Require each department to have performance improvement as part of their department meeting discussion.

2.5.19 Incorporate the role of an educator position into quality management; or train all the performance improvement specialists to educate hospital-wide staff on performance improvement tools.

2.5.20 Provide standardized education to all levels of staff on performance improvement goals.

Performance and Quality Improvement > Staffing and Process

Recommendations

2.5.21 Review and/or revise the policies on the National Safety goals.

2.5.22 Analyze Human Resource staffing measures.

2.5.23 Develop oversight for an organized and systematic approach to performance measurement in Nursing. This will include:

- Monitoring of performance through data collection.
- Analysis of current performance.
- Reduction of unacceptable variation.

2.5.24 Pilot a new method of starting performance improvement on a nursing unit to evaluate the process.

2.5.25 Revise the performance improvement model based on the pilot results and implement the model on all units.

2.5.26 Assign Nursing responsibility for data collection and analysis relative to restraint use.

2.5.27 Establish regular meeting with Nursing and the newly-designated hospital performance improvement coordinator to ensure that Nursing is measuring their performance on the appropriate indicators and that the data is being assessed and used to improve performance.

Performance and Quality Improvement > Staffing and Process

Recommendations

2.5.28 (see Risk Management)

2.5.29 Educate staff on their responsibilities related to organ procurement.

2.5.30 Provide initial and ongoing staff education for performance improvement and medical safety activities.

2.5.31 Identify all opportunities for a root cause analysis to performance improvement in a timely manner (as soon as they happen). Performance improvement will assign responsibility for oversight and assuring measures and outcomes occur.

2.5.32 Hold division chiefs accountable for evaluating physician performance and for making objective recommendations for re-appointment. Add to each physician profile; the number of cases, average length of stay (LOS), adjusted LOS, mortality rate, adjusted mortality rate, re-admit rate and adjusted re-admit rate (numbers should come from finance).

2.5.33 Assign responsibility for processes that cross departmental boundaries and lack an identified owner.

Performance and Quality Improvement > Staffing and Process

Recommendations

2.5.34 Provide administrative and data support to the peer review process.

2.5.35 Evaluate the effectiveness of Medical Staff performance improvement efforts.

2.5.36 Conduct a formal review and mentor the process of all case reviews (actual peer review session and/or root cause analysis sessions).

2.5.37 Retrain and mentor medical staff chairs in the expectations and process to conduct effective peer review.

2.5.38 Mentor QI/PI analysts.

Performance and Quality Improvement > Tools, Measurement and Technology

Assessment

- Incident report tracking is performed manually. Reports are lost and do not reach Risk Management.
- The performance improvement department staff primarily use word processing software and could benefit from additional training in the use of spreadsheets.
- There is a high-level of manual manipulation of performance improvement data.
- The County is working on an electronic version of an incident tracking system, but the date for completion has not been specified. KDMC will be a pilot site.
- The MIDAS system was previously used to analyze performance improvement data. Glitches in the system caused senior management to decide against purchasing upgrades of this system. Use of the system was subsequently abandoned.
- The hospital-wide Affinity system does not track the follow-up performed or information on individual risk management events.
- The recent enhancement installed by UHC provides attending physician-specific data on performance of core measure activities. This feature will provide peer review data for the credentialing and privileging process.

Performance and Quality Improvement > Tools, Measurement and Technology

Deficiencies

- Lack of a system to analyze performance improvement data.
- Lack of a system to analyze risk management events.
- Computer skills of performance improvement analysts could be enhanced.
- Poor coordination with Risk Management.

Performance and Quality Improvement > Tools, Measurement and Technology

Recommendations

2.5.38 Mentor QI and PI analysts.

2.5.39 Implement the use of standardized performance improvement tools.

2.5.40 Develop forms for the monthly reporting of data and easy reading of the data.

2.5.41 Develop a measure for patient falls and establish a rate.

2.5.42 Develop a daily multi-disciplinary tool for compliance assessment and other JCAHO/CMS citations.

2.5.43 Begin to track and trend risk management data.

- Follow the new performance improvement development and methodology process.
- Report data through the performance improvement structure.
- Facilitate the Risk Management staff; working more closely with performance improvement staff to reduce error and improve processes.

2.5.44 Develop a tool to measure reporting of all deaths within two-hour timeframe.

2.5.45 Standardize the performance measurement process by implementing a scientific methodology to develop measures.

2.5.46 Implement a performance improvement data analysis system.

Performance and Quality Improvement > Tools, Measurement and Technology

Recommendations

2.5.47 Review departmental staffing; provide for a data analyst position within the existing staffing complement. This position will manage databases to support the quality and medical safety initiatives of the organization.

2.5.48 Use the Cactus computer program module in Medical Staff office for physician peer review. Performance improvement specialists need to obtain access.

2.5.49 Investigate using the Nursing Data Indicator Quality Program (NDIQP). This will allow Nursing to benchmark to itself and nationally to similar hospitals.

2.5.50 Measure and track compliance with National Patient Safety goals and measures.

Performance and Quality Improvement > Tools, Measurement and Technology

Responsibility

- CEO
- Medical Director
- CNO
- Administrative Director Quality Management/Regulatory Programs

Performance and Quality Improvement > Patient Satisfaction – Inpatient

Assessment

- KDMC has been conducting the inpatient satisfaction survey in-house (not using an outside vendor).
- Survey questionnaire's format is one sheet, double-sided, available in both English and Spanish; includes 46 multiple choice questions:
  - Three types of multiple choices, depending on type of question: always/sometimes/never, yes/no, or excellent/good/fair/poor; plus two open-ended questions.
- Distribution and collection of the survey questionnaires is done on a daily basis.
- The Ambulatory Care Service Marketing Representatives (aka:unit clerks) distribute the questionnaires to all patients in the nursing units.
- One patient may have multiple questionnaires over the course of their stay.
- The same unit clerks collect the questionnaire the following day.
- The collected questionnaires are then stored in the Nursing resource office.
- The Nursing administration staff hand counts each question's answer from each survey questionnaire.
  - Nursing resources office has a scanner, however it has not been used because it is "slower than hand-counting the answers."
  - The same staff calculates the percentage of (always, yes, or excellent + good) answers relative to total number of answers for each question (using traditional calculator, not a spreadsheet).
- The results report has been prepared on a quarterly basis.

Performance and Quality Improvement > Patient Satisfaction – Inpatient

Assessment

- A trigger point, or a signal for evaluation is a satisfaction measure; resulting in less than 85% of Always, Yes, or Excellent + Good answers.
  - In the 2002-2003 result report, most of the questions including the Overall Care were scored equal or higher than 85%.

	Apr - Jun 2003	Jan - Mar 2003	Oct - Dec 2002	Jul - Sep 2002	Apr - Jun 2002	Jan - Mar 2002
Survey Response Rate	20%	19%	16%	18%	23%	17%
Overall Care (multi-choice from Excellent/Good/Fair/Poor): Percentage of "Excellent" and "Good"	N/A	85%	70%	86%	86%	85%

Notes:
- Survey Response Rate = # of surveys completed / # of discharges
- "N/A" means that results have not been tallied (the survey was conducted).
- As of December 2004, No survey results are available since Apr-Jun 2003.

- Since July 2003 there have been no survey results report issued. The survey sheets had been collected and stored in the Nursing resources office, but have not been tallied.
- The survey results for 4th quarter 2001 and the 1st thru 4th quarters of 2003 were issued in February 2004 to the CNO and Nursing Director (not clear if the report was then distributed to any other parties).

Performance and Quality Improvement > Patient Satisfaction – Inpatient

Assessment

- In 2002 the CNO made a request to the executive team that the responsibility of patient satisfaction survey be moved to “someone outside of Nursing” to “ensure unbiased patient satisfaction measure.” The request was then verbally turned down.
- In 2003 the responsibility of compiling the results report was unofficially transitioned from an assistant nurse director to a Nursing administration staff member.
- Currently, there has been no formal leadership responsibility assigned.
- No follow-up process on the result.
- In 2003 the Nursing administration staff made the suggestion to the CNO, as well as to the Director of Quality Management, to investigate an opportunity to utilize an outside vendor. There was no follow-up from the CNO or the Director of Quality Management.

Performance and Quality Improvement > Patient Satisfaction – Outpatient

Assessment

- For outpatient satisfaction survey, KDMC has had two surveys:
  - In-house Outpatient Satisfaction Survey.
  - A County-wide Outpatient Satisfaction Survey; led by the County Administrative Office (CAO).
- The last in-house satisfaction survey was conducted in 2002.
- In January 2004, a County-wide satisfaction survey was conducted by CAO's lead.
  - The County-wide satisfaction survey covered all clinics for all DHS institutions, except for ED.
  - The result was tallied and reported for the total of all DHS institutions. The result was not available for individual health institutions.
  - The result was not useful for KDMC, as it was impossible to evaluate KDMC's patient satisfaction in particular.
- Until 2002, the in-house satisfaction survey was the Ambulatory Care Administrator's responsibility (not clear if it was a formal assignment).
- Currently, the Director of Ancillary and Rehab Services, who is a member of the DHS Customer Satisfaction Taskforce, has been a contact person for the County-wide survey.
- No follow-up process is in place.

Performance and Quality Improvement > Patient Satisfaction – Deficiencies

Deficiencies

- There is no leadership assignment related to the patient satisfaction.
- There is no evidence of leadership follow-up on the inpatient survey result or leadership response to suggestions from the staff.
  - The inpatient survey results have not been reported for over one year.
- The outpatient survey results are not available at individual hospital level. Also, it is not clear if the Ancillary and Rehab Services Director, being a contact person, means a formal responsibility for the outpatient survey.
- There is no process for sharing the result among the leadership or staff on both inpatient and outpatient satisfaction.
- While capable of conducting a year-to-year comparison, neither of the existing inpatient or outpatient surveys facilitate peer comparison to outside hospitals.

Performance and Quality Improvement > Patient Satisfaction

Recommendations

2.5.51 Establish formal leadership responsibility along with logistics in result report distribution and follow-up process.

2.5.52 Investigate an opportunity to utilize an outside vendor to measure satisfaction.

2.5.53 Investigate with DHS the use of a consistent vendor across all County facilities to facilitate peer hospital comparisons.

- Potential survey vendors: Press, Ganey Associates, Inc., SF-36, etc.
- Olive View Medical Center's pricing from Press, Ganey Associates for their "Inpatient Satisfaction Survey Service" is $31,780. (Based on provision of nine months' survey service, October 2003 thru June 2004).
- Investigate an opportunity to utilize an outside vendor in conducting patient focus groups and/or exit survey (survey by mail may not be the most appropriate for the KDMC patient population).

2.5.54 Make the County-wide outpatient survey result available for individual hospitals.

Responsibility

- COO
- CNO

Patient Satisfaction

Performance Measures

Inpatient

- Percentage survey response rate
  - Current 20% (April – June 2003)
  - Target 100%
- Percentage of surveys indicating “Overall Care” excellent or good
  - Current not currently collected
  - Target TBD

Outpatient

- Percentage of survey response
  - Current not currently collected
  - Target TBD

Section II – General Operations/Organizational Structure

6. Infection Control
   - Interviews
   - Prioritized Summary of Recommendations
   - Compliance Profile
   - Structure, Leadership and Oversight
   - Process

Infection Control > Interviews

- M. Sutjita, MD — Infection Control
- I. Davis — Infection Control
- A. Preyer — Infection Control
- J. Miller, MD — Occupational Health
- V. Caldwell — Central Services (plus two additional staff members)
- H. Gharanfoli — Respiratory Care
- M. Rogers — Respiratory Care
- A. Groves — Pharmacy Consultant
- L. Knight — Administrative Director, Quality Management/Regulatory Programs
- N. Haye — Manager, Labor & Delivery
- Dialysis Staff Members
- Endoscopy Staff Members
- ENT Staff Members
- Nursing Staff of:
  - Trauma/Surgical ICU
  - Coronary Care Units 4B and 4A
  - Pediatrics
  - Emergency Department

Infection Control > Prioritized Summary of Recommendations

Infection Control – Structure, Leadership and Oversight		
Urgent	2.6.01	Reassign responsibility of infection control from Medical Director to Interim Chief Nursing Officer.
Urgent	2.6.02	Finalize infection control plan.
Short-term	2.6.03	Revise all infection control policies and procedures to be rooted in scientific principle and current CDC guidelines.
Urgent	2.6.04	Reorganize reporting structure of Infection Control Department, convert current physician Director position to a Physician Advisor position. This position would continue to report to the Medical Director.
Urgent	2.6.05	Create position of Infection Control Manager, which could be assumed by one of the existing Infection Control Practitioner (ICP) positions and coach the newly-designated Infection Control Manager in his/her new role.
Urgent	2.6.06	Reorganize reporting structure of Infection ICPs to oversight of the Interim Chief Nursing Officer.
Short-term	2.6.07	Report meaningful information to Infection Control Committee on performance of infection control activities.
Urgent	2.6.08	Reduce size of Infection Control Committee to 10-12 members.
Short-term	2.6.09	Investigate infection control module that is available with the current IS system. Investigate the purchase and integration of alternative infection control programs, e.g., EpiQuest.
Process		
Urgent	2.6.10	Eliminate twice yearly house-wide surveillance.
Urgent	2.6.11	Perform ongoing surveillance activities only in the critical care units monitoring all sites for infection.
Urgent	2.6.12	Revise data collection and analysis methods to produce meaningful data on performance of the infection control process.
Urgent	2.6.13	Select two surgical procedures to monitor for Surgical Infection Prevention (SIP).
Short-term	2.6.14	Develop methodology for post-discharge SIP data collection.
Short-term	2.6.15	Develop categories of isolation based on current CDC guidelines (revised guidelines expected in early 2005).

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Infection Control > Prioritized Summary of Recommendations

Process		
Urgent	2.6.16	Develop process for identification of unanticipated death or major permanent loss of function associated with a health care acquired infection.
Urgent	2.6.17	Follow the scientific process for the development and methodology of indicators.
Short-term	2.6.18	Report infection control findings on a quarterly schedule to the Patient Safety Committee.
Urgent	2.6.19	Assess services provided by the off-site facilities. Determine infection control needs of staff/patients. Determine if practices are standardized and consistent across the institution.
Urgent	2.6.20	Conduct daily surveillance rounds to identify and follow through on elimination of inappropriate infection control practices.
Urgent	2.6.21	Perform annual uniform competency assessment of all employees performing sterilization or high-level disinfection.
Short-term	2.6.22	Develop consistent policies outlining procedure for monitoring all sterilizers, including those located in Pathology and Environmental Services.
Short-term	2.6.23	Categorize blood and body fluid exposures as to type of exposure, category of exposed employee, circumstances surrounding the exposure, and actions to be taken to prevent additional employee exposures.
Short-term	2.6.24	Investigate, document findings and develop an action plan for each blood and body fluid exposure.
Short-term	2.6.25	Develop a Sharps Safety Program and define how the institution selects products that are engineered to provide employee safety and prevent exposures.

Infection Control > Structure, Leadership and Oversight

Assessment

- The Director of the department is an infectious diseases physician who devotes approximately eight hours per week performing Infection Control activities. His primary functions include:
  - Conducting rounds on patients with infections.
  - Statistical analysis of data.
- The Director possesses a sound knowledge of Infection Control practices, but lacks the understanding of how to apply this knowledge. He is motivated to fulfill his role as Director, but lacks the insight into how to do so. With proper direction and mentoring, he could be effective in helping Infection Control program achieve its goals.
- Staffing for the Infection Control Department consists of two Infection Control Practitioners (ICPs), one of which acts in a lead capacity. This cadre of ICPs is adequate for the current average daily census (ADC) of 200.
- Only the lead ICP has obtained Association of Professionals in Infection Control (APIC) certification.
- The lead ICP was brought to KDMC in January 2004 to turn around a struggling program.
- Although the lead ICP has an adequate knowledge of basic infection control practices, as evidenced by the program's lack of progress, *it appears that* she has difficulty translating this knowledge into practice and action *as evidenced by the program's lack of progress.*

Infection Control > Structure, Leadership and Oversight

Assessment

- The lead ICP is capable of being mentored, although her desire to do so is questionable.
- The lead ICP frequently defers to the second (non-certified) ICP on KDMC-specific Infection Control activities.
- The second ICP is reported to be near retirement.
- The ICPs report to the Director.
- There is no Infection Control plan; despite repeated instances of this issue. JCAHO has repeatedly identified the lack of an Infection Control Plan as a problem.
- Infection control policies and procedures are redundant, inconsistent with practice, and conflicting.
  - Policies are outdated and do not reflect current Centers for Disease Control and Prevention (CDC) guidelines or current literature.
- All Infection Control information and data is being manipulated manually.
- The Infection Control Committee is composed of 25-30 members, many of which are members of the Medical Staff. Attendance is relatively good.

Infection Control > Structure, Leadership and Oversight

Assessment

- A review of Infection Control Committee meeting minutes reflected a lack of understanding of actual practice hospital-wide.
- The Infection Control Committee meeting minutes lack sufficient detail to assess the effectiveness of the Committee.
- The results of Infection Control Committee meetings are forwarded onto the MEC and subsequently to the Board.
- Data from the Infection Control program is reported to the IOP Committee. Such reports consist solely of data and do not reflect any improvements in Infection Control practices.
- While the committee reporting structure may be sufficient, the substance of the reports is not.

Infection Control > Structure, Leadership and Oversight

Deficiencies

- Lack of a written Infection Control plan.
- Lack of appropriate Infection Control policies and procedures.
- An over-sized Infection Control Committee.
- Lack of integration of Infection Control indicators into the performance improvement process.
- Lack of integration of Infection Control data analysis and improvements into the hospital's patient safety program.
- Lack of inclusion of off-site facilities in Infection Control.
- All data is collected, collated, and analyzed manually.

Infection Control > Structure, Leadership and Oversight

Recommendations

2.6.01 Reassign responsibility of Infection Control from the Medical Director to the Interim CNO.

2.6.02 Develop a succinct Infection Control Plan which includes the following and obtain approval by the Infectious Disease Control and Prevention Committee:

- A description of prioritized risks.
- A statement of the goals of the Infection Control.
- A description of the hospital's strategies to minimize, reduce, or eliminate the prioritized risks.
- A description of how the strategies will be evaluated.

2.6.03 Revise all Infection Control policies and procedures to be rooted in scientific principle and current CDC guidelines.

- Infection control policies and procedures should mirror current practice and be the basis of that practice.
- Infection control policies and procedures need to become more user friendly; facilitate easy employee access to Infection Control manuals.

Infection Control > Structure, Leadership and Oversight

Recommendations

2.6.04 Change the current infection control physician director position to a physician advisor position, continuing to report to the Medical Director

2.6.05 Create position of Infection Control Manager, which could be assumed by one of the existing Infection Control Practitioner (ICP) positions and coach the newly-designated Infection Control Manager in his/her new role.

2.6.06 Reorganize reporting structure of Infection ICPs to oversight of the Interim Chief Nursing Officer.

2.6.07 Report meaningful information to Infection Control Committee on performance of infection control activities.

2.6.08 Reduce size of Infection Control Committee to 10-12 members.

2.6.09 Investigate infection control module that is available with the current IS system. Investigate the purchase and integration of alternative infection control programs, e.g., EpiQuest.

Infection Control > Process

Assessment

- There is twice yearly house-wide surveillance.
- Monthly surveillance is currently being conducted in all critical care areas.
- Infection rates are calculated using number of monthly discharges rather than on device days.
- Surgical site infection is being monitored for all operative procedures and being reported by wound class only.
- Only contact and respiratory isolation precautions are being used in addition to standard precautions.
- Non-compliance with Center for Disease Control and Prevention (CDC) guidelines for the prevention of device related bloodstream infections.
- Preparation of IV flush solution from a large volume container was witnessed. The individual flushes were drawn into unlabeled, undated syringes at the beginning of the shift (information shared with the Pharmacy advisor). This is a violation of JCAHO Standards and improper infection control practice
- There is an inappropriate use of a wooden storage cabinet for disinfected endoscopes.
- Lack of appropriate work flow pattern in endoscopy.
  - Scopes are cleaned in the dirty sink, placed in the scope processor, processed, then carried by the dirty sink out of the room for storage.
  - No designated hand washing sink is in the processing or procedure rooms.

Infection Control > Process

Assessment

- Appropriate protective barriers are not being used for initiation and termination of dialysis (employees are not wearing gowns during this process).
- Instruments used for a patient known to be HIV positive, which require high-level disinfection, are being sent to central sterile processing (separate standard of care).
- Central sterile processing is using date-related sterilization practices. Currently, a raw rate is being calculated using the number of conversions divided by the number of purified protein derivatives (PPDs) planted. No analysis of data was found to indicate that an annual TB risk assessment was conducted based on the CDC guidelines; which determines the institution's overall TB risk, i.e., low, moderate, or high.
- Occupational Health is ordering chest x-rays every two years on employees who are PPD positive; inconsistent with CDC guidelines.
- Food handlers are required to submit annual stool samples for culture and Ovum and Parasites this is an outdated practice.
- Varicella vaccine is not provided through the Occupational Health Department.

Infection Control > Process

Assessment

- Agency personnel are not required to be assessed by Occupational Health.
- A physician was observed eating at the pediatric unit nurse's station despite a sign which read, "No eating or drinking at the Nurse's Station."
- Painting of ceiling tiles is a common practice.
- Sterilization:
  - Consistent and standardized practices for sterilization and high-level disinfection are not being followed.
  - There are 15 sterilizers located throughout the institution.
  - Oversight for biological monitoring of each sterilizer lies with the area housing the sterilizer.
  - Biological monitoring results are sent to Central Sterile on a daily basis.
    - Inconsistent policies are in place for sterilizer monitoring.
    - High-level disinfection is occurring in multiple areas of the institution, including ambulatory care sites.
    - Monitoring of OPA solution is being conducted and results are being documented.
  - Existing Infection Control data has not been analyzed.
  - Due to a flawed surveillance approach, no valid conclusions may be drawn from existing Infection Control data.

Infection Control > Process

Deficiencies

- Outdated surveillance methodology. Infection rates are calculated using the number of monthly discharges rather than device days.
- Lack of Infection Control data analysis.
- Data are not being used to manage or improve processes.
- Lack of documented improvements based on analysis of data. Lack of clarity with the existing isolation system.
- Lack of compliance with JCAHO “National Patient Safety Goal #7, part B” (unanticipated death or major permanent loss of function associated with a healthcare acquired infection).
- Inappropriate Infection Control practices.

Infection Control > Process

Recommendations

2.6.10 Eliminate twice yearly house-wide surveillance.

2.6.11 Perform ongoing surveillance activities only in the critical care units monitoring all sites for infection.

2.6.12 Revise the data collection and analysis methods to produce meaningful data on performance of the Infection Control process.

- Utilize device/patient days as appropriate denominator for data collection and analysis.
- Present risk adjusted data for analysis.
- Use external databases for benchmark comparison, (e.g., CDC NNIS).
- Analysis of data should be site-specific and detailed.
- Develop control charts for infection indicators.
- Identify and implement improvements based on data analysis.

2.6.13 Select two surgical procedures to monitor for Surgical Infection Prevention (SIP). This will include: selection of appropriate prophylactic antibiotic, timeliness of prophylactic antibiotic administration, appropriate discontinuation of prophylactic antibiotic, and development of surgical site infection.

2.6.14 Develop methodology for post-discharge SIP data collection.

Infection Control > Process

Recommendations

2.6.15 Develop categories of isolation based on current CDC guidelines (revised guidelines expected early 2005).

- Delete the category of Respiratory Isolation and replace it with Airborne Precautions and Droplet Precautions.
- Droplet Precautions do not require patients to be placed in negative air pressure rooms or the use of the more expensive N95 respirators for employee respiratory protection.
- Patients with suspected or proven TB will be placed in the designated negative pressure rooms which in some instances are being used by patients who do not require them because of the inappropriate isolation categories.

2.6.16 Develop a process for identification of unanticipated death or major permanent loss of function associated with a healthcare acquired infection.

2.6.17 Follow the scientific process for the development and methodology of indicators.

2.6.18 Report Infection Control findings on a quarterly schedule to the Patient Safety Committee.

Infection Control > Process

Recommendations

2.6.19 Assess services provided by the off-site facilities. Determine Infection Control needs of staff/patients. Determine if practices are standardized and consistent across the institution.

2.6.20 Conduct daily surveillance rounds to identify and follow through on the elimination of inappropriate Infection Control practices.

2.6.21 Perform a uniform competency assessment annually of all employees performing sterilization or high-level disinfection.

2.6.22 Develop consistent policies outlining the procedure for the monitoring of all sterilizers, including those located in Pathology and Environmental Services.

2.6.23 Categorize blood and body fluid exposures as to type of exposure, category of exposed employee, circumstances surrounding the exposure, and actions to be taken to prevent additional employee exposures.

2.6.24 Investigate document findings and develop an action plan for each blood and body fluid exposure exposure.

2.6.25 Develop a Sharps Safety Program and define how the institution selects products that are engineered to provide employee safety and prevent exposures.

2.6.26 Review and revise KDMC's TB Plan annually based on the risk assessment.

2.6.27 Change central sterile process from date-related sterilization practices to event-related sterilization process.

Infection Control

Performance Measures

- Healthcare associated infection rate (based upon device days)
  - Current not currently collected
  - Target TBD
- Compliance with CDC hand hygiene guidelines
  - Current not currently collected
  - Target TBD
- Percentage of surgical infection prevention program compliance - appropriate selection, timeliness of administration and discontinuation of prophylactic antibiotics. (Identify one to two surgical procedures to monitor)
  - Current not currently collected
  - Target 95%
- Surgical site infection rate (risk stratified data, i.e., wound class, ASA score, and cut time)
  - Current not currently collected
  - Target benchmark to CDC's NNIS rates

Infection Control

Performance Measures

- Employee PPD conversion rates (stratified by converter's department/unit)
  - Current not currently collected
  - Target TBD
- Employee blood and body fluid exposures
  - Current not currently collected
  - Target TBD

Responsibility

- Medical Director
- Infection Control Coordinator

Section II – General Operations/Organizational Structure

7. Budget
   - Interviews
   - Prioritized Summary of Recommendations
   - Operating
   - Capital

Budget > Interviews

- A. Gray — KDMC Chief Financial Officer
- B. Gondo — KDMC Expenditure Manager

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Budget > Prioritized Summary of Recommendations

Budget – Operating		
Short-term	2.7.01	Develop a planning process to identify future strategic and operational goals.
Long-term	2.7.02	Develop a five-year financial assessment and plan of operational and capital needs.
Long-term	2.7.03	Develop an operating budget target driven from the five-year financial plan – not based on current year spending levels.
Intermediate	2.7.04	Identify the budgetary design/policy for budget development – i.e. 'zero based', fixed volume/workload estimates, expense revenue linkages.
Intermediate	2.7.05	Establish a process and timeline to develop an operating plan/budget involving administrators and department managers, including Chairs.
Intermediate	2.7.06	Provide timely actual to budget cost center data to administrators and managers.
Intermediate	2.7.07	Establish a process for monthly review of budget variances and identification of plans of correction.
Short-term	2.7.08	Establish a financial dashboard for KDMC administrators and DHS.
Intermediate	2.7.09	Establish positive motivational stimuli to manage the operating budget, including identification of consequences for unsatisfactory budget compliance.
Capital		
Long-term	2.7.10	Establish a capital planning committee to recommend and prioritize capital spending requests to DHS; involve chairs and medical director in process.
Long-term	2.7.11	Establish criteria such as patient safety and licensure needs, return on investment thresholds and desired new technology levels to determine spending priorities.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Budget > Operating

Assessment

- The operating budget is primarily driven by available funding through DHS, rather than on a true assessment of organizational planning and identification of goals and financial needs.
- The lack of a cost accounting system results in an inability to perform effective financial analysis of programs and services, payers and/or providers.
- Failure to utilize the budget process as an effective planning and management tool can hamper the hospital's ability to develop locally competitive salary, benefit and pricing structures.
- Proposed operating budgets and budget approvals are broken into two segments:
  - Status Quo budget – a continuation of current spending levels and volumes.
  - Critical unmet needs – new services that are perceived to meet critical needs.

Budget > Operating

Assessment

- The monthly Responsibility Summary Report (RSR) is produced through the HBOC general ledger system, which is not integrated with the budget included in the Countywide Accounting and Purchasing System (CAPS). As a result, department managers have no effective mechanism for comparing actual performance to budget, and no effective process exists to hold department managers accountable for budget variances.
- There is a plan to move general ledger reporting off of the HBOC system on July 1, 2005 and to integrate it at that time with the CAPS system.
- There is no daily financial or statistical dashboard; nor comprehensive monthly financial reporting with comparisons to industry benchmarks. As a result, there is no real dialogue among the administrative and departmental leaders regarding financial performance, comparison to industry standards, and/or correction of variances.

Budget > Operating

Deficiencies

- There is an ineffective process for developing the operating budget – lacking strategic, tactical, and financial needs of the hospital.
- Because of the lack of broad involvement during the budget process, administrators and department managers do not feel an “ownership” of the final approved budget.
- The lack of meaningful and timely feedback on budget variances inhibits management’s ability to hold managers accountable for budget performance.
- The use of separate general ledger and budgeting systems inhibits the ability to do meaningful budget comparisons.
- The budget process is controlled by DHS rather than by hospital administration.
- No budget estimate currently exists to cover potential operating requirements associated with this assessment report and related licensure/accreditation needs.

Budget > Operating

Recommendations

2.7.01 Develop a planning process to identify future strategic and operational goals, including programs and services, for KDMC consistent with community needs.

2.7.02 Develop a five-year financial assessment and plan of operational and capital needs. Included should be comparisons to operational and financial benchmarks from similar hospital organizations.

2.7.03 Develop an operating budget target driven from the five-year financial plan – not based on current year spending levels.

2.7.04 Identify the budgetary design/policy for budget development; i.e., zero-based, fixed volume/workload estimates and expense revenue linkages.

2.7.05 Establish a process and timeline to develop an operating plan/budget involving administrators and department managers, including Chairs.

2.7.06 Provide timely actual to budget cost center data to administrators and managers.

Budget > Operating

Recommendations

2.7.07 Establish a process for monthly review of budget variances and identification of plans of correction.

2.7.08 Establish a financial dashboard for KDMC administrators and DHS.

2.7.09 Establish positive motivational stimuli to manage the operating budget, including identification of consequences for unsatisfactory budget compliance.

Responsibility

- CEO

Budget > Capital

Assessment

- There is no identifiable long term capital plan for KDMC.
- The capital equipment budget, generally covering purchased items exceeding $5 K and leases exceeding $25 K, is broken down into two segments:
  - An equipment budget that is expected to approximately equal the prior year spending level, and which currently includes about $1.2 million for equipment purchases.
  - About $2 million for leases under the LAC Capital Asset Lease program (LAC-CAL).
- A maintenance budget is also provided for major maintenance needs. In the current year, this portion of the budget was approximately $1.8 million, which has been assigned primarily to roofing repairs and HVAC system upgrades. An additional $1.4 million was appropriated for Oasis and Women's Centers.
- After the final budget amounts are approved by the County, a multi-disciplinary committee including Nursing, administrators and physicians is responsible for allocating approved capital equipment funds against request equipment additions/replacements.

Budget > Capital

Deficiencies

- There is no inclusive capital budget planning process tied to KDMC's strategic and operational needs.
- There are no clearly defined capital budget responsibilities and accountabilities.
- The Allocations Committee disperses funds after they have been allocated.
- No budget estimate currently exists to cover potential capital requirements associated with this assessment report and related licensure/accreditation needs.

Budget > Capital

Recommendations

2.7.10 Establish a capital planning committee to recommend and prioritize capital spending requests to DHS; involve chairs and medical director in process.

2.7.11 Establish criteria such as patient safety and licensure needs, return on investment thresholds and desired new technology levels to determine spending priorities.

Responsibility

- CEO

Section II – General Operations/Organizational Structure

8. Productivity
   - Interviews
   - Prioritized Summary of Recommendations
   - Labor Overview
   - Cost Structure

Productivity > Interviews

• A. Gray	Chief Financial Officer
• M. McClure	Chief Information Officer
• B. Gondo	Expenditure Management
• M. Cheng	Information Systems
• L. Barber	Nursing Administration
• A. Wecker	DHS Finance
• L. Wun-Nagaoka	DHS Finance

Productivity > Prioritized Summary of Recommendations

Productivity		
Short-term	2.8.01	Establish a process in which the LCD for KDMC is retrieved by 22th calendar day of the following month.
Urgent	2.8.02	Identify source and process with which the agency hours are retrieved by 20th calendar day of the following month.
Urgent	2.8.03	Determine each cost center's UOS as a productivity measure. The UOS selection is to be made and agreed upon by C-level management and department directors. Identify source and process to collect each of the statistics.
Short-term	2.8.04	Conduct introductory sessions for the department directors and managers to assimilate them with the concept. Communicate purpose of productivity management and benefit of utilizing the tool not as a punitive tool but as a constructive tool to help managers react/plan effective staffing.
Short-term	2.8.05	Confirm with each of the C-level management and department directors that they will be accountable for his/her department's productivity compared to the baseline.
Short-term	2.8.06	Identify a process owner for productivity measurement that will be responsible for all necessary data collection, preparation and distribution of the productivity report. Train the department personnel and manager.
Short-term	2.8.07	Determine the productivity report's distribution process, including the distribution date and route, and the follow up process.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Productivity > Labor Overview

Assessment

- Setting productivity standards and measuring compliance with the standards are important to provide quality patient care. Fostering low productivity standards will increase the use of temporary staff and overtime. Both overtime and a large proportion of temporary/agency staff can have a negative impact on quality of patient care.
- FY03/04 total salaries and wages plus benefits expense was approximately 58% of total expenses. This does not include Registry (agency) expense.
- September 2004 Paid FTEs* were approximately 2,940. Those of FY03/04 were approximately 2,853 (see table below).
- Comparing the month of September 2004 to FY03/04, Registry (agency) usage has nearly doubled.
- FY03/04 Paid FTEs per adjusted occupied bed (AOB) (excluding physicians, residents and mid-level providers) was 8.25. September 2004 Paid FTEs per AOB went up to 10.48.

	Month of Sep 04	FY03/04
Paid FTEs (including Agency)	2,400	2,269
Productive FTEs (including Agency)	1,948	1,864
Registry (Agency) FTEs	297	156
Registry % of Prod Hours	18.0%	9.1%

*Paid FTEs, Productive FTEs and Registry (Agency) all exclude physicians, residents, and mid-level providers. Numbers are rounded.

Statistics presented in this page are based on General Ledger, LCD, Registry Report, Information Report, and Financial Performance Analysis; provided by DHS Finance and KDMC Expenditure Management departments.

Productivity > Labor Overview

Assessment

- There are approximately 220 cost centers in KDMC.
- Each cost center is grouped into Category and Division and collectively indicate management responsibility.
  - Category corresponds to C-level management.
  - Division corresponds to department director-level management.
- Physician cost centers for both inpatient and outpatient services are set up separately from other staff cost centers, hosting physicians, residents, and physician assistants.
  - However, some non-physician job positions, such as tech/specialist and clerical administration are also included in those physician cost centers.
- See tables on the next two pages for the cost center structure.

KDMC Cost Center Structure: Part 1

*Includes all job positions. Does not include Agency.

Category	Division	FY03-04 Productive FTEs*	# of Cost Centers
MEDICAL ADMINISTRATION	MEDICAL ADMINISTRATION	319.6	8
MEDICAL ADMINISTRATION Total		319.6	8
NURSING	NURSING	664.2	63
NURSING Total		664.2	63
FINANCE	ADMITTING	42.2	2
	EXPENDITURE MANAGEMENT	24.3	5
	FISCAL ADMINISTRATION	9.4	2
	MATERIALS MANAGEMENT	43.9	3
	REVENUE MANAGEMENT	90.0	8
	UTILIZATION MANAGEMENT	17.3	2
FINANCE Total		227.0	22
INFORMATION SERVICES	COMMUNICATIONS	11.8	1
	HEALTH INFO MANAGEMENT	70.3	2
	INFORMATION SYSTEMS	33.7	3
INFORMATION SERVICES Total		115.8	6
PERSONNEL	HUMAN RESOURCES	6.5	3
PERSONNEL Total		6.5	3
SOCIAL SERVICES	SOCIAL SERVICES	27.6	3
SOCIAL SERVICES Total		27.6	3

KDMC Cost Center Structure: Part 2

*Includes all job positions. Does not include Agency.

Category	Division	FY03-04 Productive FTEs*	# of Cost Centers
OPERATIONS	AMBULARY CARE	18.7	5
	ANESTHESIOLOGY	23.7	2
	EMERGENCY SERVICES	13.7	1
	FAMILY MEDICINE	4.6	1
	HOSPITAL ADMINISTRATION	23.0	3
	HOUSEKEEPING	101.6	3
	INTERNAL MEDICINE	53.7	11
	LAUNDRY	4.3	1
	MEDICAL LIBRARY	0.8	1
	NEUROSCIENCE	35.3	3
	OBSTETRICS AND GYNECOLOGY	29.0	3
	OCCUPATIONAL THERAPY	5.2	2
	OPTHALMOLOGY	5.2	2
	ORAL MAXILLO-FACILLA	15.0	1
	OTOLARYNGOLOGY	8.7	2
	PATHOLOGY	87.9	15
	PEDIATRICS	41.0	6
	PEDIATRICS HUB	8.2	2
	PHARMACY	46.4	4
	PHYSICAL THERAPY	14.9	1
	PLANT MANAGEMENT	101.1	5
	PSYCH HOSPITAL ADMIN	7.3	3
	PSYCH MEDICAL ADMIN	11.1	5
	PSYCH NURSING	56.1	6
	RADIOLOGY	85.3	15
	RESPIRATORY THERAPY	2.3	1
	SAFETY POLICE	0.1	1
	SURGERY	53.6	10
OPERATIONS Total		858.1	115

Productivity

Assessment

- Currently, no productivity management is in place.
  - As part of monthly financial performance analysis, the hospital's total number of FTEs (employees only, not including agency) has been reported.
  - Although detailed report on FTEs Labor Cost Distribution (LCD) is generated and distributed on a monthly basis, the FTE information is not concurrently associated with service volume statistics.
  - Some managers have been referring to the term FTE interchangeably with headcount.
  - Registry report has been issued on a monthly basis by KDMC Finance and distributed to department directors; however, the current report format is somewhat confusing.
  - Although major service volume statistics; such as, ADC, Emergency Department (ED) visits, and discharges are reported on a monthly basis in the financial performance analysis, it is difficult to relate the volume statistics to the FTE level without productivity measures in place.
- The concept of productivity management may be new to many employees within the hospital, including some of the management level employees; since the concept or management tool has never been utilized.

Productivity

Assessment

- KDMC Finance/Expenditure Management acts as local contact/local data repository for department directors and managers.
  - Handles financial data requests from department directors and managers as intermediate.
  - Prepares monthly workload statistics report on KDMC's high-level service volume statistics; including, ADC, number of births, ED visits, and ambulatory visits.
  - Understands systems surrounding payroll, as well as service volume statistics. Also understands relationship in terms of data authority between KDMC as a local hospital and DHS Finance as a centralized finance department.
  - KDMC Finance Department "finalizes" the hospital's financial or statistical data, while DHS Fiscal Program "reviews" it.
- KDMC Nursing utilizes ANSOS for timecard capture; as well as, agency usage record within nursing area.
- KDMC Information Services provides general IT-related support; including, helping KDMC Finance retrieve financial and service volume statistics remotely from DHS database.

Productivity

Assessment

- DHS Finance is responsible for closure of monthly LCD (a.k.a. payroll data), while Payroll Department is a County-wide function.
- DHS Data and Analytics Division/DHS Information Services Branch owns Data Warehousing Group that hosts a collection of local hospitals' service volume statistics.
- DHS Internal Services Department (ISD) supports the information report, which is a collection of local hospitals' service volume statistics linked to patient financial data.
- There is no formal ownership in terms of the service volume statistics, while the hospital's service volume statistics reside in multiple systems.
- Employees are paid on a monthly basis; on the 15th of the following month.
- Employees are required to input their timecard on a semi-monthly basis.

Productivity

Assessment

- LCD monthly closure.
  - As of the 25th of the month (for the payroll information pertaining to the first half of the month) and 10th of the following month (for the payroll information pertaining to the second half), payroll data reflects the employees' "home cost center" only (not reflecting actual work location).
  - On and after the 25th of the month (for the payroll information pertaining to the first half of the month) and 10th of the following month (for the payroll information pertaining to the second half of the month), department directors and/or managers make requests to DHS Finance to reflect "deviation" adjustment, i.e., adjustment to account for difference between his/her department employees' home cost center and actual worked location.
  - DHS Finance then uploads the deviation adjustment in LCD.
  - All five county hospitals and two other (non-hospital) institutions (total of seven budget units) follow the same steps.
  - After all seven budget units' deviation adjustments are completed, DHS Finance "closes" the monthly LCD.
  - LCD is not available for individual hospitals until monthly closure is completed months later.
- Definition of productive and non-productive hours.
  - DHS Finance owns a mapping of categorization of earning codes, aka: pay codes.
  - Once a year, DHS Finance in conjunction with County hospitals discusses and updates the categorization of each pay code into either productive or non-productive group.

Productivity

Assessment

- All Registry (agency) contracts are handled by DHS Finance.
  - The Finance Department of Rancho Los Amigos National Rehabilitation Center (Rancho) is handling the invoice data compilation.
- The Registry report is generated by DHS Finance and Rancho Finance, two weeks after month end.
  - The report reflects all invoices from multiple vendors that are processed as of two weeks after month end.
  - Some vendors are submitting the invoices <30 days following the day of service rendered, others submit later than 30 days after the service.
  - There is no standard format for the invoice submission; multiple vendors submit invoices with different formats. No electronic invoicing system in place.
  - KDMC Finance, upon receipt of the original Registry report from DHS Finance, prepares its own summarized Registry report, including monthly projection on the agency expense.
    - The monthly projection has been made on the agency expenses only, not on the agency hours. (The agency hours reflect the invoices that are processed at the time of the original registry report issuance).

Productivity

Assessment

- When KDMC Finance receives another month's registry report from DHS Finance, KDMC Finance updates past months' Registry reports, to account for invoices processed later than the last month's registry report publication.
- The report has been compiled by vendors and by service areas (not by cost centers where the agency services were provided). It is possible to reconcile the report by cost centers that used the agency, however, DHS Finance describes it "very time-consuming and needs large amount of efforts."

- At KDMC, Nursing uses ANSOS to record the agency usage within nursing area.
  - From ANSOS, monthly agency hours are available by units in nursing area.
- KDMC Finance also prepares a quarterly Registry report on the agency usage at the individual agency worker level.

Productivity

Assessment

- Unit of service (UOS) data source: information report.
  - Fed by Affinity and multiple of other independently working systems, such as Lab information system and ORSOS. Hosts all County hospitals' service volume statistics.
  - Supported by DHS Finance and DHS ISD.
  - Inpatient days are available by nurse stations (units), outpatient visits are available by clinic codes, and ancillary procedures are available by artificial department codes (not corresponding to hospital cost centers) defined by DHS Finance.
  - KDMC Finance does not have direct connection to the IR. KDMC Finance only has "remote data retrieval access to the DHS database".
  - For IR data retrieval, KDMC has been experiencing limitation in knowledgeable/experienced resource to program the data retrieval.
- Due to the County's all-inclusive billing practice (i.e., non-existence of itemized billing), ancillary procedure counts are not those of billed procedures, but reflects procedures/services conducted (reported procedures).
- All ancillary procedures are also computed into relative value units (RVUs).

Productivity

Assessment

- A traditional adjustment factor is not available due to the County's all-inclusive billing practice; adjustment factor tends to be skewed. The hospital never used it to account for inpatient/outpatient service volume relativity.
  - For the purpose of normalizing inpatient/outpatient service volume relativity among the County hospitals, equivalent patient days has been used by converting number of outpatient visits into inpatient days. (The conversion ratio is approximately 1:3, currently being reviewed for exact conversion number by DHS Finance.)
  - Although KDMC does not utilize, OSHPD (Office of Statewide Health Planning & Development) calculates all participating hospitals' gross patient service revenue, as well as the break down of the patient service revenue into inpatient and outpatient. The traditional adjustment factor can be calculated from the gross revenue. As of 1/26/05, the available data is based on FY02/03.

Productivity

Assessment

- Labor Cost Natural Class, aka: job class, is used to categorize employees in the payroll.
- For productivity management, the following job classes are excluded due to inappropriateness of measuring those employees' productivity by hours per UOS measure:
  - Physicians (including dentists) and physicians assistants.
  - Interns, residents and post-graduates.
  - Mid-level providers.
- Management positions are included in the productivity management.

NCC	NCC Name	Included / Not Included in Productivity Management
001	MANAGEMENT & SUPERVISION	Included
003	MGT/SUP-SUPV STAFF NURSE	Included
010	TECHNICIAN & SPECIALIST	Included
011	DENTAL SPECIALIST	Included
015	NURSE ANESTHETIST	Not Included
020	REGISTERED NURSE	Included
030	LICENSED VOCATIONAL NURSE	Included
040	AIDES & ORDERLIES	Included
050	CLERICAL & OTHER ADMIN	Included
060	ENVIRONMENTAL & FOOD SVCS	Included
070	PHYSICIANS	Not Included
080	NON-PHYS MED PRACTITIONER	Not Included
081	DENTISTS	Not Included
084	PHYSICIAN'S ASSISTANT	Not Included
090	OTHER SALARIES & WAGES	Included
091	DENTAL INTERNS	Not Included
092	DENTAL RESIDENTS	Not Included
093	PHYS POST GRAD 1ST YR	Not Included
094	PHYS POST GRAD 2ND-7TH YR	Not Included
097	STUDENT NURSE WORKER	Included

Productivity

Deficiencies

- The delay in LCD closure is too lengthy (for example, it took more than three months to close July and August 2004 LCD), and there is no deadline enforced for the LCD closing process.
- Inaccurate registry reports have been identified, and KDMC Finance is currently investigating the cause.
- The process of electronically retrieving IR statistics is difficult and not timely.
- Operational issues affect accuracy of the data.
- Often times, data is not provided in usable format, or it takes long time to obtain certain data in a requested format.

Productivity

Recommendations

2.8.01 Establish a process in which the LCD for KDMC is retrieved by 22th calendar day of the following month.

2.8.02 Identify source and process with which the agency hours are retrieved by 20th calendar day of the following month.

2.8.03 Determine each cost center's UOS as a productivity measure. The UOS selection is to be made and agreed upon by C-level management and department directors. Identify source and process to collect each of the statistics.

2.8.04 Conduct introductory sessions for the department directors and managers to assimilate them with the concept. Communicate purpose of productivity management and benefit of utilizing the tool not as a punitive tool but as a constructive tool to help managers react/plan effective staffing.

2.8.05 Confirm with each of the C-level management and department directors that they will be accountable for his/her department's productivity compared to the baseline.

Productivity

Recommendations

2.8.06 Identify a process owner for productivity measurement that will be responsible for all necessary data collection, preparation and distribution of the productivity report. Train the department personnel and manager.

2.8.07 Determine the productivity report's distribution process, including the distribution date and route, and the follow up process.

Productivity

Performance Measures

King/Drew Medical Center Key Productivity Indicators

	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04
Hours	Paid Hours		Productive Hours		OT Hours		Registry (Agency) Hours	
	411,455	4,746,196	333,931	3,897,575	Data to be Provided	Data to be provided	50,874	326,464
Volume	OP Adjustment Factor*		ALOS		AOB		ADC	
	1.36	1.36	6.28	6.77	229.1	275.1	169.0	202.9
Volume	Patient Days (Excluding Nbs)		Discharges (Excluding Nbs)		Adjusted Patient Days		Adjusted Discharges	
	5,070	74,269	807	10,966	6,872	100,673	1,094	14,865
Ratios	Non-Productive as a % of Paid Hrs		Overtime as a % of Productive Hrs		Registry (Agency) as a % of Productive Hrs		Paid FTEs	
	21.5%	19.2%			18.0%	9.1%	2,400	2,269
Indicators	Case Mix Index*		Paid FTEs per AOB		Paid Hrs per Adj Disch		NAVIGANT CONSULTING	
	1.1	1.1	10.48	8.25	376.1	319.3		

Source / Notes:

- OP Adjustment Factor is calculated based on FY02-03OSHPD report on KDMC. KDMC does not calculate OP Adjustment Factor due to its "all-inclusive" (per diem / per visit) billing practice.
- Paid Hours (therefore Paid FTEs), Productive Hours, and Registry (Agency) Hours exclude physicians, residents, and mid-level providers.
- Case Mix Index was provided by OSHPD, reflecting FY00-01 data.
- For sectios that indicate "Data to be provided", the data is unavailable as of December 2004.
- The blank sections will have the calculated indicators once all the data elements become available.

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Productivity

Responsibility

- COO
- CNO

Section II – General Operations/Organizational Structure

9. Space Planning
   - Interviews
   - Prioritized Summary of Recommendations

Space Planning – Interviews

• M. Henderson	Interim Director of Plant Management
• M. Meade	Safety Officer
• A. Kattan	Chief of Staff, DHS

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Space Planning > Prioritized Summary of Recommendations

Space Planning		
Urgent	2.9.01	Develop a comprehensive summary of facilities needs and issues (by department) and prioritize them.
Urgent	2.9.02	Identify critical space requirements and implement remediation plan for areas such as outpatient pharmacy.
Intermediate	2.9.03	Formulate a facilities development strategy consistent with KDMC organizational goals and strategies (seismic considerations).
Short-term	2.9.04	Create a Health Facilities Planner decision to develop a strategic facilities plan and coordinate space allocation committee activities.
Urgent	2.9.05	Launch a newly constituted space allocation committee.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Space Planning

Assessment

- Several inpatient units are closed and unlikely to reopen soon, and two floors of the Trauma Center are unused; one is being built-out to house the Women's Center in May 2005, creating more vacant space.
- There is a perception by KDMC leadership and physicians that there is inadequate space for current programs and support needs.
- A Space Committee does exist as a sub-committee of the Hospital Environment of Care Committee. It is composed largely of middle management and does not have significant medical representation. Its purpose is to consider and recommend to senior management short-term space allocations. It has not addressed long-range facility planning.
- The last master facility plan was completed in 1994; a copy is not available.
- The facilities and space allocation at KDMC are not coordinated with the County's stated plan to; among other elements, regionalize neonatal care, suspend indefinitely the trauma service, improve the quality and effectiveness of current services, limited pediatrics, and others.

Space Planning

Deficiencies

- Facility planning and space allocation are not tied to an overall strategic plan.
- Space allocation lacks significant input from the Medical Staff and other stakeholders, other than championing individual program requests. There is no structural link/committee structure that provides oversight and coordination that effectively involves senior management and physicians.
- There is a lack of coordination and communication with Drew University. Since the academic chairs and the clinical chiefs are the same person in each department, this should be relatively easy to address.
- There is no effective space planning function; including, input from, and review by, administration and Medical Staff.
- Lack of available existing space allocation inventory (by department) documentation and composite floor plans illustrating current departmental boundaries.
- No coordination of deferred maintenance issues with anticipated departmental functional reconfigurations.

Space Planning

Recommendations

2.9.01 Develop a comprehensive summary of facilities needs and issues (by department) and prioritize according to the following:

- Urgency and timing
- Supportive of strategic goals
- Life safety corrections
- Return on investment potential
- Improved functional/operational efficiency
- Patient comfort/confidentiality
- Quality improvements
- System breakdown avoidance

2.9.02 Identify critical space requirements and implement remediation plan for areas such as outpatient pharmacy.

2.9.03 Formulate a facilities development strategy consistent with KDMC organizational goals and strategies (seismic considerations).

2.9.04 Create a Health Facilities Planner decision to develop a strategic facilities plan and coordinate space allocation committee activities.

Space Planning

Recommendations

2.9.05 Launch a newly constituted space allocation committee.

- Include administration and Medical Staff.
- Develop specific space and facilities timetable, budget and accountabilities, and select facility priorities for structural and/or cosmetic upgrades.
- Focus on direct patient care improvements as identified in the JCAHO surveys (such as confidentiality of counseling and long waiting lines).
- Focus should also include OR, Pharmacy and ED deficiencies not identified explicitly in the surveys.
- Space analysis must also include infrastructure (i.e., HVAC, elevators, roofing and grounds).

Responsibility

- CEO

Section II – General Operations / Organizational Structure

10. Environment of Care
    - Interviews
    - Prioritized Summary of Recommendations

Environment of Care > Interviews

• M. Meade	Environmental Safety Officer
• N. Datta, MD	Acting Chair, Surgery
• N. Smith	Clinical Manager, OR
• M. Henderson	Interim Director, Plant Management
• A. Smith	Psych Manager
• O. O'Rourke	Interim Nursing Director

Environment of Care > Prioritized Summary of Recommendations

Environment of Care		
Short-term	2.10.01	Develop a format for all Environment of Care programs to follow in assessing their Annual Effectiveness including the Performance Measure Indicator summary; Establish monitors that demonstrate continued compliance within each EOC.
Short-term	2.10.02	Establish a format for reporting that includes all of the JCAHO Elements of Performance (EPs) and Performance Measures and criteria for effectiveness.
Urgent	2.10.03	Redesign and implement an effective Patient Safety Committee.
Urgent	2.10.04	Develop daily, monthly, quarterly safety review requirements.
Short-term	2.10.05	Fill the vacant Safety Officer position immediately and provide clerical/statistical assistance to the safety office (perhaps a shared position with Patient Safety or Performance Improvement).
Urgent	2.10.06	Review and revise all seven Environment of Care polices, procedures, and guidelines.
Urgent	2.10.07	Clarify and communicate Recall and Hazard warning policy, procedures, and accountabilities; Monitor compliance and provide routine reporting.
Short-term	2.10.08	Report at least quarterly, measures with a denominator that allows some benchmarking and trending to occur (example: injuries per 1,000 employee hours; lost workdays per 10,000 employee hours).
Short-term	2.10.09	Develop and implement a comprehensive plan to reduce patient safety issues for mental health patients.
Short-term	2.10.10	Complete an updated SOC for each Healthcare Occupancy per JCAHO requirements based on the 2000 NFPA 101 Life Safety Code per JCAHO and CMS; Track the compliance of the identified EC deficiencies.
Urgent	2.10.11	Conduct/complete comprehensive risk assessment of all Surgery areas to reduce hazards to patients and staff.
Short-term	2.10.12	Review and design standardized processes and procedures for fire drills and disaster responses.
Short-term	2.10.13	Design and implement an infant abduction system.
Urgent	2.10.14	Provide coaching / support to the Environmental Safety Officer and Interim Director, Plant Management.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Environment of Care

Assessment

- The annual evaluation for effectiveness of the environment of care program for 2003 reviewed in the safety minutes does not appear consistent in format nor does it include performance measure indicator annual summary.
- Documentation in Safety Committee minutes is sparse based on deferred and tabled reports due to absenteeism of members and lack of data/information from programs.
- Daily safety rounds are not being consistently met.
- The safety office currently is providing almost all of the environment of care compliance effort. It is understaffed by one vacant position and requires additional clerical/statistical support. If the environment of care program is expected to perform effectively and efficiently, there needs to be the necessary staffing support to sustain that effort.
- The leadership has not approved the current environment of care, as well as other crucial supporting documents.
- The recall and hazard warning policy for products and equipment has recently been rewritten but is not yet followed by all participants within the organization. The coordination of services with separate purchasing abilities (pharmacy) and other contract services (dietary) make for a somewhat fragmented effort at present.

Environment of Care

Assessment

- The lone incident/accident report for 2004 was submitted to the safety office in November and contained raw data only (injury breakdown by organization for all County healthcare services).
- The County Police staff serving at KDMC are frequently drawn from other County healthcare facilities including the supervising officers. However, there is little, if any, standardization between healthcare facilities within the County system; which puts the officers, employees, patients, and community served at some risk.
- A tour of the mental health units indicates that there are potentially serious environmental safety issues in patient rooms, even in the remodeled rooms.
- A review of the Statement of Conditions (SOC) and brief tours of the patient care buildings indicates that the current SOC is not accurate.
- A tour of the Surgery Suites indicates that there are potentially serious environmental safety issues in storage rooms, and even in the surgery suites.
- Incident commanders are not provided the same communication/notification system that other programs within the hospital have.
- The areas that house infants do not have adequate alarms or anti-abduction systems in place; beyond local alarms on a few doors.

Environment of Care

Assessment

- Daily fire safety rounds are not being consistently met.
- It is not known if the current fire drill schedule includes all shifts worked by staff.
- The damper testing has not yet been accomplished although it is approved and will be scheduled by 2005.
- Not all medical equipment is inspected prior to use as it does not follow the prescribed protocol for incoming medical equipment. This is a department/service violation of policy issue.
- The integration of safety and patient safety is fragmented at best. The ongoing reorganization and rotating door of leadership seems to have further complicated this issue.
- There are many contract medical equipment maintainers (ICU monitors, anesthesia, respiratory, radiology, and dialysis) that should be better integrated into the medical equipment program.

Environment of Care

Deficiencies

- Insufficient resources to the environment of care compliance.
- Ineffective environment of care program.
- Ineffective governance by the Safety Committee.

Recommendations

2.10.01 Develop a format for all Environment of Care programs to follow in assessing their Annual Effectiveness, including the Performance Measure Indicator summary. Establish monitors that demonstrate continued compliance within each EOC.

2.10.02 Establish a format for reporting that includes all of the JCAHO Elements of Performance (EPs), Measures of Success (MOS) and Performance Measures and criteria for effectiveness.

2.10.03 Redesign and implement an effective Patient Safety Committee.

2.10.04 Develop daily, monthly, quarterly safety review requirements.

Environment of Care

Recommendations

2.10.05 Fill the vacant Safety Officer position immediately and provide clerical/statistical assistance to the safety office (perhaps a shared position with Patient Safety or Performance Improvement).

2.10.06 Review and revise all seven Environment of Care polices, procedures, and guidelines.

2.10.07 Clarify and communicate Recall and Hazard warning policy, procedures, and accountabilities; Monitor compliance and provide routine reporting.

2.10.08 Report at least quarterly, measures with a denominator that allows some benchmarking and trending to occur (example: injuries per 1,000 employee hours; lost workdays per 10,000 employee hours).

2.10.09 Develop and implement a comprehensive plan to reduce patient safety issues for mental health patients.

Environment of Care

Recommendations

2.10.10 Complete an updated SOC for each Healthcare Occupancy per JCAHO requirements based on the 2000 NFPA 101 Life Safety Code per JCAHO and CMS; Track the compliance of the identified EC deficiencies.

2.10.11 Conduct/complete comprehensive risk assessment of all Surgery areas to reduce hazards to patients and staff.

2.10.12 Review and design standardized processes and procedures for fire drills and disaster responses.

2.10.13 Design and implement an infant abduction system.

2.10.14 Provide coaching/support to the Environmental Safety Officer and Interim Director, Plant Management.

Environment of Care

Performance Measures

Safety

- Total patient slips and falls per 1,000 patient days
  - Current not currently measured
  - Target TBD
- Number of self-injury per 1,000 psychiatric patient days (Adolescent/Adult to be separated)
  - Current not currently measured
  - Target TBD
- Number of physical assault per 1,000 psychiatric patient days (Adolescent/Adult to be separated)
  - Current not currently measured
  - Target TBD
- Employee injuries per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Employee Workers' Compensation claims per 100 actual FTEs
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Security

- Number of security actual FTEs per 100,000 sq. ft. (including parking)
  - Current not currently measured
  - Target TBD
- Number of assaults against patients per 100,000 sq. ft. (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of assaults against employees per 100,000 sq. ft. (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of assaults against visitors per 100,000 sq. ft. (buildings & parking)
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Security

- Number of thefts per 100,000 sq. ft. (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of property damage/vandalism per 100,000 sq. ft. (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of auto break-ins per 100,000 sq. ft. parking
  - Current not currently measured
  - Target TBD
- Number of auto thefts per 100,000 sq. ft. parking
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Hazmat

- Number of skin/mucous membrane exposures per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Number of solid needle/sharps injuries per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Number of hollow needle injuries per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Number of chemical spills
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Emergency Management

- Number of Emergency Management drills
  - Current not currently measured
  - Target TBD
- Number of Emergency patients requiring decontamination facilities
  - Current not currently measured
  - Target TBD
- Number of employees that received smallpox immunization since 2002 (exclude military)
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Fire Safety

- Number of fires per 1,000 sq. ft. (occupied)
  - Current not currently measured
  - Target TBD
- Failure rate (percentage of total count)
  - Supervisory signal devices
  - Valve tamper & flow switches
  - Duct detectors, smoke detectors, heat detectors, pull stations, electromechanical releasing devices
  - Occupant notification devices (audible & visual)
  - Fire/smoke dampers
  - Automatic smoke detection shutdown for air handling
    - Current not currently measured
    - Target TBD

Environment of Care

Performance Measures

Medical Equipment

- Percentage of medical equipment inventory with failure
  - Current not currently measured
  - Target TBD
- Percentage of medical equipment inventory with failed test/inspection
  - Current not currently measured
  - Target TBD
- Percentage PM completion rate
  - Current not currently measured
  - Target TBD
- Percentage of medical equipment inventory that could not find
  - Current not currently measured
  - Target TBD
- Percentage of medical equipment inventory with user error
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Medical Equipment

- Number of pumps without free flow protection
  - Current not currently measured
  - Target TBD
- Number of incidents where clinical staff did not hear or respond timely to medical equipment alarm
  - Current not currently measured
  - Target TBD
- Number of pieces of medical equipment per actual in-house Biomed employee hours worked
  - Current not currently measured
  - Target TBD
- Number of pieces of medical equipment found without incoming inspection
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Utility Systems

- Percentage PM completion rate
  - Current not currently measured
  - Target TBD
- Emergency electrical generator failure per generator
  - Current not currently measured
  - Target TBD

Responsibility

- COO

Section II – General Operations / Organizational Structure

11. Facilities Management
    - Interviews
    - Prioritized Summary of Recommendations
    - Clinical Engineering
    - Plant Engineering
    - Environmental Services

Facilities Management > Interviews

- M. Henderson — Interim Director
- P. Valenzuela — Lead Administrator
- R. Ward, PhD — Director, Biomedical Engineering
- F. Ponder — Director, Environmental Services

Facilities Management > Prioritized Summary of Recommendations

Facilities Management – Clinical Engineering		
Short-term	2.11.01	Identify responsibility for maintaining and cleaning medical equipment.
Urgent	2.11.02	Develop an annual plan for inservice education for nurses and others regarding monitoring equipment. Involve Medical Equipment manager with all ME contract activities to assure a consistent program/compliance.
Short-term	2.11.03	Develop productivity standards and hold staff individually responsible for performance, particularly with regard to preventive maintenance.
Plant Engineering		
Short-term	2.11.04	Develop a comprehensive preventive maintenance plan in plant management.
Short-term	2.11.05	Develop a comprehensive plan for routinely refurbishing the facility. Priority given to public and patient areas.
Intermediate	2.11.06	Conduct a “make or buy” evaluation should be done for future construction and renovation projects.
Environmental Services		
Long-term	2.11.07	Evaluate outsourcing management and the operations of Environmental Services.
Short-term	2.11.08	Review and evaluate processes and procedures to maintain regulatory documentation.
Intermediate	2.11.09	Evaluate and ensure access for facilities management to all accountable areas.
Intermediate	2.11.10	Develop process and procedures to identify and return unused equipment.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Facilities Management > Clinical Engineering

Assessment

- Staff consists of 10 engineers and technicians for approximately 6,000 pieces of equipment. Repair and maintenance for major radiologic equipment is contracted out.
- Leadership is perceived as very capable and knowledgeable, relating well with customers on a limited basis.
- Quality of the repair and preventive maintenance is seen as adequate.
- Inservice and training on the use of the equipment is not consistently programmed.
- Preventive maintenance schedules exist but are not monitored for completion.
- Equipment logs and PM schedules are not integrated.

Facilities Management > Clinical Engineering

Deficiencies

- Responsibility for maintaining, repairing, and cleaning is split among biomedical engineering, environmental services, and selected contractors.
- Nurses and other clinicians do not demonstrate consistent proficiency in the use of monitoring equipment.
- Preventive maintenance is not consistently monitored and accomplished.

Recommendations

2.11.01 Identify responsibility for maintaining and cleaning medical equipment.

2.11.02 Develop an annual plan for inservice education for nurses and others regarding monitoring equipment. Involve Medical Equipment manager with all ME contract activities to assure a consistent program/compliance.

2.11.03 Develop productivity standards and hold staff individually responsible for performance, particularly with regard to preventive maintenance.

Facilities Management > Clinical Engineering

Performance Measures

- See Environment of Care Performance Measures (pages 180 -188)
- Productivity: Worked hours per adjusted patient day
  - Current not currently collected
  - Target .12
- Total repair and maintenance cost per occupied bed
  - Current not currently collected
  - Target TBD

Responsibility

- COO
- Director, Biomed

Facilities Management > Plant Engineering

Assessment

- Staff consists of 103 items, including all trades, not including biomedical engineering for a facility slightly in excess of 1.5 million square feet.
- Leadership is provided on an interim basis by three managers on loan from DHS. The interim director is perceived as capable, knowledgeable and works well with peers.
- The functions of the department include preventive maintenance and repair. Virtually all significant construction and renovation is outsourced.
- Preventive maintenance and a sustained investment in the facility and its aesthetics have been lacking. The priority has been repair, rather than maintenance. Selected PM schedules exist but have not been adhered to.
- The scope and quality of the work done is good. All technical capabilities to do more significant construction and renovation exist.
- Interaction with customers, such as Nursing directors, is perceived as improving with new management.

Facilities Management > Plant Engineering

Deficiencies

- Preventive maintenance plans exist but are not routinely monitored or accomplished.
- There is not an ongoing schedule of refurbishment.
- Virtually all significant construction and renovation is outsourced, despite significant in-house capability.
- Staff priority has been repair, then maintenance, then renovation.

Recommendations

2.11.04 Develop a comprehensive preventive maintenance plan in plant management.

- Include, at least, HVAC systems, power plant, roofing, elevators, lighting, and ceiling repair.

2.11.05 Develop a comprehensive plan for routinely refurbishing the facility. Priority given to public and patient areas.

2.11.06 Conduct a make-or-buy evaluation for future construction and renovation projects.

Facilities Management > Plant Engineering

Performance Measures

- See Environment of Care Performance Measures (pages 180 -188)
- Productivity: Worked hours per 1,000 sq. ft. maintained
  - Current not currently collected
  - Target TBD
- Number of unresolved work orders
  - Current not currently collected
  - Target TBD

Responsibility

- COO
- Director of Plant Management

Facilities Management > Environmental Services

Assessment

- Staff consists of 137 FTEs; including 6 in laundry.
- Leadership is seen as committed to improvement; but ineffective in changing the perceptions of customers that the place is dirty.
- There is a general perception that there is too much clutter, litter, and dust. Limited satisfaction studies and personal observation support that perception.
- Off-shift support and supervision is seen as particularly weak.
- Includes housekeeping and laundry service for the entire campus.

Facilities Management > Environmental Services

Deficiencies

- The level of cleanliness is not measured, trended, and analyzed. The evidence that exists indicates an unsatisfactory level.
- Off-shift supervision and performance is consistently reported to be unsatisfactory with regard to availability and responsiveness.

Recommendations

2.11.07 Evaluate outsourcing management and the operations of Environmental Services.

2.11.08 Review and evaluate processes and procedures to maintain regulatory documentation.

2.11.09 Evaluate and ensure access for facilities management to all accountable areas.

2.11.10 Develop process and procedures to identify and return unused equipment.

Facilities Management > Environmental Services

Performance Measures

- Productivity: Worked Hours per 1,000 sq. ft. Maintained
  - Current not currently collected
  - Target TBD
- Quality scores from objective sampled review of cleanliness
  - Current not currently collected
  - Target TBD
- Percentage of routine rooms responded to within 30 minutes
  - Current not currently collected
  - Target 90%
- Percentage of STAT rooms responded to within 15 minutes
  - Current not currently collected
  - Target 95%
- Percentage of rooms called STAT
  - Current not currently collected
  - Target 20%

Responsibility

- COO
- Director of Environmental Services

Section II – General Operations / Organizational Structure

12. Materials Management
    - Interviews
    - Prioritized Summary of Recommendations

NAVIGANT CONSULTING

Materials Management > Interviews

• A. Gray	Chief Financial Officer
• E. Bolden	Materials Management
• S. Trejo	Value Analysis Facilitator

Materials Management > Prioritized Summary of Recommendations

Materials Management		
Short-term	2.12.01	Implement electronic requisitioning process.
Urgent	2.12.02	Fill vacant positions as appropriate.
Short-term	2.12.03	Enhance working relationship between Materials Management and Value Analysis Facilitator.
Short-term	2.12.04	Consolidate the invoice processing/accounts payable unit in Materials Management with Expenditure Management.
Short-term	2.12.05	Establish the supply chain operations infrastructure with clearly defined lines of accountability and authority.
Short-term	2.12.06	Complete an inventory assessment in the cath lab and operating room.
Short-term	2.12.07	Work to develop consignment relationships with vendors particularly for high-priced physician preference items.
Short-term	2.12.08	Formalize and enhance supply chain performance measurement reporting.
Short-term	2.12.09	Distribute performance reports to key executives and department leadership.
Short-term	2.12.10	Conduct detailed analysis of Novation contracts with respect to KDMC purchases to identify optimization opportunities where reasonable and appropriate.
Short-term	2.12.11	Increase communication with physicians, with support from hospital leadership, to increase standardization of clinical product selection.
Short-term	2.12.12	Establish Product Evaluation/Standardization Team that encompasses all clinical and non clinical areas.
Short-term	2.12.13	Develop and adopt a product acquisition and management approach to managing entry of new products and evaluating existing products/services for standardization/utilization opportunities.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Materials Management

Assessment

- Materials Management at KDMC reports to the CFO.
- Local functions include:
  - Warehouse Management
  - Procurement
  - Central Services
  - Forms Design
  - Invoice Processing
  - Fixed Asset/Processing
- Department has 76 budgeted FTEs with 24 currently vacant.
  - 39 in Sterile Processing and PAR Distribution with 13 vacant.
  - 18 in the Warehouse with 12 vacant.
  - 6 in Materials Management Administration with 1 vacant.
  - 5 in Invoice Processing all filled.
  - 8 in Procurement with 2 vacant.

Materials Management

Assessment

- The management positions include a financial analyst and a staff assistant. Two managers and an information coordinator.
- Pharmacy purchases are coordinated through the Los Angeles County (LAC) and USC Medical Center. The KDMC pharmacy manages its own inventory and utilizes Hospital Materials Management Services (HMMS) in a manner similar to Materials Management.
- Materials Management is a DHS-wide process. Other DHS hospitals use similar processes.
- The group purchasing organization is UHC/Novation.
- There is a value analysis facilitator whose role it is to identify and evaluate the use of new products and improved efficiencies; reports to the COO.

Materials Management

Assessment

- Procurement:
  - All purchases go through a bid process or require substantial justification.
  - ISD purchasing has delegated pre-approved authority to KDMC thresholds:
    - $15 K with an appropriate quote, justification and vendor contract.
    - Minority or woman's (female owned) vendors - $10K post to their internet.
    - $5 K sole source.
    - Internal $1,500 requires secondary administrative approval within the facility.
  - Requisitions go first to Materials Management then Purchasing (County) who has final clearance. This varies depending on cost, product or service being requested, and delegated authority.
  - There are 1,100 to 1,300 requisitions per month that are all hard copy and processed manually.
  - Items ordered by departments are often made without use of specifications, catalogues or vendor references.
  - A PC-based, home grown system, on-line requisitioning process (currently up in two of the County hospitals) should be functioning in February 2005. It does not interface with ISD.
  - The requisitioning process has many steps and a long purchasing cycle.

Materials Management

Assessment

- Equipment Management:
  - Maintenance contracts are centrally coordinated, but managed at the department level.
  - A formal process for the approval of equipment exists but is not linked with scheduled retirement and replenishment. Group oversight exists but does not fully asses each department's true need. A cost benefit is not evaluated at the time each request is submitted. Most equipment gets approved; subject primarily to the discretion of each department.
  - No comprehensive equipment inventory exists that closely tracks movement of equipment throughout the hospital.
  - There are problems tracking minor equipment and items that move frequently between units and service departments.
  - There is no system for tracking useful life for planned replenishment.
  - There is no preventative maintenance program in place.
    - No bed rotation plan.
  - There is no process for ensuring that cost effective maintenance contracts are in place.

Materials Management

Assessment

- Inventory:
  - Warehouse inventory is automated with pre-authorized stock replenishment activities.
  - The cath lab and operating room maintain their own inventory.
    - There is an antiquated inventory system - all manual.
    - There is no use of consignment.
    - Current levels and turns are not known.
- Expense Management:
  - Responsibility summary report comes out monthly, 30 to 40 days after the period, with YTD actual service/supply expenditure. Reports are formatted to compare actual to budget.
  - At the department level there is minimal to no focus or effort on management of expenses.
  - At the department level there is no accountability to manage expenses.
  - Some minimal supply benchmarks are reported at executive meetings.
- Invoice Processing:
  - Interfaces with County-wide payment system.
  - Expenditure management processes Board-approved contract invoices for payment, but invoice payments for supplies are handled by Materials Management.

Materials Management

Deficiencies

- Inadequate plant asset system to track equipment inventory.
- Contract payment processing and purchase order processing is not integrated.
- All requisitioning is currently done manually.
- Inventories in high-cost areas are not managed by Materials Management.
- There is a lack of a coordinated expense management process.
- Lack of purchasing data.

Recommendations

2.12.01 Implement electronic requisitioning process.

2.12.02 Fill vacant positions as appropriate.

2.12.03 Enhance working relationship between Materials Management and Value Analysis Facilitator.

2.12.04 Consolidate the invoice processing/accounts payable unit in Materials Management with Expenditure Management.

2.12.05 Establish the supply chain operations infrastructure with clearly defined lines of accountability and authority.

2.12.06 Complete an inventory assessment in the cath lab and operating room.

Materials Management

Recommendations

2.12.07 Work to develop consignment relationships with vendors; particularly for high-priced, physician-preference items.

2.12.08 Formalize and enhance supply chain performance measurement reporting.

2.12.09 Distribute performance reports to key executives and department leadership.

2.12.10 Conduct detailed analysis of Novation contracts, with respect to KDMC purchases, to identify optimization opportunities where reasonable and appropriate.

2.12.11 Increase communication with physicians, with support from hospital leadership, to increase standardization of clinical product selection.

2.12.12 Establish a Value Analysis Team that encompasses all clinical and non-clinical areas.

2.12.13 Develop and adopt a product acquisition and management approach to managing entry of new products and evaluating existing products/services for standardization/utilization opportunities.

- Include major categories of products/services with key representatives.

Materials Management

Performance Measures

- Percentage of electronic requisitions
  - Current not available
  - Target 70%
- Percentage of departmental orders reviewed and assigned to procurement within 24 hours of receipt
  - Current not currently collected
  - Target TBD
- Percentage of vendor invoices processed to HMMS within 24 hours of receipt
  - Current not currently collected
  - Target TBD
- Percentage of warehouse product deliveries to user departments within two days of receipt from the vendor
  - Current not currently collected
  - Target TBD
- Reported occurrences of incomplete surgical trays
  - Current not currently cllected
  - Target TBD

Materials Management

Performance Measures

- Percentage of orders placed by procurement staff with vendors within five business days from receipt
  - Current not currently collected
  - Target TBD
- Time from requisition of order to receipt of product (end user)
  - Current not currently collected
  - Target TBD
- Inventory turns – warehouse
  - Current 11.5
  - Target 15 - 20
- Inventory turns – central supply
  - Current 15
  - Target 15 - 20
- Supply, drugs and consumables (SDC) as a percentage of operating expense
  - Current not currently calculated
  - Target 18 – 17.5%

Materials Management

Performance Measures

- SDC dollars per adjusted patient day
  - Current not currently calculated
  - Target TBD
- SDC dollars per adjusted discharge
  - Current not currently calculated
  - Target TBD

Responsibility

- CFO
- Director of Materials Management
- Value Analysis Facilitator

Section II – General Operations / Organizational Structure

13. Contracted Services
    - Interviews
    - Prioritized Summary of Recommendations
    - Respiratory Care
    - Dietary Services
    - Security

Contracted Services > Interviews

• Captain C. Tyus	LA County Police
• Chief M. York	LA County Police
• V. Turner	Health Services Bureau Chief
• N. Cortes	Director, Respiratory Therapy
• T. Gutierrez	Director, Dietary Services
• P. Price	Chief Nursing Officer
• M. Meade	Chief Safety Officer
• O. O'Rourke	Interim Nursing Director

Contracted Services > Prioritized Summary of Recommendations

Contracted Services – Respiratory Care		
Urgent	2.13.01	Hold IHS accountable for lack of performance against contract terms.
Urgent	2.13.02	Insure and document that all contractors participate in orientation.
Short-term	2.13.03	Conduct a monthly audit of compliance with contracted performance measures.
Urgent	2.13.04	Insure the appropriate use and control of respiratory medications.
Short-term	2.13.05	Develop a plan for the regular replacement and upgrading of equipment.
Short-term	2.13.06	Develop and adopt a weaning protocol and program for patients on ventilators.
Dietary Services		
Short-term	2.13.07	Review of the kitchen's facility needs should be undertaken. Specific timetables, costs and accountabilities should be developed.
Short-term	2.13.08	Conduct a review of the cafeteria's aesthetics and traffic flow.
Urgent	2.13.09	Ensure inservice classes are provided on therapeutic diets, proper food storage procedures and sanitation of equipment..
Urgent	2.13.10	Institute a daily log to ensure that appropriate temperatures are being maintained and communicate the results go to the Ancillary IOP and then on to the Hospital IOP.
Short-term	2.13.11	Include content on fluid restriction and portion size in the dietary orientation. Ensure Registered Dieticians monitoring fluid restrictions.
Short-term	2.13.12	Conduct random reviews of cardexes and compare them to Affinity for issues and identify plans for resolution.
Short-term	2.13.13	Establish a prioritized matrix to provide nursing information on the routine consults by dietary based on diagnosis and ensure all patients are receiving a nutritional assessment by a Registered Dietician.
Security		
Urgent	2.13.14	Develop and implement modified policies and procedures for use of tasers including conducting training and monitoring compliance.
Intermediate	2.13.15	Develop a succession plan for leadership.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Contracted Services > Respiratory Care

Assessment

- Respiratory Care is contracted out to IHS Symphony. The contract is for KDMC and expires in 2006.
- Administrative responsibility lies with the Lead Administrator for Clinical Services.
- Respiratory has been cited for non-compliance in JCAHO and CMS reviews and must ensure that all contracted employees have documented participation in orientation. Currently, fewer than half the contracted employees have documented participation.
- Detailed performance requirements exist in the contract identifying 36 required services.
  - Each service has an indicator, performance standard, maximum allowable variance, and method of monitoring.
- Recent sample audit of compliance (done by Nursing Service) with contract terms relating to documentation and technical performance shows substantial lack of compliance.
  - With regard to required documentation, compliance ranged from 31 -100%.
  - With regard to technical performance, compliance ranged from 0 - 71%. The threshold in the contract is 95%.
- A plan of correction is in development.

Contracted Services > Respiratory Care

Assessment

- A sampling of physicians and nurses perceived service to be average by. Number of staff is deemed to be adequate. The contract specifies fees that vary with volume, but does not specify that staff will vary proportionately; thereby, creating an incentive for increasing volume without increasing staff.
- However, a significant component of contractors are Registry staff, compromising continuity.
- Fewer than half the current contractors have documented participation in orientation.
- Respiratory therapists do not appear to be aggressive about treatment modalities or involvement with care planning. There are no regular forums for joint Nursing/Respiratory Therapy (RT) issues to be addressed.
- Much of the equipment is not state-of-the-art. Specifically, one blood gas analyzer and many ventilators are two generations old technologically.

Contracted Services > Respiratory Care

Deficiencies

- The contractor has not complied with the performance requirements of the contract.
- Management has not held the contractor to the terms.
- Much of the equipment is technologically out of date, and there is not an ongoing schedule for replacement and upgrading.

Recommendations

2.13.01 Hold IHS accountable for lack of performance against contract terms.

2.13.02 Insure and document that all contractors participate in orientation.

2.13.03 Conduct a monthly audit of compliance with contracted performance measures.

2.13.04 Insure the appropriate use and control of respiratory medications.

2.13.05 Develop a plan for the regular replacement and upgrading of equipment.

2.13.06 Develop and adopt a weaning protocol and program for patients on ventilators.

Responsibility

- Lead Administrator
- COO

Contracted Services > Dietary Services

Assessment

- The service is outsourced to Morrison, a County contractor. It is accountable administratively to the Lead Administrator for Support Services.
- The contract expires in mid-2006 and only generally describes performance expectations in terms of satisfaction, regulatory compliance, and management cooperation.
- There were no significant regulatory deficiencies identified in the last series of surveys.
- Total staff is 75 FTEs including 6 clinical dieticians.
- Quality of food in cafeteria is regarded as good. Limited information from patient surveys and anecdotal information supports assessment of good quality on inpatient units.
- Clinical staff interaction with Nursing is good. Clinicians are reasonably well-integrated into the care planning process. Number of special diets is high.
- Management has been responsive to customer complaints with changes in menu, special services, and catering.
- The kitchen area needs renovation and repair. Broken tiles, leaking faucets and peeling paint are chronic problems.

Contracted Services > Dietary Services

Deficiencies

- The physical facilities in the kitchen area are sub-standard.
- Inconsistent implementation of dietary standards, i.e., accurate measurement of intake and output, variable portion size.
- Inconsistent assessment of patient-specific dietary needs.

Recommendations

2.13.07 Review of the kitchen's facility needs should be undertaken. Specific timetables, costs and accountabilities should be developed.

2.13.08 Conduct a review of the cafeteria's aesthetics and traffic flow.

2.13.09 Ensure inservice classes are provided on therapeutic diets, proper food storage procedures and sanitation of equipment.

2.13.10 Institute a daily log to ensure that appropriate temperatures are being maintained and communicate the results go to the Ancillary IOP and then on to the Hospital IOP.

2.13.11 Include content on fluid restriction and portion size in the dietary orientation. Ensure Registered Dieticians monitoring fluid restrictions.

Contracted Services > Dietary Services

Recommendations

2.13.12 Conduct random reviews of cardexes and compare them to Affinity for issues and identify plans for resolution.

2.13.13 Establish a prioritized matrix to provide nursing information on the routine consults by dietary based on diagnosis and ensure all patients are receiving a nutritional assessment by a Registered Dietician.

Responsibility

- COO
- Dietary Director

Contracted Services > Security

Assessment

- Security is provided by The Office of Public Safety (OPS) of LA County, which is responsible for security services at all County facilities, not just hospitals.
- Management is perceived as knowledgeable and responsive.
- Security in the hospital's locale is a primary concern. Officers are perceived to be well-trained and effective in prevention and detection. Rounds are staggered randomly to avoid a detectable pattern.
- The use of tasers as a means of dealing with menacing patients, particularly in psychiatry, has been problematic. While there has been a decrease in injuries to both patients and staff as a result of their use, regulatory standards have required minimizing their use and only as a very last resort.
- Coordination with the campus Safety Officer and patient safety program is good.
- Leadership is in transition with the upcoming retirement of the current Director.

Contracted Services > Security

Deficiencies

- The use of tasers has been a significant regulatory barrier, and is perceived to be inconsistent with the hospital's overall duty to provide safe care.
- Officers who rotate onto the campus from other non-hospital County assignments do not have a standard orientation to KDMC.
- Leadership in the department is in transition, with the impending retirement of the department's Captain.

Recommendations

2.13.14 Develop and implement modified policies and procedures for use of tasers including conducting training and monitoring compliance.

2.13.15 Develop a succession plan for leadership.

Responsibility

- Department Director (Captain) with OPS Chief
- COO

Contracted Services

Performance Measures

Respiratory Care

- Percentage of contractors that have completed orientation
  - Current <50%
  - Target 100%
- Number of Required Services (identified in the contract) with Variance from the performance standard
  - Current 12
  - Target 0

Contracted Services

Performance Measures

Dietary Services

- Productivity: Worked hours per equivalent meal
  - Current not currently collected
  - Target TBD
- Overall Satisfaction
  - Current not currently collected
  - Target TBD
- Time from Order to Tray Delivery
  - Current not currently collected
  - Target TBD
- Documentation of accurate Intake and Output
  - Current not currently available
  - Target 100%
- Percentage of patients who receive a nutritional assessment
  - Current not currently available
  - Target 100%

Contracted Services

Performance Measures

Security

- See Environment of Care Performance Measures (pages 180-188)
- Percentage of Code 9s resulting in police action
  - Current Not currently collected
  - Target TBD
- Productivity: worked hours per 100 sq. ft. patrolled
  - Current not currently collected
  - Target TBD

Section III – Clinical Organizations

NAVIGANT CONSULTING

Section III – Clinical Organization

1. Case Management / Utilization
   - Case Management
     - Organizational Structure and Model
     - Processes
       - Utilization
       - Discharge Planning
       - Care Coordination/Facilitation
       - Denial Management
   - Physician Roles, Practice Patterns and Clinical Pathways/Order Sets
   - Utilization Data

Case Management / Utilization > Prioritized Summary of Recommendations

Care Management and Utilization – Organization Structure and Model		
Intermediate	3.1.01	Integrate the Departments of Social Work, Admitting and Care Management into a single Care Management Department with one director and an Assistant Director for Social Work.
Short-term	3.1.02	Align the Department, administratively to the Medical Director.
Short-term	3.1.03	Integrate the UM and case manager roles.
Short-term	3.1.04	Reassign the new Care Managers to units with a ratio of no more than 1 to 20.
Intermediate	3.1.05	Create and develop unit-based teams of case manager, social worker and community worker who work collaboratively to provide service to all the patients on their unit.
Short-term	3.1.06	Realign the Patient Flow Nurse with the new Care Management Department
Short-term	3.1.07	Identify case management responsibilities by role and establish performance expectations and indicators.
Intermediate	3.1.08	Monitor and manage the performance of all staff and assess their competencies.
Short-term	3.1.09	Reassess the role of the Community Workers who are currently working outside their job description.
Processes – Utilization		
Short-term	3.1.10	Adjust coverage of Admission Nurse to 16 hours/5 days/week and 8 hours on Saturday and Sunday.
Short-term	3.1.11	Revise the Admission Nurse Job Description.
Short-term	3.1.12	Adopt InterQual as the standard criteria for clinical reviews.
Short-term	3.1.13	Utilize M&R as reference tool for concurrent reviews/clinical milestones but not sole source for reviews.
Short-term	3.1.14	Create an interdisciplinary referral screening tool which is to be completed during the initial review.
Short-term	3.1.15	Incorporate assignment of a working DRG into initial review process.
Intermediate	3.1.16	Identify process to revise working DRG throughout hospital stay; communicate ELOS to interdisciplinary team and guide discharge planning.
Short-term	3.1.17	Revise initial clinical review screening tool to more appropriately incorporate InterQual type standards to address patient admit status, LOC and discharge criteria.
Intermediate	3.1.18	Revise concurrent clinical review screening tool to reflect minimum standards of documentation required.
Short-term	3.1.19	Review role of Patient Flow Nurse; expand to include duties typical to “Bed Manager” responsible for all bed placement.
Short-term	3.1.20	Develop/implement clear transfer/admission acceptance protocols; communicate to accepting physicians.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Case Management / Utilization > Prioritized Summary of Recommendations

Processes – Discharge Planning		
Short-term	3.1.21	Complete a comprehensive assessment of discharge needs for all patients at the point of admission.
Short-term	3.1.22	Identify roles for case managers/social workers in screening all patients for potential discharge needs.
Urgent	3.1.23	Initiate daily huddles between case manager, social worker and Nursing to briefly discuss each patient, plan of care and any identified needs.
Intermediate	3.1.24	Revise discharge planning process and documentation.
Intermediate	3.1.25	Identify strategies to include patient/patient's family/significant others in discharge assessment/planning process.
Short-term	3.1.26	Reformat Interdisciplinary Rounds currently held in Medicine, Pediatrics and NICU.
Long-term	3.1.27	Institute Interdisciplinary Rounds on all nursing units.
Long-term	3.1.28	Perform routine chart audits of all units to ensure Interdisciplinary plan is documented adequately in the medical record take action to resolve issues.
Urgent	3.1.29	Leverage formal meetings (huddles and Rounds) to educate Interdisciplinary Team as to role of case manager and social worker in discharge planning process.
Urgent	3.1.30	Revise/standardize current policy for documentation to ensure requirements meet JCAHO standards and other state/local governing bodies.
Short-term	3.1.31	Provide education and develop tools to implement standards.
Processes – Care Coordination/Facilitation		
Short-term	3.1.32	Provide education and training to case managers to assist them in understanding their role in facilitating patients care.
Long-term	3.1.33	Incorporate predictive indicators such as established order sets, care maps or key clinical milestones into their work processes.
Short-term	3.1.34	Educate case managers to physician advisor role and potential for physician intervention for patients they identify with this need.
Urgent	3.1.35	Initiate weekly ELOS meetings to discuss and problem-solve patients with LOS >10 days.
Short-term	3.1.36	Identify reasons driving long LOS and seek resolutions.
Short-term	3.1.37	Perform individual case review for the high outlier physicians.

Case Management / Utilization > Prioritized Summary of Recommendations

Processes – Denial Management		
Intermediate	3.1.38	Conduct a preadmission initial review by Admitting RN and rigorous management of concurrent reviews.
Intermediate	3.1.39	Develop consolidated denial reporting and trending for all payers.
Physician Roles, Practice Patterns and Clinical Pathways/Order Sets		
Short-term	3.1.40	Recruit/train Physician Advisor to provide physician intervention for such issues as appropriateness of admission/LOC; timeliness/appropriateness of plan of care.
Long-term	3.1.41	Share individual physician performance data with physicians and develop targets and interventions for outliers with timelines and accountabilities.
Intermediate	3.1.42	Standardize use of clinical pathways. Begin with goal of 100% implementation for simple diagnoses such as pneumonia, CHF.
Intermediate	3.1.43	Develop a policy and procedure to define the process and monitor compliance.
Utilization Data		
Short-term	3.1.44	Focus attention and effort on patients with diagnoses within MDCs most deviant from the CMS geometric mean LOS (either by degree or frequency). Begin with MDC 8, musculoskeletal groups.
Short-term	3.1.45	Initiate weekly Extended LOS meetings.
Short-term	3.1.46	Trend the LOS data by DRG and MDC on a monthly basis, to monitor the improvement made in decreasing LOS.

Case Management / Utilization > Care Management – Organizational Structure and Model

Assessment

- Case Management, including Utilization Review (UR), and Social Work are separate departments with different administrative reporting.
- The Director of Case Management reports to the Chief Financial Officer.
- The Director of Social Work reports to the Chief Operating Officer.
- The Director of Care Management also manages Admitting.
- Social Work has three supervisors who manage line staff.
- Both case managers and social workers are unit-based.
- Current staffing ratios are at or above leading practice.
  - The ratio of case managers to patient caseload is 1 to15; with leading practice being 1 to 20 - 25.
  - The ratio of social workers to patient caseload is 1 to 12; with leading practice being 1 to 30 - 40.

Case Management / Utilization > Case Management – Organizational Structure and Model

Table of Employees per Classification

Case Management Department	
Role	**FTEs**
Administrative	9
UR Nurse	11
Care Manager	4
Patient Resource Worker	2
Total FTEs	**26**

Social Work Department	
Role	**FTEs**
Administrative	4
Community Worker	7.75
CSW	4
LCSW	6
Psych Social Worker	7
Medical Case Worker	2
Total FTEs	**30.75**

Case Management / Utilization > Case Management – Organizational Structure and Model

Assessment

- Historically the role of utilization managers and case managers have been separated.
- Case managers are responsible for the discharge needs of patients returning to home situations.
- Utilization managers review patients for appropriateness of admission, LOS, LOC, and communicate with payers.
- Currently the case management (CM) and utilization management (UM) functions are being integrated into a single job description called Case Manager.
- Case managers in the main hospital are available 9 hours from 7:30 AM – 4:30 PM, Monday through Friday.
- Admit nurse is staffed in the ED, 24 hours a day, Monday through Friday.
- Social workers are responsible for all psycho-social needs and the discharge planning needs of patients who require post-hospital placement.
  - There is a social worker on call 24/7.

Case Management / Utilization > Case Management – Organizational Structure and Model

Assessment

- Community workers within the Social Work department were introduced to provide translation, resource, referral, and community outreach services.
  - Staffing challenges have affected the ability to perform the tasks originally intended, and currently staff in this position fulfill tasks such as; manning the information desk, compiling data for report to the County, etc.
  - Community workers are available nine hours, Monday through Friday.
- ED admissions nurse is staffed 24 hours, Monday through Friday, and reviews all non-scheduled admissions for appropriateness of admission and level of care. The ED Admission Nurse reports to the Case Management Director.
- Patient flow nurse is responsible for arranging transfers into and from KDMC and reports to Nursing.
- Clerical support is available to Case Management and Social Work.
  - Social Work administrative staff log in referrals, transcribe any correspondence, and perform receptionist and general administrative assistant tasks.
  - Care Management administrative staff provide support and documentation to the MediCal Payment Authorization Form (TAR) process and DHS reporting.

Case Management / Utilization > Case Management – Organizational Structure and Model

Deficiencies

- Uncoordinated, ineffective structure does not support a coordinated approach to management of patients across the continuum.
- Unclear roles and responsibilities amongst providers.

Recommendations

3.1.01 Integrate the Departments of Social Work, Admitting and Case Management into a single Case Management Department with one director and an Assistant Director for Social Work.

3.1.02 Align the Department, administratively to the Medical Director.

3.1.03 Integrate the UM and case manager roles.

3.1.04 Reassign the new Case Managers to units with a ratio of no more than 1 to 20.

3.1.05 Create and develop unit-based teams of case manager, social worker and community worker who work collaboratively to provide service to all the patients on their unit.

3.1.06 Realign the Patient Flow Nurse with the new Case Management Department

Case Management / Utilization > Case Management – Organizational Structure and Model

Recommendations

3.1.7 Identify case management responsibilities by role and establish performance expectations and indicators.

- Case managers continue to organize discharge planning and directly arrange straightforward services, i.e., home care needs
- Case managers screen all patients for LOC, opportunities to facilitate care delivery, and potential discharge needs.
- Social workers coordinate complex discharge planning, such as, nursing home placements.
- Social workers provide all psycho-social evaluations.
- Community workers provide translation and support services.

3.1.08 Monitor and manage the performance of all staff and assess their competencies.

3.1.09 Reassess the role of the Community Workers who are currently working outside their job description.

Case Management / Utilization > Case Management – Processes / Utilization

Assessment

- All un-scheduled admissions are reviewed prior to admit for appropriateness of admission 24 hours a day, 5 days a week. Monday through Friday.
- Initial assessments are completed within 24 working hours, on Monday through Friday, of admission for all patients.
  - LOC assessments are completed, based upon experience rather than empirical data, such as, InterQual or Millimen & Roberts (M and R).
  - M & R standards are available in the case manager office for reference, but are not routinely used by the case managers for assessments.
- Case managers contact payers with initial review findings.
- Concurrent reviews are performed every three days, or more often if required by payer.
- Case managers do not establish an expected LOS.
- Transfers into and from KDMC are facilitated by the Patient Flow Nurse, in coordination with the LA County Medical Transfer Center (MAC).
  - Transfers are to other County facilities or contracted facilities only.
  - Lack of insurance is a significant factor in delayed transfer.

Case Management / Utilization > Case Management – Processes / Utilization

Deficiencies

- Generally accepted standards are not used for initial and concurrent reviews, or Level of Care (LOC) determinations.
- Clinical screenings do not occur seven days per week.
- Failure to determine an expected LOS hinders the ability to proactively impact care coordination.

Recommendations

3.1.10 Adjust coverage of Admission Nurse to 16 hours/5 days/week and 8 hours on Saturday and Sunday.

3.1.11 Revise the admission nurse job description. Include the following

- Review of all admissions.
- Coordinate with social worker for complex discharge planning.
- Communicate with payer.
- Govern the use of observation status.
- Utilize screening criteria to identify referrals to Inter-disciplinary Team.
- Monitor and review documentation to support admission and LOC status.
- Collaborate with bed czar to monitor appropriate bed utilization and patient placement.

3.1.12 Adopt InterQual as the standard criteria for clinical reviews.

Case Management / Utilization > Case Management – Processes / Utilization

Recommendations

3.1.13 Utilize M&R as reference tool for concurrent reviews/clinical milestones but not sole source for reviews.

3.1.14 Create an interdisciplinary referral screening tool which is to be completed during the initial review.

3.1.15 Incorporate assignment of a working DRG into initial review process.

3.1.16 Identify process to revise working DRG throughout hospital stay; communicate ELOS to interdisciplinary team and guide discharge planning.

3.1.17 Revise initial clinical review screening tool to more appropriately incorporate InterQual type standards to address patient admit status, LOC and discharge criteria.

3.1.18 Revise concurrent clinical review screening tool to reflect minimum standards of documentation required.

3.1.19 Review role of Patient Flow Nurse; expand to include duties typical to “Bed Manager” responsible for all bed placement.

3.1.20 Develop/implement clear transfer/admission acceptance protocols; communicate to accepting physicians.

Case Management / Utilization > Case Management – Processes / Discharge Planning

Assessment

- Screening for discharge needs is not routinely completed on all patients.
- There is no formal mechanism for daily, routine communication between case manager, social worker, Nursing and other disciplines.
- The specific role of social worker and case manager in the discharge planning process is not clear. Although all units have both a case manager and social worker assigned, these professionals work primarily independent of one another.
- Discharge needs are not anticipated, but appear primarily identified at the time of discharge or referral.
- Inter-disciplinary rounds occur weekly for medicine, pediatric and NICU patients only.
  - They are led by house staff, who present medical status on each of their patients and include members of Inter-disciplinary Team, with the exception of Nursing and the attending.
  - The content is more status focused; less on planning and disposition.

Case Management / Utilization > Case Management – Processes / Discharge Planning

- Documentation
  - Documentation of discharge planning is not consistent.
  - All documentation is manual.
  - Case manager and social worker use different forms, which are located in a variety of different tabs within the chart.
  - There is no discharge planning chart tab and consequently no specific, preferred location for discharge planning notes.
  - The format for documenting varies among the professionals and within professional groups.
  - Resource limitations in the community (related to post-acute options for SNF, rehab, and long-term acute care), delay discharge plans and result in a backup in available acute beds. Such delays are not consistently documented in the chart or elsewhere.
  - A coordinator for home health services works with the case managers to provide in-home skilled services and equipment through County contracted home health agencies.
  - Hospital-to-hospital transfers are arranged by the County-wide MAC, with on-site coordination from the Patient Flow Nurse.
  - The role of Nursing in the discharge planning process is not clear and often lacking.

Case Management / Utilization > Case Management – Processes / Discharge Planning

Deficiencies

- Discharge planning is not a formal, coordinated process for all patients
- Leading practice tools to assist with discharge planning, are not employed
- Inter-disciplinary rounds do not meet industry standards.
- Documentation does not meet standards of JCAHO or other state/local governing bodies

Recommendations

3.1.21 Complete a comprehensive assessment of discharge needs for all patients at the point of admission.

3.1.22 Identify roles for case managers/social workers in screening all patients for potential discharge needs.

3.1.23 Initiate daily huddles between case manager, social worker and Nursing to briefly discuss each patient, plan of care and any identified needs.

3.1.24 Revise discharge planning process and documentation.

3.1.25 Identify strategies to include patient/patient's family/significant others in discharge assessment/planning process.

Case Management / Utilization > Case Management – Processes / Discharge Planning

Recommendations

3.1.26 Reformat Interdisciplinary Rounds currently held in Medicine, Pediatrics and NICU.

3.1.27 Institute Interdisciplinary Rounds on all nursing units.

3.1.28 Perform routine chart audits of all units to ensure Interdisciplinary plan is documented adequately in the medical record take action to resolve issues.

3.1.29 Leverage formal meetings (huddles and Rounds) to educate Interdisciplinary Team as to role of case manager and social worker in discharge planning process.

3.1.30 Revise/standardize current policy for documentation to ensure requirements meet JCAHO standards and other state/local governing bodies.

3.1.31 Provide education and develop tools to implement standards.

Case Management / Utilization > Case Management – Processes / Care Coordination/Facilitation

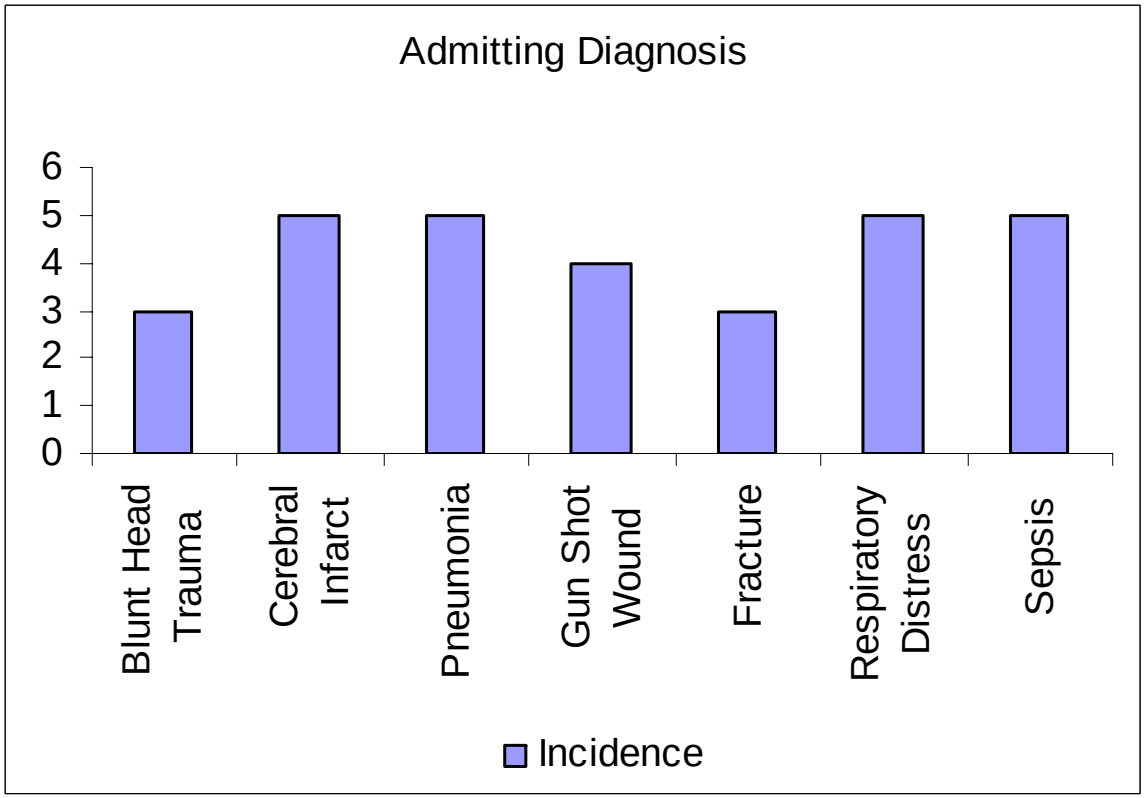
Assessment

- Case managers do not exhibit a responsibility to facilitate timely and appropriate care for patients.
- Case managers do not incorporate predictive indicators such as established order sets, care maps, or key clinical milestones into their work processes.
- There is no forum for discussion or problem solving of patients with complex medical management or discharge needs.
  - Random sample revealed 28% of patients (43) with LOS >10.
    - Ten patients were neonates with low birth weights.
    - Seven patients were vent dependent and in critical care units.
    - Nine patients were trauma admits with head trauma or gunshot wounds.

Case Management / Utilization > Case Management – Processes / Care Coordination/Facilitation

- LOS greater than ten days across multiple patient types.

Admitting Diagnosis of Patients with LOS >10 days



*Random sample of patients (N=43) with LOS >10
Reported from house census 11/17/04

NAVIGANT CONSULTING

Case Management / Utilization > Case Management – Processes / Case Coordination/Facilitation

Deficiencies

- No process is in place to identify long-stay patients and problem-solve issues driving extended stay.
- Care facilitation, the oversight of patients' plan of care, and progression towards discharge is not seen as role of case manager.
- Physician support for care facilitation is informal and non-specific.

Recommendations

3.1.32 Provide education and training to case managers to assist them in understanding their role in facilitating patients care.

3.1.33 Incorporate predictive indicators such as established order sets, care maps or key clinical milestones into their work processes.

3.1.34 Educate case managers to physician advisor role and potential for physician intervention for patients they identify with this need.

3.1.35 Initiate weekly ELOS meetings to discuss and problem-solve patients with LOS >10 days.

3.1.36 Identify reasons driving long LOS and seek resolutions.

3.1.37 Perform individual case review for the high outlier physicians.

Case Management / Utilization > Case Management – Processes / Denial Management

Assessment

- Only MediCal denials are tracked.
- The majority of MediCal denials are for patients with emergency coverage only.
  - Not categorically eligible for MediCal but receive one- to three-day eligibility for emergency treatment only.
  - Balance of hospitalization is denied.
- MediCal denied days for July 2004 represent 56% of total MediCal patient days for the month.
  - 20% - TAR denials for LOC or inappropriate admission (64 days, $142K).
  - 72% - Emergency coverage only (230 days, $380K).

Deficiencies

- Denials are not tracked – problems are not identified and resolved.

Recommendations

3.1.38 Conduct a preadmission initial review by Admitting RN and rigorous management of concurrent reviews.

3.1.39 Develop consolidated denial reporting and trending for all payers.

Case Management / Utilization > Physician Roles, Practice Patterns and Clinical Pathways/Order Sets

Assessment

- Physician advisor role is not specifically provided in the acute setting.
- Medical Officer of the Day (MOD) is designated resource for physician assistant (PA) type assistance, but is staffed during evening/night hours only, when case manager and social worker unlikely to be in house.
- Clinical pathways are defined, County-wide, for a variety of diagnoses. Implementation is currently in process at KDMC, led by a designated Medical Director and staff.
- The process requires the admitting physician to initiate the clinical pathway, and both the attending physician and nurse to participate in following and updating the patients performance within the pathway.
- Limited review of charts revealed that pathways are in use, inconsistently, but a more in-depth review is necessary to determine efficacy.

Deficiencies

- Limited use of pathways to plan/provide care.
- MOD role cannot reasonably provide the service of physician advisor within current scope of practice.
- Clinical Pathway program is not fully implemented.

Case Management / Utilization > Physician Roles, Practice Patterns and Clinical Pathways/Order Sets

Recommendation

3.1.40 Recruit and train a physician advisor to provide physician intervention for such issues as appropriateness of admission/LOC; timeliness/appropriateness of plan of care.

3.1.41 Share individual physician performance data with physicians and develop targets and interventions for outliers with timelines and accountabilities.

3.1.42 Standardize the use of clinical pathways. Begin with a goal of 100% implementation for simple diagnoses, such as pneumonia, CHF.

- Integrate the current CRM staff responsible for pathway roll-out into the new CRM (Care management) department, and eliminate the CRM Medical Director role, embedding these functions in an expanded Associate Medical Director UM Clinical Programs role to oversee Care Management, CRM, and clinical Performance Improvement activities.
- Begin with goal of 100% implementation of pathways or order sets for simple diagnoses such as pneumonia, CHF.

3.1.43 Develop a policy and procedure to define the process and monitor compliance.

Average LOS by Payer Type

King/Drew:
Avg Los by Payor Type
Discharge Data for FY03/04 - All Payor Cases

Change payor to payer, add border & lines in last column, put the note on the bottom was unable to add lines when ungrouped

*****Note: Excludes MDCs :14- Pregnancy, Childbirth & the Puerperium, 15 - Newborns & Other Neonates, 19 - Mental Diseases & Disorders, 20 - Alcohol/Drug Use & Alcohol/Drug**

Payor Type	Patients	Days	Alos
BLUE CROSS	27	141	5.22
CHAMPUS	3	14	4.67
COMMERCIAL	866	3,891	4.49
HMO	41	177	4.32
MEDICAID	4,099	30,125	7.35
MEDICARE	601	5,124	8.53
OTHER	602	2,613	4.34
SELF PAY	2,526	12,057	4.77
	8,765	**54,142**	**6.18**

Case Management / Utilization > Utilization Data

Assessment

- Analysis was completed on all KDMC discharges for FY03, to determine average LOS, per diagnosis related group (DRG) and medical diagnostic category (MDC).
  - The KDMC average LOS was compared to the CMS geometric mean LOS for each MDC to determine the relative similarity of management for patients at KDMC in comparison to Medicare patients within the same MDC.
  - Comparison reveals that KDMC uses more resources, and hospitalizes patients longer than other Medicare patients within the same MDC across the country.
    - 42% of discharges from all payer sources have LOS > than CMS mean.
    - The average length of stay (ALOS) for these 3,675 cases was 8.72.
  - Comparison with all payers provides an estimate of financial implication of extended LOS.
    - !00% recovery of 2.228 excess days would allow 359 new admissions (based upon target LOS of 6.73) annually.

Case Management / Utilization > Utilization Data

Assessment

- 42% of all cases have LOS > than CMS mean. The ALOS for these 3,675 cases was 8.72.

King/Drew: External Benchmark Analysis - MDC Level
Comparison to CMS Geometric Length of Stay/Up to two-day targeted reduction in Los
Discharge Data for FY03/04 - All Payer Cases

*****Note: Excludes MDCs :14- Pregnancy, Childbirth & the Puerperium, 15 - Newborns & Other Neonates, 19 - Mental Diseases & Disorders, 20 - Alcohol/Drug Use & Alcohol/Drug**

MDC	MDC Title	All Payer Cases With Opportunity	Total Cases	%	KD Days	KD LOS	KD Target Days	KD Target Alos	Day Opportunity
1	Nervous System	297	671	44%	2,703	9.10	2,147	7.228619529	556
2	Eye	39	71	55%	202	5.18	136	3.497435897	66
3	Ear, Nose, Mouth & Throat	112	285	39%	514	4.59	325	2.903571429	189
4	Respiratory System	457	1209	38%	4,121	9.02	3,311	7.245076586	810
5	Circulatory System	340	974	35%	2,763	8.13	2,117	6.225	647
6	Digestive System	397	871	46%	2,743	6.91	2,050	5.164735516	693
7	Hepatobiliary System & Pancreas	228	592	39%	1,998	8.76	1,543	6.76622807	455
8	Musculoskeletal System & Connective Tissue	497	964	52%	4,287	8.63	3,367	6.774849095	920
9	Skin, Subcutaneous Tissue & Breast	237	706	34%	1,691	7.14	1,237	5.220253165	454
10	Endocrine, Nutritional & Metabolic	138	375	37%	1,070	7.75	837	6.065217391	233
11	Kidney & Urinary Tract	217	482	45%	1,366	6.29	954	4.394930876	412
12	Male Reproductive System	32	56	57%	192	6.00	139	4.3375	53
13	Female Reproductive System	144	296	49%	677	4.70	470	3.260416667	208
16	Blood, Blood Forming Organs, Immunological	50	154	32%	300	6.00	207	4.132	93
17	Poorly Differentiated Neoplasm	47	113	42%	473	10.06	397	8.45106383	76
18	Infectious & Parasitic Diseases	80	169	47%	1,028	12.85	885	11.065	143
21	Injuries, Poisonings & Toxic Effects of Drugs	151	348	43%	956	6.33	676	4.479470199	280
23	Factors Influencing Health Status	8	14	57%	48	6.00	33	4.075	15
24	Multiple Significant Trauma	78	188	41%	1,452	18.62	1,296	16.61538462	156
25	Human Immunodeficiency Virus Infections	48	87	55%	611	12.73	520	10.83541667	91
26	Other	78	140	56%	2,867	36.76	2,711	34.75641026	156
		3,675	**8,765**	**42%**	**32,062**	**8.72**	**25,358**	**6.90**	**6,705**

All cases in the payer category with a positive variance from the CMS mean LOS. The specific variance is included for all cases with variance of two or less days. For each case with a variance > 2 days, a two day variance is included in the analysis.

NAVIGANT CONSULTING

Case Management / Utilization > Utilization Data

Assessment

- Patients with > 15 Days LOS, Analysis, All Payer

King/Drew:
Number of Patients and Patient Days for cases that have LOS>15 - MDC level
Discharge Data for FY03/04 - All Payer Cases

*****Note: Excludes MDCs :14- Pregnancy, Childbirth & the Puerperium,**
15 - Newborns & Other Neonates, 19 - Mental Diseases & Disorders,
20 - Alcohol/Drug Use & Alcohol/Drug

MDC	MDC Title	Patients	Days	ALOS
1	Nervous System	58	1,814	31.28
2	Eye	1	16	16.00
3	Ear, Nose, Mouth & Throat	3	66	22.00
4	Respiratory System	80	2,248	28.10
5	Circulatory System	48	1,371	28.56
6	Digestive System	38	1,111	29.24
7	Hepatobiliary System & Pancreas	31	983	31.71
8	Musculoskeletal System & Connective Tissue	95	2,952	31.07
9	Skin, Subcutaneous Tissue & Breast	25	625	25.00
10	Endocrine, Nutritional & Metabolic	29	721	24.86
11	Kidney & Urinary Tract	13	324	24.92
12	Male Reproductive System	3	66	22.00
13	Female Reproductive System	5	145	29.00
16	Blood, Blood Forming Organs, Immunological	5	117	23.40
17	Poorly Differentiated Neoplasm	6	234	39.00
18	Infectious & Parasitic Diseases	26	801	30.81
21	Injuries, Poisonings & Toxic Effects of Drugs	20	519	25.95
24	Multiple Significant Trauma	48	1,733	36.10
25	Human Immunodeficiency Virus Infections	19	539	28.37
26	Other	84	4,381	52.15
	King/Drew Medical Center	**637**	**20,766**	**32.60**

NAVIGANT CONSULTING

Case Management / Utilization > Utilization Data Utilization

Assessment

- Average LOS by MDC (excluding one- and two- day stays)

King/Drew:
Avg Los after excluding 1 and 2 day Stays. MDC level
Discharge Data for FY03/04 - All Payor Cases

*****Note: Excludes MDCs :14- Pregnancy, Childbirth & the Puerperium,**
15 - Newborns & Other Neonates, 19 - Mental Diseases & Disorders,
20 - Alcohol/Drug Use & Alcohol/Drug

MDC	MDC Title	Patients	Days	ALOS
01	Nervous System	455	4,129	9.07
02	Eye	41	252	6.15
03	Ear, Nose, Mouth & Throat	156	778	4.99
04	Respiratory System	805	6,365	7.91
05	Circulatory System	533	4,137	7.76
06	Digestive System	575	4,074	7.09
07	Hepatobiliary System & Pancreas	387	3,128	8.08
08	Musculoskeletal System & Connective Tissue	671	6,320	9.42
09	Skin, Subcutaneous Tissue & Breast	428	2,881	6.73
10	Endocrine, Nutritional & Metabolic	192	1,635	8.52
11	Kidney & Urinary Tract	325	2,032	6.25
12	Male Reproductive System	36	246	6.83
13	Female Reproductive System	209	1,033	4.94
16	Blood, Blood Forming Organs, Immunological	82	531	6.48
17	Poorly Differentiated Neoplasm	71	571	8.04
18	Infectious & Parasitic Diseases	136	1,522	11.19
21	Injuries, Poisonings & Toxic Effects of Drugs	197	1,480	7.51
23	Factors Influencing Health Status	8	48	6.00
24	Multiple Significant Trauma	156	2,510	16.09
25	Human Immunodeficiency Virus Infections	76	957	12.59
26	Other	114	4,599	40.34
		5,653	**49,228**	**8.71**

Case Management / Utilization > Utilization Data Utilization

Recommendations

3.1.44 Focus attention and effort on patients with diagnoses within MDCs most deviant from the CMS geometric mean LOS (either by degree or frequency). Begin with MDC 8, musculoskeletal groups. Begin with MDC 8, musculoskeletal groups.

- Audit all discharges of patients with diagnoses within the MDC.
- Collaborate with physician advisor or physician consultant to analyze the treatment plan.
  - Identify patients with LOS greater than the CMS target.
  - Identify patients with LOS shorter than the CMS target.
  - Isolate practice patterns that contribute to both greater LOS and shorter LOS.
- Trend LOS by physician to identify any providers with LOS longer/shorter than the average.
  - Identify physicians whose treatment regimen contribute to shorter LOS.

    > Seek assistance from physician advisor or physician consultant in sharing best practices with other physicians.
  - Continue monitoring LOS by physician for indicators of improved treatment efficiency.

3.1.45 Initiate weekly Extended LOS meetings.

3.1.46 Trend the LOS data by DRG and MDC on a monthly basis, to monitor the improvement made in decreasing LOS.

Case Management / Utilization > Utilization Data

Performance Measures

- Case rate ALOS
  - Current 7.95
  - Target 6.73
- Percentage of Medical denials
  - Current 20%
  - Target 5%
- MediCal denials: TAR denials; LOC or inappropriate admission
  - Current 64 days
  - Target 45 days
- MediCal denials: Emergency coverage only
  - Current 230 days
  - Target 161 days
- Patients with LOS >15 days
  - Current 43
  - Target 30
- Aggregate LOS less 1 & 2 day stays (excluding Rehab, PSYCH, OB)
  - Current 8.71
  - Target TBD

Case Management / Utilization > Utilization Data

Performance Measures

- Percentage of patients with initial discharge plan documented within 24 hours of referral
  - Current not currently collected
  - Target 100%
- Percentage of patients will have an initial discharge plan screening documented within 48 hours of admission
  - Current not currently collected
  - Target 100%
- Percentage of patients with evidence of updated discharge plan
  - Current not currently collected
  - Target 100%
- Percentage of patients with use of appropriate care pathway
  - Current not currently collected
  - Target 100%

Section III – Clinical Organization

2. Capacity and Throughput
   - Interviews
   - Prioritized Summary of Recommendations
   - Admission Process
   - Bed Control
   - Disposition
   - Ancillaries Issues
   - Transport

Capacity / Throughput > Interviews

• B. Taylor	Director of UM/UR &Admitting
• V. DeGuezman	Manager Admitting / ER Registration
• S. Webb	Flow Manager
• L. Barber	Manager House Supervisors
• M. Lang	Director of Nursing
• A. Kimmel	Interim COO
• P. Price	Interim CNO
• O. O'Rourke	Interim Director of Nursing
• M. Jones, Jr. MD	Surgery
• C. Ducksworth	Nurse Manager 4B
• V. Williams	Nurse Manager 3A
• A. Hamilton	Nurse Manager 3C
• P. Venezeula	Administrator of Ancillary Services
• F. Ponder	Director of Environmental Services
• Payne, MD	Chief Radiologist
• L. Dubois	Chief Radiology Technician
• Admitting Nurses	
• Bed Control Clerical Staff	

Capacity / Throughput > Prioritized Summary of Recommendations

Capacity and Throughput – Admissions Process		
Urgent	3.2.01	Establish baseline performance metrics for admission process.
Short-term	3.2.02	Develop and implement a system to track metrics at defined intervals (i.e., daily, each shift).
Short-term	3.2.03	Define results reporting and corrective action plan requirements.
Intermediate	3.2.04	Implement a practice where admitted ED patients are only moved to “blue side” when there are no appropriate beds available.
Short-term	3.2.05	Implement patient flow coordinator position.
Urgent	3.2.06	Expand the role of the admissions nurse to facilitate transfers when the flow manager is not on-site.
Urgent	3.2.07	Expand role of house supervisor to act as patient flow coordinator on weekends and off shifts.
Bed Control		
Short-term	3.2.08	Track and trend all points of patient access to enable complete planning for all admissions.
Urgent	3.2.09	Develop a system to inform the patient flow coordinator of all potential discharges.
Short-term	3.2.10	Implement tools which clearly define when each patient is expected to be discharged.
Urgent	3.2.11	Implement daily “bed huddle”, run by patient placement coordinator, to review rest of day admissions/discharges and plan for next day admissions and discharges.
Urgent	3.2.12	Re-institute floor rounds to follow-up on pending discharges, admissions, and transfers.
Intermediate	3.2.13	Implement a system which clearly shows each units census and available beds for admissions.
Urgent	3.2.14	Establish a policy which clearly defines who is in control of beds.
Short-term	3.2.15	Design a new process for bed assignment.
Long-term	3.2.16	Assign work to the Bed Control Clerks to complete in-between current workload.
Intermediate	3.2.17	Adjust available beds by type to meet requirements.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

NAVIGANT CONSULTING

Capacity / Throughput > Prioritized Summary of Recommendations

Disposition		
Short-term	3.2.18	Establish agreed upon metrics and communicate to all personnel.
Short-term	3.2.19	Implement a system to track metrics on a daily basis and report on a bi-weekly basis.
Urgent	3.2.20	Implement an accountability system for prioritizing discharges and communicating discharges in a timely manner.
Short-term	3.2.21	Institute a program to support early morning discharges by having a discharge plan order written the night before discharge.
Urgent	3.2.22	Create a multifaceted approach to eliminate discharge delays.
Short-term	3.2.23	Implement a Capacity Management Oversight/Steering Committee.
Intermediate	3.2.24	Analyze discharge medication prescription filling process and utilize tube system for sending pharmacy orders.
Environmental Services		
Short-term	3.2.25	Implement a system to assist in assigning and dispatching work (including prioritization).
Urgent	3.2.26	Develop and implement a communication system which notifies EVS of bed cleaning needs both anticipated and actual.
Short-term	3.2.27	Analyze workload and develop a staffing/assignment plan to be based on workload demand.
Short-term	3.2.28	Develop quality metrics to be tracked daily and reported bi-weekly.
Urgent	3.2.29	Develop and implement an accountability system within EVS department and with nursing areas.
Short-term	3.2.30	Improve management and supervision.
Physical Therapy		
Short-term	3.2.31	Develop productivity monitoring process.
Short-term	3.2.32	Initiate a process to identify patients who may require PT service but were not identified during nursing evaluation.
Short-term	3.2.33	Track missed treatments with identified reason and develop plans for resolution as appropriate.
Short-term	3.2.34	Identify clinical outcomes based upon patients meeting established treatment goals.
Short-term	3.2.35	Implement appropriate staffing levels to volume of treatments by time of day and day of week.
Short-term	3.2.36	Revise skill mix of PT to PTA's to national standards.

Capacity / Throughput > Prioritized Summary of Recommendations

Transportation		
N/A	3.2.37	Design a centralized transport system for patients. and supplies
N/A	3.2.38	Develop clinical criteria to define need for licensed vs. non-licensed personnel to assist with transport.
N/A	3.2.39	Develop a flexible staffing and scheduling plan to deploy transporters according to activity and demand.
N/A	3.2.40	Create baseline measurements and establish performance expectation targets for transport times.
N/A	3.2.41	Implement performance measurement and reporting.
Transportation – Emergency Room and Radiology		
N/A	3.2.42	Set and communicate expectation that patients will be undressed, in hospital gown with jewelry removed 20 minutes after admission to the emergency department.
N/A	3.2.43	Create clear and visible system in the Emergency Department for identifying patient location including bay and hallway spaces.
N/A	3.2.44	Create radiology transporter positions to manage transport specifically for radiological testing.
N/A	3.2.45	Create baseline measurements and establish performance expectation targets for transport times.
N/A	3.2.46	Measure performance to target and report monthly at Radiology and Emergency Department meetings.
N/A	3.2.47	Implement corrective action plan for variance to targeted performance.
N/A	3.2.48	Utilize performance measurement data to determine optimal practice for patient transport between emergency department and radiology.

Capacity / Throughput > Admission Process

Assessment

- There are four access points for the hospital; ED, direct, scheduled, and clinic.
- Access points are where the patient enters the hospital.
- The majority of the patients are coming from their home (not another hospital), which should limit delays in transfer of information.
- Admission Type Data: Majority of admissions are emergent, allowing for control/influence of process by King/Drew.

Description	Admission Type	Admission Total	% of Total
Emergency	1	1787	76%
Emergency / Not Your Emergency	1a	3	< 1%
Urgent / Your Emergency	2	149	6%
Urgent, Not from the ER	2a	67	3%
Elective	3	173	7%
Newborn / Not Your ER	4a	169	7%

Source: Affinity July – September 04

Capacity / Throughput > Admission Process

Assessment

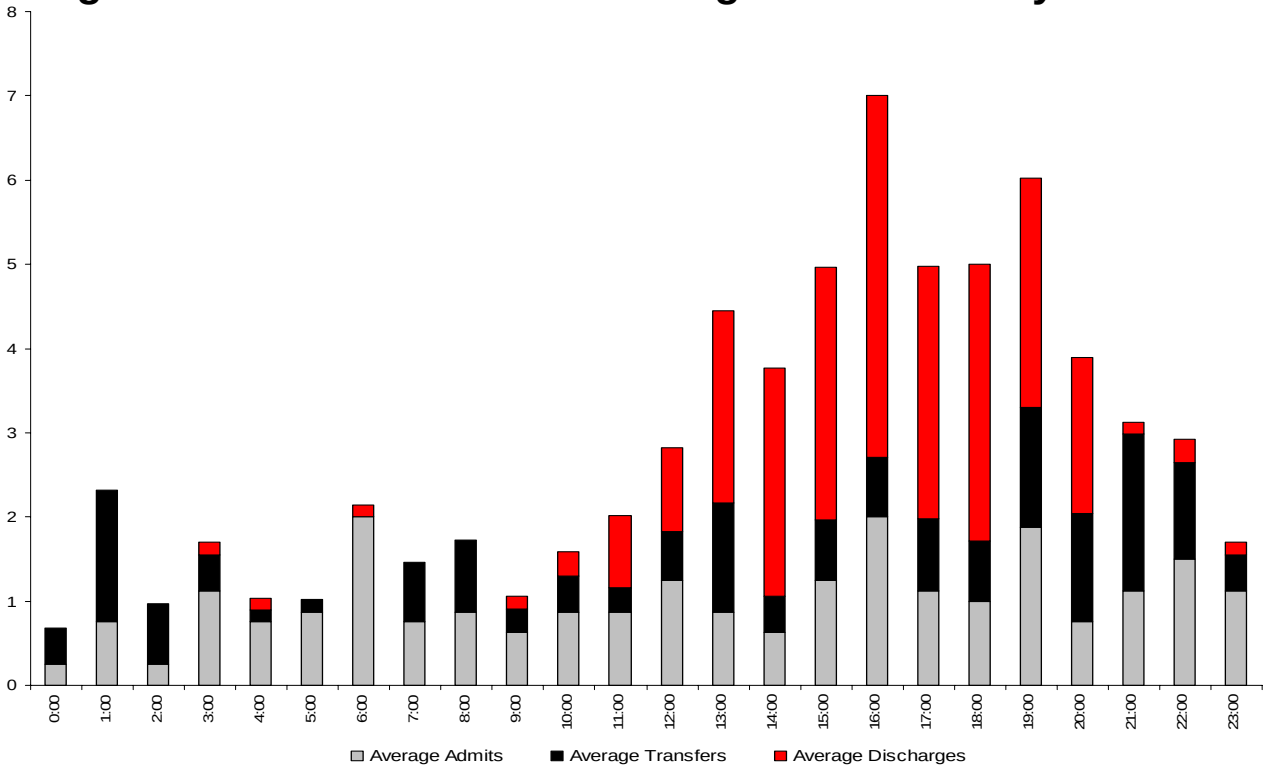
- There is a flow manager, 8 AM to 5 PM, Monday through Friday who coordinates transfers from other facilities to and from KDMC. The flow manager will come in on Saturdays (on her own time) to ensure patients are assisted. (This is an hourly position).
- The admit nurse coordinates and reviews ED and scheduled admissions for appropriateness. If a patient is not appropriate they do communicate with the physician; but there continues to be inappropriate admits. It is not clear whether this reflects lack of agreement with admit nurse recommendation, or the absence of clear alternatives for providing care.
- Once a patient in the ED has been identified as requiring inpatient admission, the patient is moved to the blue side, even if there are beds available on the inpatient unit.
  - The intent was for the blue side to be a holding unit for admitted patients, when the appropriate bed was not available.
  - Upon observation the blue side is not meeting the intended purpose; ED and admitted patients are scattered throughout the department causing confusion.
- ED staff transport all patients from the ED to their inpatient unit; there is no Transportation department.

Capacity / Throughput > Admission Process

Assessment

- Late discharges force admissions to occur throughout the night hours.

Average of Total Admissions/Discharges/Transfers by Time of Day



11/1/04 – 11/8/04
Source: Affinity ADT report

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

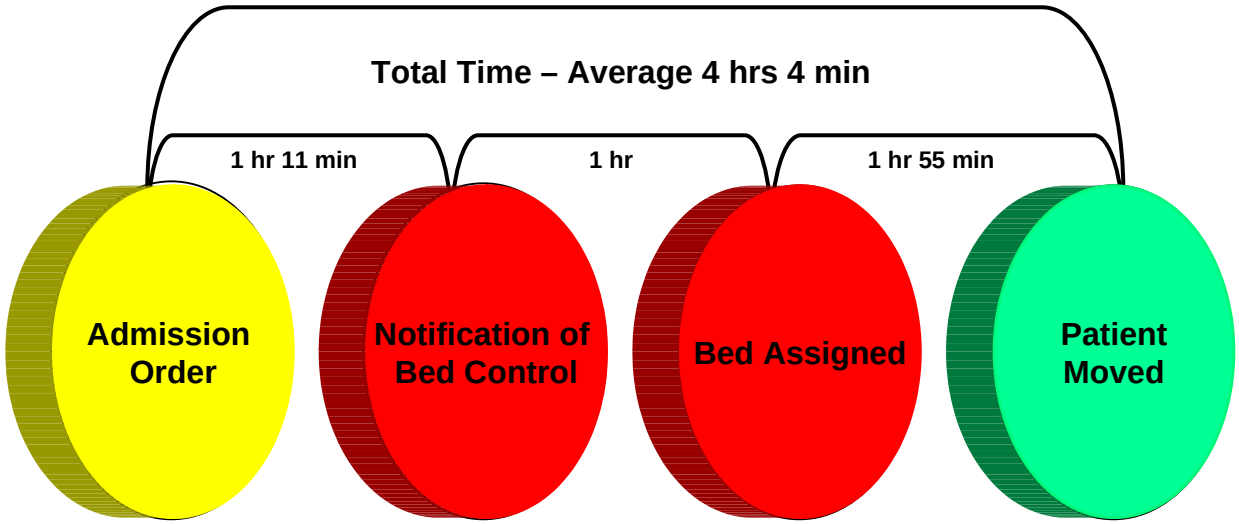
Assessment

- Scheduled patients:
  - The key steps in the patient admission process for scheduled patients are:
    1) Registration clerk or secretary inpatient care area calls bed control clerk with bed request.
    2) Bed control clerk completes notification of admission form.
    3) Bed control clerk reviews magnetic bed board for available, appropriate bed; then calls unit with patient information and bed need.
    4) Bed control clerk calls registration clerk or secretary inpatient care area with bed assignment.
  - The bed control clerk is not planning for next day scheduled patients.
  - There are times when a bed is assigned the day prior for chemo therapy patients.
  - Delays exist when no appropriate bed is available for post anesthesia recovery (PAR) patient.
- Newborn Admissions:
  - There are two steps in the newborn admission process:
    1) Patient arrives and is admitted to Labor and Delivery.
    2) After delivery, bed control is notified of delivery.
  - No barriers noted with newborn admission process.

Capacity / Throughput > Admission Process

Assessment

- ED admissions:
  - Approximately 76% of all patients admitted come via the ED.
  - The key steps for ED patient admission process are:
    1) ED physician writes order and clerk sends notice to bed control.
    2) Bed control receives notice and assigns clean appropriate bed.
    3) ED receives bed assignment and calls receiving unit with report than moves patient.



Source: Notification of Admission form
Manual data collection
Sample of patients from 11/30/04

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

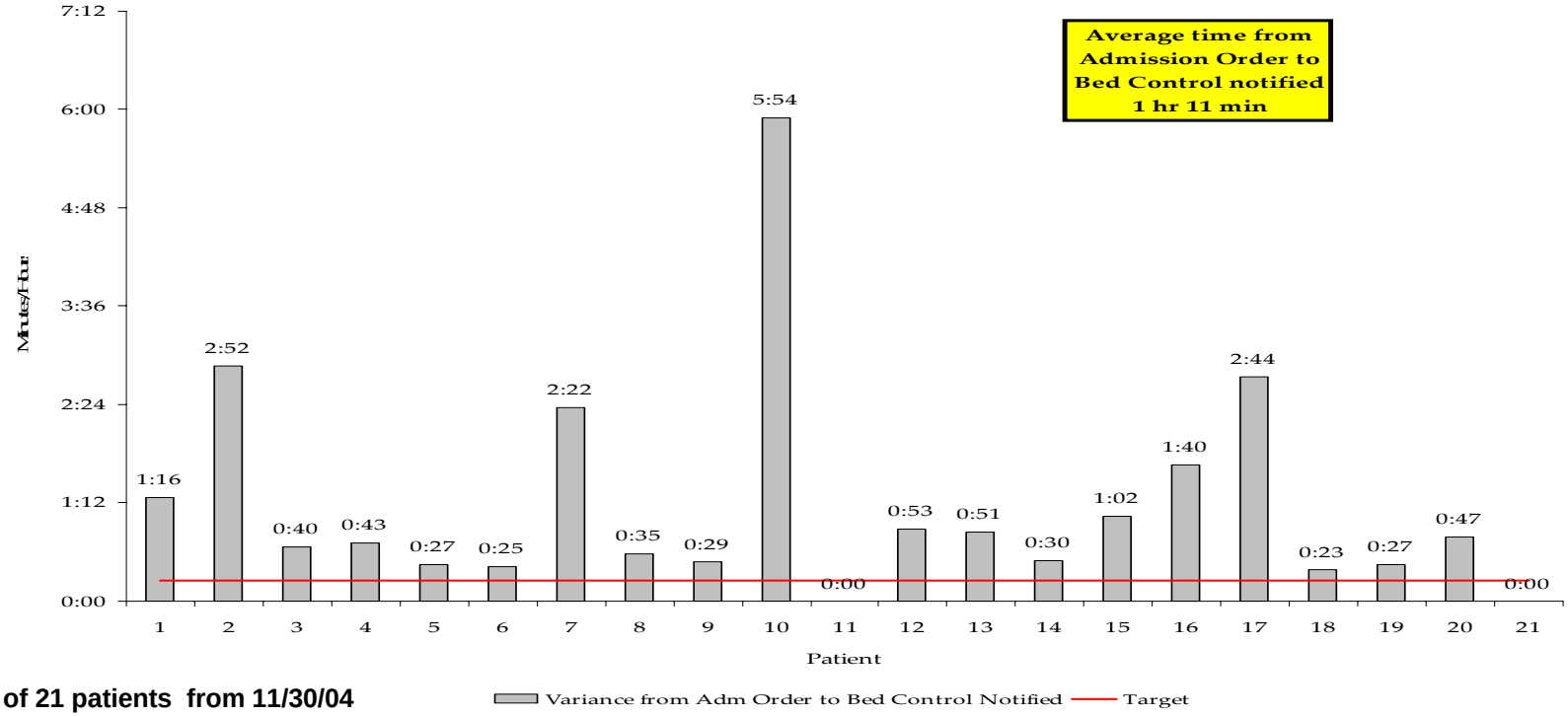
Assessment

- The bed assignment process for an ED admit is convoluted and there are too many steps involved. The steps include:
  1) Bed control receives printout with patient admission information.
  2) Bed control fills out a notification of admission form.
  3) Bed control contacts registration to complete an advanced directive.
  4) Bed control checks for insurance in meds.
  5) Bed control pages admitting nurse who reviews chart for appropriateness of admission.
  6) Admitting nurse calls bed control with clearance for admission.
  7) Bed control reviews magnetic bed board for open bed, then calls unit to speak with charge nurse regarding patient admission (if unit refuses assignment, bed control contacts house supervisor).
  8) Bed control pages admitting nurse with room assignment.
  9) Bed control enters admission information into Affinity.
  10) Admitting nurse notifies ED of room assignment and marks room number on face sheet.
  11) Receiving unit calls bed control when patient arrives.

Capacity / Throughput > Admission Process

Assessment

- There are delays from the ED in notifying bed control clerk of the admission order.
  - Physician does not immediately give the chart to the ED clerk.
- The average time from admission orders to the notification of bed control clerk is 1 hour and 11 minutes with an extreme length of 6 hours.



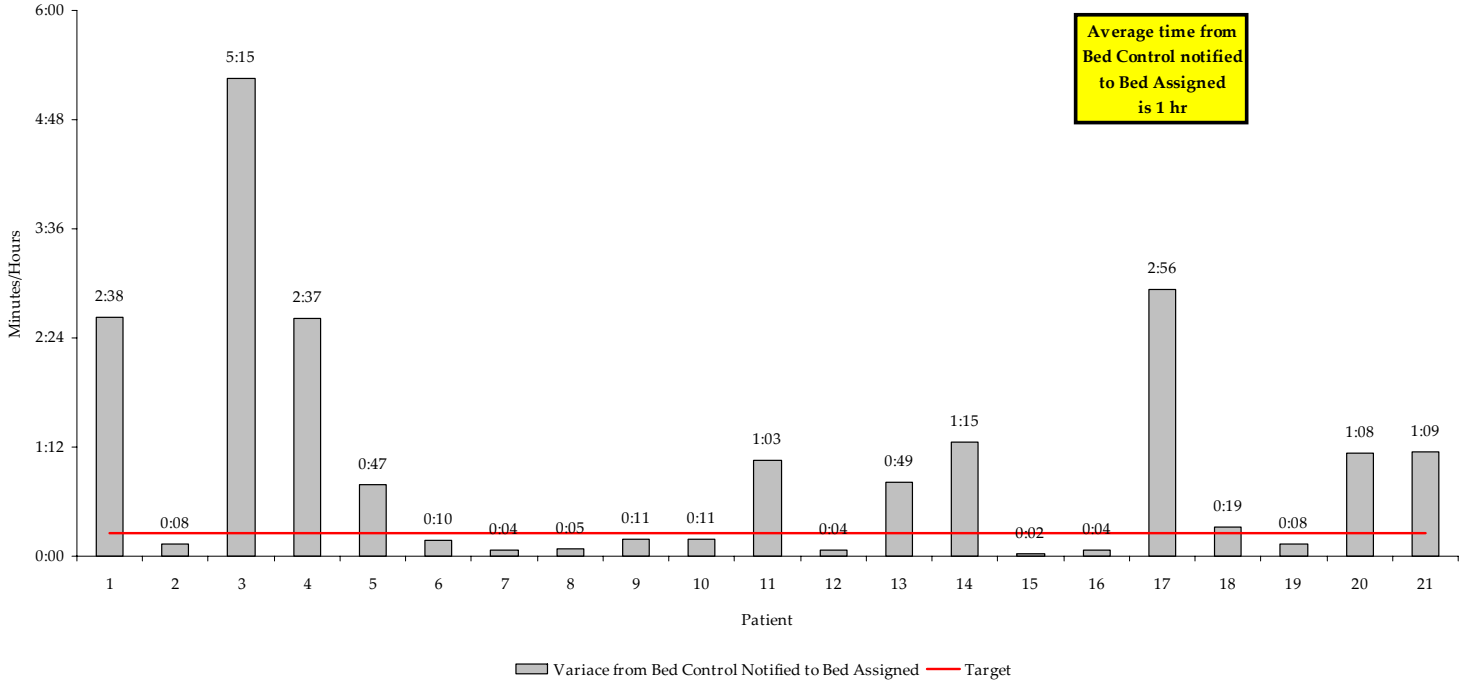
Sample of 21 patients from 11/30/04
Source: Notification of Admission form

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

Assessment

- Delays in patient throughput for ED Admissions occur when bed control clerk does not immediately take information off the printer. (Observed over one-hour delay on four different cases).
- The average time from bed control clerk notification to the bed being assigned is one hour.



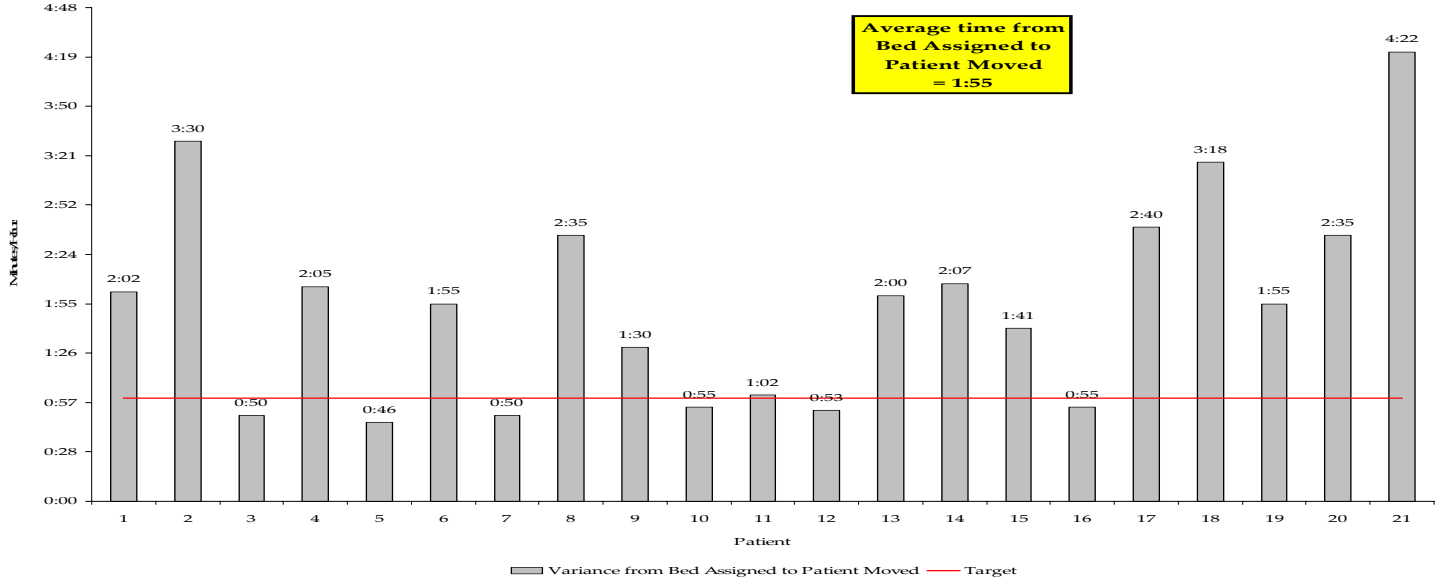
Sample of 21 patients from 11/30/04
Source: Notification of Admission form

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

Assessment

- There are significant delays from bed assignment to patient moved.
  - Staff nurses refuse to take report.
  - Staff nurse say bed is dirty.
  - Tests must be completed prior to patient being moved to an inpatient bed.
- The average time from bed assignment to the patient being moved is 1 hour and 55 minutes.



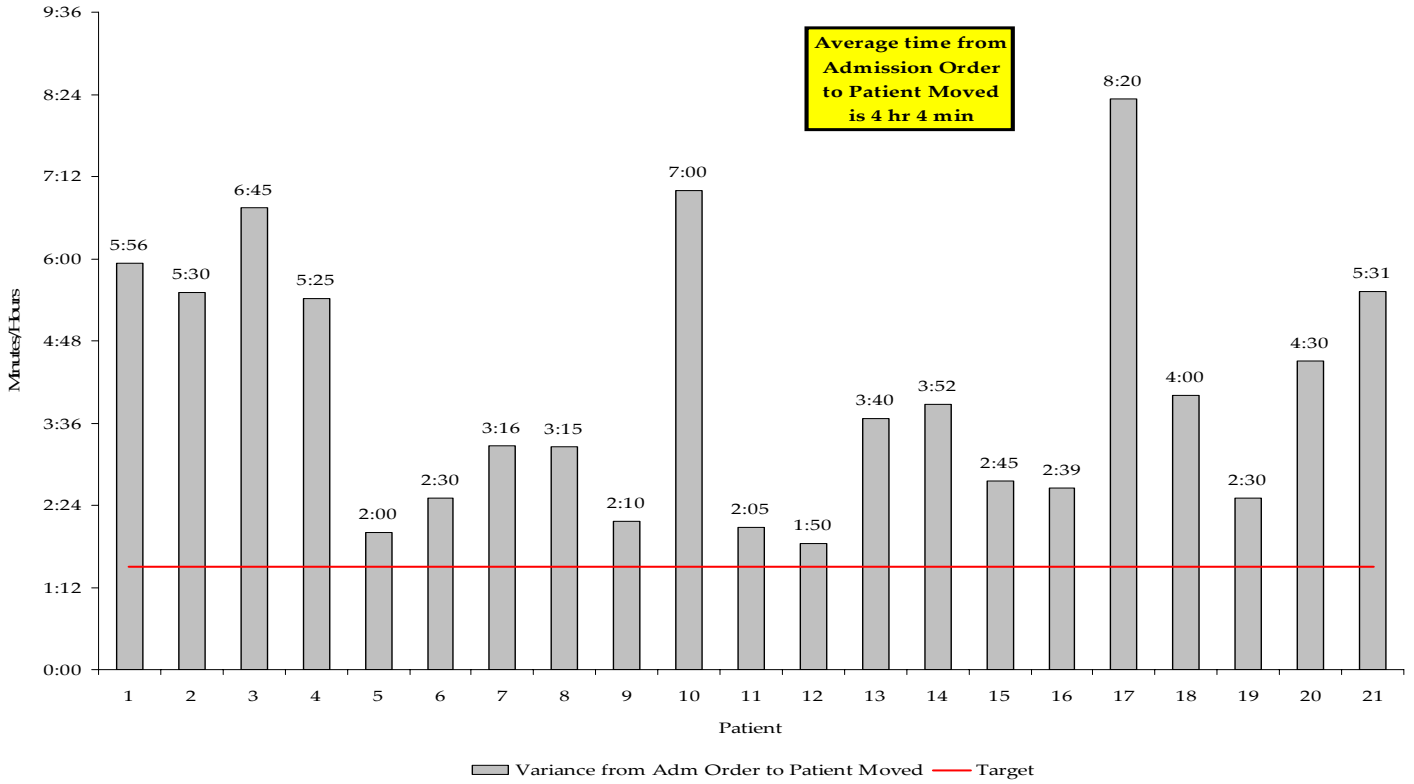
Sample of 21 patients from 11/30/04
Source: Notification of Admission form

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

Assessment

- The average time from admission order to the patient being moved is 4 hours and 4 minutes.



Sample of 21 patients from 11/30/04
Source: Notification of Admission form

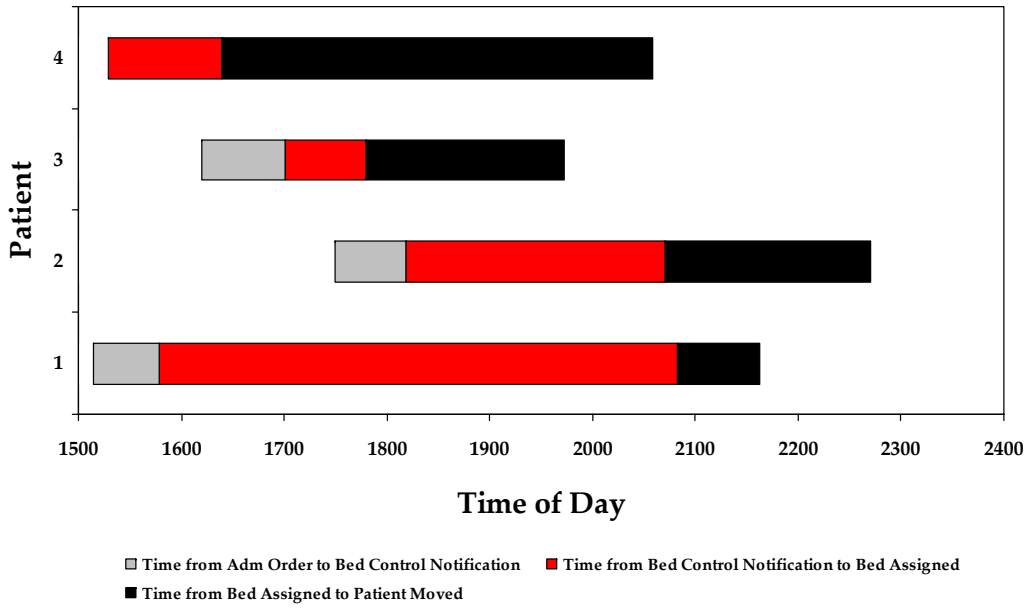
NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

Assessment

- There are differences from patient to patient of where the admission process breaks down.
- Patients are waiting on stretchers in the ED even though a clean, ready bed has been assigned.

Time from Admission Order to Patient Moved by Time of Day
3 PM to 12 Midnight

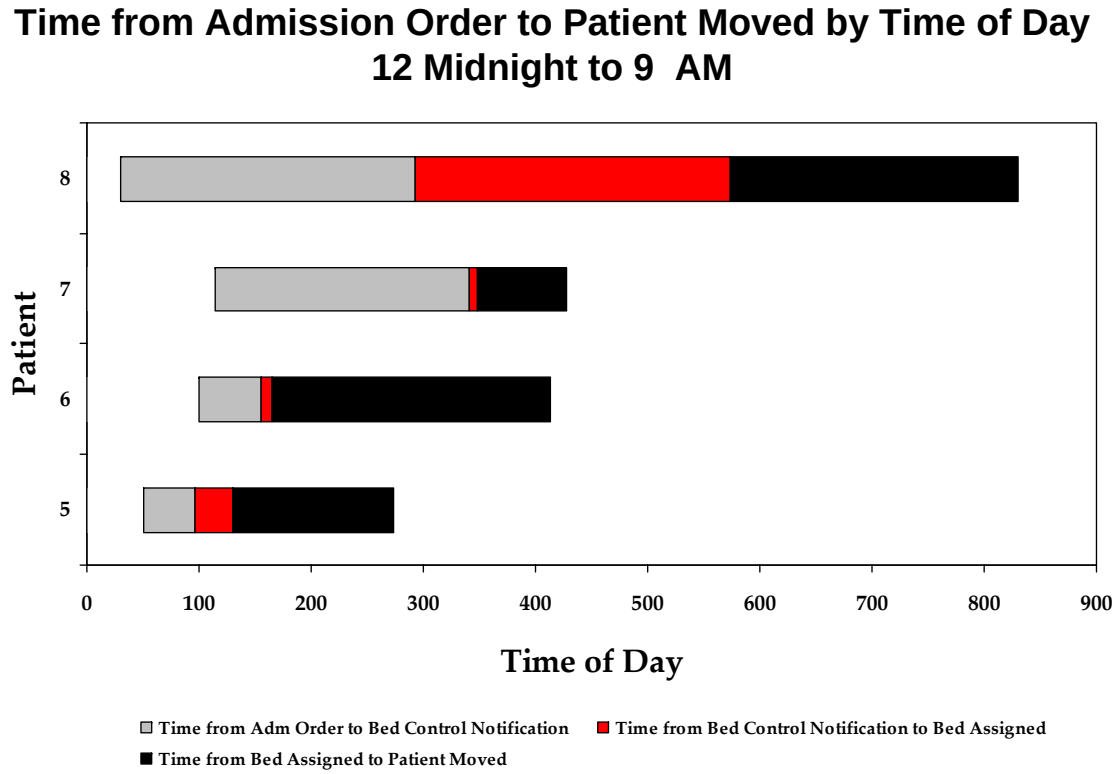


Sample patients from 11/30/04
Source: Notification of Admission Form

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

Assessment



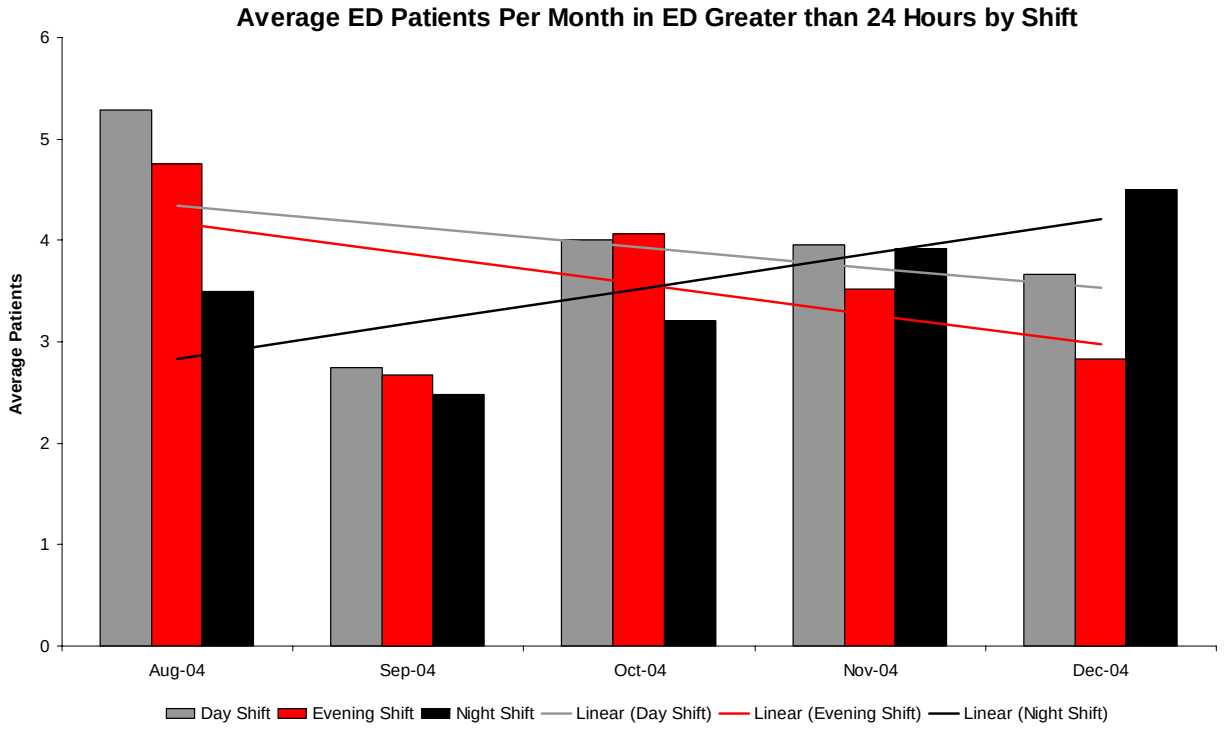
Sample patients from 11/30/04
Source: Notification of Admission Form

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

Assessment

- Changes in process have had impact on patients waiting in the ED greater than 24 hours on the day and evening shifts.



Source: Daily Shift Summary
8/3/04 – 12/9/04

NAVIGANT CONSULTING

Capacity / Throughput > Admission Process

Deficiencies

- There are no processes in place for planning of all admissions and discharges.
- There are no established metrics, systems for tracking metrics, or systems for ensuring accountability for patient throughput.
- Multiple people are involved in the bed assignment process causing delays and confusion.
- Additional work is created by moving patients to holding area when there are available beds on the inpatient units.
- The hospital operates 24/7, but many positions are Monday through Friday and/or only day shift.

Capacity / Throughput > Admission Process

Recommendations

3.2.01 Establish baseline performance metrics for admission process.

3.2.02 Develop and implement a system to track metrics at defined intervals (i.e., daily, each shift).

3.2.03 Define results reporting and corrective action plan requirements.

3.2.04 Implement a practice where admitted ED patients are only moved to “blue side” when there are no appropriate beds available.

3.2.05 Implement patient flow coordinator position.

3.2.06 Expand the role of the admissions nurse to facilitate transfers when the flow manager is not on-site.

3.2.07 Expand role of house supervisor to act as patient flow coordinator on weekends and off shifts.

Capacity / Throughput > Bed Control

Assessment

- The occupancy report from Affinity is based on total beds not open beds.
  - Open beds are determined by Nursing staffing office personnel, and based on staffing availability.
- Based on staffed beds, the occupancy in the intensive care unit (ICU) is very high which reflects why patients are waiting in the ED for greater than 24 hours for a bed.

Capacity / Throughput > Bed Control

Assessment

Occupancy by Unit

UNIT/WARD AND MEDICAL SERVICE	LICENSED BED CAPACITY	STAFFED BEDS (ACTUAL COUNT 12/9/04)	AVERAGE DAILY CENSUS (AFFINITY REPORT 1/1/04 - 7/31/04)	OCCUPANCY RATE - BASED ON LICENSED BEDS	OCCUPANCY RATE - BASED ON STAFFED BEDS
2C/Baby - Nursery (18+33)	-	26	2.2	0%	9%
OBSN - Observation Nursery	-	9	-	0%	0%
2G - L&D Rm.	-	14	1.6	0%	12%
2E (CLOSED)	5	-	-	0%	0%
3E - PICU	12	6	2.9	24%	48%
5C - Neonatal ICU	43	28	17.7	41%	63%
5E - Neuro ICU (CLOSED)	6	-	2.9	49%	0%
ICU - A	12	12	6.8	56%	56%
ICU - B	12	6	7.3	61%	121%
4B-CCU - Coronary Care	6	6	4.9	81%	81%
3A-10 - Step down (CLOSED)	-	-	-	0%	0%
5B-7 - Step down (CLOSED)	-	-	-	0%	0%
2A - Norm. Birth. Ctr. (CLOSED)	33	-	0.7	2%	0%
2B - Ante/Post Partum (CLOSED)	31	-	-	0%	0%
2C OB Post Partum	30	27	13.2	44%	49%
3A - Med/Surg	33	29	24.5	74%	84%
3B - Med/Surg (CLOSED)	33	-	9.0	27%	0%
3C - Med/Surg	33	33	26.6	81%	81%
4A - Med/Surg	31	31	25.9	83%	83%
4B - Telemetry	22	15	14.7	67%	98%
4C - Med/Surg (CLOSED)	31	-	10.7	34%	0%
5B - Med/Surg (CLOSED)	28	-	4.5	16%	0%
5B - DTRU Neuro Surg (CLOSED)	-	-	-	0%	0%
5F - Pediatrics (CLOSED)	27	-	-	0%	0%
5G - Pediatrics	27	27	14.7	54%	54%
MLK MED. ACUTE	455	269	190.8	42%	71%
A.F. HAWKINS	76	34	31.2	41%	92%
GRAND TOTAL	531	303	222.0	42%	73%

Source: Affinity Report 1/1/04 – 7/31/04 and Daily Occupancy Report

NAVIGANT CONSULTING

Capacity / Throughput > Bed Control

Assessment

- Bed control reports to Admitting.
- Typical staffing would include an admission nurse on all three shifts, Monday – Friday with clerical staff support.
  - Four on from 7AM to 3PM, three on from 3PM to11PM and three on from 11PM to 7AM.
- Admits occur throughout the day.
- Bed control clerks utilize a magnetic bed board for tracking available versus occupied beds and male versus female beds.
- Bed control manager is responsible for completing a daily occupancy report, but they must make many calls to get information.
- It is difficult to get information from Nursing staffing office personnel on what units are open for admissions and how many admissions they can accept, it is perceived that the Nursing staffing office personnel does not make this a priority causing delays in bed assignments.
- Staff nurses refuse report from the ED nurses, stating they are closed to admissions.
- A policy was referenced to state that Admitting office personnel controls all the beds, but many times the staff nurse will refuses an admit.
  - There are no stats kept on how often or why this occurs.
  - Reasons stated were: nurse too busy, room dirty, not enough staff.

Capacity / Throughput > Bed Control

Assessment

- There is no planning for admissions or discharges.
- In the past, bed control clerks made rounds on the units to determine discharges, clean/ready rooms, and census; but they state they no longer have enough staff to continue rounds.
  - At all times there are two clerks at the desk for bed control, and most of the time no work is assigned for in-between admissions/discharges/transfers.
- Each shift bed control clerks calls each unit to find out census and discharges.
- Around 12 noon bed control clerks calls each unit to find out about pending discharges.
- Bed control clerks relies on information from charge nurses regarding when a patient has been discharged, when a patient has arrived on a unit, and when a room has been cleaned.
  - Bed control clerk will call a unit about 45 minutes after the discharge to check to see if the room has been cleaned, and if not they will then call housekeeping to get the room cleaned.
- Many patients wait for a bed assignment due to lack of ICU/CCU/Telemetry beds.
  - Stats are not kept on volumes or length of time patients wait.

Capacity / Throughput > Bed Control

Assessment

- Small data-sample sizes were used for the assessment since no electronic reports were available, and all data collection was based on manual logs either in place or implemented to understand patient flow and barriers to a seamless process.
- There are no clear criteria, and a seemingly low threshold, for canceling elective procedures or admissions based on bed availability.

Deficiencies

- Multiple access points into the hospital; but no planning for admissions.
- There are no established metrics, systems for tracking metrics, or systems for ensuring accountability for patient throughput.
- No follow-up or accountability system in place after a bed is assigned to ensure that patients are moving in an efficient and timely manner.
- Many patients are waiting in holding areas until an appropriate bed is available.

Capacity / Throughput > Bed Control

Recommendations

3.2.08 Track and trend all points of patient access to enable complete planning for all admissions.

3.2.09 Develop a system to inform the patient flow coordinator of all potential discharges.

3.2.10 Implement tools which clearly define when each patient is expected to be discharged.

3.2.11 Implement daily “bed huddle”, run by patient placement coordinator, to review rest of day admissions/discharges and plan for next day admissions and discharges.

3.2.12 Re-institute floor rounds to follow-up on pending discharges, admissions, and transfers.

3.2.13 Implement a system which clearly shows each units census and available beds for admissions.

3.2.14 Establish a policy which clearly defines who is in control of beds.

3.2.15 Design a new process for bed assignment.

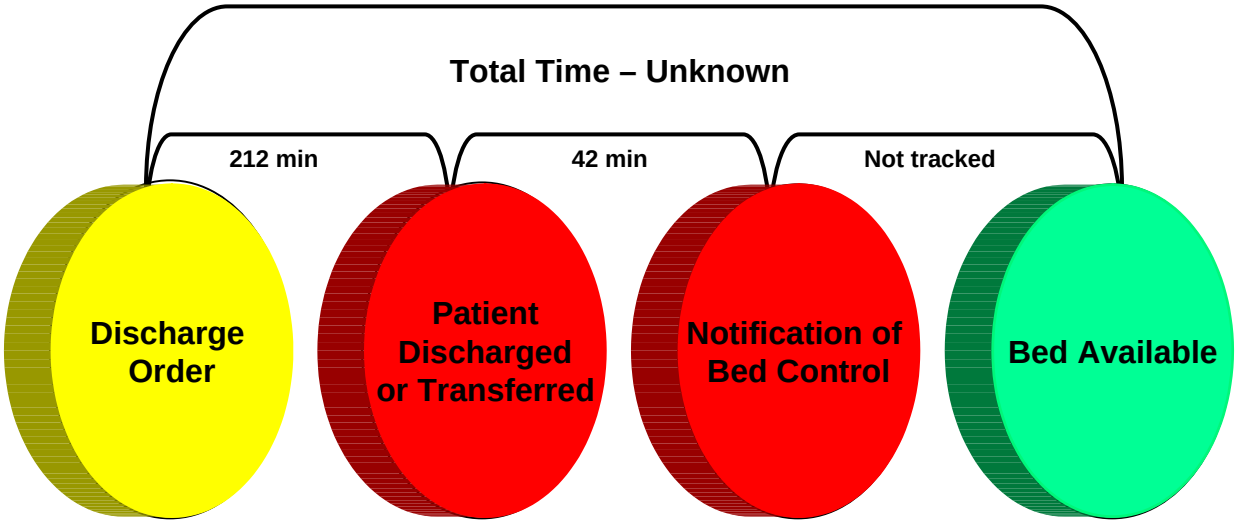
3.2.16 Assign work to the Bed Control Clerks to complete in-between current workload.

3.2.17 Adjust available beds by type to meet requirements.

Capacity / Throughput > Disposition

Assessment

- The key steps for discharging a patient are:
  1) Physician writes the discharge order and unit secretary takes off orders.
  2) RN prepares patient for discharge and sends patient home.
  3) Unit secretary enters discharge into Affinity which prints out notice in bed control.
  4) Environmental services cleans room.



Target Order Time 9 AM
Current 12%

Target Order Time 11 AM
Current 29%

Sample Order Time 11/11/04 – 11/24/04, manual logs
Sample D/C to Notification of Bed Control 11/30/04, Affinity printout

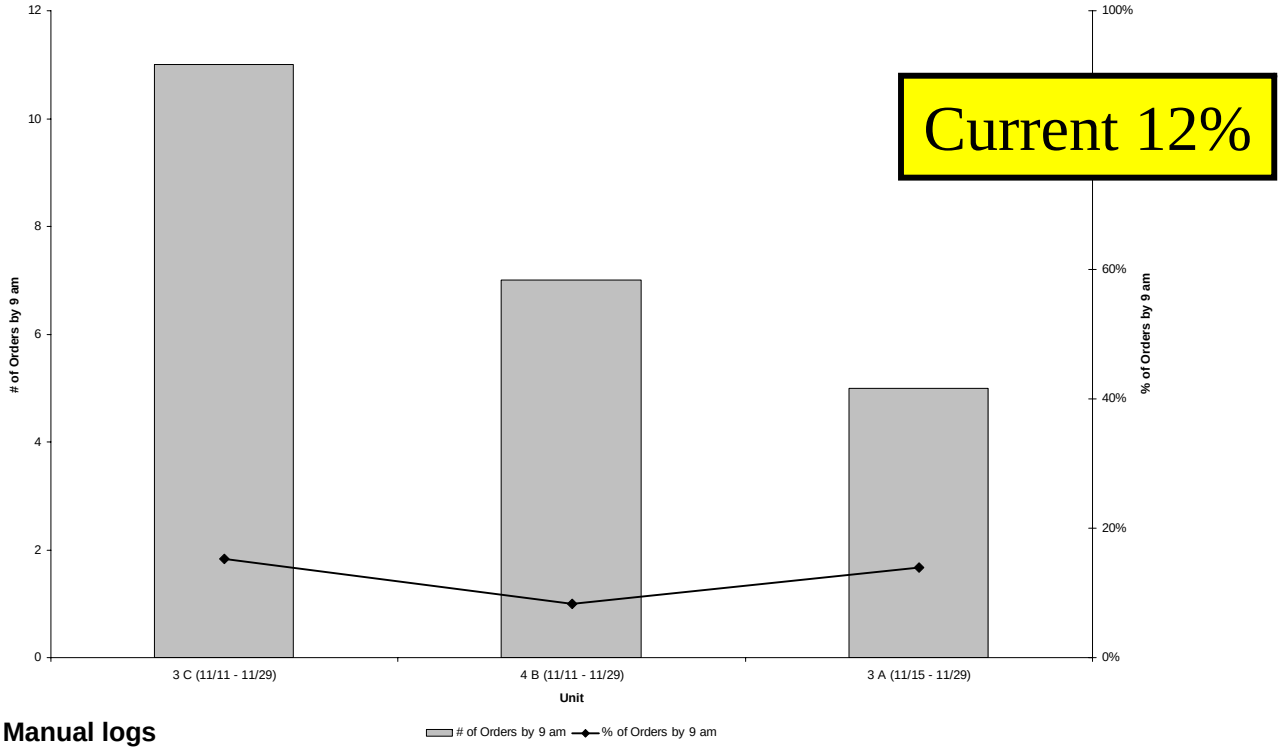
NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- There is a policy for 11AM discharge, but it is not enforced. Based on a small 7-day sample, only 12% of discharge orders occur before 9AM.

Discharge Orders Received by 9AM by Unit



Source: Manual logs

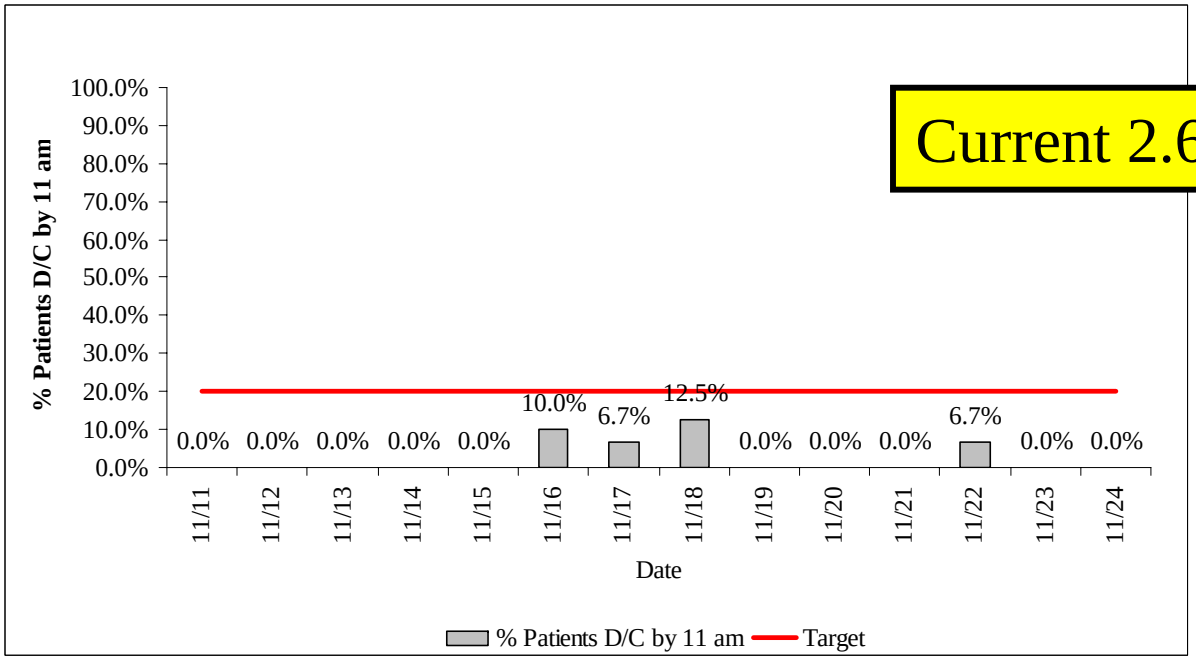
NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- 2.6% of discharges occur before 11AM. Many patients occupy rooms until later in the day because they have no ride.

Percentage of Discharges by 11AM



Source: Manual logs

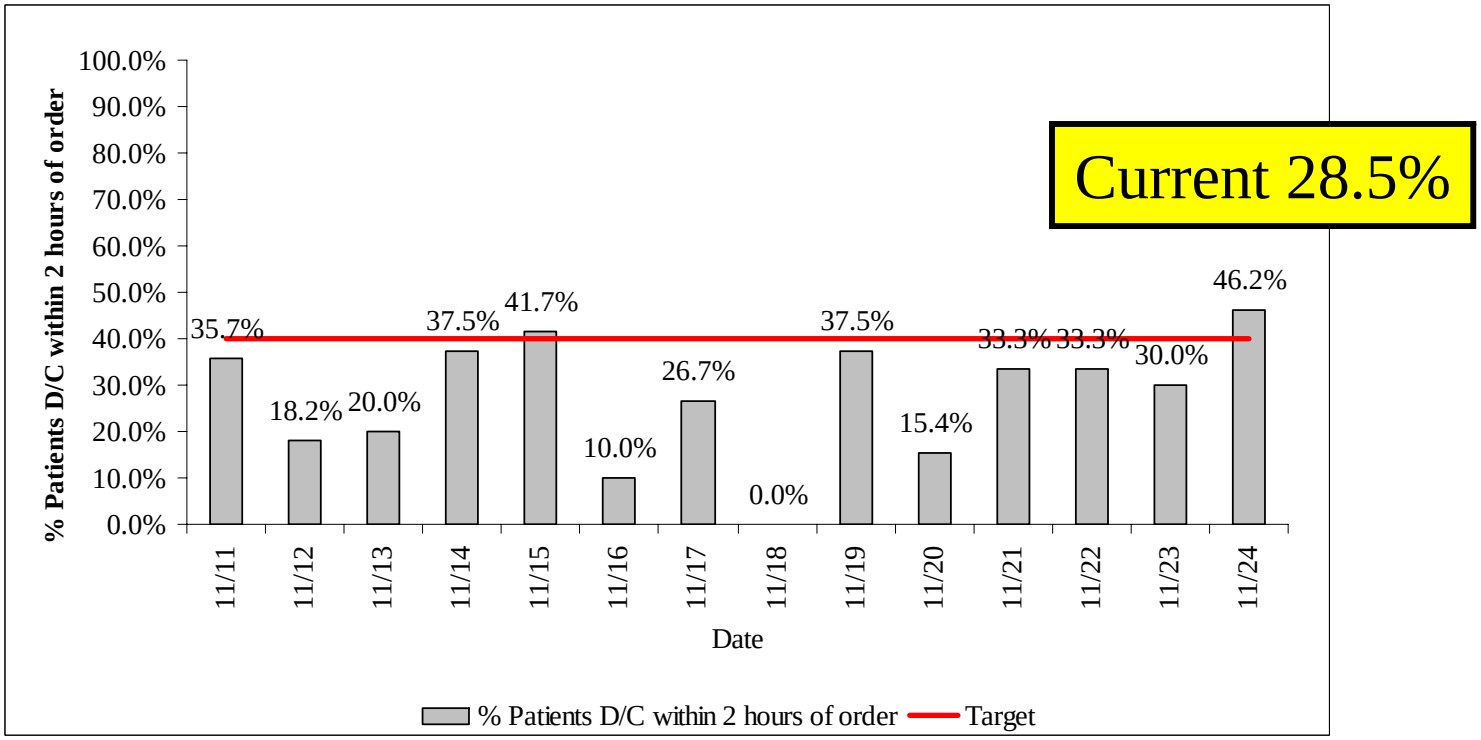
NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- 28.5% of discharges occur within two hours of the order.

% of Discharges within 2 Hours of Order



Source: Manual logs

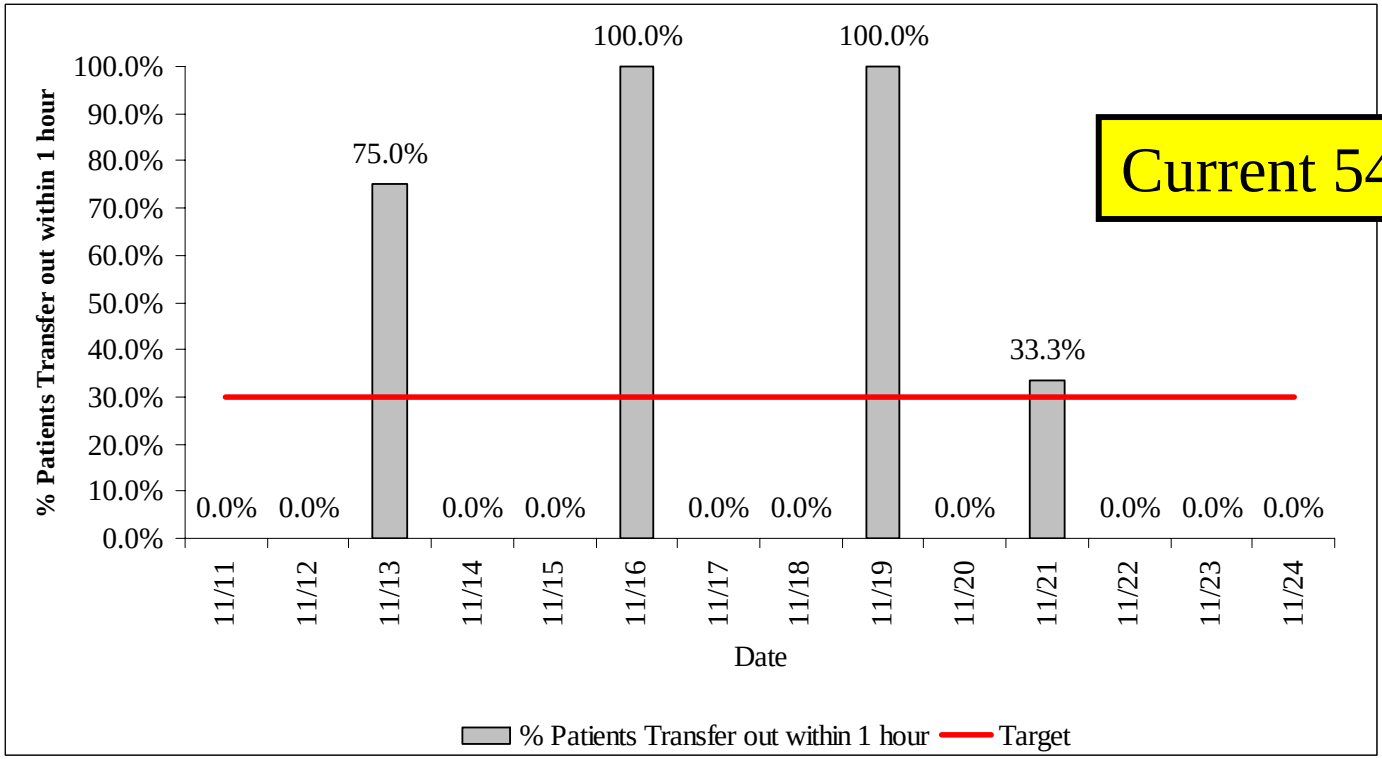
NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- 54.4.5% of internal transfers occur within one hour of the order.

Internal Transfers out within 1 Hour



Source: Manual logs on units 3A, 3C, 4B

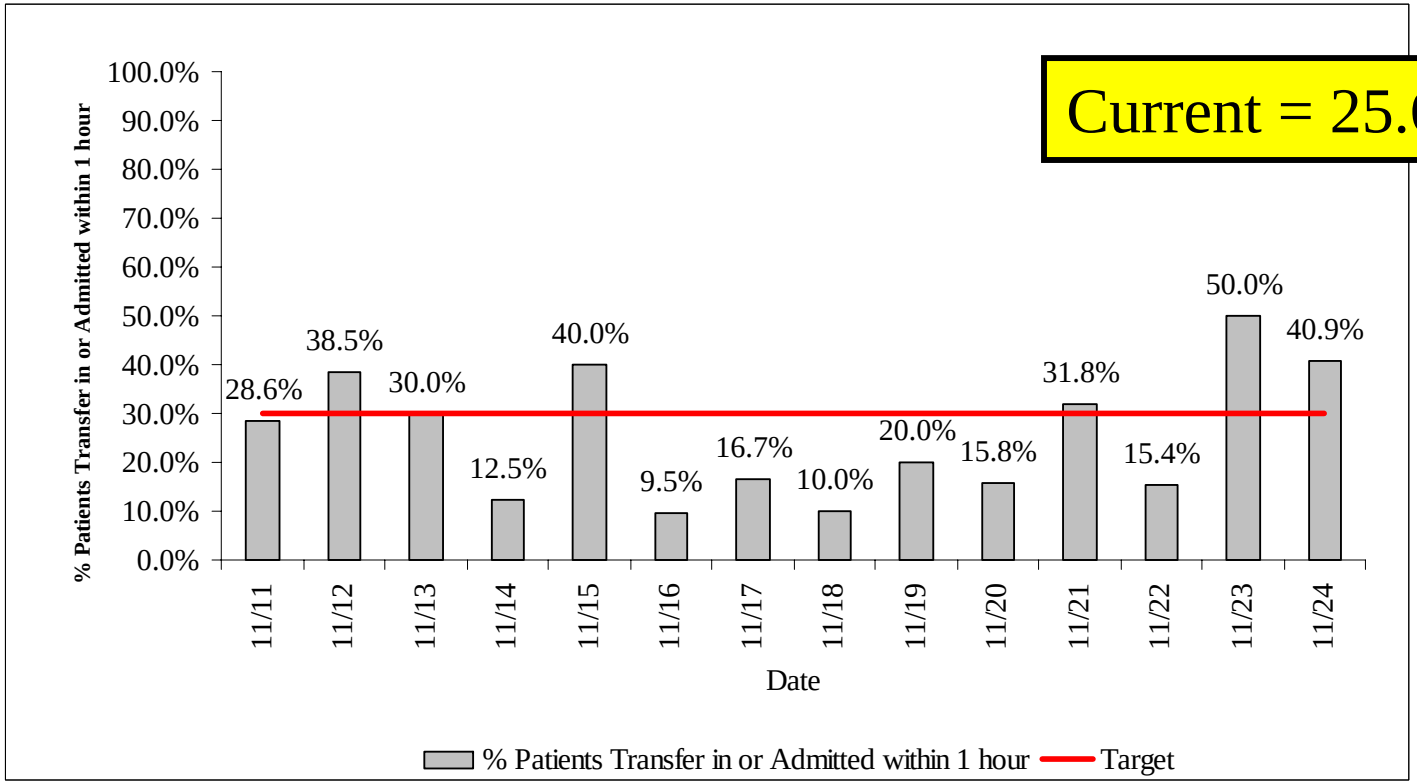
NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- 25.6% of internal transfers occur within one hour of the order.

Internal Transfers in / Admissions within 1 Hour



Source: Manual logs on units 3A, 3C, 4B

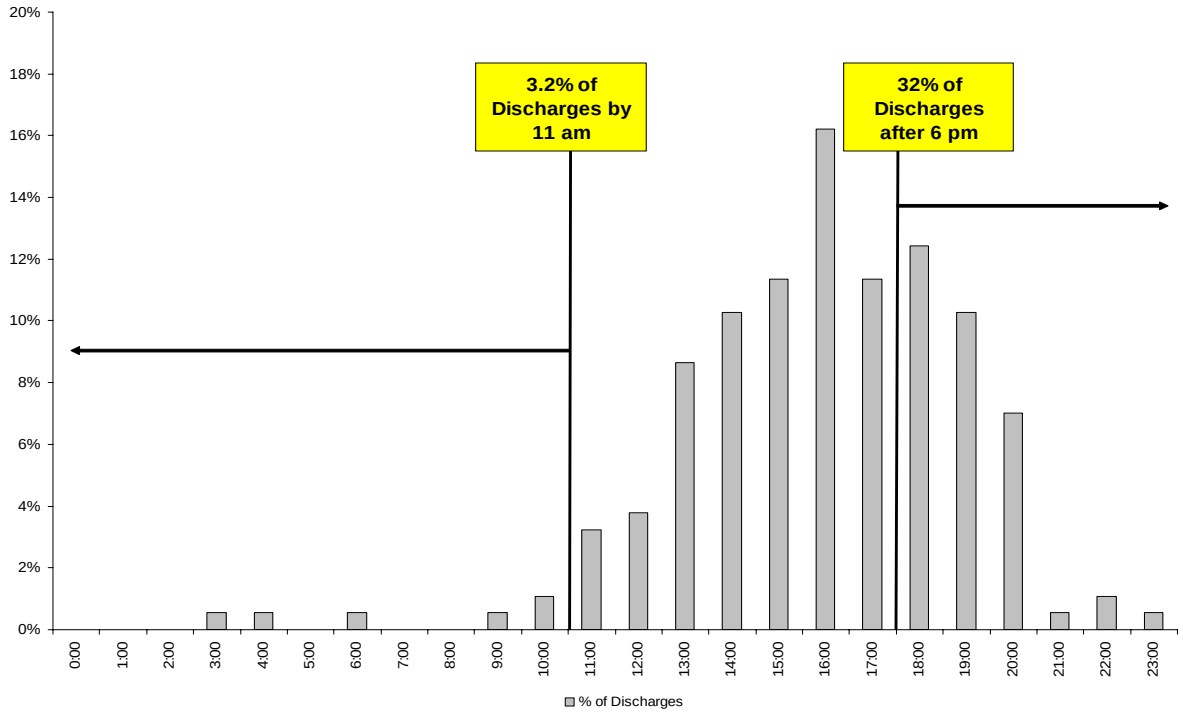
NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- The policy for 11AM discharge is not enforced.
- 64.8% of patients are discharged between 11AM and 6PM.

Percent of Discharges by Time of Day



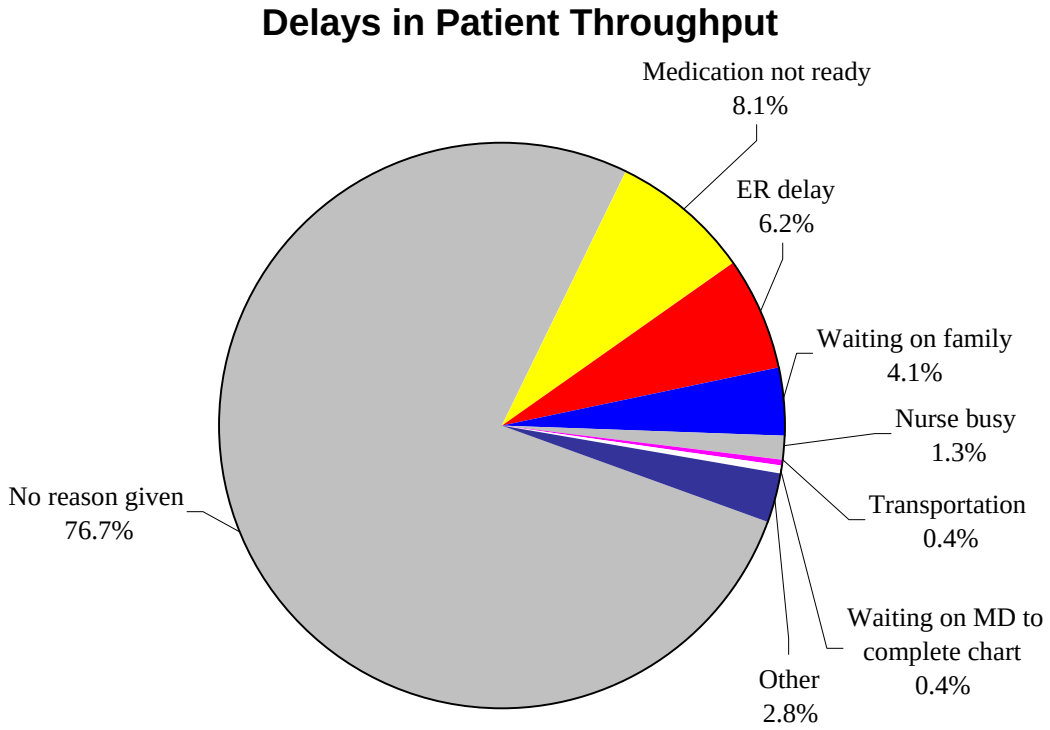
11/1/04 – 11/8/04
Source: Affinity ADT report

NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- 76.7% of delays in patient throughput had no documented reason for delay.



11/11/04 – 11/24/04
Source: Manual logs on units 3A, 3C, 4B

NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Assessment

- There are no metrics in place or systems available for tracking metrics. All data had to be collected manually.
- In the past, bed control staff have kept stats on percent of patients moved within six hours of order, but this was not kept up on a regular basis and was all manual collections.
- Discharge planning is not initiated consistently on admission.
  - Patient/family is unaware of planned day of discharge.
  - No plan was seen to identify discharges the day before.
  - There is not an identified discharge order target time.
- Afternoon discharges are part of the staff culture.
- There is no effort to organization of workload seen on the Nursing units to prioritize getting patients out earlier in the day.
- Once the physician writes the discharge order, the chart is placed in the rack by the unit secretary, the unit secretary takes off the orders, and puts the chart in a rack for the nurses review. The orders can sit in the chart rack for a long time without being reviewed by a nurse.

Capacity / Throughput > Disposition

Assessment

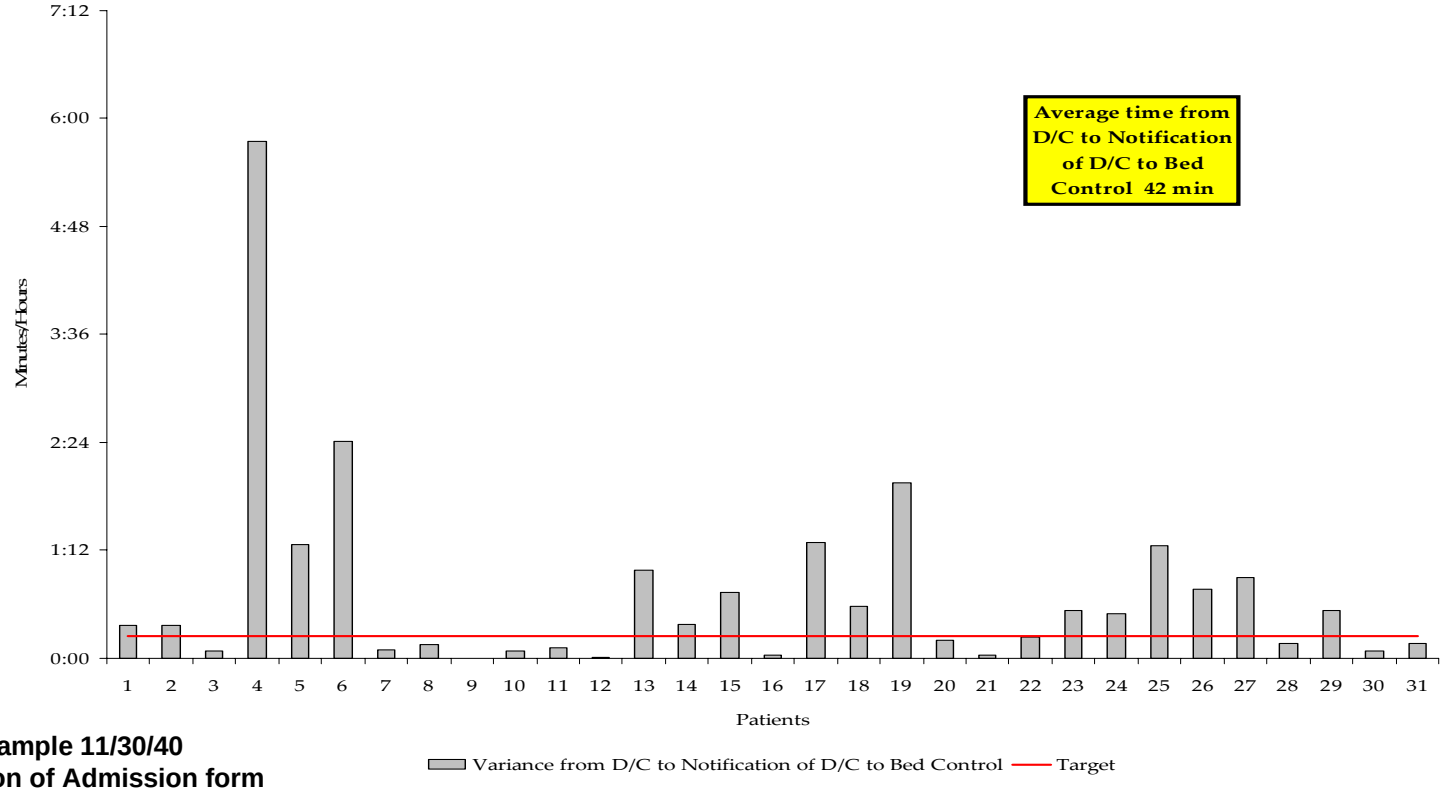
- Observations of the discharge process process showed a lack of basic clerical skills and ability to handle workload in the front desk position.
- Patients came to desk dressed and ready to leave after the physician has told them they will be discharged, but Nursing staff have not started the paperwork.
- Doctors and nurses have difficulty discerning what nurse/tech is assigned to which rooms.
- Pharmacy orders are placed in a bin for pharmacy to pick up and fill.
  - Nursing believes that the policy is for pharmacy to round every 30 minutes.
  - Observations on 3 A showed pharmacy orders remained in the bin for > 2 hours on 3 C showed pharmacy rounding hourly.

Capacity / Throughput > Disposition

Assessment

- There is an average delay of 42 minutes in unit secretaries/nurses inputting discharges.

Variance from Discharge to Notification of Discharge to Bed Control



Source: sample 11/30/40 Notification of Admission form

NAVIGANT CONSULTING

Capacity / Throughput > Disposition

Deficiencies

- There are no established metrics, systems for tracking metrics, or systems for ensuring accountability for patient throughput.
- Physicians are writing discharge orders later in the day, causing evening discharges.
- Discharge planning is not consistently initiated on admission.
- Discharges are delayed due to patients waiting for discharge prescriptions to be filled.

Recommendations

3.2.18 Establish agreed upon metrics and communicate to all personnel.

3.2.19 Implement a system to track metrics on a daily basis and report on a bi-weekly ` basis.

3.2.20 Implement an accountability system for prioritizing discharges and communicating discharges in a timely manner.

3.2.21 Institute a program to support early morning discharges by having a discharge plan order written the night before discharge.

Capacity / Throughput > Disposition

Recommendations

3.2.22 Create a multifaceted approach to eliminate discharge delays.

- Identify the anticipated date at admission and revise daily through the rounding process.
- Coordinate the patient's ride at home the day prior to discharge.
- Require necessary paperwork be completed the evening prior.
- Nurse, or designee, to speak with physician to set patient/family expectation and identify other criteria for discharge (e.g., results of testing, lab result).
- Identify accountabilities for agreed upon metrics.

3.2.23 Implement a Capacity Management Oversight/Steering Committee.

3.2.24 Analyze discharge medication prescription filling process and utilize tube system for sending pharmacy orders.

Capacity / Throughput

Performance Measures

- Percentage of discharges to be entered into Affinity within 15 minutes of discharge
  - Current 45% (Sample 11/30/04 Notification of Admission form)
  - Target 90%
- Time: transfer of ED patient to inpatient bed
  - Current 244 minutes (Sample 11/30/04 Notification of Admission form)
  - Target 90 minutes
- Percentage of discharge orders received by 9 AM
  - Current 12.0%*
  - Target 30.0%
- Percentage discharged by 11AM
  - Current 2.6%*
  - Target 30.0%
- Percentage discharged within two hours of order
  - Current 28.5% *
  - Target 75.0%

Capacity / Throughput

Performance Measures

- Percentage of internal transfers within one hour
  - Current 54.5%*
  - Target 90.0%
- Percentage of admission within one hour
  - Current 25.6%*
  - Target 90.0%

* (Manual logs 3A, 3C, 4B 11/11/04 – 11/24/04)

Responsibility

- CNO

Capacity / Throughput > Ancillaries Issues – Environmental Services

Assessment

- Management and Staffing:
  - The Director, interim even though he has been in the position for two years, reports to the Administrator of Ancillary Services.
  - Management includes:
    - Day shift; senior supervisor and two custodial supervisors.
    - Evening shift; two custodial supervisors and a working supervisor on evening shift.
    - Night shift; working supervisor.
  - The Director and the supervisors round several times during the day to check on the cleanliness of the departments and pitch-in to assist when necessary.
    - The Director will talk with the managers and let them know what he cleaned.
  - Maintaining staff is a major concern; there are approximately 30% of staff members out on long-term leave. This is a difficult position to recruit and retain staff, due to the pay and nature of the job.
  - Staff members are assigned according to department /units.

Capacity / Throughput > Ancillaries Issues – Environmental Services

Assessment

- Process:
  - There is an informal priority system to determine what should be cleaned if there is not appropriate staff for all areas – starting with the 1st floor (ED, trauma, public areas), then the 3rd (surgery), the 5th (NICU and Peds) and lastly the 2nd and 4th floors.
  - The Affinity system is used, which allows EVS to enter when they have cleaned a bed. However, the EVS staff does not use the Affinity system, and relies on the rounding of the supervisors to determine bed availability.
  - There is no system in place, electronic or paper, to inform EVS staff of discharges.
  - EVS staff are assigned to specific areas or units, and they rely on the charge nurse to let them know when a bed needs to be cleaned.
  - Nursing staff does not always volunteer information and beds can sit empty (clean or dirty) for hours without EVS or bed control knowing the status.
  - Per the Director, many beds are found when the supervisors and EVS Director make rounds.
  - EVS staff do not carry pagers and rely on face-to-face contact with the Nursing staff or EVS supervisor to know that a bed needs to be cleaned.
  - EVS is often paged overhead if there is an immediate need for a bed clean.

Capacity / Throughput > Ancillaries Issues – Environmental Services

Assessment

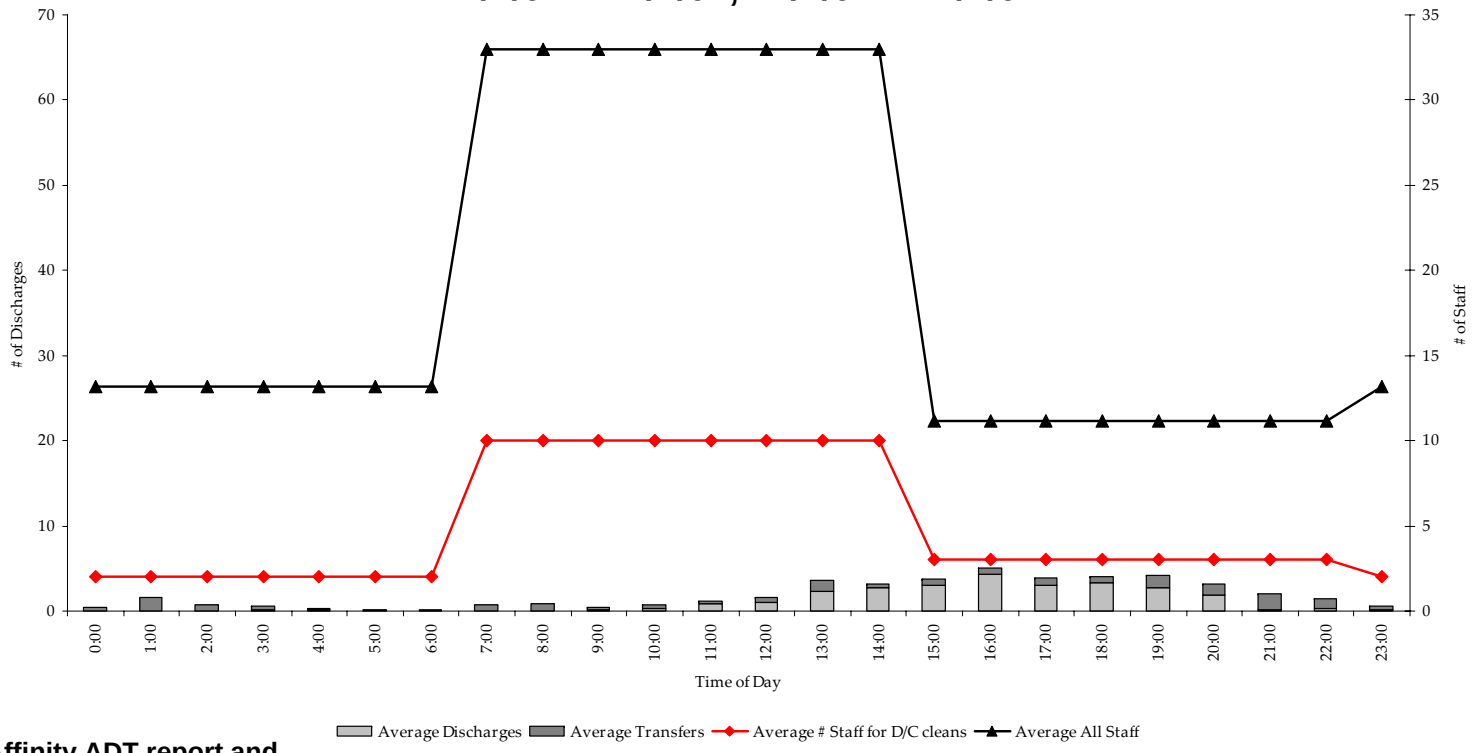
- EVS does not track any quality and service indicators on a consistent basis.
- On some months, EVS have gathered data relating to room clean time, however, the data only includes the time from when the EVS staff member enters the room to when they are finished with the room clean.
- EVS maintain a checklist for every discharge room cleaned, which includes only the basic information related to cleaning the room.
- Expectations for a discharge room clean are about 45 minutes, but can take over an hour for a room that is maintained (rooms that have thorough cleanings periodically).
- Those rooms that are not periodically maintained can take an additional 30 minutes to clean at discharge.

Capacity / Throughput > Ancillaries Issues – Environmental Services

Assessment

- The majority of staffing is on day shift and the majority of workload is on evening shift.

Average Discharge Workload vs. Average Staffing
11/1/04 – 11/2/04, 11/4/04 – 11/7/04



Source: Affinity ADT report and daily EVS staffing

NAVIGANT CONSULTING

Capacity / Throughput > Ancillaries Issues – Environmental Services

Deficiencies

- No systems in place to assist in assigning and dispatching work.
- Workload imbalance due to assignments by area rather than workload demand.
- No clear prioritization of what needs to be done and when.
- Lack of communication systems (such as pagers) to contact EVS staff for bed cleaning needs.
- Strained relationship with Nursing staff and dynamics such as RNs instructing EVS staff to not clean dirty beds.
- Lack of clear expectations and accountability systems within department and with Nursing areas.
- There is no consistent data to compare performance to expectations.
- Difficulty recruiting and retaining employees in EVS department.
- Lack of consistent follow-up by supervisory staff.

Capacity / Throughput > Ancillaries Issues – Environmental Services

Recommendations

3.2.25 Implement a system to assist in assigning and dispatching work (including prioritization).

3.2.26 Develop and implement a communication system which notifies EVS of bed cleaning needs both anticipated and actual.

3.2.27 Analyze workload and develop a staffing/assignment plan to be based on workload demand.

3.2.28 Develop quality metrics to be tracked daily and reported bi-weekly.

3.2.29 Develop and implement an accountability system within EVS department and with nursing areas.

3.2.30 Improve management and supervision.

Capacity / Throughput > Ancillaries Issues – Environmental Services

Performance Measures

- Percentage of routine rooms responded to within 30 minutes
  - Current not currently collected
  - Target 90%
- Percentage of STAT rooms responded to within 15 minutes
  - Current not currently collected
  - Target 95%
- Percentage of rooms called STAT
  - Current not currently collected
  - Target 20%

Responsibility

- Administrator of Ancillary Services

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Hours of operations:
  - Emergency Dept (2 /7)
    - Three rooms / three machines / two mobile units
  - Trauma Radiology (8AM – 4:30PM, Monday - Friday)
    - Nine rooms / nine machines
  - Trauma Bay (24/7)
    - Two mobile units
  - Ultrasound
    - Four machines 8AM – 5PM, Monday - Friday, one machine 5PM – 8AM, Monday - Friday
    - One machine 24/7 Sat-Sun
  - CT (24/7)
    - Two machines
  - Nuclear Med (7AM – 6PM, Monday - Friday
    - Three rooms
  - MRI (7AM – 7PM, Monday - Friday, 8AM – 4PM, Saturday)
    - One machine
  - Radiation Therapy (8AM – 6PM, Monday - Friday)

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Hours of operation: (cont)
  - Special Procedures (8AM - 4:30PM, Monday - Friday), 4:30PM – 8AM on-call Monday - Friday, Weekends on-call)
    - Three rooms
  - Surgery (one - three techs dedicated 24/7)
  - Mammography (8AM - 4:30PM)
    - Three techs
- There has been a decrease in volume; an average number of cases per day was 485, current average is 280 cases per day. 80 -100% of the staffing is still in place from the historic caseload.

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Average daily volumes by modality:
  - Ultrasound – 30/day
  - MRI – 11/day
  - Nuclear Med – 5/day
  - Mammography – 5/day
  - Trauma Radiology (general) – 198/day
  - CT Scan – 47/day

Modality	Hours Open / Day	# of Days Open	# of Machines	Time Slots	Avail Cap / week	Avg Cap/Day	Avg. Volume	Avg Additional Cap/Day
US	9	5	4	30	360			
US	3	5	1	30	30			
US	24	2	1	30	96			
US Total				30	486	69	30	39
CT	24	7	2	30	672	96	47	49
Nuc Med	11	5	3	60	165	33	5	28
MRI	12	5	1	45	80			
MRI	8	1	1	45	11			
MRI Total				45	91	13	11	2

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Great variances noted among modalities from order to procedure complete.
- Diagnostic ED routine tests completed quicker than STAT.

Average Time from Order to Procedure Complete

Modality	ED / Inpatient	Stat / Routine	Volume	Average Time from Order to Procedure Complete
CT	ED	Stat	2	2:59
CT	IP	Routine	3	0:58
CT	IP	Stat	5	2:23
Diagnostics	ED	Routine	30	0:38
Diagnostics	ED	Stat	41	0:49
Diagnostic	IP	Routine	32	2:02
Diagnostic	IP	Stat	10	1:01
Nuc Med	IP	Routine	2	0:40
Nuc Med	IP	Stat	2	0:29
Ultrasound	ED	Routine	1	1:52
Ultrasound	ED	Stat	1	19:35
Ultrasound	IP	Routine	3	6:58

Sample 12/1/04 manual log

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Management and Staffing:
  - Interim Chief of Radiology has been there six weeks.
  - 99% digital and processes have improved since the implementation of PACS .
  - Management roles/expectations are not clearly defined.
- Process:
  - Process steps include:
    1) Film generated.
    2) Turned into file room.
    3) A report is dictated.
    4) A charge sheet generated.
    5) A number is entered.
    6) A read on PACS.
    7) A report generated in medical records.

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- There are few to no policies and procedures in the department.
- Trauma/ER patients take priority over inpatients.
- The dictation process is done via Medquest. After dictation, the transfer back to the Affinity system has a major typo/reject issue. An estimated 30 - 45% of the dictated reports do not get back to Affinity, due to typos and other transcription errors.
  - This is a problem because the manual matching process used is inherently slow and arduous, but due to the lack of skilled employees in the department the problem is even worse.
- There are no metrics for machine utilization, staff utilization, productivity, report turnaround times, and patient wait times.
- Process where reports are generated in medical records is very confusing, inefficient, etc.
- Equipment in the departments seems to be “OK” according to the Director.
  - CT is one generation old; with CT requests increasing, could be an area to look at equipment additions.

Capacity / Throughput > Ancillaries Issues – Radiology

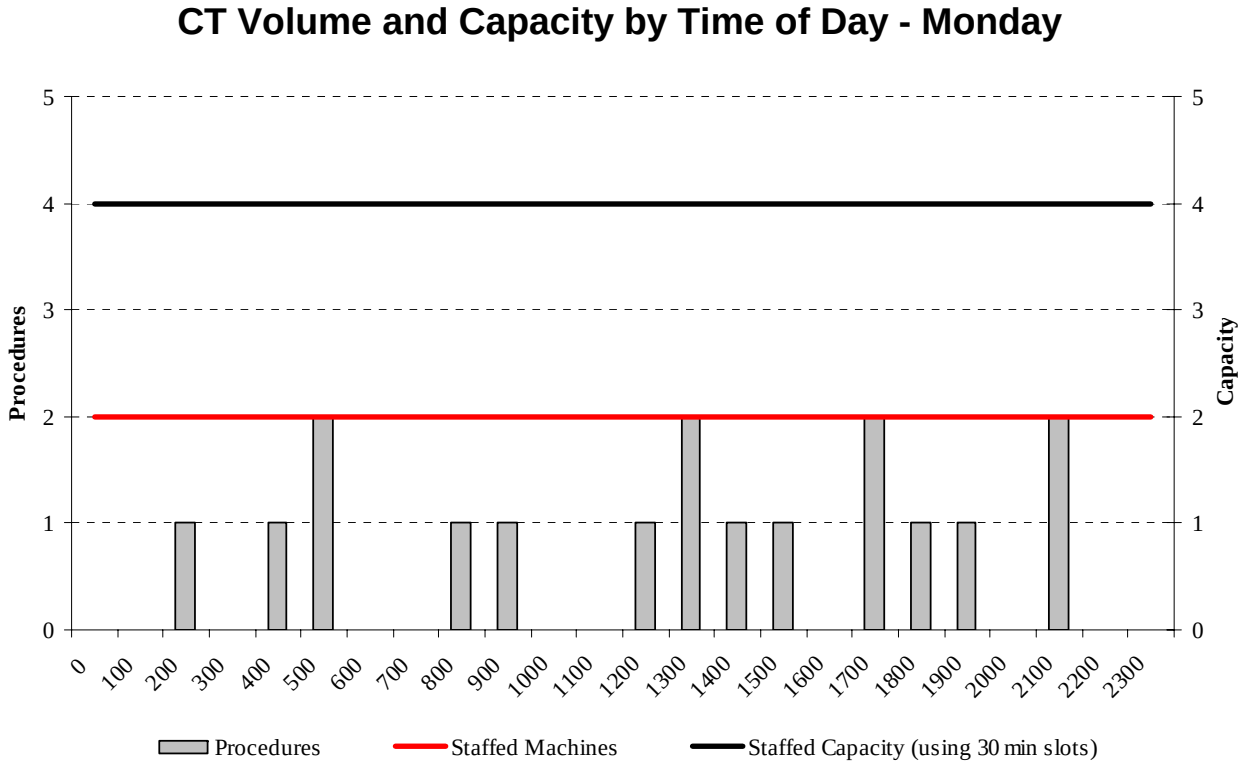
Assessment

- Lack of criteria for ordering tests results in ED physicians ordering everything; causing inappropriate delays, due to many potentially unnecessary procedures in the queue.
- Significant amount of tests in ED ordered as portable.
- No reports available for tracking metrics for response to order, complete to report available, and order to report available.
- Manual logs implemented to identify deficiencies in throughput; inconsistent data was received.
  - No report complete time was available; to complete, this area would required multiple logs and intensive manual collection.
- Manual log showed inpatient MRI ordered November 28, but not completed until December 1.
  - Unsure if cause for delay was a medical condition or availability of modality.

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Based on Capacity, there should be no delays in having a CT completed.



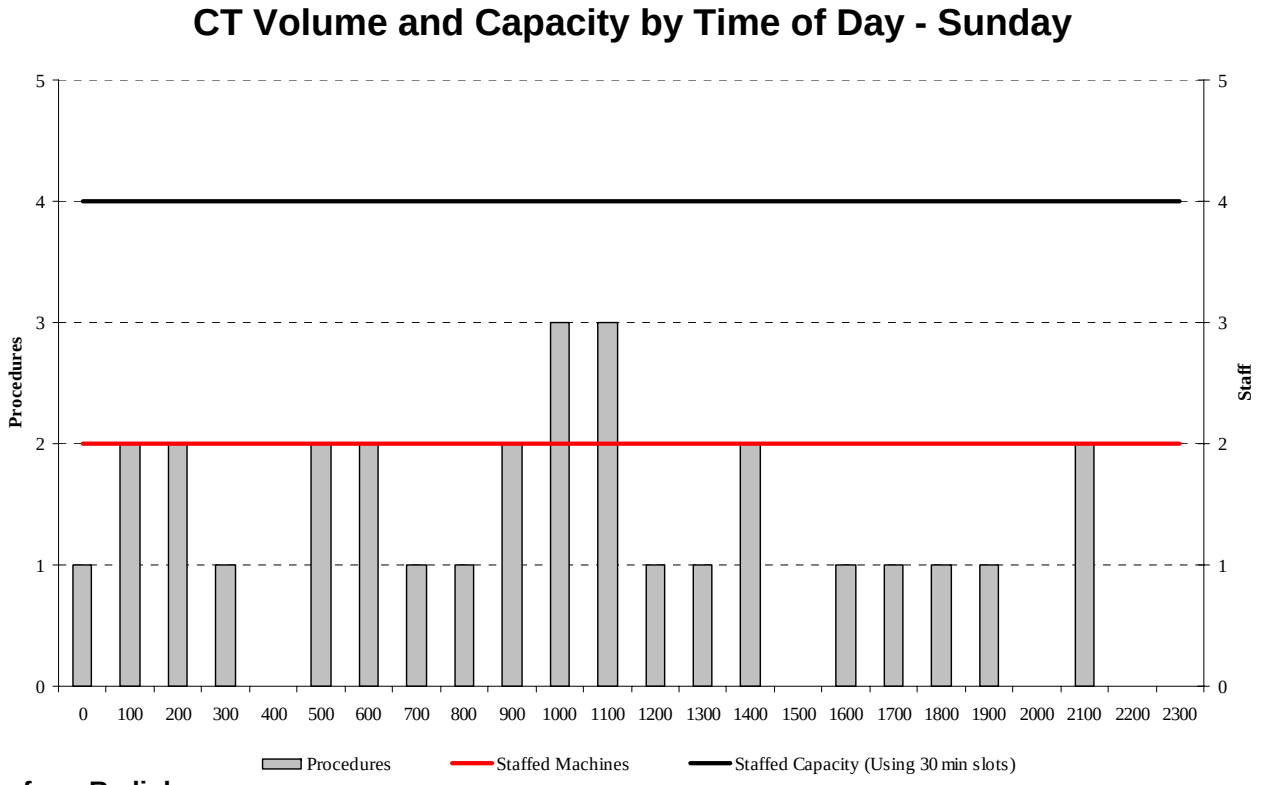
November 1, 2004
Source: Manual logs from Radiology

NAVIGANT CONSULTING

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Based on Capacity, there should be no delays in having a CT completed.



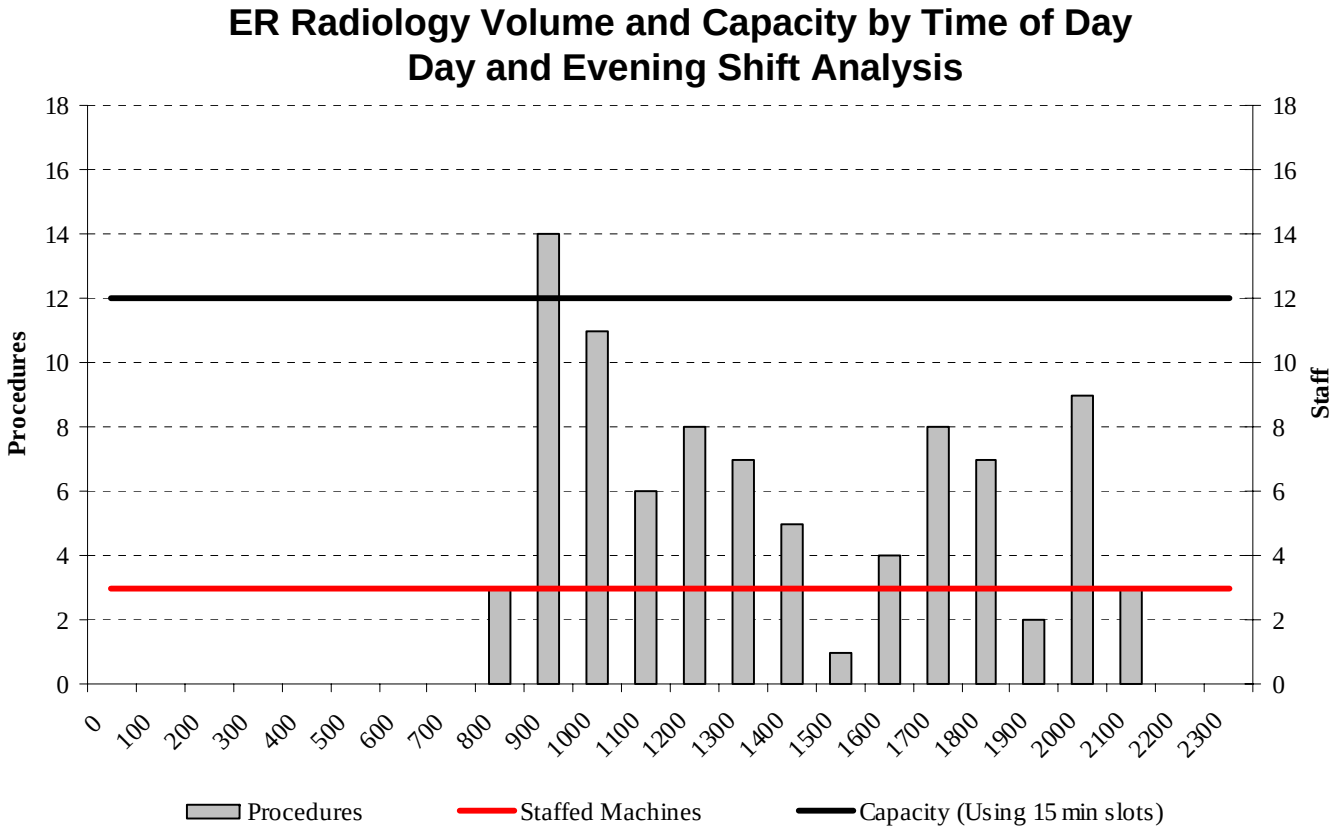
November 7, 2004
Source: Manual logs from Radiology

NAVIGANT CONSULTING

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Between 9AM and 11PM there may be delays in having a test completed.



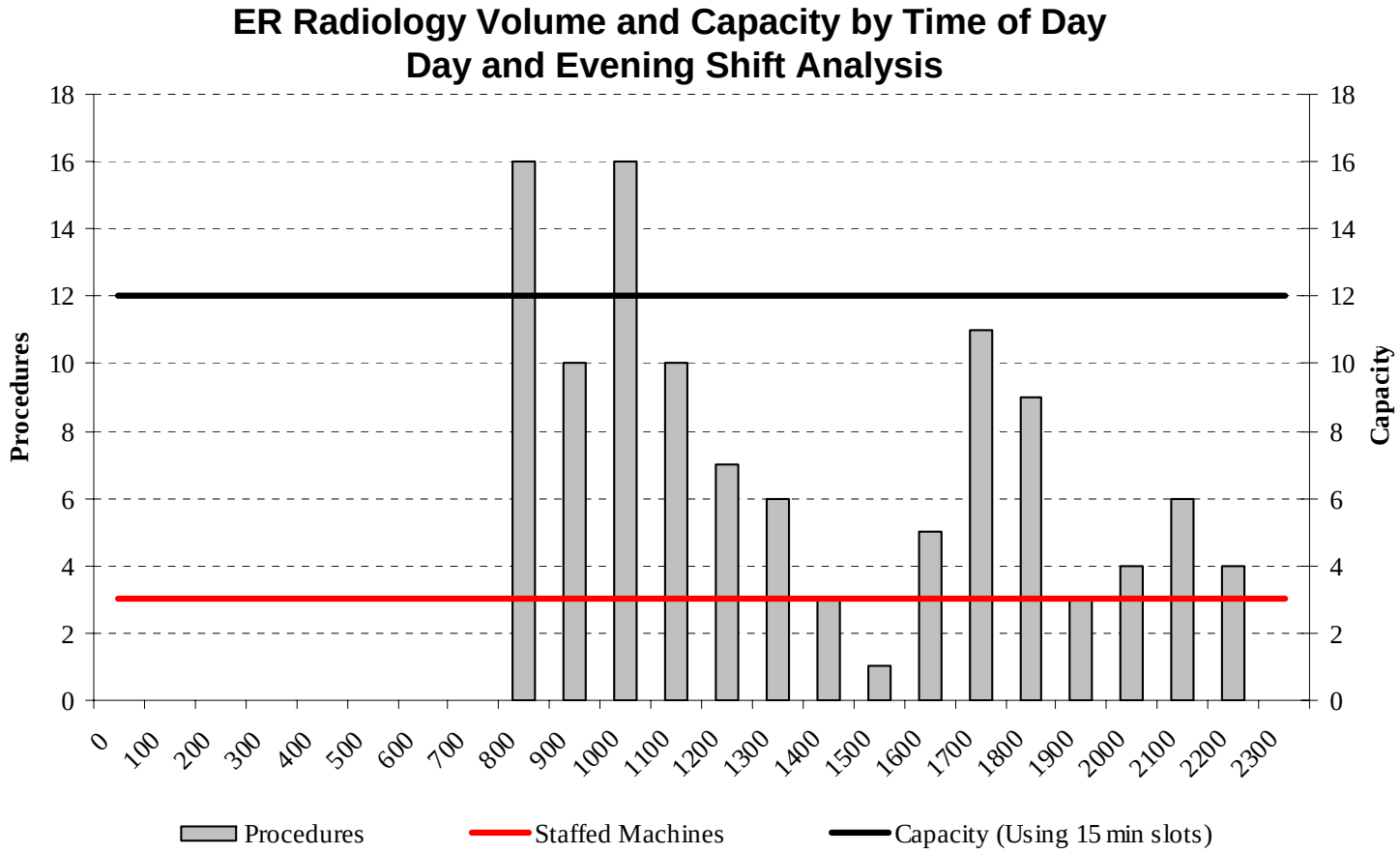
November 1, 2004 (Monday)
Source: Manual logs from Radiology

NAVIGANT CONSULTING

Capacity / Throughput > Ancillaries Issues – Radiology

Assessment

- Between 8 AM and 11 AM there may be delays in completing a test.



November 5, 2004 (Friday)
Source: Manual logs from Radiology

NAVIGANT CONSULTING

Capacity / Throughput > Ancillaries Issues – Radiology

Deficiencies

- Currently no day-to-day management positions.
- An ill-defined scheduling process; both inpatient and outpatient.
- Transportation delays causing a problem in processing inpatients.
- Lack of patient prioritization.
- Potentially excessive radiology orders in the ED, which is secondary to lack of guidelines or protocols.
- Lack of performance management system.
- Inappropriate ordering of portables.
- Error-ridden dictation with a subsequent ineffective transcription process.
- No established metrics.
- No available reports for tracking and reporting of metrics.

Capacity / Throughput > Ancillaries Issues – Radiology

Performance Measures

- ED: Time from order to procedure completion
  - Current not currently collected
  - Target 75% within 1 hour; 100% within 2 hours
- In Patient Stat: Time from order to procedure completion
  - Current not currently collected
  - Target 75% within 1 hour; 100% within 2 hours
- In Patient Routine: Time from order to procedure completion
  - Current not currently collected
  - Target 80% within 6 hours; 100% within 16 hours
- Procedure completion to report completion (on record)
  - Current not currently collected
  - Target 90% stat within 3.5 hours; 90% routine within 24 hours

Responsibility

- Administrator of Ancillary Services

Capacity / Throughput > Ancillaries Issues – Physical Therapy

Assessment

- Does not appear that delay in PT referrals and treatments create any throughput issues, however missed referral triggers could potentially extend patient overall LOS and LOC needs.
- PT criteria for referrals exist in policy format with identified assessment triggers.
- Policy indicates that Nursing staff is responsible for identifying the triggers for PT during their initial assessment. It is not clear in the referral policy and procedure that PT performs any generalize patient screening based upon diagnosis.
- For outpatients the PT referral form is completed by the physician and an initial evaluation appointment within ten business days from the date the order was received.
- Outpatient the waiting time, after log-in and until the therapist sees the patient, is less than 15 minutes.
- Inpatients will have an initial assessment within 24 hours from the date of the request.

Capacity / Throughput > Ancillaries Issues – Physical Therapy

Assessment

- Documentation of patient/family education is in all required records.
  - The inter-disciplinary patient/family teaching assessment and flow sheet is completed.
  - The Nursing care plan, part A is completed.
  - Initial plain assessment is complete for all patients that are experiencing pain.
  - The required initial assessment is complete
- A thorough patient satisfaction survey exists.
- Current staffing: One PT (level 10), two PT (level 2), one clinical instructor, two supervisors, two PTAs.
- Random observation/audit within the critical care unit revealed only on1 PT referral for 12 patients. Majority of these patients where bed bound and ventilated indicating that PT referral triggers may be being missed by Nursing or PT.
- Patient transport issues exist with getting inpatients to hydrotherapy. Currently nurse staff are transporting these patients to PT.

Capacity / Throughput > Ancillaries Issues – Physical Therapy

Deficiencies

- No productivity monitoring process.
- Department is not meeting the inpatient standard of initial assessments completed within 24 hours.
- Action steps listed in the performance improvement report are not clearly identified.
- Patient PT triggers are being missed.
- No established metrics for clinical outcomes, (i.e., percentage of patients meeting treatment plan goals).
- No available reports for tracking and reporting monthly variance to budgeted inpatient and outpatient visits.
- No available reports comparing the frequency and volume of patient treatments compared to available staff by time of day or day of week.

Capacity / Throughput > Ancillaries Issues – Physical Therapy

Recommendations

3.2.31 Develop productivity monitoring process.

3.2.32 Initiate a process to identify patients who may require PT service but were not identified during nursing evaluation.

- This could include 100% review of all critical care patients and/or targeted patient populations based upon admitting diagnosis by the PT staff.

3.2.33 Track missed treatments with identified reason and develop plans for resolution as appropriate.

3.2.34 Identify clinical outcomes based upon patients meeting established treatment goals.

3.2.35 Implement appropriate staffing levels to volume of treatments by time of day and day of week.

3.2.36 Revise skill mix of PT to PTA's to national standards.

Capacity / Throughput > Ancillaries Issues – Physical Therapy

Performance Measures

- Percentage of initial assessments complete
  - Current 95% (3rd Qtr)
  - Target 100%
- Percentage of documentation of patient/family education
  - Current 84% (3rd Qtr)
  - Target 100%
- Percentage of outpatient evaluation within five business days from date the order was received
  - Current 49% (3rd Qtr)
  - Target 100%
- Percentage of inpatients are evaluated within 24 hours of the referral
  - Current 83% (3rd Qtr)
  - Target 100%
- Percentage of patients meeting their initial treatment goals
  - Current not currently collected
  - Target 100%

Capacity / Throughput > Ancillaries Issues – Physical Therapy

Performance Measures

- Percentage of outpatient referrals with completed forms
  - Current 62% (3rd Qtr)
  - Target 100%

Responsibility

- Administrator of Ancillary Services

Capacity / Throughput > Transport

Assessment

- There is no centralized or coordinated system or processes for transport at KDMC.
- Individuals identified as “transporters” have additional and varied job responsibilities. The percentage of these roles dedicated to transport varies, but not more than 45%.
- The majority of patient transports occur between ED and Radiology, or inpatient units and Radiology/other clinical ancillary services, and for patient discharge. Transport assistance is also occasionally needed for patients from clinics to other areas of KDMC.
- Departmental staff are frequently required to leave their departments to “fetch” supplies that are not readily available for patient care.
- There are no clinical criteria/guidelines available to define patient transports that require licensed personnel.
- Due to legislation requiring maintenance of licensed nurse to patient ratios at all times, all licensed personnel required to leave unit for transport must be replaced for duration of time they are off the unit.

Capacity / Throughput > Transport

Deficiencies

- There is no organized transport system at KDMC.
- Individuals assigned to transport patients are also accountable for multiple other tasks.
- Lack of clinical criteria to define need for licensed personnel for transport results in excess time away from unit and patient assignment.

Recommendations

3.2.37 Design a centralized transport system for patients. and supplies

3.2.38 Develop clinical criteria to define need for licensed vs. non-licensed personnel to assist with transport.

3.2.39 Develop a flexible staffing and scheduling plan to deploy transporters according to activity and demand.

3.2.40 Create baseline measurements and establish performance expectation targets for transport times.

3.2.41 Implement performance measurement and reporting.

Capacity / Throughput > Transport – Emergency Department and Radiology

Assessment

- The current practice for transport between the two departments is as follows:
  - Diagnostic radiology – ED personnel transport patients to Radiology and Radiology personnel transport patients back to the ED.
  - CT – ED personnel transport patients to and from Radiology
  - MRI – outsourced department; MRI department staff transport patients to and from Radiology
  - Clinical needs of the patient are accounted for in decision regarding who transports the patient especially for CT and MRI.
- Radiology reports significant delays from the time the test is ordered until the time that the patient is transported to the department to have the requested test. In these cases, Radiology personnel may choose to go get the patient in the ED.
- Multiple delays are reported in the ED including:
  - Inability to find patients in the ED due to lack of signage above beds and many located in the hallways.
  - Patients are not undressed and in hospital gowns.
  - Patients have not been instructed to remove and secure jewelry.

Capacity / Throughput > Transport – Emergency Department and Radiology

Assessment

- The appropriate mode of transport (gurney, wheelchair) for patients is not consistently identified and/or is not available. There is no waiting area for Radiology patients. Wheelchairs are not frequently available for transport of ambulatory ED patients, therefore, many are transported unnecessarily on gurneys and await testing in the hallway.
- Unnecessary transports to and from the ED are reported due to inconsistent and untimely communication between ED physicians/staff and Radiology when tests that have been ordered are cancelled.
- It is reported that appropriateness of Radiology testing orders is inconsistent and may result in unnecessary utilization; increased and/or unnecessary transports result.
- The performance measurement that is currently used is from the time test is ordered to time test is completed; metrics to define root cause of delays in individual process steps is not tracked.

Capacity / Throughput > Transport – Emergency Department and Radiology

Deficiencies

- There is no organized transport system at KDMC.
- Individuals assigned to transport patients are also accountable for multiple other tasks.
- Delays in transport have resulted in “workarounds” to current practice which have not resulted in decrease in delays.

Recommendations

3.2.42 Set and communicate expectation that patients will be undressed, in hospital gown with jewelry removed 20 minutes after admission to the emergency department.

3.2.43 Create clear and visible system in the Emergency Department for identifying patient location including bay and hallway spaces.

3.2.44 Create radiology transporter positions to manage transport specifically for radiological testing.

Capacity / Throughput > Transport – Emergency Department and Radiology

Recommendations

3.2.45 Create baseline measurements and establish performance expectation targets for transport times.

3.2.46 Measure performance to target and report monthly at Radiology and Emergency Department meetings.

3.2.47 Implement corrective action plan for variance to targeted performance.

3.2.48 Utilize performance measurement data to determine optimal practice for patient transport between emergency department and radiology.

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Capacity / Throughput > Transport

Performance Measures

Transport

- Time request for transport is made until time transporter arrives on until
  - Current not currently collected
  - Target TBD

ED and Radiology

- Time test is ordered to time patient arrives in Radiology department
  - Current not currently collected
  - Target TBD
- Time test is completed to time patient returns to the ED
  - Current not currently collected
  - Target TBD

Responsibility

- Administrator for Ancillary Services

Section III – Clinical Organization

3. Emergency Services
   - Interviews
   - Prioritized Summary of Recommendations
   - Emergency Room
     - Overview
     - Capacity/Throughput
     - Leadership/Management
     - Physician Management
     - Staffing
     - Clinical Care
   - Trauma Center
   - Emergicenter
     - Overview
     - Leadership/Management
     - Staffing
     - Clinical Care
     - Disposition

Emergency Services > Interviews

• A. Loomis	Manager, Emergency Services
• A. Beldran	Assistant Nurse Manager, ED
• C. Castillo	Supervisor Staff Nurse I, Charge Nurse
• T. Wilson	Prehospital Care Coordinator
• D. Porter	Supervisor, Emergicenter and Triage
• T. Chau	Clinical Nurse II, Educator/Documentation Auditor
• R. Meza	Intermediate Typist Clerk, ED Secretary
• L. Pascal	Manager Psychiatric ED
• E. Hardin, MD	Medical Director, ED
• J. Claud Henry, MD	Medical Director, Trauma
• O. Wilson	Coordinator, Trauma
• M. Sanky	Affinity

Emergency Services > Prioritized Summary of Recommendations

Emergency Services – Capacity / Throughput		
Short-term	3.3.01	Develop staffing model that meets the physician commitment in Triage.
Short-term	3.3.02	Develop performance standards for triaging patients and hold staff to meeting the standards.
Short-term	3.3.03	Review and revise current Triage criteria so that patients are placed in appropriate areas.
Short-term	3.3.04	Identify ED specific functions of Affinity including tracking patients.
Short-term	3.3.05	Develop a consistent five level acuity system that starts in triage and continues through the charge process.
Short-term	3.3.06	Implement process so that patients in triage waiting to be seen, are reassessed according to acuity.
Long-term	3.3.07	Renovate triage to assure there is privacy for patients being triaged.
Short-term	3.3.08	Develop and implement Triage protocols.
Short-term	3.3.09	Change staffing model so there are three RNs in triage during peak hours.
Short-term	3.3.10	Define data collection criteria for elopement and AMA.
Intermediate	3.3.11	Elevate data collection standards to facilitate fact based decision making.
Short-term	3.3.12	Change processes so that admissions waiting for inpatient beds are kept at a minimum.
Short-term	3.3.13	Work in conjunction with Capacity Management to identify the appropriate bed request and assignment process.
Long-term	3.3.14	Implement FAX report policy to decrease delays in calling report.
Long-term	3.3.15	Develop process so that ED Admissions are admitted to the appropriate level of care.
Intermediate	3.3.16	Develop/implement a consistent downgrading policy.
Intermediate	3.3.17	Develop policy for downgrading patients that all physician staff are required to follow.
Short-term	3.3.18	Develop internal policy that follows DHS Guidelines for determining what will happen when Divert becomes a possibility and divert status is called.
Short-term	3.3.19	Develop policy for determining who the responsible parties are concerning divert.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

NAVIGANT CONSULTING

Emergency Services > Prioritized Summary of Recommendations

Emergency Services – Capacity / Throughput		
Short-term	3.3.20	Develop policy for 30 minute re-assessment to determine if the ED can safely come off of divert.
Short-term	3.3.21	Collect data regarding patient acuity and base decisions on diversion.
Short-term	3.3.22	Educate appropriate staff on diversion criteria.
Short-term	3.3.23	Develop process to expedite patient flow to decrease diversion.
Leadership / Management		
Intermediate	3.3.24	Develop an ED Joint Practice Group.
Urgent	3.3.25	Revise the Nursing Management structure.
Intermediate	3.3.26	Develop an ED Quality and Performance Measurement position to support data-driven decision making.
Physician Management		
Intermediate	3.3.27	Develop a multidisciplinary physician team to identify process changes and create a forum for physician collaboration.
Short-term	3.3.28	Implement ED protocols for all ED physicians to follow.
Long-term	3.3.29	Provide patient satisfaction training to all ED physician staff.
Long-term	3.3.30	Develop a mechanism for monitoring ED physician productivity.
Intermediate	3.3.31	Mandate all ED physicians attend cultural sensitivity training.
Emergency Room Staffing		
Short-term	3.3.32	Identify strategies for recruitment and retention of KDMC nursing staff.
Long-term	3.3.33	Develop pre-printed orders for commonly seen complaints.
Clinical Care		
Short-term	3.3.34	Develop process for implementing/following care plans for ED patients waiting for I/P admission.
Urgent	3.3.35	Initiate ICU Flow Sheets on ED patients waiting for ICU admission. (ICU flow sheets were implemented December 2004 and are currently being used).
Short-term	3.3.36	Insure that there are a sufficient number ED monitors in working condition and linked to a central monitoring station.
Urgent	3.3.37	Assure that all staff is compliant with BLS, ACLS and PALS by year end.
Intermediate	3.3.38	Initiate a policy that requires certification as a job qualifier.

Emergency Services > Prioritized Summary of Recommendations

Trauma Center		
Short-term	3.3.39	Eliminate the Trauma Coordinator role.
Short-term	3.3.40	ED Performance/Quality Coordinator will assume trauma data collection and reporting.
Short-term	3.3.41	Track patients by trauma level.
Urgent	3.3.42	Perform monthly concurrent chart review on deaths.
Emeregicenter		
Intermediate	3.3.43	Develop plan to provide patients with clinic appointments.
Urgent	3.3.44	Remove the sputum induction chamber and create a 5th room for Emergicenter.
Urgent	3.3.45	Restructure ED Management to have a Charge Nurse, responsible for meeting Emergicenter performance metric targets and assure new processes are implemented.
Intermediate	3.3.46	Develop performance standards for physician staff to improve performance.
Intermediate	3.3.47	Consider Physician Extender to see patients from 4:30PM to 12:30AM when attending leaves and Blue team physician has to cover resident.
Short-term	3.3.48	Hold physician staff accountable to assure they are always available.
Short-term	3.3.49	Develop a plan for appropriate oversight for residents.
Short-term	3.3.50	Use consistent staff in the Emergicenter.
Short-term	3.3.51	Identify appropriate staffing model that supports California ratios.
Short-term	3.3.52	Identify interdeparatment process to improve flow.
Short-term	3.3.53	Identify process to capture POP patients when transferred to the ED for care.
Short-term	3.3.54	Develop a plan for appropriate oversight for residents.
Short-term	3.3.55	Review and revise current registration process.

Emergency Services > Emergency Room – Overview

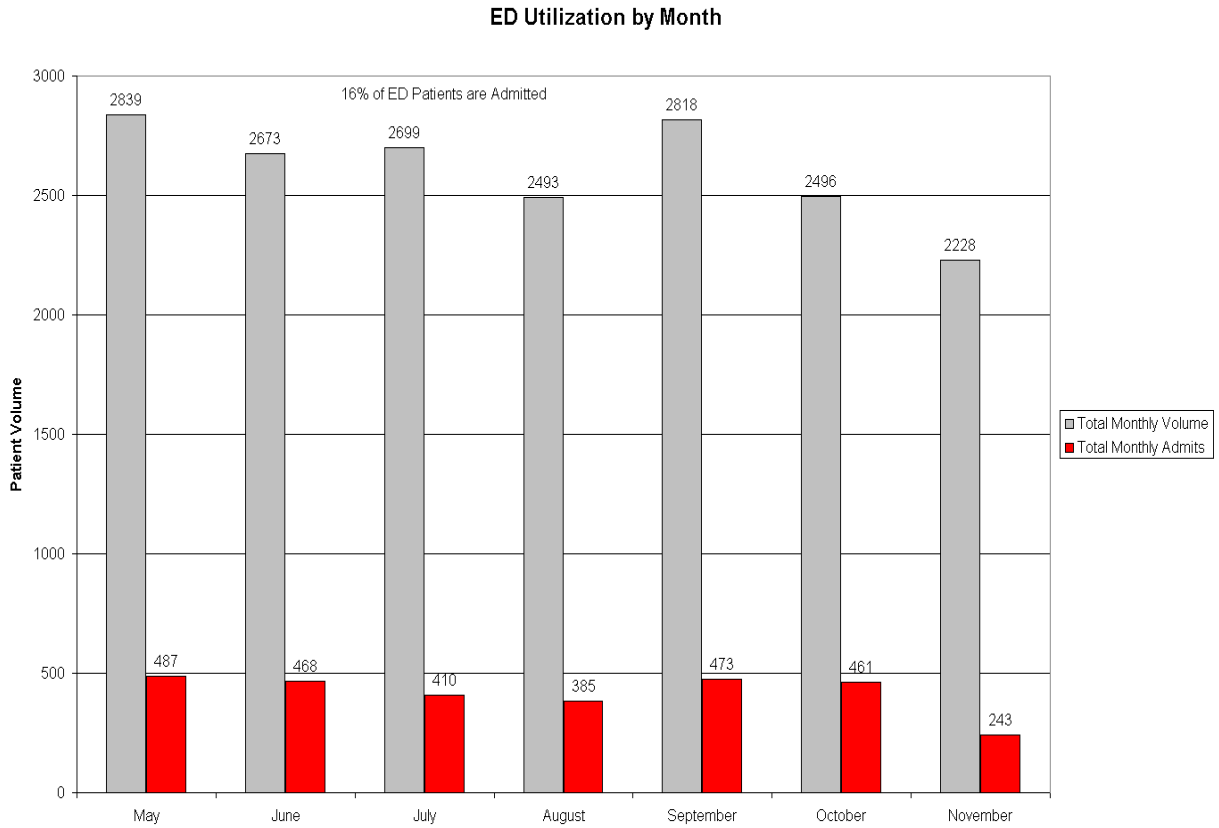
Assessment

- The ED consists of 19 bays.
  - Two isolation rooms, three GYN rooms, and one code room with four beds.
  - Eight bays for medical surgical holding patients.
  - Five bays for ICU holding.
- Holding patients in the ED decreases the number of bays available to see new patients. Many options have been suggested to create additional space.
  - Moving the ED to the Trauma/ICU area and using the current ED as an observation area, opening up the ICUs that were closed within the hospital; 5E, 3E, and 5B.
  - There are limited isolation rooms in the current ED and the move would create an increase in isolation rooms.
  - This idea was presented to the County at an unknown earlier date.
- The ED sees approximately 31,748 patients per year.

Emergency Services > Emergency Room – Overview

Assessment

- 16% of the ED patients are admitted.



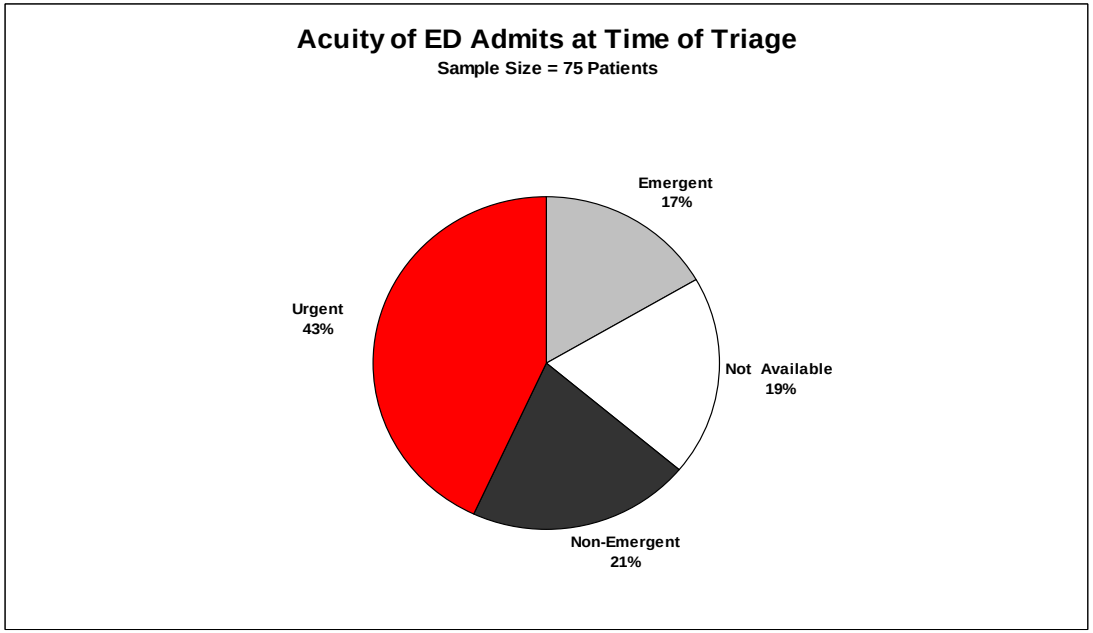
Source: IS Affinity Query. 12.10.04

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Overview

Assessment

- A sample size reflected that 17% were emergent, 43 were non-urgent, 21% were non-emergent and 19% were unidentified.



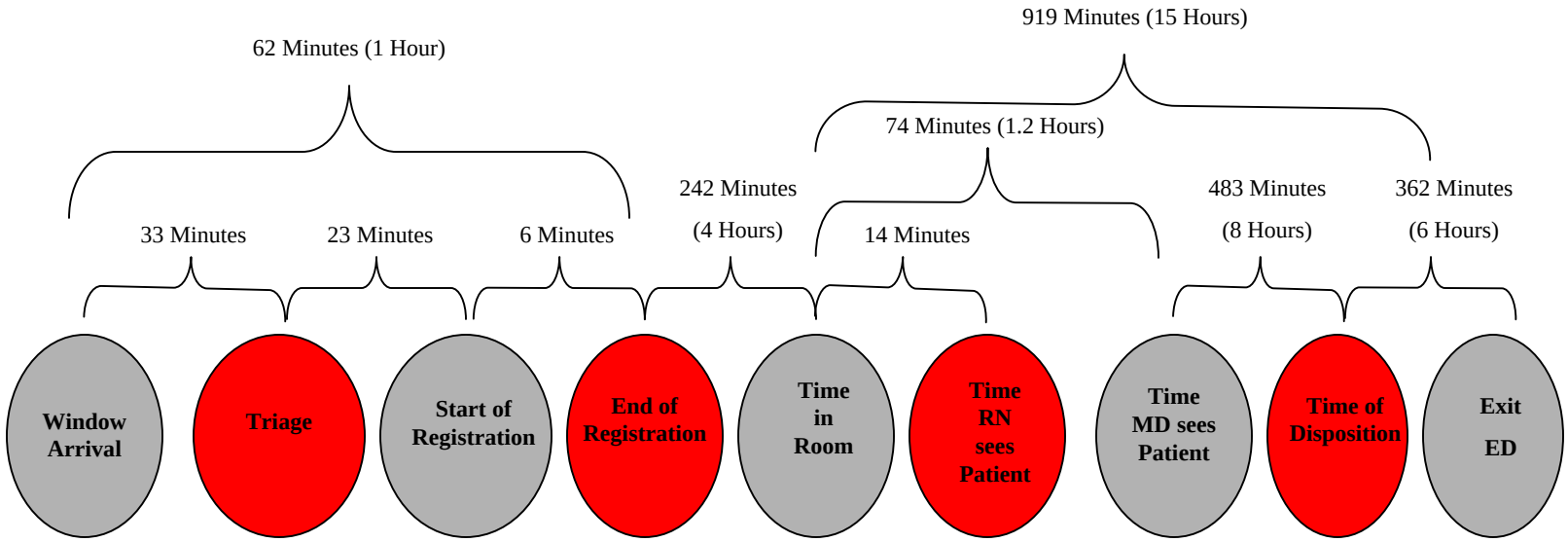
Source: Manual data collection tool developed by NCI.
Data collected from 11/30/04 – 1/2/04
(75 out of a possible 123 cases had completed documentation)

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

Process Times: ED Patients Requiring Admission



Source: Manual Data Collection

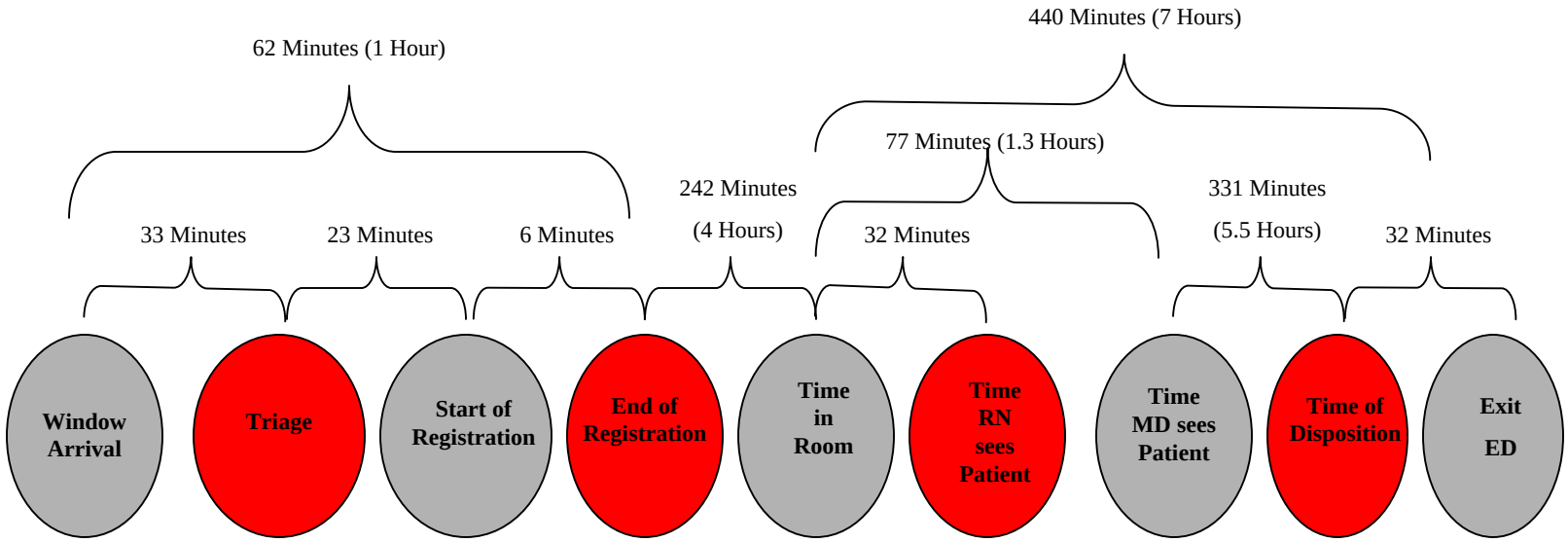
Data collected from 11/30/2004 - 12/10/04.

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

Process Times: ED Patients Treated and Discharged



Source: Manual Data Collection

Data collected from 12/13/04 – 2/15/04.

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- Triage:
  - Triage is staffed 24/7.
  - Staffing consists of two RNs, and two NAs.
    - Two RNs, one at the window and one triages patients (except when there are staffing issues).
    - One NA who assists with transferring patients, does EKG's, and assists the physician staff
    - One LVN assigned to the 170 physicians.
    - Physician staffing consists of a 170 physicians, 9 AM to 9 PM, when staffing allows.
  - The ED uses three different acuity systems depending on the patients place in their ED visit.
    - Three level acuity system in triage.
    - Four level retrospective acuity system when the patient leaves.
    - Five level acuity system used by the physician staff.
  - All documentation is manual.
  - There is a breech of the patients privacy at triage based on the physical set up. Conversations are not private when patients approach the triage area and during the triage process.
  - Patients are registered and tracked through the Affinity system which has been phased in since June 2004. Prior a homegrown Lotus tracking system was used.

Emergency Services > Emergency Room – Capacity/Throughput

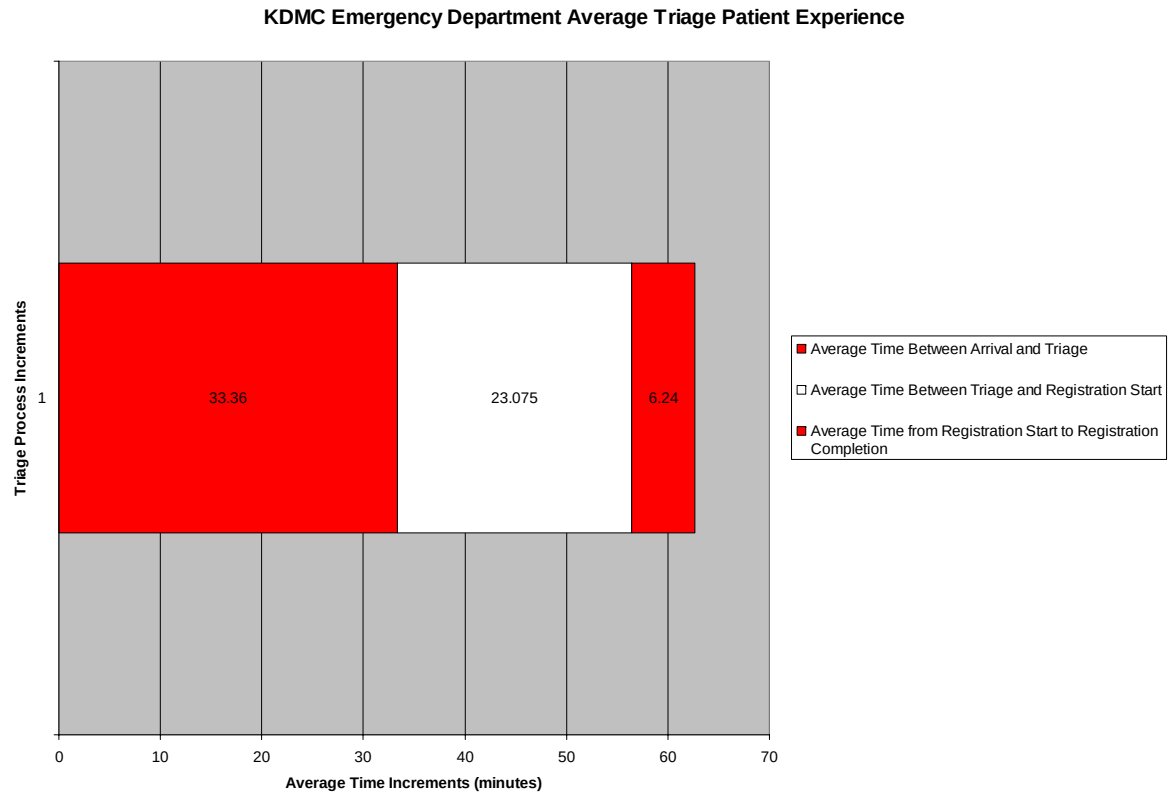
Assessment

- Triage: (continued)
  - Patients stay in triage for long periods of time due to ED beds being occupied by admissions.
    - The average time from arrival to triage is 33 minutes.
    - The average time from triage to registration is 23 minutes.
    - The average time to complete registration is 6 minutes.
  - There is minimal re-assessment of patients after the initial triage process while they wait in the waiting room to be brought back to the treatment area.
  - The registration process is fragmented.
- Pediatric Outpatient Clinic (POP)
  - Pediatric patients that meet specific criteria, as outlined in the triage policy, are triaged to the POP.
    - On December 1, 2004, 17 pediatric patients were triaged to the POP.
  - The POP is not located close to the ED, is difficult to find and not clearly marked.
  - There are no written guidelines outlining criteria to be seen in the clinic.
  - Patients are transferred to the Emergency Department for continued care or to be seen when the POP closes.
  - POP patients are not captured on the Emergency Department log. These patients receive only a clinic charge. The Emergency Department does not charge for a visit or supplies.

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- Average time between arrival to the end of the registration process is 62 minutes.



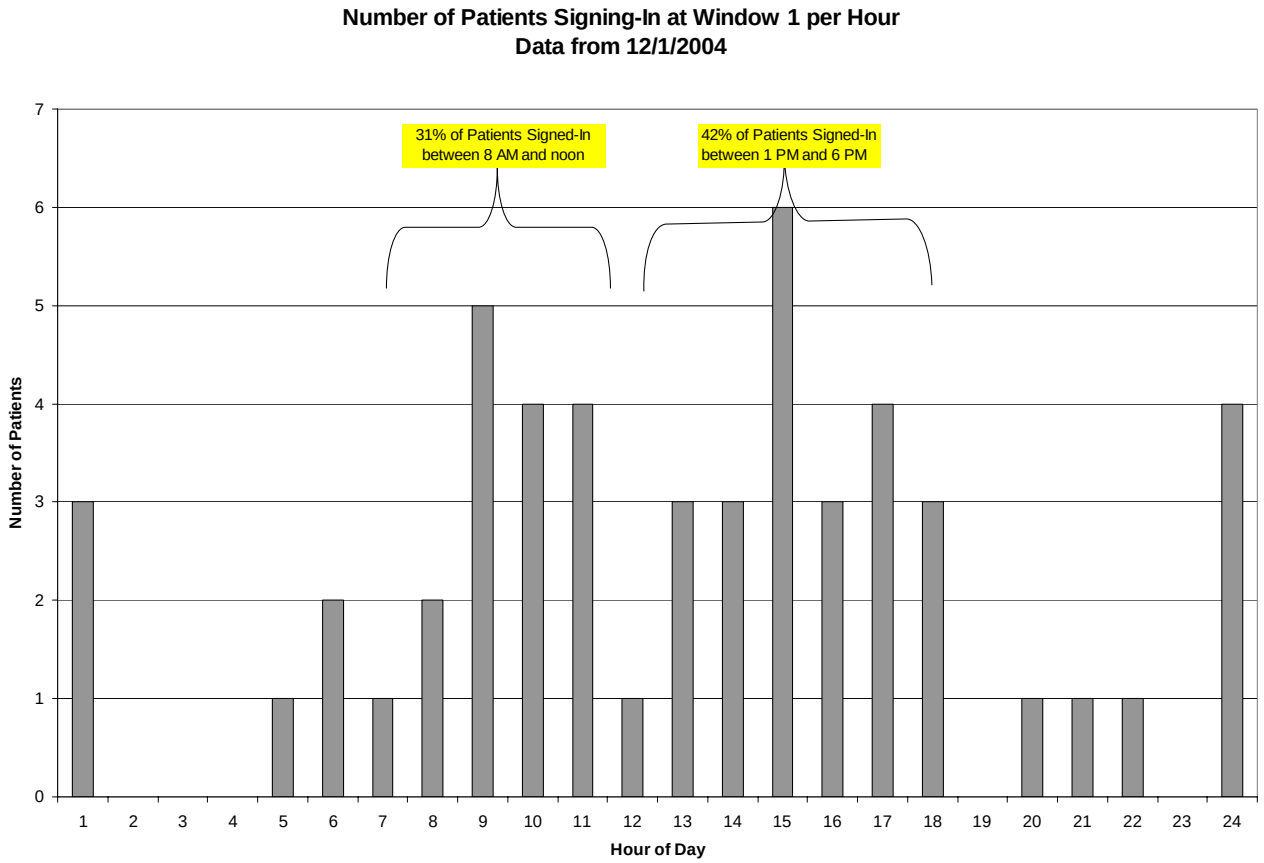
Source: Data collection 11/15/04 – 12/02/04

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- 42% of the patients signed in between 1 PM and 6 PM.



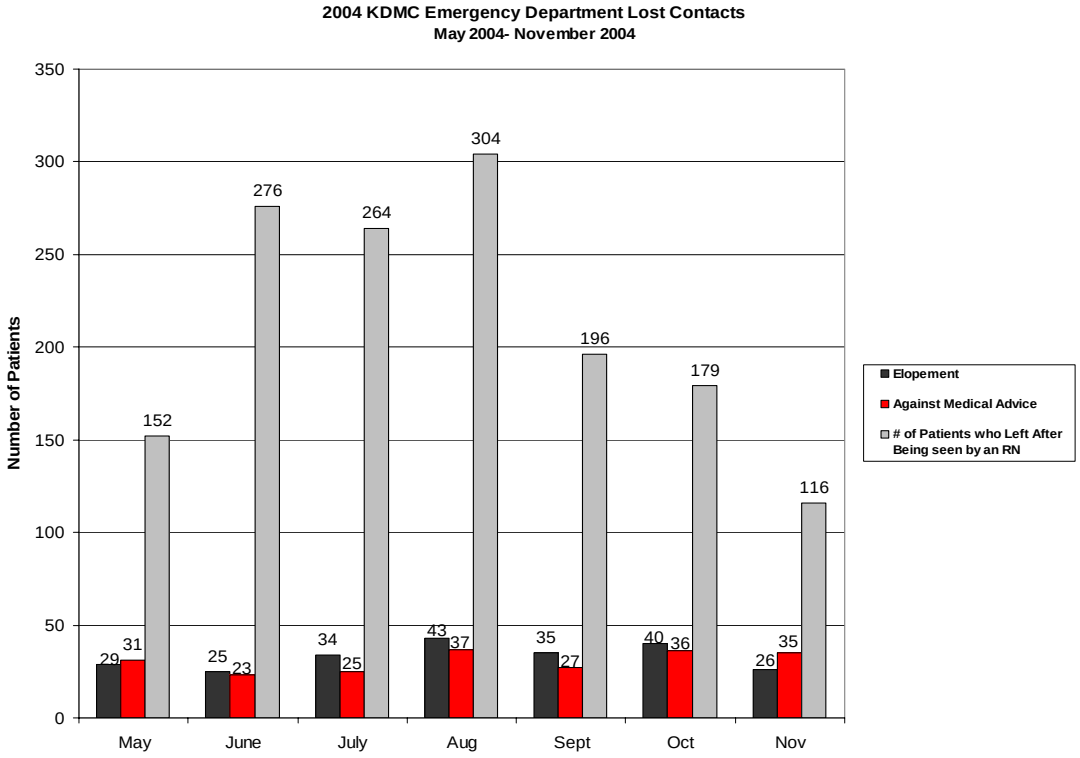
Source: Manual data collection: Triage Log. 12/1//04

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- The number of patients who leave after seeing a nurse has steadily declined since August 2004.



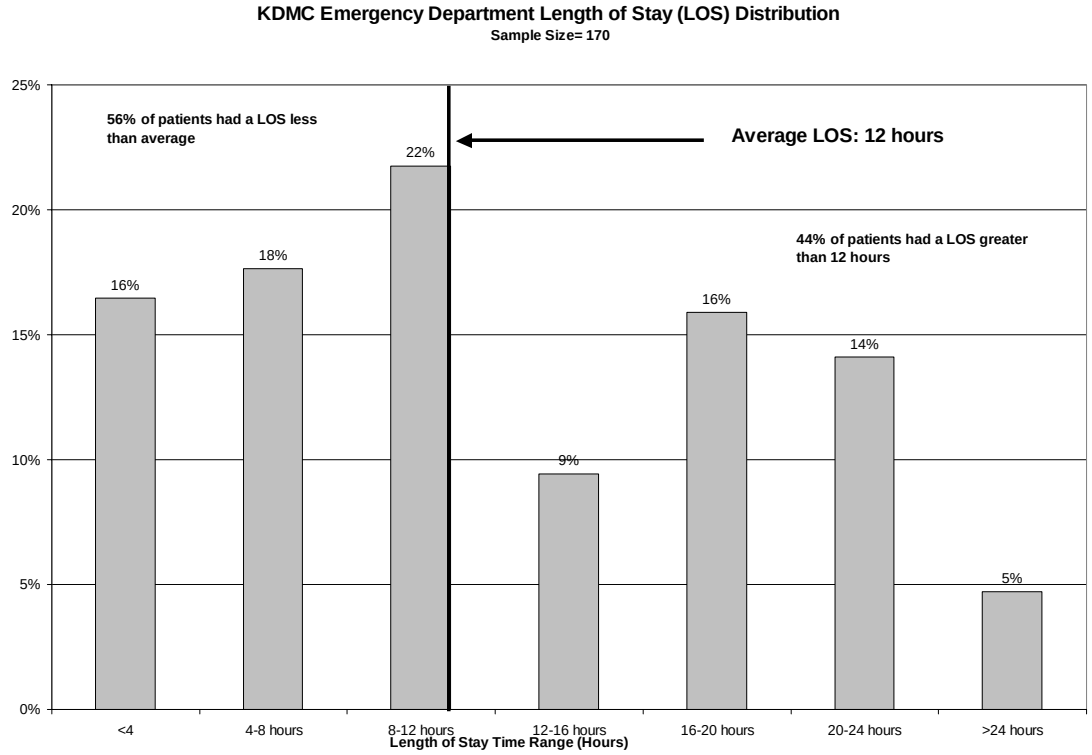
Source: Emergency Nursing Event Notifications, Emergency Department Nursing Administration

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- Length of stay:
  - The ED average LOS is 12 hours. 56% of the patients have a LOS of 12 hours or less, 44% of the patients have a LOS greater than 12 hours.



Source: KDMC Nursing Services Daily Emergency Services Log. 11/29/04 – 12/1//04

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

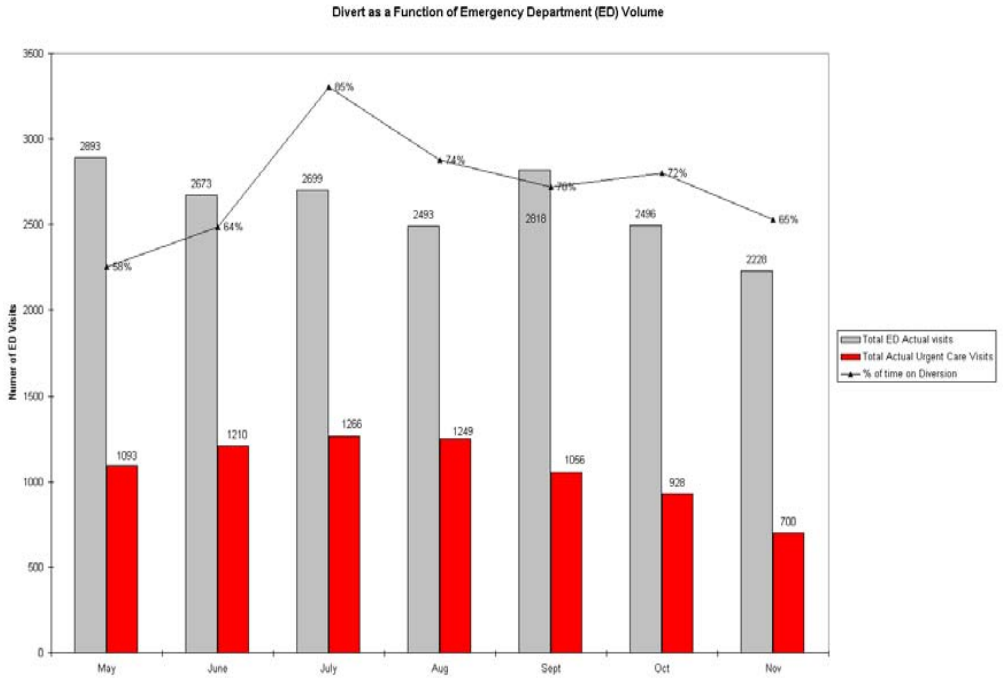
Assessment

- Length of stay: (continued)
  - Holding patients in the ED holding areas limits the number of ED bays where new patients can be seen; resulting in an increase in the LOS.
  - There are delays in calling report to the inpatient units.
  - Inpatient units are unable to take report in a timely manner.
  - Patients are not downgraded consistently; resulting in unnecessary waits for inappropriate beds.
  - ED admissions are holding in the ED for approximately 6 hours, and some as long as 15 days.
  - New patients wait to be triaged for an average of 33 minutes.
  - ED patients are not always transferred out of the department in a timely manner.
  - GYN rooms have exam tables instead of pelvic stretchers, hampering the universal use of the rooms.

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- Diversion:
  - The ED was on diversion approximately 70% of the time during May through October.
  - Based on the data, there is no relationship between diversion and ED volume.
  - There are DHS Guidelines for Requesting Diversion.



Source: IS Affinity Query and EMS reported Divert data.

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

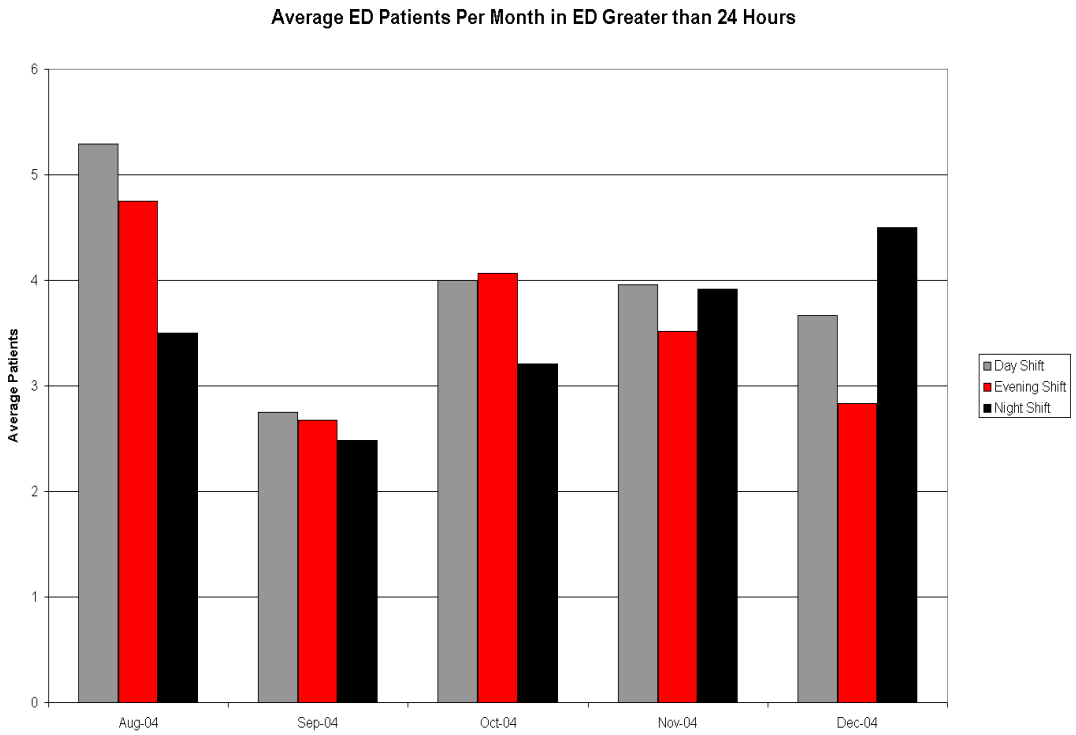
Assessment

- Disposition:
  - Patients are held in the ED, sometimes for days.
  - There is difficulty getting ICU beds.
  - Some patients waiting for ICU beds do not meet ICU criteria.
  - Once patient is identified as needing an ICU bed it is difficult to get the patient downgraded, even when the patients condition has improved.
  - Patients routinely wait for a bed with a higher LOC than needed.
  - The perception among the consulting physicians is that patients should not be downgraded but admitted to a step down unit.
  - It is especially difficult to get neuro/neurosurgical patients downgraded.
  - In general, there are frequent delays with neuro/neurosurgical.
  - The current culture allows the consulting residents to override the ED physicians decision to admit.
  - Hospitalists tend to “side” with the inpatient attending and resident.
  - There are delays in calling report to the inpatient units for various reasons; i.e,, nurse is at lunch, on break, too busy, or there is not enough staff.
  - Physicians write admit orders and do not promptly submit them to the ED unit secretary.

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- Disposition: (continued)
  - The number of ED patients that are in the department for over 24 hours has declined on the day and evening shift since October, but has risen on the night shift.



Source: KDMC Nursing Services Shift Summary 8/1/04 – 12/10/04

NAVIGANT CONSULTING

Emergency Services > Emergency Room – Capacity/Throughput

Assessment

- Lost Contacts:
  - Consist of elopements, against medical advice (AMA), and the number of patients that left after being seen by a nurse.
    - Elopement: Seen, but left before the end of treatment. Did not advise anyone they were leaving.
    - AMA: Seen, but left and let someone know they were leaving. Patient was advised against leaving.
    - Left after being seen by a nurse: Patients were triaged but when called to go to a room they could not be found.
  - Long waits in triage have lead to an excessive number of patients leaving without seeing a nurse.
    - May 2004-October 2004, an average of 150-300 patients left without seeing a nurse.
    - It was reported that many homeless patients sign into the ED and then disappear.

Emergency Services > Emergency Room – Capacity/Throughput

Deficiencies

- There is a breech of patient privacy at triage based on the physical set up.
- No re-assessment of patients after triage.
- A delay in getting patients triaged in a timely manner.
- Insufficient triage nurses create delays in getting patients triaged.
- Admission of patients to inappropriate areas.
- Admissions holding in the ED for extended periods of time are not being cared and assessed as inpatients.
- Inconsistencies in requesting diversion.
- No triggers for diversion to plan/prevent diversion.
- No data surrounding patient acuity to support diversion requests.
- No policy outlining the chain of command and responsible parties for determining when calling divert is appropriate.
- No re-assessment of ED status once divert is called in order to determine if the ED can come off divert in a more timely manner.
- Admit orders are not promptly turned in.

Emergency Services > Emergency Room – Capacity/Throughput

Deficiencies

- Patients are being held in the ED for long periods of time.
- Patients are not being admitted to the appropriate LOC.
- There is not an appropriate downgrading policy.
- The ED is crowded and has poor configuration which augments the lack of flow.
- The registration process in fragmented and adds time to the LOS.

Recommendations

3.3.01 Develop staffing model that meets the physician commitment in Triage.

3.3.02 Develop performance standards for triaging patients and hold staff to meeting the standards.

3.3.03 Review and revise current Triage criteria so that patients are placed in appropriate areas.

3.3.04 Identify ED specific functions of Affinity including tracking patients.

3.3.05 Develop a consistent five level acuity system that starts in triage and continues through the charge process.

3.3.06 Implement process so that patients in triage waiting to be seen, are reassessed according to acuity.

Emergency Services > Emergency Room – Capacity/Throughput

Recommendations

3.3.07 Renovate triage to assure there is privacy for patients being triaged.

3.3.08 Develop and implement Triage protocols.

3.3.09 Change staffing model so there are three RNs in triage during peak hours.

3.3.10 Define data collection criteria for elopement and AMA.

3.3.11 Elevate data collection standards to facilitate fact based decision making.

3.3.12 Change processes so that admissions waiting for inpatient beds are kept at a minimum.

3.3.13 Work in conjunction with Capacity Management to identify the appropriate bed request and assignment process.

3.3.14 Implement FAX report policy to decrease delays in calling report.

3.3.15 Develop process so that ED Admissions are admitted to the appropriate level of care.

3.3.16 Develop/implement a consistent downgrading policy.

3.3.17 Develop policy for downgrading patients that all physician staff are required to follow.

Emergency Services > Emergency Room – Capacity/Throughput

Recommendations

3.3.18 Develop internal policy that follows DHS Guidelines for determining what will happen when Divert becomes a possibility and divert status is called.

3.3.19 Develop policy for determining who the responsible parties are concerning divert.

3.3.20 Develop policy for 30 minute re-assessment to determine if the ED can safely come off of divert.

3.3.21 Collect data regarding patient acuity and base decisions on diversion.

3.3.22 Educate appropriate staff on diversion criteria.

3.3.23 Develop process to expedite patient flow to decrease diversion.

Emergency Services > Emergency Room – Leadership / Management

Assessment

- The ED/OR administrator spends the majority of time in the ED expediting patient flow.
- There is a nurse manager responsible for running the unit.
- There is an assistant nurse manager (ANM) that is very knowledgeable and has a good working relationship with all physician and Nursing staff within the ED.
- There is an intermediate typist clerk that serves as timekeeper and secretary and develops monthly reports.
- There is an educator who is responsible for documentation reviews and orientation.
- There is a pre-hospital care coordinator that serves as the Emergency Medical Services (EMS) liaison and provides education for EMS and Mobile Intensive Care Nurse (MICNS). They are also responsible for EMS QI including:
  - Oversee EMS care.
  - Assists with maintaining compliance.
  - Completes filed care audits by reviewing tapes.
  - Reviews issues.
  - Tracks advanced cardiac life support (ACLS) for MICNs
  - Provides education to ED and paramedic staff.
  - MICNs take all EMS calls when available.

Emergency Services > Emergency Room – Leadership / Management

Assessment

- The ED nurse manager is not supported by the ED Medical Director.
- There is minimal collaboration between the nurse manager and ED Medical Director.
- The ANM is not involved consistently with patient flow.
- The ANM is more involved with manager responsibilities; i.e., schedule, staffing issues, and coordinates in-service training.
- There is a charge nurse on each shift that manages patient flow, and has minimal time to assist Nursing staff with their tasks.
- There is not one specific individual that coordinates performance measurement for all ED areas.

Emergency Services > Emergency Room – Leadership / Management

Deficiencies

- Lack of effective collaboration between Nursing and physician management.
- Ineffective Nursing management structure.
- Lack of data driven decision making.

Recommendations

3.3.24 Develop an ED Joint Practice Group.

3.3.25 Revise the Nursing Management structure.

3.3.26 Develop an ED Quality and Performance Measurement position to support data-driven decision making.

Emergency Services > Emergency Room – Physician Management

Assessment

- There is a full-time ED Medical Director.
- There is a lack of collaboration between the ED Medical Director and the ED nurse manager.
- There are two physician faculty members on each shift:
  - One in the Main ED and one in urgent care.
- Physician staffing is not consistent across shifts
- There has been a turnover of 7 ED physicians in the last 15 months.
  - It was reported that the reasons for the turnovers are related to issues with GME, salaries, and working with less physicians than the staffing model calls for.
- Currently the ED physician's decision to admit can be overturned by the resident of a consulting service.
- Patients are held in the ED for observation rather than admitted to a unit, due to a lack of trust in the inpatient care.
- ED physician practice is not consistent in managing patients.
- The physician and Nursing staff were not able to agree upon the content for triage protocols or clinical pathways.

Emergency Services > Emergency Room – Physician Management

Assessment

- The ED Residency Program currently has 39 Emergency Medicine residents.
- The program is is due for review in 2006. It has recently been noted that there are a decrease in interviews and web site hits for the Emergency Residency Program.
- The program is is due for review in 2006.
- Many residents completing the program have stayed on as attendings, carrying on the culture.
- The ED is medical control for 12 rescue services and receives approximately 1,200 calls per month.
  - The MICNs take EMS calls when available. MICNs are not always used, due to Nursing staffing shortages.
  - The ED physician staff prefers that the MICNs take the calls and consult with the ED physicians if orders are needed. The physician staff are requested to answer the calls, but would prefer the Nursing staff answer the calls and contact them when necessary.

Emergency Services > Emergency Room – Physician Management

Deficiencies

- There is a lack of collaboration between the ED Medical Director and nurse manager.
- There is no method for dealing with consistency of practice in the ED.

Recommendations

3.3.27 Develop a multidisciplinary physician team to identify process changes and create a forum for physician collaboration.

3.3.28 Implement ED protocols for all ED physicians to follow.

3.3.29 Provide patient satisfaction training to all ED physician staff.

3.3.30 Develop a mechanism for monitoring ED physician productivity.

3.3.31 Mandate all ED physicians attend cultural sensitivity training.

Emergency Services > Emergency Room – Staffing

Assessment

- ED attempts to staff appropriately to meet the California nursing ratios.
- Seventeen RNs of the current ER staff are MICN.
  - MICNs are responsible for taking the EMS calls and provides orders for field treatment according to standardized DHS emergency service protocols.
- There are several long-term employees, and those employees express a strong commitment.
- The current staff are 58% KDMC and 42% travelers/County per diem.
  - Traveler and agency RNs are required to be compliant with ACLS, PALS and BLS.
- Night shift staff are sleeping during their shift, and staff on all shifts are known to disappear.
- Of the current KDMC RN staff (47), 7 had expired ACLS, 6 had expired PALS, 7 had expired BLS.
- Of the current NA staff (68), 6 had expired BLS.
- The ED staff pay for their ACLS, PALS and BLS classes.
  - This creates a problem when staff are unable to pay for their class and certifications have expired.

Emergency Services > Emergency Room – Staffing

Assessment

ED Staffing by Time of Day

Time of Day	ED Arrivals per hour	% arrival per hour	Estimated arrivals per hour	Total ED pts (Arrivals +4 hours)	Triage	RN	Nurse Assistant	Unit Secretary	FTE	Worked Hours per Visit	Paid Hours per Visit
MN	1.0	1.2%	1.4	21	2	9	8	0	80	13.87	15.39
1am	1.0	1.2%	1.4	15	2	9	8	0	80	13.87	15.39
2am	2.0	2.4%	2.7	16	2	9	8	0	80	6.93	7.70
3am	2.0	2.4%	2.7	10	2	9	8	0	80	6.93	7.70
4am	1.0	1.2%	1.4	10	2	9	8	0	80	13.87	15.39
5am	2.0	2.4%	2.7	11	2	9	8	0	80	6.93	7.70
6am	2.0	2.4%	2.7	12	2	9	8	0	80	6.93	7.70
7am	2.0	2.4%	2.7	12	2	13	10	1	109.5	9.49	10.53
8am	2.0	2.4%	2.7	12	2	13	10	1	109.5	9.49	10.53
9am	7.0	8.3%	9.6	21	2	13	10	1	109.5	2.71	3.01
10am	4.0	4.8%	5.5	23	2	13	10	1	109.5	4.75	5.27
11am	8.0	9.5%	11.0	32	2	15	10	1	117.9	2.55	2.84
12 Noon	4.0	4.8%	5.5	34	2	15	10	1	117.9	5.11	5.67
1pm	4.0	4.8%	5.5	37	2	15	10	1	117.9	5.11	5.67
2pm	2.0	2.4%	2.7	30	2	15	10	1	117.9	10.22	11.34
3pm	5.0	6.0%	6.8	32	2	15	8	1	109.5	3.80	4.21
4pm	7.0	8.3%	9.6	30	2	15	8	1	109.5	2.71	3.01
5pm	3.0	3.6%	4.1	29	2	15	8	1	109.5	6.33	7.02
6pm	6.0	7.1%	8.2	32	2	15	8	1	109.5	3.16	3.51
7pm	4.0	4.8%	5.5	34	2	12	8	1	96.9	4.20	4.66
8pm	5.0	6.0%	6.8	34	2	12	8	1	96.9	3.36	3.73
9pm	1.0	1.2%	1.4	26	2	12	8	1	96.9	16.80	18.64
10pm	7.0	8.3%	9.6	32	2	12	8	1	96.9	2.40	2.66
11pm	1.0	1.2%	1.4	25	2	11	8	0	88.4	15.32	17.01
Totals									Total Worked Hours		
Per DAY	84		115								
Per Mont	2604										
Per Year	30660		42000								

Source: Staffing from 12/1/04 nursing schedule.
ED arrivals from Affinity data for 12/01/04.

Emergency Services > Emergency Room – Staffing

Deficiencies

- Staffing model does not always meet the California nursing ratios.

Recommendations

3.3.32 Identify strategies for recruitment and retention of KDMC nursing staff.

3.3.33 Develop pre-printed orders for commonly seen complaints.

Emergency Services > Emergency Room – Clinical Care

Assessment

- As identified in the JCAHO review, tests are routinely delayed due to poor physician penmanship.
  - The ED physician staff are not routinely using pre-printed orders.
- Physician orders are not always given to the unit clerk in a timely manner; resulting in delays ordering test and/or requesting admission.
- The initial admission assessment is not completed consistently on admitted patients holding in the ED.
- Documentation on ICU admissions in the ED holding area is not completed on an ICU flow sheet.
- The ED has 26 monitors. Of those only 6 monitors are linked to the central monitoring station. No red team monitors are linked and monitors frequently require biomed for repair.
- There is no consistency between the MODs for the ED. This results in patients not being downgraded to the appropriate LOC on a consistent basis.
- Care plans are not consistently being initiated in the ED.

Emergency Services > Emergency Room – Clinical Care

Assessment

- Patients are held in the ED for observation rather than discharged with a scheduled appointment to return for outpatient procedures.
- The admission nurse works Monday through Friday. There is no weekend coverage which creates a back log on Monday.
- The ED blue team physician is not always available and the ED physicians are reluctant to help with blue team patients; since these are primary care patients.
- There are no standardized orders for common diagnoses that present routinely in the ED.

Deficiencies

- The initial admission assessment is not completed consistently on the ED admissions holding in the ED.
- Due to physical design of the ED, it is difficult to see monitors not linked to the central monitoring station.
- Monitors are not in good working condition and frequently require biomed to assess and repair.
- A number of staff have expired certification requirements.
- Blue team physician is not readily available.
- Physicians and residents are frequently not available in their assigned area.

Emergency Services > Emergency Room – Clinical Care

Recommendations

3.3.34 Develop process for implementing/following care plans for ED patients waiting for I/P admission.

3.3.35 Initiate ICU Flow Sheets on ED patients waiting for ICU admission. (ICU flow sheets were implemented December 2004 and are currently being used).

3.3.36 Insure that there are a sufficient number ED monitors in working condition and linked to a central monitoring station.

3.3.37 Assure that all staff is compliant with BLS, ACLS and PALS by year end.

3.3.38 Initiate a policy that requires certification as a job qualifier.

Emergency Services > Emergency Room

Performance Measures

- Time: Arrival to triage
  - Current 33 minutes
  - Target 15 minutes
- Time: Triage time to registration start
  - Current 23 minutes
  - Target 10 minutes
- Time: Triage to room
  - Current 271 minutes
  - Target 20 minutes
- Time: Triage to MD visit - admitted patient
  - Current 345 minutes
  - Target 30 minutes
- Time:Triage to MD visit - discharged patient
  - Current 381 minutes
  - Target 30 minutes

Emergency Services > Emergency Room

Performance Measures

- Productivity: Worked hours per visit
  - Current not currently collected
  - Target TBD
- Time: Registration to admission
  - Current 1161 minutes (19 hours)
  - Target 120 minutes
- Time: Registration to discharge
  - Current 682 minutes (11hours)
  - Target 90 minutes
- Elopement
  - Current 9%
  - Target <1%
- AMA
  - Current 1%
  - Target <1%

Emergency Services > Emergency Room

Performance Measures

- Percentage patients return within 24 hours
  - Current 2% (September through November)
  - Target 0
- Time on Diversion
  - Current 72%
  - Target 0

Responsibility

- ED Director
- Medical Director
- CNO
- Proposed ED Quality and Performance Measurement Coordinator

Emergency Services > Trauma Center

Assessment

- KDMC sees approximately 3,000 trauma visits per year.
- From May through October trauma volume has continued to drop, except for the month of September.
- The trauma service does not break out the trauma visits by level.
- Patients remain on the trauma service for 24 hours and then are transferred to the appropriate service.
- They have a 40% penetrating and 60% blunt rate.
- The trauma area consists of four bays.
- If a trauma patient arrives on the ED side; the patient is seen in the code room, stabilized, and transferred to the trauma unit.
- There are two operating rooms across from the trauma area.
- The ICU is in the immediate vicinity.
- Current trauma related data being collected and reported is weak and lacking in consistency.
- Trauma diversion does not appear to be related to volume.

Emergency Services > Trauma Center

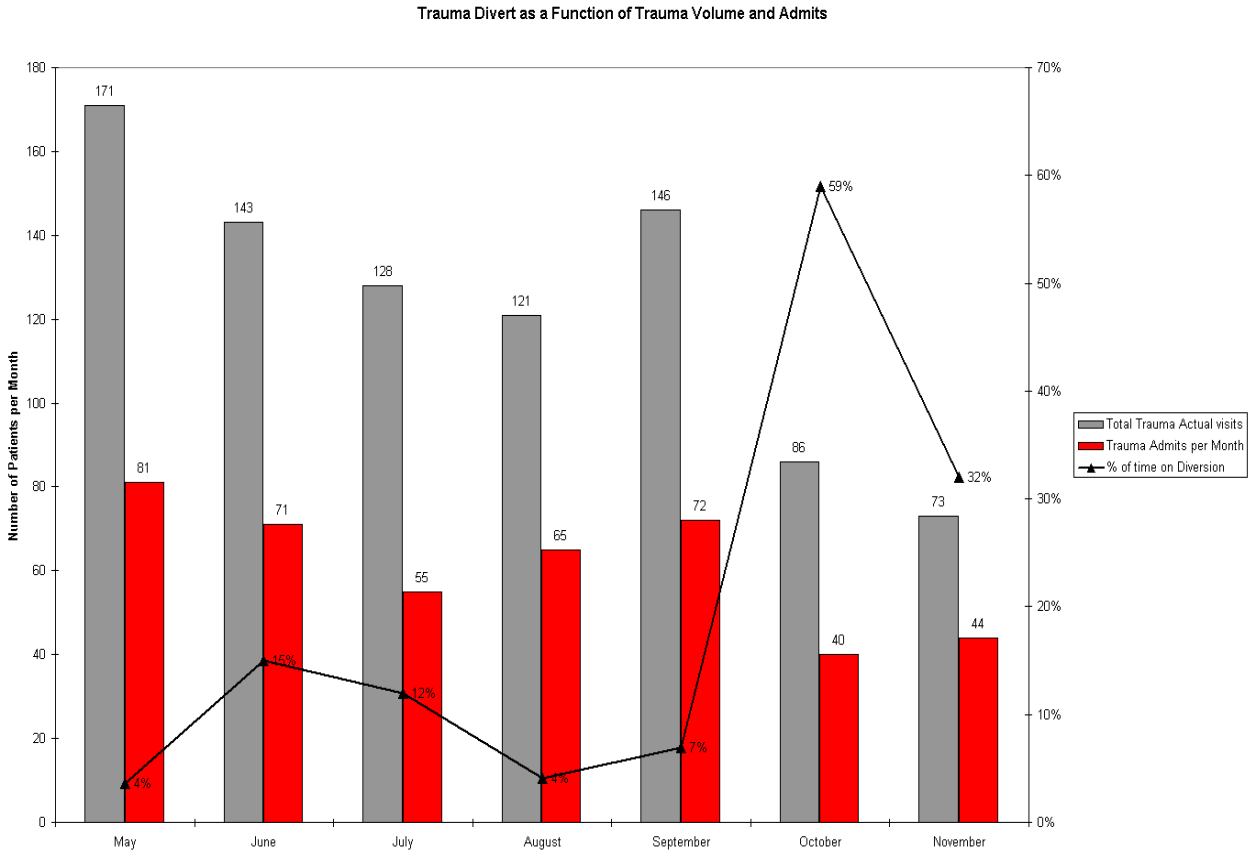
Assessment

- The ED is a Level I Trauma Center.
- The trauma center was reviewed in October 2003 and found to have deficiencies.
- A decision was made to suspend the Trauma Center effective February 2005.
- Leadership/Management
  - There is a full-time Trauma Medical Director.
  - There are ten surgeons that take trauma calls, and six of the ten are full-time.
  - Medical Director chairs the IOP and Peer Review Committees.
  - Trauma manager works five days a week, eight hours a day.
  - Responsibilities include:
    - Collecting and reporting data.
    - Coordination of care for trauma patients.
    - Follows trauma inpatients.
    - Follows up on trauma related issues.
    - Trauma related committees, Peer Review, Morbidity/Mortality, IOP, QA.
  - Minimal collaboration between ED and the Trauma Center.

Emergency Services > Trauma Center

Assessment

- Trauma diversion is not consistent with volume.



Source: DHS Trauma Database and EMS Reported Divert Numbers.

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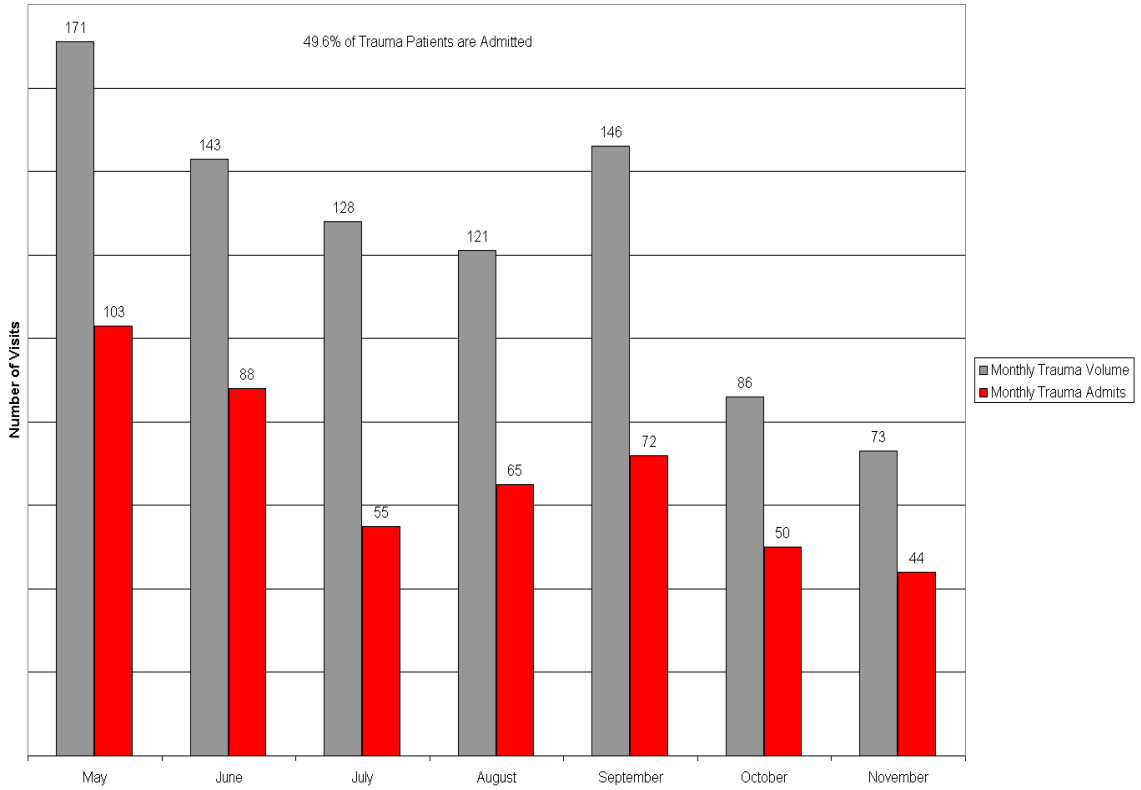
Emergency Services > Trauma Center

Assessment

- 49.6% of trauma patients are admitted.



Source: KDMC Trauma Database reported to LA County.

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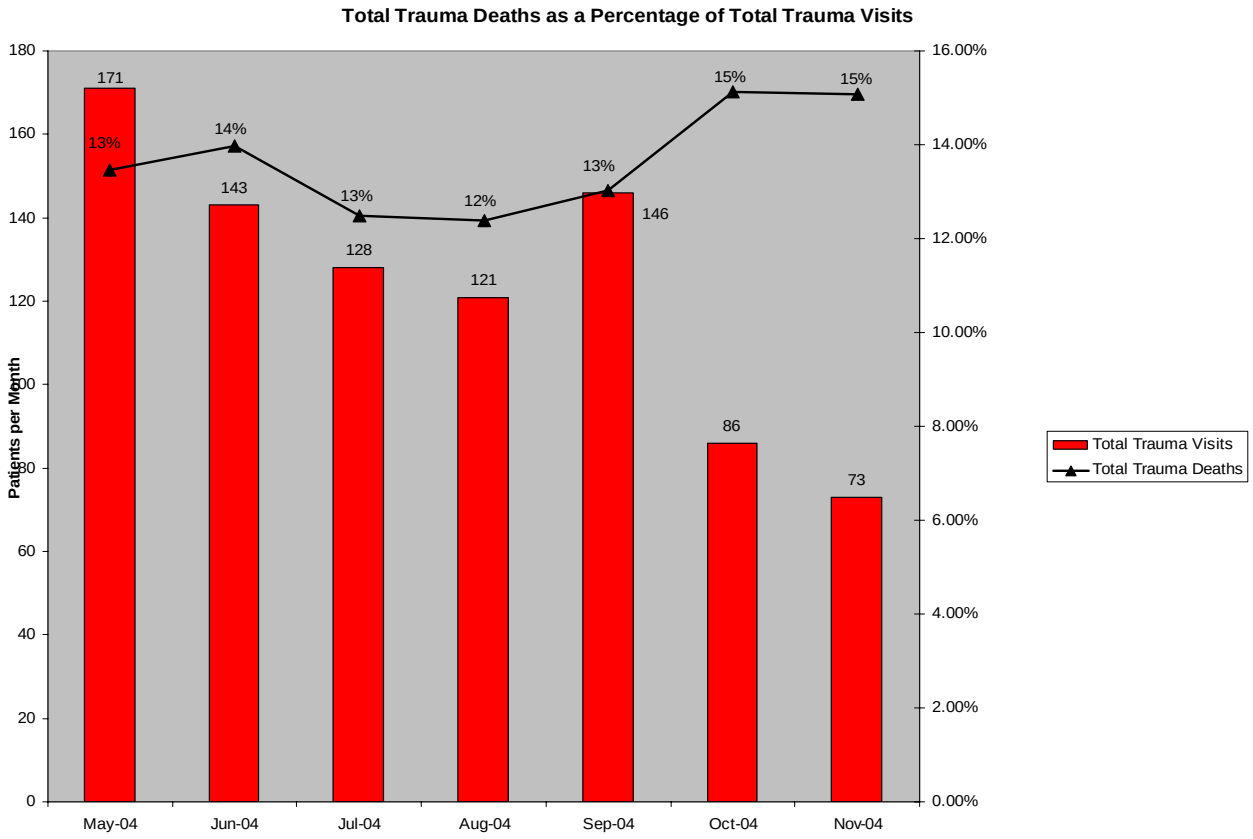
Emergency Services > Trauma Center

Assessment



Source: Trauma Statistics generated by Trauma Coordinator.

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Emergency Services > Trauma Center

Deficiencies

- Trauma services is not meeting ACS standards.
- Trauma services does not track trauma patients by their trauma level.
- Trauma services data collection is weak.

Recommendations

3.3.39 Eliminate the Trauma Coordinator role.

3.3.40 ED Performance/Quality Coordinator will assume trauma data collection and reporting.

3.3.41 Track patients by trauma level.

3.3.42 Perform monthly concurrent chart review on deaths.

Emergency Services > Trauma Center

Performance Measures

- Number trauma deaths
  - November 1
- Acuity
  - Percentage Level 1 not currently collected
  - Percentage Level 2 not currently collected
  - Percentage Level 3 not currently collected
- Mortality rate 15%
- Percentage Trauma diversion
  - Current 32% November
  - Target 0
- Average trauma surgeon response time
  - Current not currently collected
  - Target 20 minutes

Responsibility

- Proposed ED Quality and Performance Measurement Coordinator

Emergency Services > Emergicenter – Overview

Assessment

- The Emergicenter consists of four exam rooms.
  - One room with a stretcher, three rooms with exam tables, an additional room houses the sputum induction chamber.
- The Emergicenter is open five days a week 8 AM to 12:30 AM.
- Approximately 40 patients visits a day.
  - January 2004 – October 2004 the Emergicenter has seen 11,179 patients.
  - Of the 11,179 patients seen, 327 were admitted.
- Patients that are seen outside of the hospital and referred to the clinic - but do not have appointments - must be triaged and seen in the Emergicenter, and then given a clinic appointment. The clinics do not take walk-ins.

Deficiencies

- Clinic patients are mixed in with Emergicenter patients.

Recommendations

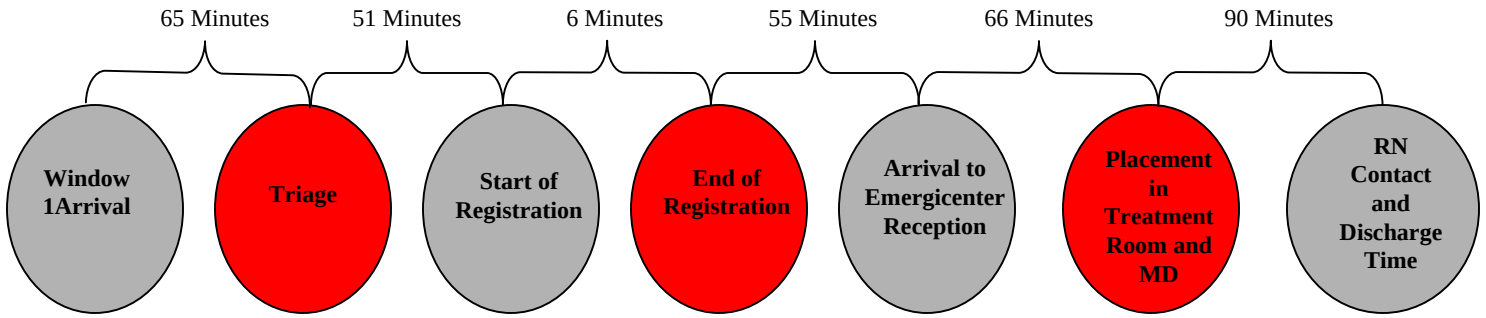
3.3.43 Develop plan to provide patients with clinic appointments.

3.3.44 Remove the sputum induction chamber and create a 5th room for Emergicenter..

Emergency Services > Emergicenter – Patient Experience

Assessment

Emergicenter Patient Process Times



Source: Manual Data Collection

Data collected from 12/13//04 – 12/15//04.

NAVIGANT CONSULTING

Emergency Services > Emergicenter – Leadership / Management

Assessment

- The Emergicenter is supervised by a supervisor staff nurse.
  - The supervisor reports to the ED nurse manager.
- Physician staffing consists of:
  - One attending, 8 AM to 7:30 PM.
  - One attending, 9 AM to 7:30 PM.
  - Three residents, 8 AM to 4 PM, 2 PM to10 PM, and 4 PM to 12:30 AM.
  - Currently the 2 PM resident also covers Trauma, and is frequently unavailable.
- After the attendings leave, the blue team attending oversees the Emergicenter residents.
- Staff report that physicians frequently “wander off” and have to be called to return and see patients.
  - It was reported that the attendings do not see patients and only oversee the residents.
  - The staff feel that they could see a larger volume of patients and reduce wait times if the physicians were “up to speed.”
  - At times, excessive orders and work-ups are written on Emergicenter patients.

Emergency Services > Emergicenter – Leadership / Management

Deficiencies

- Emergicenter does not interface with the ED.
- There are no performance standards for ED physician staff.
- Physicians staffing Emergicenter are not always available.

Recommendations

3.3.45 Restructure ED Management to have a Charge Nurse, responsible for meeting Emergicenter performance metric targets and assure new processes are implemented.

3.3.46 Develop performance standards for physician staff to improve performance.

3.3.47 Consider Physician Extender to see patients from 4:30PM to 12:30AM when attending leaves and Blue team physician has to cover resident.

3.3.48 Hold physician staff accountable to assure they are always available.

3.3.49 Develop a plan for appropriate oversight for residents.

Emergency Services > Emergicenter – Staffing

Assessment

- Staffing consists of:
  - One RN, one NA, and one clerk, 8 AM to 4:30 PM.
  - One RN, one LVN, one NA, and one clerk, 4:00 PM o 3:30 PM.
- Staffing based on a two-hour turnaround time.
- Currently one RN on sick leave, one RN on maternity leave, one RN on restrictions for a back injury.
- Prior to October 2004 there was not a consistent group of staff scheduled for this area, except for the clerks.
- Currently there is no unit clerk in the Emergicenter until 4:00 PM on Mondays. On Monday the unit clerk is off, and works on Saturday in the main ED.
- Patients are placed in the rooms by the physician staff. The RN does not see the patient until her services are needed. When the RN discharges the patient, this may be the first encounter with the patient.

Emergency Services > Emergicenter – Staffing

Deficiencies

- Changing staff lends to the department running inconsistently.
- Staffing does not always coincide with the volume.

Recommendations

3.3.50 Use consistent staff in the Emergicenter.

3.3.51 Identify appropriate staffing model that supports California ratios.

Emergency Services > Emergicenter – Staffing

Staffing by Hour

Time of Day	ED Arrivals per hour	Total ED pts (Arrivals +2 hours)	Triage	RN /LVN	Nurse Assistant	Unit Secretary
MN	0.0	0	0	2	1	1
1am	0.0	0	0	0	0	0
2am	0.0	0	0	0	0	0
3am	0.0	0	0	0	0	0
4am	0.0	0	0	0	0	0
5am	0.0	0	0	0	0	0
6am	0.0	0	0	0	0	0
7am	4.0	4	0	0	0	0
8am	5.0	9	0	1	1	1
9am	5.0	14	0	1	1	1
10am	5.0	15	0	1	1	1
11am	5.0	15	0	1	1	1
12 Noon	3.0	13	0	1	1	1
1pm	5.0	13	0	1	1	1
2pm	1.0	9	0	1	1	1
3pm	1.0	7	0	1	1	1
4pm	1.0	3	0	2	1	1
5pm	0.0	2	0	2	1	1
6pm	0.0	1	0	2	1	1
7pm	0.0	0	0	2	1	1
8pm	0.0	0	0	2	1	1
9pm	0.0	0	0	2	1	1
10pm	0.0	0	0	2	1	1
11pm	0.0	0	0	2	1	1

Source: Staffing information 12/1/04 nursing schedule.
ED arrivals from Affinity data for 12/01/04.

NAVIGANT CONSULTING

Emergency Services > Emergicenter – Clinical Care

Assessment

- There are currently no written Emergicenter guidelines outlining which patients should be seen in this area.
- When the ED is extremely busy, patients with greater acuity are seen in Emergicenter than would normally qualify for the area. Many patients triaged to Emergicenter are sent back to the ED.
- The staff reported that there are long delays in getting Emergicenter films read, sometimes four to five hours.
- 18% of 120 patients sampled were sent back to the ED from the Emergicenter
- Emergicenter staff have also reported that patients triaged to the ED and waiting a long period of time are routed over to the Emergicenter with the mentality that "since they've waited this long they can't be that sick." This increases the patients overall wait for care as they will often be sent back to the ED from the Emergicenter
- Point of care testing is in place and consists of blood glucose, Hgb, and urine pregnancy.
- Currently all documentation is manual.
- The RN does not see the patient upon placement to a room. Currently from the time patient is placed in room, to first RN encounter is 90 minutes.
- Patients who present to the ED are triaged to the Emergicenter and may not be seen until the following day. It is unclear where these patients wait until the next day.

Emergency Services > Emergicenter – Clinical Care

Deficiencies

- Patients waiting for long periods of time are not being re-assessed in the waiting room.
- Patients with inappropriate LOC are being seen in the Emergicenter.
- Patients are not seen by a nurse upon placement in a room.
- Emergicenter patients are not followed after hours of operation.

Recommendations

3.3.52 Identify interdeparatment process to improve flow.

3.3.53 Identify process to capture POP patients when transferred to the ED for care.

3.3.54 Develop a plan for appropriate oversight for residents.

3.3.55 Review and revise current registration process.

Emergency Services > Emergicenter – Disposition

Assessment

- Baseline LOS for Emergicenter patients is 323 minutes. Industry standard is 90 minutes.
- Time from arrival to Emergicenter to first MD encounter is 66 minutes.
- Data review revealed that patients sign into the Emergicenter but may not be seen until the next day.
  - While reviewing data, it was noted that nine patients who were registered on November 15, 2004 were not seen in the Emergcienter until the following morning, starting at 8:55 AM November 16, 2004. The last discharge of the nine was at 2:55 PM on November 16, 2004.

Deficiencies

- The area is not meeting industry standards for LOS.
- There is not a clear process for following patients when the Emergicenter closes.

Emergency Services > Emergicenter

Performance Measures

- Time from arrival to Emergicenter reception
  - Current 177 minutes*
  - Target 30 minutes
- Time from arrival to Emergicenter reception to room
  - Current 66 minutes *
  - Target 30 minutes
- Time from Emergicenter room to MD encounter
  - Current 66 minutes*
  - Target 20 minutes
- Time from Emericenter room to RN encounter
  - Current 90 minutes*
  - Target 15 minutes
- Total time from KDMC arrival to discharge
  - Current 333 minutes (5.5 hours)*
  - Target 90 minutes
- Percentage of patients return within 24 hours
  - Current 1% (September – November)
  - Target 0

*** Data collection took place from 12/13/04 – 12.15.04,.**

Emergency Services > Emergicenter

Responsibility

- Proposed ED Quality and Performance Measurement Coordinator

Section III – Clinical Organization

4. Perioperative Services
   - Interviews
   - Prioritized Recommendation Summary
   - Operating Room
     - Overview
     - Governance
     - Leadership/Management
     - Anesthesia
     - Information System
     - Scheduling
     - Throughput
       - Case Starts and Delays
       - Incision Time
       - TOT
       - Capacity
     - Intraoperative Care
       - Staffing, Orientation, Policies, Patient Safety, Competency
       - Environment
       - Materials Management
   - Outpatient Surgery Anesthesia
   - Post Anesthesia Recovery
   - Cath Lab
   - GI Lab
   - Cystoscopy
   - Central Sterile

Perioperative Services > Interviews

• J. Jahr, MD	Interim Chair, Anesthesiology
• K. Lewis, MD	Vice Chair, Anesthesiology/Director of Perioperative Services
• S. Ashley, MD	Director of Risk Management, Anesthesiology
• D. Dix, MD	Anesthesiologist
• Z. Steffens, MD	Clinical Coordinator, Anesthesiology
• R. Yumul, MD	Residency Program Director, Anesthesiology
• R. Scott, MD	Surgeon, Cardiothoracic
• I. Giannikopoulos, MD	Chairman, Gastroenterology
• N. Datta, MD	Interim Chair, Surgery & Chair, Urology
• M. Lang	Nursing Administration
• N. Smith	OR Manager/Assistant Director of Perioperative Services
• I. Stevenson	OR Supervisor, Day
• J. Hams	PAR Supervisor
• T. Carter	Executive Administrator, Anesthesiology
• D. Liddell	ORSOS

Perioperative Services > Prioritized Summary of Recommendations

Clinical Organization – Perioperative Services		
Urgent	3.4.01	Restructure OR Governance including membership, accountabilities and decision rights.
Urgent	3.4.02	Develop/incorporate Dashboard as standing monthly agenda item for OR Governance Committee to review and analyze, identifying issues/problems and providing stewardship to develop/implement plans for resolution.
Urgent	3.4.03	Eliminate the Director of Perioperative Services position and replace with OR Governance Committee.
Urgent	3.1.04	Relocate OR Manager's office to OR.
Urgent	3.4.05	Develop the breadth and depth of nursing management by engaging an Interim Advisor for the OR Manager.
Urgent	3.4.06	Institute regular, relevant communication between executive leadership and physicians.
Short-term	3.4.07	Fully engage select surgeon and anesthesia leadership in OR Governance Committee.
Urgent	3.4.08	Develop the breadth and depth of anesthesia management by engaging an Advisor for the Interim Chair.
Short-term	3.4.09	Ensure all moderate sedation tracking forms consistent.
Short-term	3.4.10	Develop criteria for OSA in-person visits.
Urgent	3.4.11	Assign OSA to Nursing Director of Perioperative Services.
Short-term	3.4.12	Assign anesthesia to carry Code Blue beeper to optimize airway management.
Short-term	3.4.13	Assess PAR nursing skills to begin discharge by Aldrete score.
Urgent	3.4.14	Develop productivity targets for ORSOS personnel to facilitate timely entry of data.
Urgent	3.4.15	Design and implement a Perioperative Dashboard.
Short-term	3.4.16	Revise OR scheduling policy and procedures.
Short-term	3.4.17	Apply consistent, data driven approach to block allocation and utilization.
Short-term	3.4.18	**Revise block schedules.**
Intermediate	3.4.19	Develop a performance improvement team to address the late start issues.
Short-term	3.4.20	Consistently utilize delay codes.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Perioperative Services > Prioritized Summary of Recommendations

Perioperative Services		
Intermediate	3.4.21	Decrease time between “patient in room” to “incision” and correct.
Intermediate	3.4.22	Adopt and achieve service specific TOT.
Short-term	3.4.23	Reduce staffed suites and hours of operation to match utilization.
Short-term	3.4.24	Match staffing to volume, reducing overall requirements for staff.
Short-term	3.4.25	Measure and monitor suite utilization.
Intermediate	3.4.26	Revise all OR Policies and Procedures and enforce consistently.
Short-term	3.4.27	Initiate comprehensive OR education plan for all staff, including PA staff.
Short-term	3.4.28	Decrease staffing to better match supply with demand.
Short-term	3.4.29	Correct Perioperative Services environment.
Intermediate	3.4.30	Consider closing three ORs and renovating the remaining three.
Intermediate	3.4.31	Update preference card and prepare for automation.
Intermediate	3.4.32	Establish par levels.
Intermediate	3.4.33	Insure maximum number of items are on consignment.
Intermediate	3.4.34	Establish performance expectations for materials management personnel and OR.
Short-term	3.4.35	Relocate OSA to 3B.
Urgent	3.4.36	Capture PAR data electronically.
Short-term	3.4.37	Compose and use PAR admission and discharge criteria.
Short-term	3.4.38	Review practice variance in anesthesia and develop a plan of correction
Short-term	3.4.39	Reduce available hours.
Short-term	3.4.40	Relocate GI Lab immediately to vacant or soon to be vacant unit.
Short-term	3.4.41	Renovate existing space, either in the operating room or cystoscopy suite, to accomplish cystoscopy volume.
Urgent	3.4.42	Process instrument sets promptly and do not store contaminated items in hallway.
Short-term	3.4.43	Set performance expectations for set completion and instrument inspection.
Short-term	3.4.44	Compose plan to standardize instrument sets and ensure trays do not exceed weight.

Perioperative Services > Operating Room – Overview

- Operating Room:
  - Six operating rooms (A-F), original in size and design to the building, are located on the third floor; adjacent to the PACU and preoperative holding areas.
    - OR G is out of service and has been converted into a storage area for orthopedic instrumentation, equipment and supplies.
    - No less than one in-house team (RN circulator and scrub) staffed 24/7/365, in addition to Trauma coverage.
    - Top 40 procedures follow:

PROCEDURE (GROUPED)	2004 Annualized
IRRIGATION & DEBRIDEMENT	344
ORIF	341
LAPAROSCOPIC CHOLECYSTECTOMY	218
APPENDECTOMY	181
CATARACT EXTRACTION	163
EXPLORATION LAPAROTOMY	159
SUCTION DILATATION & CURETTAGE	123
BREAST BIOPSY	109
HYSTERECTOMY	105
HERNIORRAPHY	88
SALPINGO-OOPHERECTOMY	87
TEETH EXTRACTION	83
INCISION & DRAINAGE	81
BONE GRAFT	68
DILATATION & CURETTAGE	65
VITRECTOMY	56
HYSTEROSCOPY	55
HERNIA REPAIR	49
IM RODDING	49
AMPUTATION	48

PROCEDURE (GROUPED)	2004 Annualized
ARTHROPLASTY	48
CLOSED REDUCTION	45
TYMPANOPLASTY	45
LARYNGOSCOPY	44
DEBRIDEMENT	43
ARTHROSCOPY	39
LAPAROSCOPY	39
EXTERNAL FIXATION	35
SEPTOPLASTY	35
BRONCHOSCOPY	33
TONSILLECTOMY & ADENOIDECTOMY	33
CYSTOSCOPY	32
TENDON REPAIR	32
CRANIOTOMY	31
EXAM UNDER ANESTHESIA	29
IM NAILING	29
SALPINGECTOMY	29
TURBINATE REDUCTION	29
FASCIOTOMY	28
THORACOTOMY	29

Perioperative Services > Operating Room – Overview

- Trauma Emergency Room:
  - Two new operating rooms (Trauma 1 and Trauma 2) are located in the trauma emergency room.
    - Two in-house teams (RN circulator and scrub) staffed 24/7/365.
    - Per the Interim Chair, Anesthesiology; KDMC trauma commitment mandates two dedicated teams available at all times.
      - National standard for Level I Trauma coverage is one team immediately available.
    - Top 40 procedures follow:

PROCEDURE (GROUPED)	2004 Annualized
EXPLORATION LAPAROTOMY	160
BOWEL RESECTION/REPAIR	43
TRACHEOSTOMY	35
IRRIGATION & DEBRIDEMENT	27
THORACOTOMY	25
CHEST TUBE INSERTION/PLACEMENT	24
LIGATION	17
SPLENECTOMY	16
THORACOSTOMY	13
DIAPHRAGM REPAIR	12
GASTRORRHAPHY	11
COLONRRHAPHY	9
DEBRIDEMENT	9
NEPHRECTOMY	9
PHRENORRHAPHY	9
PLACEMENT JACKSON PRATT DRAIN	9
COLOSTOMY	8
JEJUNOSTOMY	7
NECK EXPLORATION	7
PERICARDIAL WINDOW	7

PROCEDURE (GROUPED)	2004 Annualized
BRACHIAL ARTERY	5
BULLECTOMY	5
HEMOSTASIS	5
HEPATORRHAPHY	5
PLACEMENT CHEST TUBE	5
COLON RESECTION	4
DISTAL PANCREATECTOMY	4
EXPLORATION & REPAIR	4
EXTERNAL FIXATION	4
HEMICOLECTOMY	4
JACKSON PLATE DRAIN & PLACEMENT	4
LAPAROSCOPY	4
OMENTECTOMY	4
PROCTOSIGMOIDOSCOPY	4
REMOVAL BULLET	4
RETROPERITONEAL EXPLORATION	4
STOMACH INJURY	4
ABDOMINAL AORTA	3
APPENDECTOMY	3
CLOSED REDUCTION	3

Perioperative Services > Operating Room – Overview

- Cystoscopy Suites:
  - Two cystoscopy suites (3G-7 & 3G-9) are located on the 3rd floor, directly across the hallway from the operating room.
    - One RN, and one urology technician provided for one room, is funded by the Department of Urology.
      - If there are no cases, this team covers Outpatient Surgery Clinic.
    - Monday through Friday, 8:00 AM – 4:30 PM.
    - Top 40 procedures follow:

PROCEDURE (GROUPED)	2004 Annualized
CYSTOSCOPY	128
URETHERAL DILATATION	47
FOLEY CATHETER PLACEMENT/REMOVAL/CHANGE	35
CIRCUMCISION	21
BLADDER SCAN	15
CHANGE SUPRAPUBIC CATHETER	9
VASECTOMY	9
BCG	8
CYSTO-URETHROSCOPY	8
MARSHALL TEST	7
TRANSURETHRAL RESECTION BLADDER TUMOR	7
URETERAL STENT PLACEMENT/REMOVAL	7
D/C FOLEY CATHETER	5
DORSAL SPLIT	5
FILIFORM & FOLLOWES	5
REMOVAL URETHERAL STENT	5
RETROGRADE URETHRAGRAM	5
SUPRAPUBIC CATHETER	5
URETHROSCOPY	5
BLADDER IRRIGATION	4

PROCEDURE (GROUPED)	2004 Annualized
RETROGRADE PYELOGRAM	4
TRANSURETHRAL VAPORIZATION OF PROSTATE	4
URETERAL CATHETERIZATION	4
URETERAL DILATATION	4
BIOPSY BLADDER	3
CATHETERIZATION	3
COUDE CATHETER PLACEMENT	3
CYSTOGRAM	3
CYSTOGRAPHY	3
D/C SUPRA CATHETER	3
DILATATION	3
DOUBLE PIGTAIL STENT	3
FLEX CYSTOSCOPY	3
FULGURATION	3
NEEDLE BIOPSY PROSTATE	3
NEOURETHRAL DILATATION	3
PENILE BIOPSY	3
PLACEMENT URETERAL STENT	3
POST VOIDING RESIDUAL	3
REMOVAL BLADDER STONE	3

Perioperative Services > Operating Room – Overview

- OB/GYN Operating Room:
  - Three operating rooms (separate from the eight labor rooms and two delivery rooms) are located on the 2nd floor within the Department of Gynecology.
  - The circulator and scrub roles filled by L&D staff composed of four RNs and one LVN.
    - Operating room staff may cover emergency Cesarean sections, as needed.
  - Two of the three operating rooms (2I & 2II) are currently in use for OB cases only.
    - Both obstetrical and gynecological surgical interventions have been performed in this area, with decreasing volume in recent years.
    - Gynecological volume re-directed to operating room in recent months; however, the Chair of Gynecology has requested to the OR Committee to re-open the two OR suites in this area, to better meet the perceived GYN needs.
    - All procedures follow:

PROCEDURE (GROUPED)	2004 Annualized
CESAREAN SECTION	149
TUBAL LIGATION	35
CERCLAGE	7
HYSTERECTOMY	7
FALLOPIAN TUBALS	4
BREECH PRESENTATION	3
MANUEL REMOVAL PLACENTA	3
REMOVAL CERCLAGE	3
ABDOMEN TITED LEFT SIDE	1
CURRETTAGE	1
CYSTECTOMY	1

PROCEDURE (GROUPED)	2004 Annualized
CYSTOCTOMY	1
DELIVERY FETUS & PLACENTA	1
DILATATION	1
DILATATION & CURETTAGE	1
EXPLORATION LAPAROTOMY	1
LUBAL LIGATION	1
POST PARTUM DILATATION & CURETTAGE SUCTION	1
REMOVAL PLACENA, SUCTION DILATATION & CURETTAGE	1
REMOVAL PLACENTAL	1
UTERINE CURRETTAGE, USING POST PARTUM CURRETTAGE	1

Perioperative Services > Operating Room – Governance

Assessment

- OR Committee:
  - The OR Committee identified as the formalized venue for governance issues.
  - Director of Perioperative Services serves as Chairman of OR Committee as well as several related sub-committees, such as:
    - OR Scheduling
    - PAR Standards
    - ORSOS
  - No formal charter or timeline for sub-committees.
  - Sub-committee recommendations are presented to OR Committee for comment, revision, and approval.
  - Key performance indicators, such as Turnover Time (TOT), late starts, and delays are mentioned in meeting minutes throughout 2003 and 2004. However, there are no specific improvement plans or timelines for corrective actions.
  - Current perioperative leadership unable to cite any accomplishments of Committee in the last two years.
  - Compliance with Operating Room Committee Charter reviewed annually by Committee members.
  - Duties of OR Committee, revised in March 2004, are appropriate.

Perioperative Services > Operating Room – Governance

Assessment

- OR Committee: (continued)
  - Committee Attendance:
    - Unknown attendance status on the following slide is indicated in yellow by NCI, despite detailed coding used to record attendance.
    - Chronic poor physician OR Committee attendance unresolved.

Perioperative Services > Operating Room – Governance

OR Committee Membership - 2004 Attendance	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV
Sebhat Afework, MD, Obstetrics/Gynecology		X	X	X				X	E	Meeting Cancelled	X
Bonnie Archie, RN, Utilization Review				*					A		A
Jimmy Brown, DDS, MD, Otolaryngology					X				A		R
Barbara Bundage, RN, Nursing	X	R	R	N							
Anna Bush, RN, Utilization Review		R							A		A
Thomas Carter, Anesthesiology		X	X	X	X	X	X	E	X		X
Richard Casey, MD, Ophthalmology									A		
Nand Datta, MD, Surgery	X			X	X		E		X		X
Irma Davis, RN, Infection Control		X	N						X		X
Victoria DeGuzman, RN, Admitting						X			A		A
Norma Haye, RN, Nursing						*		X	X		X
Deborah Hooper, Hospital Administration	X	X	X	X	X	X	X		X		X
Jonathan Jahr, MD, Anesthesiology		*	X	E	X			E	X		R
Melvin Jones, MD, General Surgery		X	X	X	E	X	E	X	X		X
Mary Lang, RN, Nursing					X	E		X	X		X
Daniel LeMay, MD, Neuroscience									X		E
Kenneth Lewis, MD, Anesthesiology	X		X	X	X		X	X	X		X
Denise Liddell, Medical Admin./ORSOS	X	X	E	X	E	E	X	X	R		X
Teresa Malone, Quality Management		N							A		
Aljerita Mobley, RN, Nursing Education								*	X		A
Arlesia Preyer, RN, Infection Control		*	X	R	X		X	X	N		
LaVerne Russeau, RN, Quality Management		X	X						X		N
Frederick Rutherford, DDS, Oral Maxillofacial				R			N				
Rosalyn Scott, MD, Cardiothoracic Surgery	X	E	X	X	X		X		X		X
Nancy Smith, RN, Nursing	X	X	X	X	X	X	X	X	X		X
Zohreh Steffens, MD, Anesthesiology			*	X	X	X	X	X	X		X
Marilou Tandoc, RN, Quality Management											X
Mary Villaflor, RN, CMSC, Medical Administration		X	E		X			X	X		R
Roger Ward, Ph.D., Surgery		X	X	X	X			X	X		X
Clarence Woods, MD, Orthopedic Surgery	X	X	X		X		X		X		X
Earl Bolden, Materials Management (Guest)									X		X

X = Present, E = Excused, N = No longer member, * = New member, R= Rep for excused member, V= Vacation, A = Absent

Perioperative Services > Operating Room – Governance

Assessment

- OR Committee goals for 2004 are appropriate. OR Committee meetings do not mention strategies to achieve these goals, or progress made.
- Prioritization of Issues:
  - OR Committee does not appear to prioritize and bring issues to conclusion.
  - All new business in 2004 deferred due to number of open, unresolved items from 2003.
  - Despite backlog of issues, October 2004 meeting cancelled for lack of a secretary.
- Infection Control Issues:
  - Representative from Infection Control attended three meetings in 2004.
  - Infrequent and disputed Infection Control reports to OR Committee, with no discussion or plan to investigate or correct root cause.
  - Infection Control presented data at 2 of 22 OR Committees.
- Perioperative Committee is held monthly with open invitation to all OR and anesthesia staff.
  - Format appears to be a staff meeting, rather than a Committee.
  - Full breakfast served, reportedly purchased by Director of Perioperative Services, not KDMC or Anesthesia.

Perioperative Services > Operating Room – Governance

Deficiencies

- Ineffective Governance structure.

Recommendations

3.4.01 Restructure OR Governance including membership, accountabilities and decision rights.

3.4.02 Develop and incorporate a dashboard as a standing monthly agenda item for the OR Governance Committee to review and analyze; identifying issues/problems, and providing stewardship to develop and implement plans for resolution. Committee to report to CEO.

Perioperative Services > Operating Room – Leadership / Management

Assessment

- Overall responsibility for management of the OR is the Director of Perioperative Services, who is also Vice Chair of Anesthesia, and the OR Manager, who carries the title of Assistant Director of Perioperative Services.
- Director of Perioperative Services:
  - There are no specific performance expectations for this role
  - Per the Interim Chair, Anesthesiology; original title of OR Director of Anesthesia was discussed and agreed to by medical leadership.
- OR Manager:
  - The title of Assistant Director of Perioperative Services was granted to the OR Manager.
  - OR Manager's office not located in vicinity of operating room.
  - OR Manager has 24-hour responsibility for Perioperative Services; including, ensuring quality patient care is provided, staffing, and administrative assignments.
  - OR Manager demonstrates the following opportunities to improve performance:
    - Infuse fiscal reality into management decisions.
    - Assume responsibility to complete assignments.
    - Utilize proactive problem solving skills.
    - Ensure Perioperative Services reflects leading practice in Policies & Procedures and daily practice.
    - Manage Staff Performance.

Perioperative Services > Operating Room – Leadership / Management

Assessment

- OR Supervisor responsible for the day-to-day management of the OR schedule.
- Surgeon Leadership and Perceptions:
  - Interim Chair, Surgery appears loyal to KDMC and dedicated to the community served.
  - Lack of surgical strategic plan noted by surgeons.
  - Physicians interviewed perceived action only taken if there is a crisis in progress.
  - Surgeons appear acclimated to lack of data, and resultant decision-making stalemate.
  - General attitude appeared helpless and resigned to mediocrity.
  - KDMC culture described by long-term surgeons as adverse to facing problems directly and holding individuals accountable.

Deficiencies

- Current state of Perioperative Services suggest the role of Director of Perioperative Services has not been effective in optimizing Perioperative Services.
- OR Manager does not present a history of effective management or decision-making.
- Lack of effective physician leadership and communication with administration.

Perioperative Services > Operating Room – Leadership / Management

Recommendations

3.4.03 Eliminate the Director of Perioperative Services position and replace with OR Governance Committee.

3.4.04 Relocate OR Manager's office to OR.

3.4.05 Develop the breadth and depth of Nursing management by engaging an Interim Advisor for the OR Manager.

3.4.06 Institute regular, relevant communication between executive leadership and physicians.

3.4.07 Fully engage select surgeon and anesthesia leadership in OR Governance Committee.

Perioperative Services > Operating Room – Anesthesia

Assessment

- Staffing/Productivity:
  - Budgeted positions within the Department of Anesthesiology include:
    - Twelve physicians; plus two board certified for trauma coverage contracted through LA County.
    - Eighteen anesthesia residents (17 residents currently in program and one vacancy).
    - Three certified registered nurse anesthetists (CRNA); one is on extended leave due to health issues.
  - Department Staffing Models – Zero-Based Budgeting, prepared by Interim Chair in May 2004 emphasize "the department has been stripped of necessary resources."
    - Phrases, such as "crisis requests", peppered throughout document.
  - Interim Chair challenged to provide salaries in the 50th percentile for the Western region.
    - County starting salary = $212 K, but inputs total $170 K as detailed below:
      - An academic unit = 480 hours annually, and is valued at $50 K.
      - County salary base = $120 K.
  - Medical School Operating Agreement, completed in October 2004, has been interpreted by CMO as "funding only physician salaries" according to Interim Chair.
    - All administrative and research to be funded from other unidentified sources from Drew University.
    - Interim Chair concerned residency accreditation will be lost if there is inadequate staffing for research.

Perioperative Services > Operating Room – Anesthesia

Assessment

- Anesthetizing Locations:
  - Anesthesia provides coverage for multiple locations:
    - Operating rooms (A-F); Trauma 1 & 2; OB 2I
    - Gynecology
    - OS
    - PAR
    - Pain Service
  - Beeper coverage provided for Code Yellow (trauma) and Code Purple (L&D), but not Code Blue.
- Residency Program Accreditation:
  - Availability of 17 hand-on providers is jeopardized due to residency program's probationary accreditation from American College of Graduate Medical Education (ACGME) and Residency Review Committee (RRC).
  - Adverse accreditation action is based on failure of the program to be in substantial compliance with four areas, however, following the appeals process, all citations were rescinded except:
    - "The performance of program graduates on the certifying examination of the ABA has been poor For the period of 1996-2000, only 18% of all candidates achieved certification."
  - Interim Chair and Residency Program Director anticipate full accreditation will be restored in May 2005 with the next ACGME site visit, given improvements in test performance.

Perioperative Services > Operating Room – Anesthesia

Assessment

- Outpatient Surgery Anesthesia (OSA):
  - OSA officially recognized as a clinic by LA County, although it does not report to the Nursing Director for Clinics.
    - OR Manager has current responsibility.
  - Interim Chair reported OSA revenue-based as encounters, but is insignificant.
  - Anesthesia attending physician assigned full-time to OSA.
    - Anesthesia department requires all outpatients, regardless of American Society of Anesthesiologists (ASA) classification, to complete an in-person visit to OSA.
  - OSA described as a “screening clinic for patients,” with anesthesia serving as de facto primary care hospitalists.
    - Superficial surgical work-ups reported to precipitate this assessment level.
    - Action, if any, to address quality of surgical work-ups unknown to Interim Chair.
  - Individual attending anesthesiologists frequently override prior OSA assessment by colleague; undermining the point and effectiveness of the original OSA visit.

Perioperative Services > Operating Room – Anesthesia

Assessment

- Preoperative:
  - Proactive approach by anesthesiologists to cases not evident, i.e., routine is to insert invasive lines once the patient is in the OR, rather than prior to entering OR.
    - Current designated holding area for patients the morning of surgery located in PAR and may not be conducive for line placement, however, anesthesia has not requested the need for such an area to perform appropriate tasks outside of the operating room.
- Intraoperative:
  - Quality of care described as acceptable to excellent, but dependent on the individual provider.
  - Moderate sedation self-learning module prepared with input from anesthesia.
    - Module appears thoughtful and complete, although monitoring form used in GI Lab different from form included in module.
      - GI Lab form includes critical elements, such as:
        - » Scale for pupil reaction.
        - » Level of conscious code.
        - » Pain assessment chart.

Perioperative Services > Operating Room – Anesthesia

Assessment

- Intraoperative: (continued)
  - All units that provide moderate sedation complete case statistics for Department of Anesthesia.
    - Medications stocked in department for sedation.
    - Total number of anesthetics performed with IV sedation.
    - Total pediatric (< age12) and geriatric (> age 65) patients.
    - Total number of injuries/equipment due to faulty equipment.
    - Total number of complications by: airway, cardiovascular, respiratory, and technical.
    - Total number of cases cancelled.
- Postoperative:
  - Anesthesia mandates that all patients must be discharged by anesthesiologist.
    - Nursing uses Aldrete scoring system to assess patient's condition and initiate call to anesthesia for discharge.
  - Medical Director provided for PAR.

Perioperative Services > Operating Room – Anesthesia

Deficiencies

- Current Anesthesia management style reinforces perception that staffing and resources inadequate and preclude process improvements.
- Moderate sedation tracking forms inconsistent.
- Criteria for OSA visits too broad.
- Anesthesia coverage responsibilities should include Code Blue.

Recommendations

3.4.08 Develop the breadth and depth of Anesthesia management by engaging an advisor for the Interim Chair.

3.4.09 Ensure all moderate sedation tracking forms consistent.

3.4.10 Develop criteria for OSA in-person visits.

3.4.11 Assign OSA to Nursing Manager of Clinics.

3.4.12 Assign anesthesia to carry Code Blue beeper to optimize airway management.

3.4.13 Assess PAR nursing skills to begin discharge by Aldrete score.

Perioperative Services > Operating Room – Information System

Assessment

- Operating Room Scheduling Operating System (ORSOS) version 8.5.3.2 in use.
  - Other DHS facilities use newer version, 8.6.1.1.
  - KDMC cannot migrate to up newer version until data backlog is cleared.
  - Newest version of ORSOS, 10x, is being considered for purchase by DHS.
- KDMC IT department supports only the network and hardware.
  - Application support provided by Nursing.
- There are no technical impediments to utilizing current ORSOS to the fullest.
  - OR nursing education would be needed.
- Perception that data are not available due to inadequate number of ORSOS dedicated personnel.
  - Currently have sufficient staff with two FTEs assigned full-time to ORSOS. One is frequently absent.
- Data may be extracted into Crystal reports to facilitate analyses completed in Excel.
  - KDMC Director of Data Administration has the capability to perform this task.
- Current patient level data is incomplete and not concurrently entered into the system.
- "Big board" module provides minute-to-minute information of every case throughout Perioperative process.
  - Real time case status color coded on board located at the OR front desk.

Perioperative Services > Operating Room – Information System

Deficiencies

- Lack of data and information to manage patient throughput.

Recommendations

3.4.14 Develop productivity targets for ORSOS personnel to facilitate timely entry of data.

3.4.15 Design and implement a Perioperative dashboard.

Perioperative Services > Operating Room – Scheduling

Assessment

- Case Scheduling:
  - Overall scheduling process described as cumbersome and confusing.
    - Sub-committee on scheduling appointed in August 2004 to improve overall process.
  - Elective cases scheduled by submitting a typed surgery request; referred to as the buck sheet.
  - Case scheduling completed by ORSOS staff.
  - Next day's schedule closes at noon the day prior.
  - Key aspects of case scheduling, previously invested in chief resident, being redistributed to attending surgeons and PAs.
  - OR Manager stated that scheduling rules are, "never hard and fast, and rarely enforced."
  - Scheduling policy, last revised in 2004, appears cumbersome.
    - Multiple definitions.
    - Key processes not clearly articulated.
  - Surgeons interviewed did not identify problems securing time on OR schedule.

Perioperative Services > Operating Room – Scheduling

Assessment

- Urgent and Emergent Cases:
  - Data not available to distinguish urgent and emergent cases.
  - Definitions of urgent and emergent differed among interviewees.
  - Policy defines three classifications of emergent cases and four classifications of urgent cases.
    - In addition to patient's condition and status (inpatient versus outpatient), surgeon's personal schedule reported to influence case classification.
- Modified Block Scheduling:
  - Current modified block scheduling by service.
  - Release time for all services is noon the day prior.
    - Weekends managed as, first come, first served.
  - Block utilization is case hours, excluding TOT /available hours in block.
    - Per policy, 75% utilization expected to maintain a block.
    - Block allocation and utilization reviewed by Director of Perioperative Services and OR Manager.
  - Consequences for low utilization nebulous – it would be very unusual to have block time taken away.
  - Lack of data cited as reason for conservative changes in block allocations.

Perioperative Services > Operating Room – Scheduling

Deficiencies

- Scheduling process is inconsistent and unclear.
- Block scheduling decisions are not data driven.

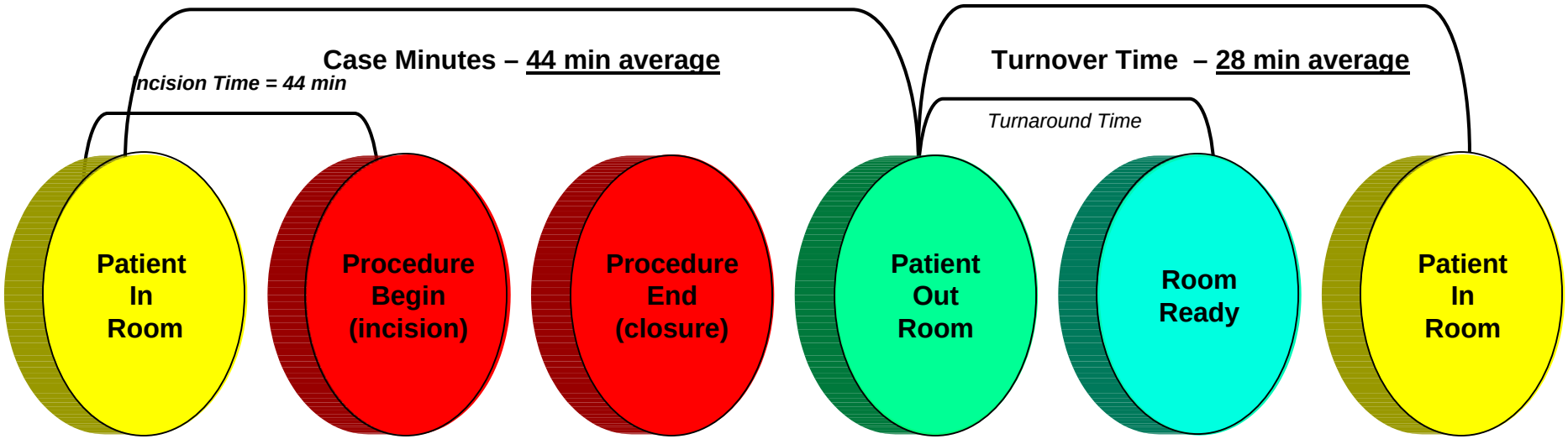
Recommendations

3.4.16 Revise OR scheduling policy and procedures.

3.4.17 Apply consistent, data driven approach to block allocation and utilization.

3.4.18 Revise block schedules.

Perioperative Services > Operating Room – Throughput / Case Starts and Delays



On Time - 61%

- Unless otherwise noted, the completed models reflect patient level data for the period **January 1, 2004 – September 30, 2004**.

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Case Starts and Delays

Assessment

- Start time defined as “patient in room” time.
- Late starts identified as chronic problem; most recent process improvement effort was initiated seven months ago, but without any recommendations due to lack of data.
- No grace period allocated before a case is considered late. Per OR Manager; “late is late.”
- Current performance demonstrates 61% of cases analyzed are considered on time.
- Contrary to national practices, essential activities; such as, performing a surgical hand scrub, creating the sterile field, setting up instruments, and completing counts are completed after the patient crosses the OR suite threshold – not before.
- Late starts attributed to multiple factors, as noted in OR Committee minutes.
- Specific criteria for being designated a late surgeon (frequency in a predetermined time frame) not defined. Unknown consequences, if any, for a late surgeon.
- Surgeons are never challenged if late, regardless of length of delay or the impact on the schedule.
- Delay codes are rarely and inconsistently used.
- Case set-up is not initiated until patient enters the operating room.

Perioperative Services > Operating Room – Throughput / Case Starts and Delays

Assessment

- The standard practice in operating rooms is to complete key tasks prior to patient entry, including:
  - Case instrumentation and supplies checked for sterility, completeness and availability.
  - Completed hand washing by scrub person.
  - Back table, Mayo stand, prep table and other key set-ups ready.
  - Initial instrument count begun.
- Delayed case preparation prolongs total case minutes and creates several problems, such as:
  - Prolonged time for patient to anesthetized.
  - Utilization inflated by non-productive patient on table time.
  - Lackadaisical approach to case preparedness, rather than purposeful, premeditated actions.

Deficiency

- Late on time starts due to multiple, undocumented factors.

Recommendations

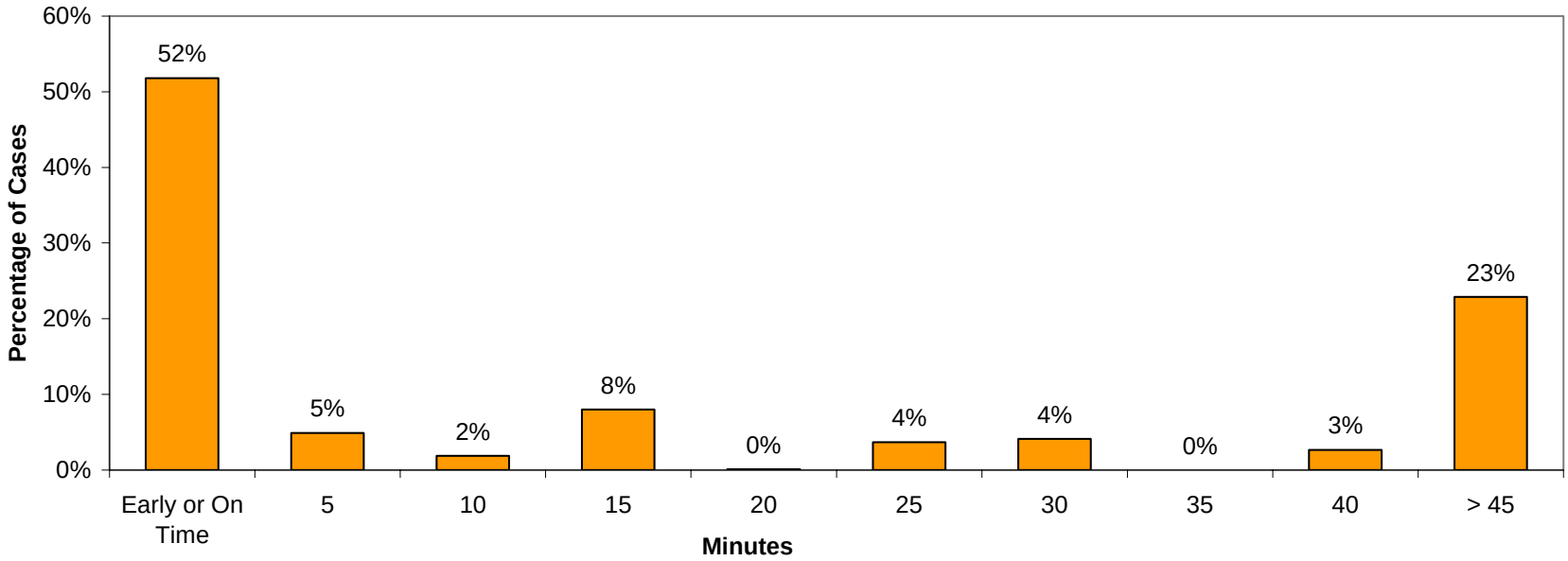
3.4.19 Develop a performance improvement team to address the late start issues.

3.4.20 Consistently utilize delay codes.

Perioperative Services > Operating Room – Throughput / Case Starts and Delays

Assessment

OR First Scheduled Case of the Day
On Time Starts
Monday - Friday
January 1, 2004 - September 30, 2004



- Start time defined as patient in room time
- Current Performance: 52% of first cases start on time
- Target Performance: 95% of first cases start on time

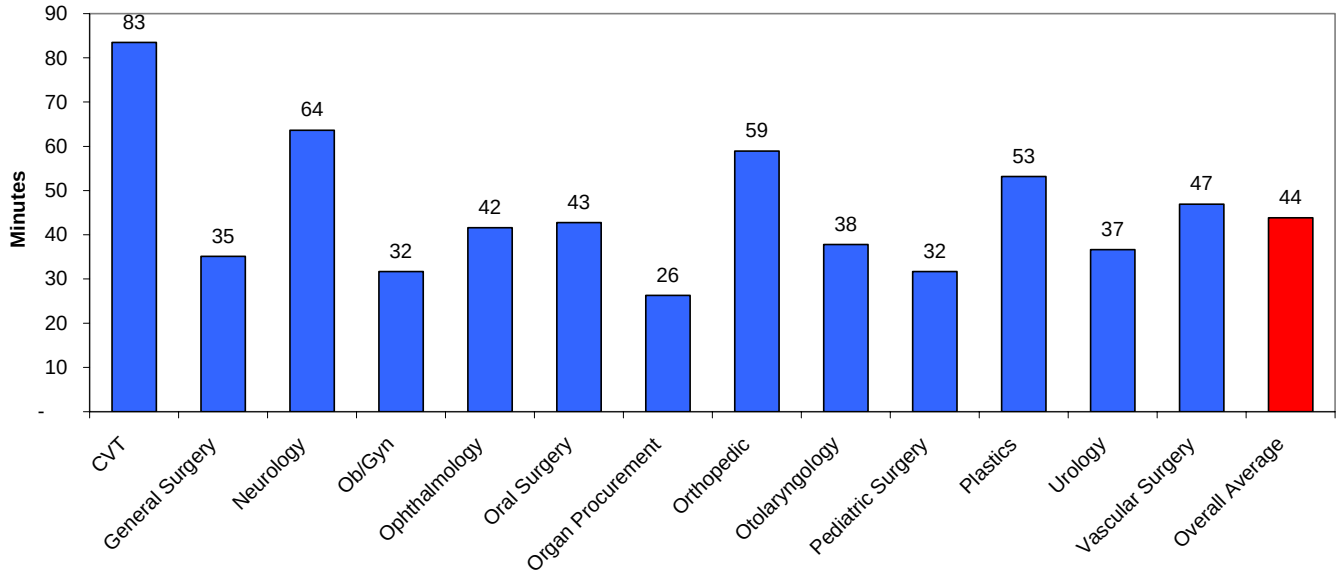
Note: 900 of 2743 cases analyzed

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Incision Time

Assessment

OR Time Lapse between Patient In & Cut Time
January 1, 2004 - September 30, 2004



Note: 2743 cases anlayzed

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Incision Time

Assessment

- Length of time from patient in room to incision is currently not measured.
  - NCI model measured 44 minutes.
- Chronic problem identified in OR Committee meeting minutes.
  - "Dr. Rosalyn Scott looked back approximately two years ago to see what the length of time was between the time the patient entered the OR to the time of incision. The total time was 120 minutes." (July 2003).
  - Period of patient in room time to incision time is influenced by multiple factors:
    - Patient condition.
    - IV insertion and intubation challenges.
    - Preference card accuracy.
    - Availability of key items, such as blood products and implants.

Deficiencies

- Prolonged time from patient in room to incision due to unspecified causes.

Recommendations

3.4.21 Decrease time between patient in room to incision and correct.

Perioperative Services > Operating Room – Throughput / TOT

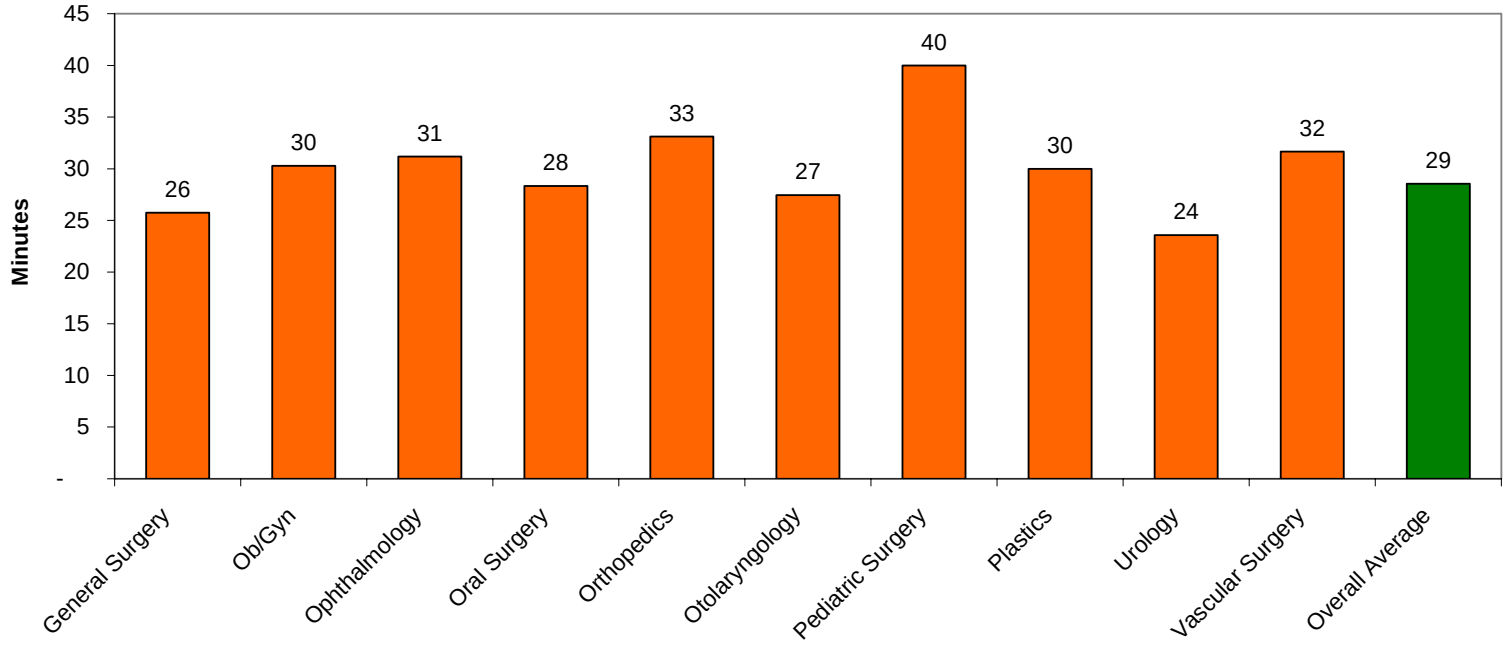
Assessment

- TOT identified as a significant and chronic problem.
  - The length of room turnover reported to be dependent upon the team in the room.
  - Anesthesia identified as contributor to delayed TOT, due to lack of proactive planning.
- Parallel processing to begin cases not in place, which delays patients from entering the OR.
- TOT is a reflection of case complexity, with 25 minutes for the most instrument and equipment intensive cases; such as, spinal surgery, total joint replacement, and open heart surgery.
- The following analyses consider the best case scenario (consecutive cases in the same room by the same surgeon).
  - An average TOT of 28 minutes is not acceptable, given the case mix, and compactness of the OR.
  - 58% of the cases analyzed had TOT of 25 minutes or longer, which is incongruent with the case mix.
  - Leading practice suggests 15 to 20 minutes TOT for the majority of cases.
    - Most ophthalmic, ENT and plastics cases should be 10 to 15 minutes.

Perioperative Services > Operating Room – Throughput / TOT

Assessment

OR Turnover Time by Service - Average
Same Surgeon, Same Room, Consecutive Cases
January 1, 2004 - September 30, 2004

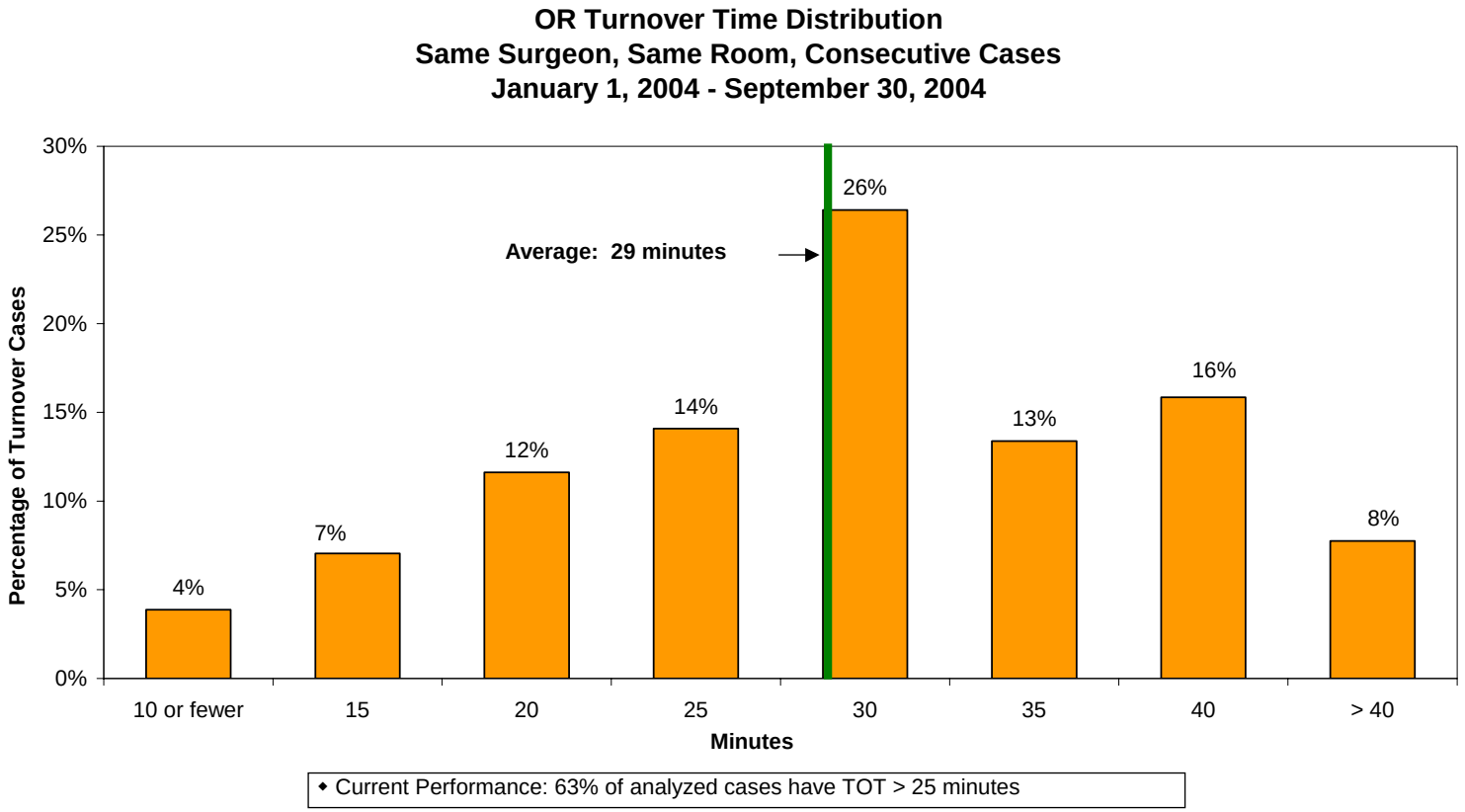


Note: 284 of 2743 cases anlayzed

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / TOT

Assessment



Note: 284 of 2743 cases anlayzed

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / TOT

Deficiencies

- Prolonged TOT due to multiple unspecified factors.

Recommendations

3.4.22 Adopt and achieve service specific TOT.

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

- Suite Utilization, without TOT
  - Overall 26%
  - NCI Target 70%

OR - Overall						
week day	days	rooms open	hour open	hour close	hours available	hours per week
M,T,W,H	4	6	7:30 AM	3:30 PM	8.00	192.00
F	1	6	8:30 AM	3:30 PM	7.00	42.00
M,T,W,H,F	5	4	3:30 PM	11:00 PM	7.50	150.00
M,T,W,H	4	3	11:00 PM	7:30 AM	8.50	102.00
F	1	3	11:00 PM	8:30 AM	9.50	28.50
Sat-Sun	2	4	7:30 AM	3:30 PM	8.00	64.00
Sat-Sun	2	3	3:30 PM	11:00 PM	7.50	45.00
Sat-Sun	2	3	11:00 PM	7:30 AM	8.50	51.00
total hours per week						674.50
total hours per week * 50 weeks						**33,725**

8,863	total case hours
33,725	total available hours
26%	**overall utilization**

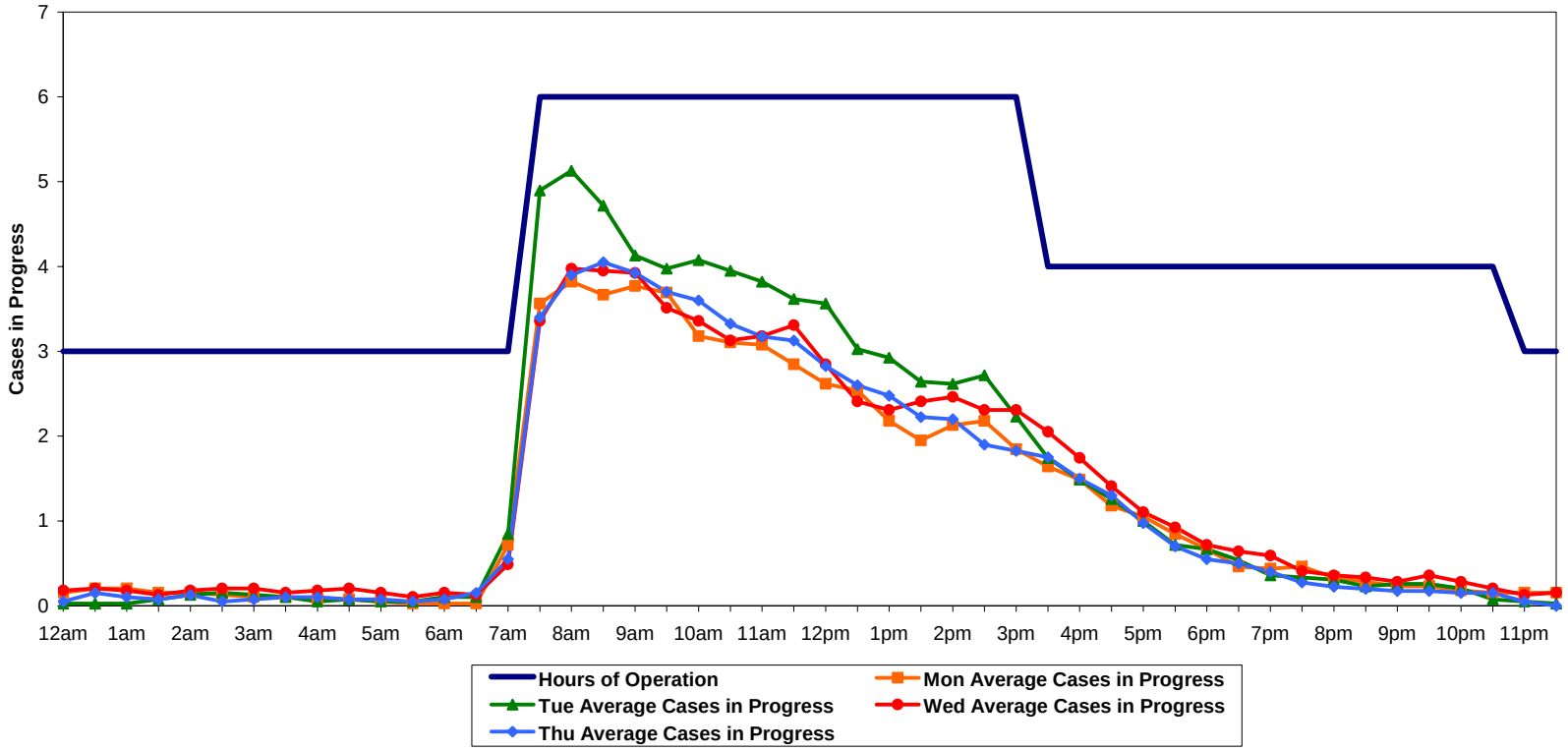
Source: ORSOS Download, Mary Villaflora, Medical Staff Coordinator.
Timeframe: January 1, 2004 - September 30, 2004 annualized.
Notes: Inservice every Friday, all rooms begin at 8:30 AM.
2743 cases included in analysis.
136 cases (4.7%) excluded due to data entry error or missing information.
8 cases (0.3%) excluded due to cancellation.
Rooms: A,B,C,D,E,F. Room G converted to storage.

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Average
Monday - Thursday
January 1, 2004 - September 30, 2004



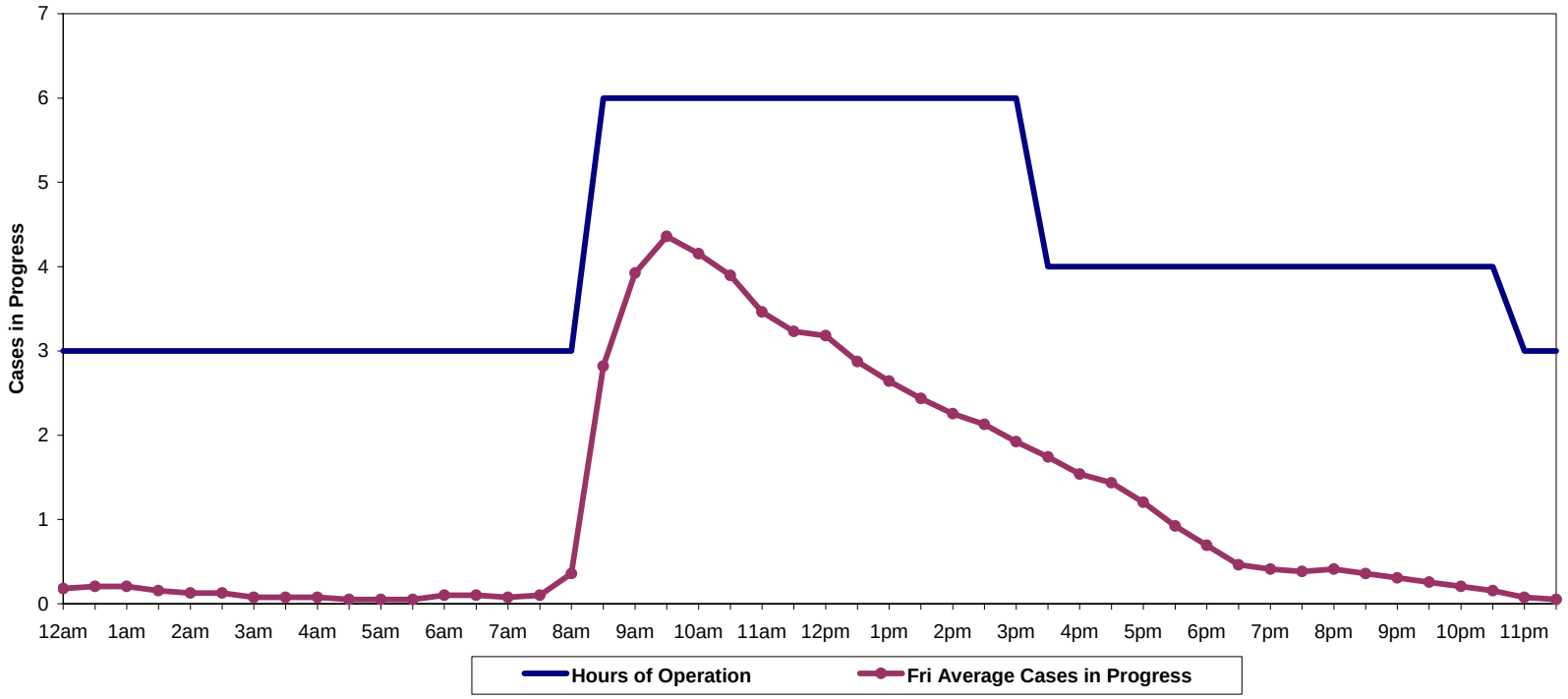
Note: 2743 of 2887 cases included in analysis

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Average
Friday
January 1, 2004 - September 30, 2004



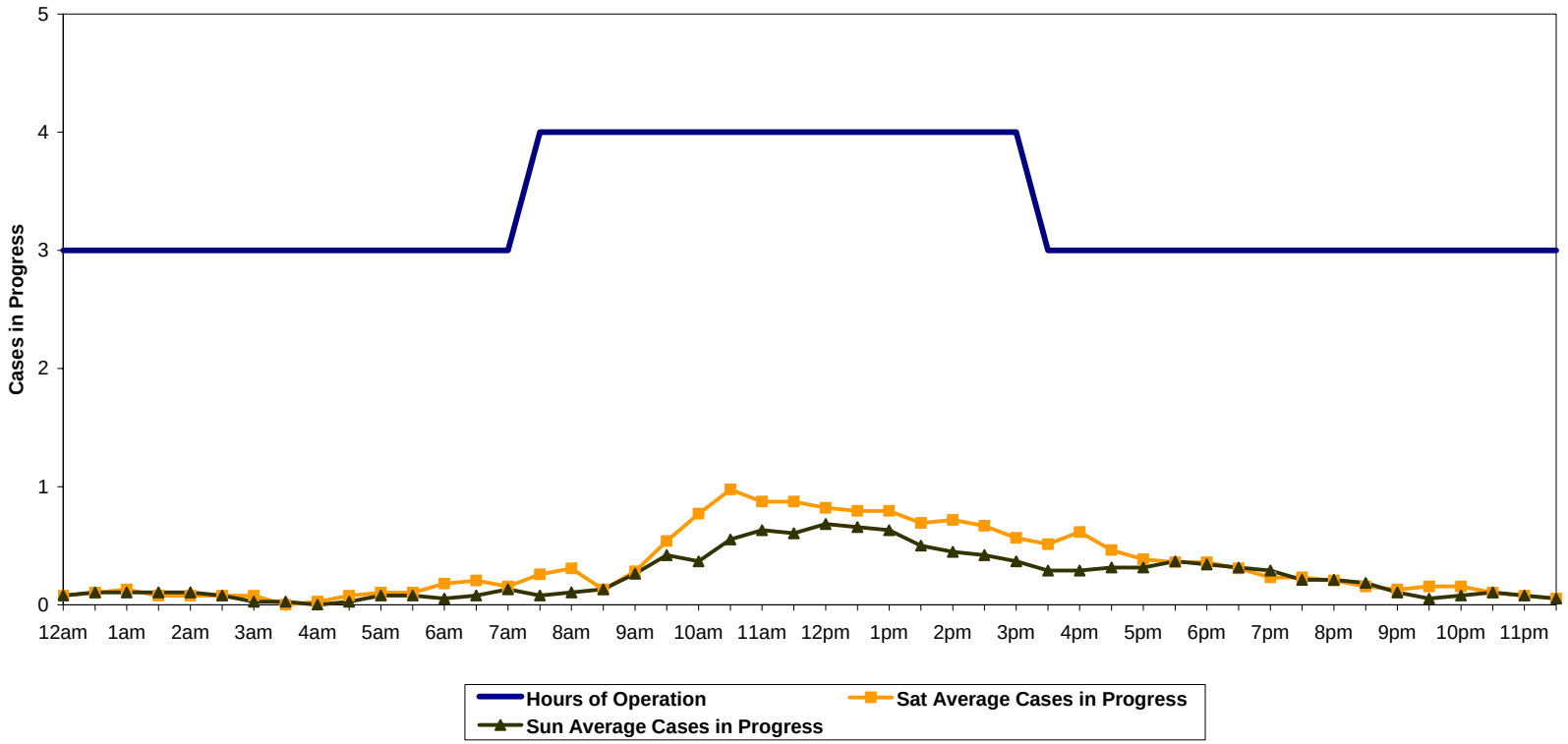
Note: 2743 of 2887 cases included in analysis

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Average
Saturday, Sunday
January 1, 2004 - September 30, 2004



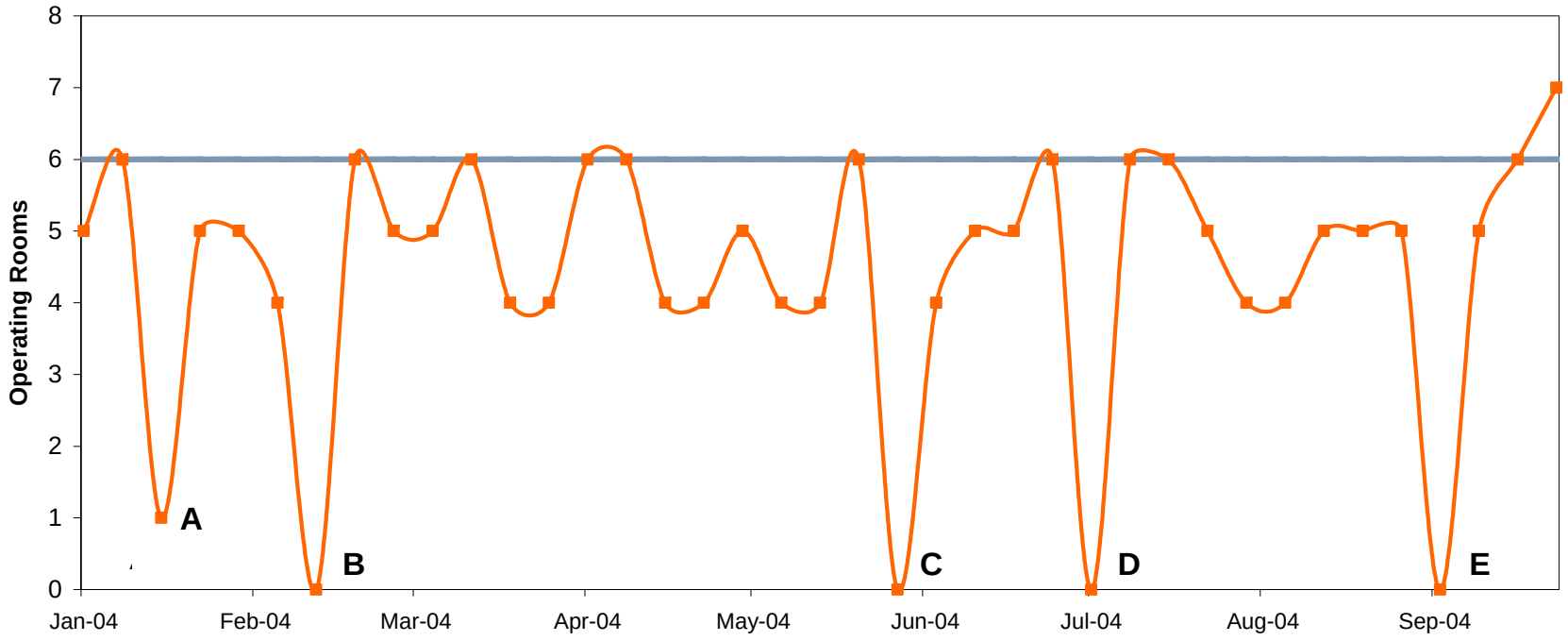
Note: 2743 of 2887 cases included in analysis

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Actual
January 1, 2004 - September 30, 2004
Monday 8:00 am - 9:00 am



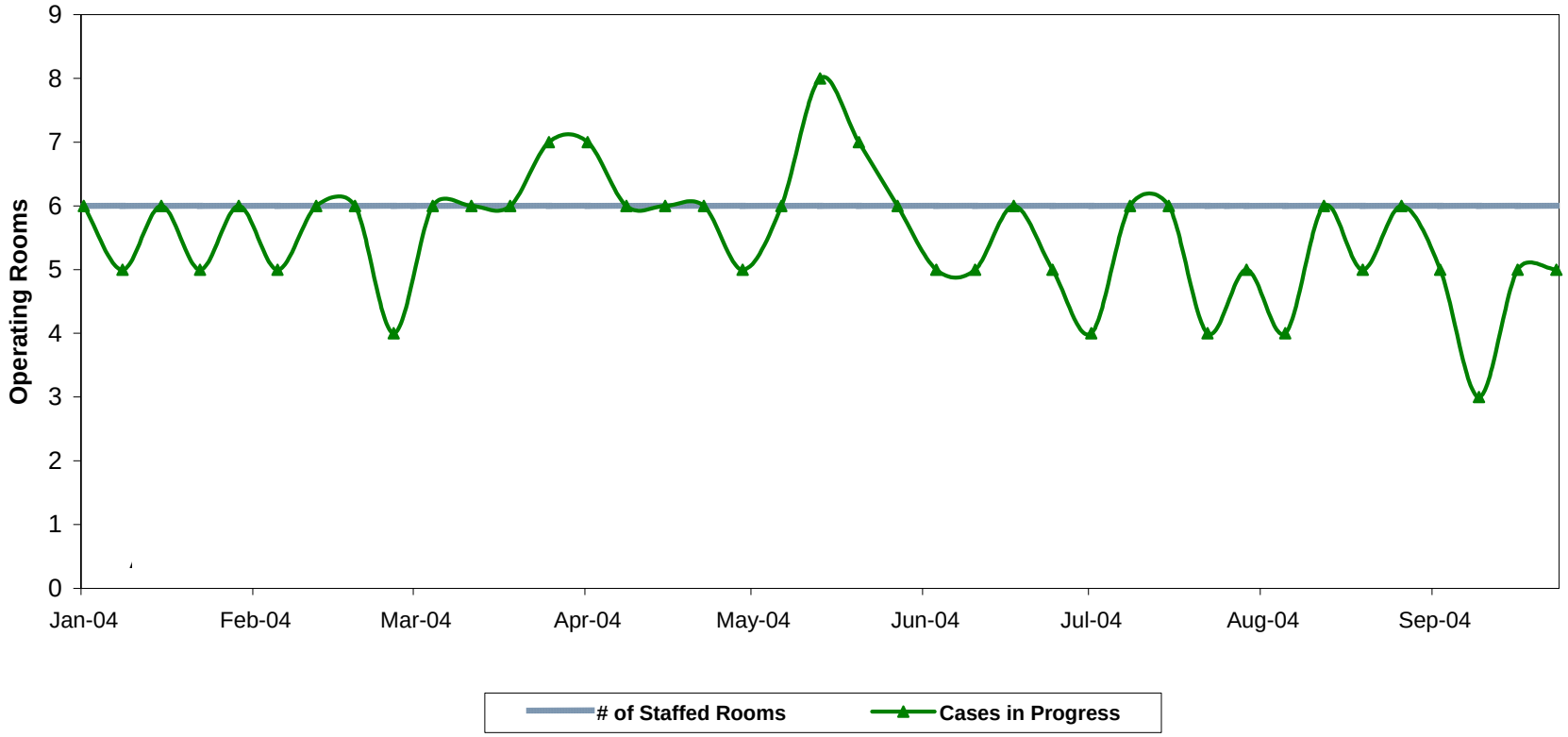
A = Martin Luther King
B = President Day
C = Memorial Day
D = Independence Day
E = Labor Day

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Actual
January 1, 2004 - September 30, 2004
Tuesday 8:00 am - 9:00 am

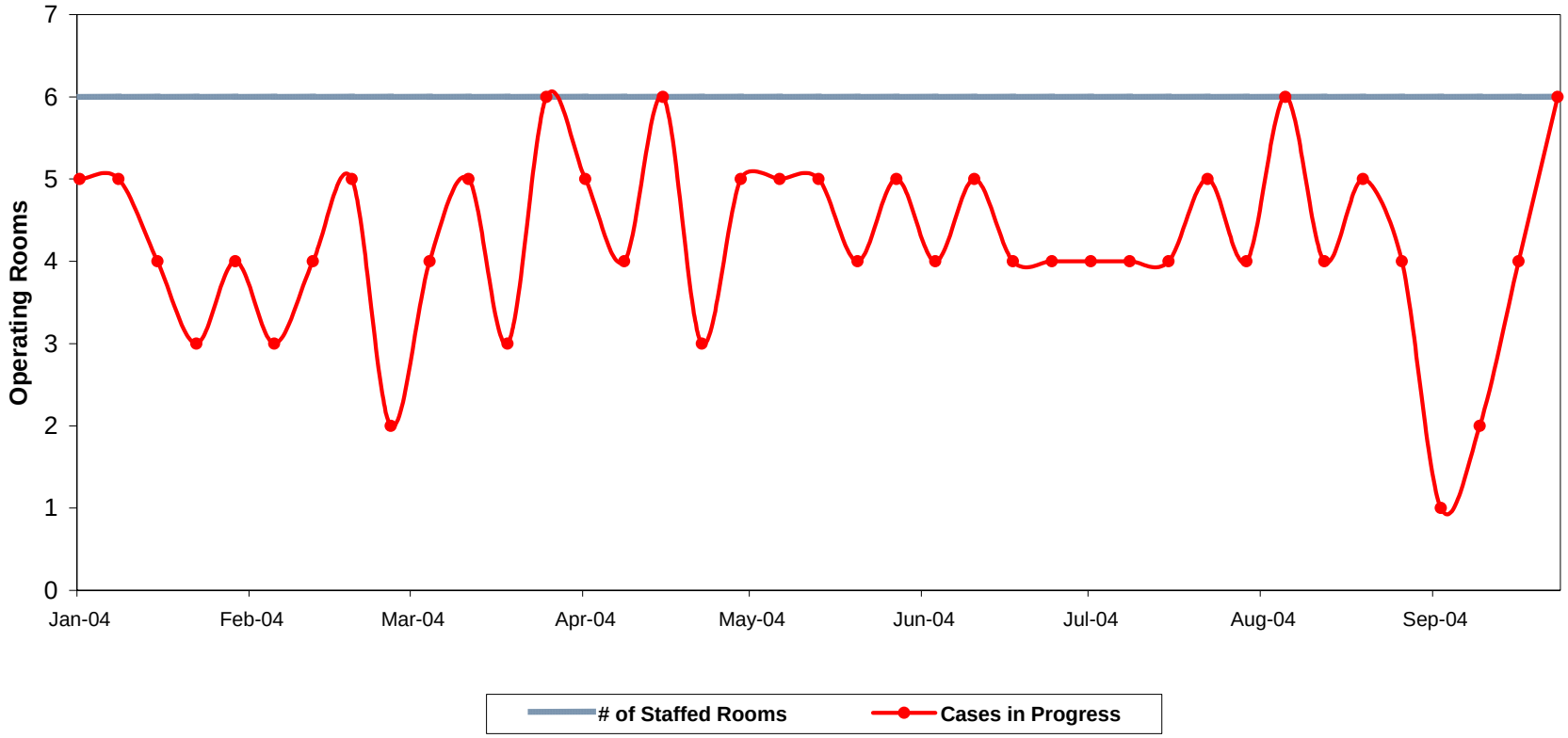


NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Actual
January 1, 2004 - September 30, 2004
Wednesday 7:00 am - 8:00 am

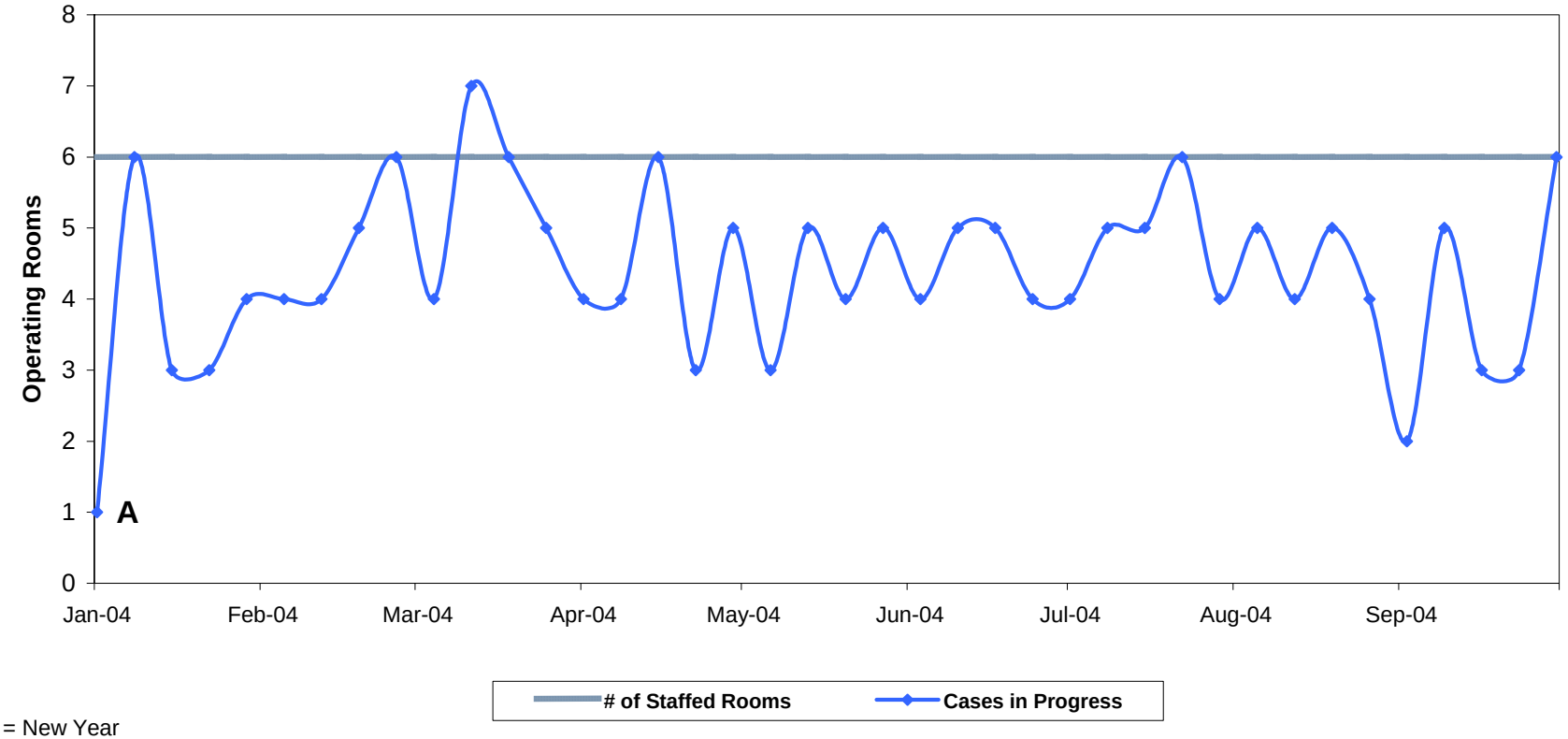


NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Actual
January 1, 2004 - September 30, 2004
Thursday 7:00 am - 8:00 am



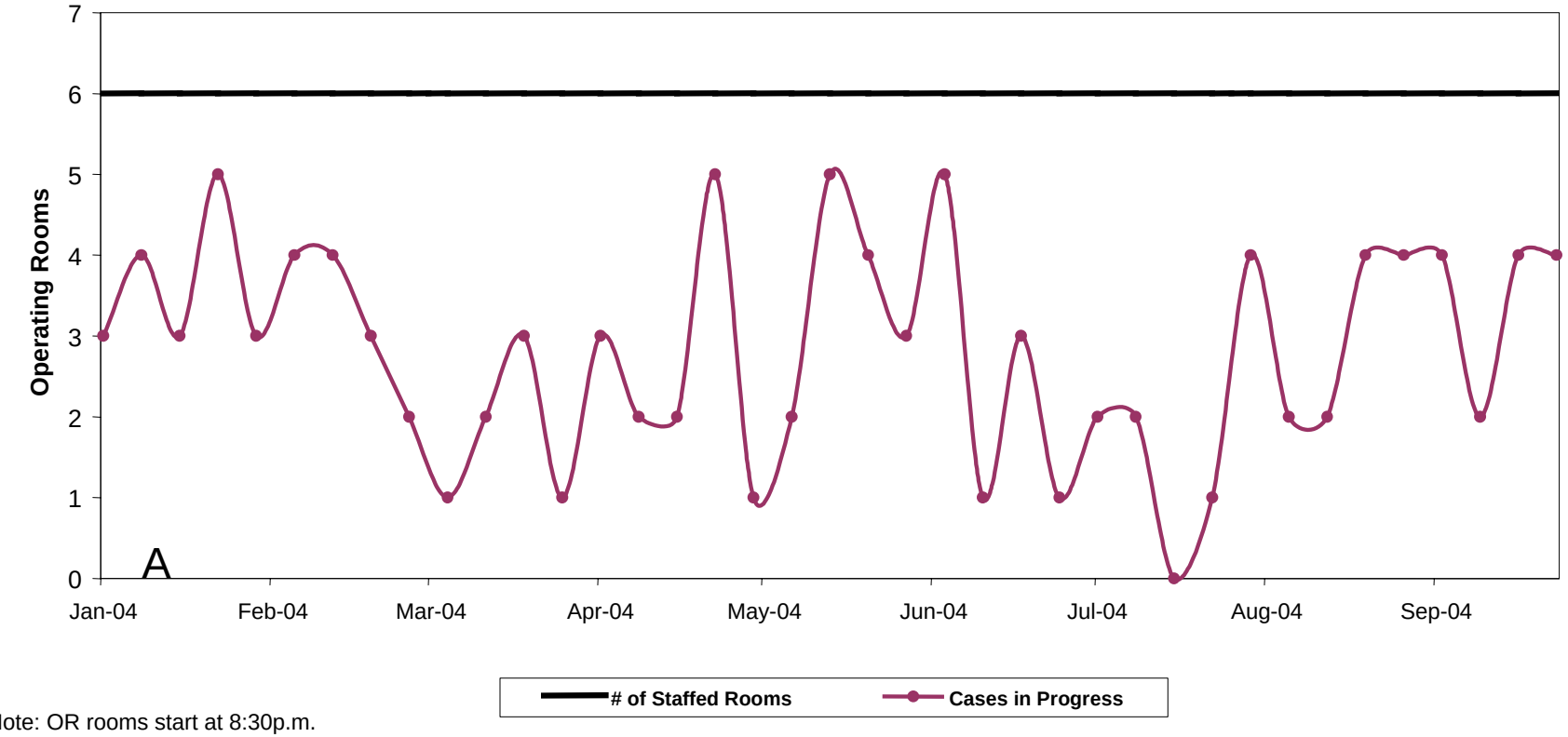
A = New Year

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

OR Cases in Progress - Actual
January 1, 2004 - September 30, 2004
Friday, 8:30 AM – 9:30 AM



Note: OR rooms start at 8:30p.m.

NAVIGANT CONSULTING

Perioperative Services > Operating Room – Throughput / Capacity

Assessment

- NCI model considers the entire case volume and case hours, regardless of day or time case was completed, accomplished within available hours.
  - 52 weeks of case hours/50 weeks of available hours (to account for holidays).
- Current utilization suggests the capacity and staffing for approximately 6,519 additional cases, given the current available hours and staffing.
- OR Suite Utilization may be improved by increasing case volume, decreasing available hours or both.
- Reported backlog of cases due to lack of OR time incongruent with exceptionally low utilization.
  - OSA mandatory visit identified as contributing factor to case backlog.

2,743	Total Main OR case volume
8,863	Total Main OR case hours
3.23	Average case length (hours)
194	Average case length (min)
33,725	Current available hours
12,662	Target available hours at 70% utilization
21,063	Excess available hours
6,519	Potential additional cases (194 min in length)

Perioperative Services > Operating Room – Throughput / Capacity

Deficiencies

- Poor suite utilization reflects excess available hours.

Recommendations

3.4.23 Reduce staffed suites and hours of operation to match utilization.

3.4.24 Match staffing to volume, reducing overall requirements for staff.

3.4.25 Measure and monitor suite utilization.

Perioperative Services > Operating Room – Intraoperative Care / Staffing, Orientation, Policies, Patient Safety, Competency

Assessment

- Staffing:
  - Extraordinary staffing patterns noted; with no less than three in-house teams on nights and weekends, with four rooms staffed during weekend days.
  - Several students, unsupervised for long periods of time, observed in all operating rooms.
    - OR supervisor unable to identify all of the programs represented by the students, the skill level of the students and the location of the program instructors.
  - Many staff members congregated in operating rooms, storage areas and dirty instrument room, from 7:00 AM to 7:45 AM, with no apparent incentive to check supplies and instrumentation for first case of day, nor setting up their assigned room.
  - Call coverage managed through a voluntary sign-in by staff members, documented as RN or Scrub Tech Overtime Schedule. As a result, some shifts may not have call coverage.
- Staff Competency:
  - Critical thinking noted as a key skill lacking in some staff members.
  - Competencies delineated in OR Specialty Manual for RNs and surgical technicians identified as the competency statements from AORN.
    - Nursing Skills/Competency Validation Checklist last updated April 2004.
      - Employee completes self-assessment for delineated critical elements by applicable patient age group(s)
      - Method(s) of instruction and validation include written materials, verbal, visual and return demonstration
    - Individual staff competency records not available.

Perioperative Services > Operating Room – Intraoperative Care / Staffing, Orientation, Policies, Patient Safety, Competency

Assessment

- Orientation and Training:
  - OR orientation plan for experienced and novice staff not available.
  - One traveler currently in OR, orientation program non-specific.
- Patient Safety and Quality of Care:
  - Several violations of basic OR principles observed during one visit.
  - Instrument, sponge and sharp counts inconsistently performed..
  - Los Angeles County DHS Performance Measures Results (July – December 2003), reported an improvement opportunity for percent with documentation of site verification in chart among patients receiving left-right specific surgery.
    - Quarter 1 67.1%
    - Quarter 2 79.5%
    - Benchmark 100%
- Policies and Procedures:
  - Difficult to read and understand.
  - Text appears to be poor quality copies, rather than printed pages.
  - Incomplete, incoherent sentences peppered throughout text.
  - Cumbersome and not user-friendly.

Perioperative Services > Operating Room – Intraoperative Care / Staffing, Orientation, Policies, Patient Safety, Competency

Assessment

- PA role in the OR undefined and without required skills, competencies, and training.

Deficiencies

- Policies and procedures are poorly written and inconsistently followed.
- Excess staffing and uncontrolled traffic in OR.
- Sub-committee public and clinical OR environment.

Recommendations

3.4.26 Revise all OR Policies and Procedures and enforce consistently.

3.4.27 Initiate comprehensive OR education plan for all staff, including PA staff.

3.4.28 Decrease staffing to better match supply with demand.

Perioperative Services > Operating Room – Intraoperative Care / Environment

Assessment

- Overall Perioperative Services area compromises multiple aspects of providing patients a safe, clean environment. Specific areas of improvement detailed in the following references:
  - JCAHO IC.4.10
  - JCAHO EC.5.50
  - AORN Recommended Practice for Environmental Cleaning in the Surgical Practice Setting.
- Life Safety Code issues:
  - OR is a suite of rooms and the recommendation regarding the storage in the exit corridor is not applicable to a suite of rooms per the Life Safety Code.
  - The SHRED bins (for patient specific information to be destroyed) appear to be over the 32 gallon volume limitations allowed by the Life Safety Code.
  - Roller latches observed on some corridor doors.
- Operating Room G:
  - Operating room converted to storage for both sterile and non-sterile items.
  - Floor tiles cracked.
  - Walls and baseboard damaged and with missing tiles.
  - Wood shelving delaminating and musty smelling.
  - Abandoned sink and utilities neither covered not removed.
  - Non-functional OR lights remain in place.
  - Broken ceiling tiles.
  - Fluorescent light tubes without covers.

Perioperative Services > Operating Room – Intraoperative Care / Environment

Assessment

- Inner Core:
  - Sterile storage in common passageway.
  - Wood shelving and doors delaminating.
  - Rubber base throughout.
  - Surgical tape and labels on walls and carts.
  - Drain stopped up in surgical scrub sink.
  - Rust on carts and medical equipment.
  - Cork bulletin boards.
  - Steris area with hose on faucet without a vacuum breaker.
- Room 2A-14 Outpatient Waiting:
  - Records with patient specific information in unlocked closet.
  - Chairs with torn cushions.
  - Miscellaneous storage in room.
- Lack of security apparent in both the OR and PAR, with poorly secured doors and minimal traffic control.

Deficiencies

- Overall condition of the OR area is sub-standard.

Perioperative Services > Operating Room – Intraoperative Care / Environment

Recommendations

3.4.29 Correct Perioperative Services environment.

3.4.30 Consider closing three ORs and renovating the remaining three.

Perioperative Services > Operating Room – Intraoperative Care / Materials Management

Assessment

- Surgeons' buy-in and participation in cost containment effort describes as minimal, due to a perception by some surgeon that the decisions are already made.
- Perioperative leadership perceive product changes made at LA County level with no concern for acceptance at the hospital level.
- Need to establish par level in all areas.
- Supply areas and operating rooms packed with excessive inventory, yet key items, such as mask, not readily available.
- Office for materials management staff in OR houses huge stack of invoices, requisitions, vendor books, and other items that confound speedy resolution and problem solving.
- Majority of sutures purchased from US Surgical but significant confusion over how to re-order.
- Orthopedic implants provided by limitless vendors.
  - All orthopedic supplies, including expensive implants, in disarray with sterile mixed with non sterile item.
- Paper-based preference card with no plan to automate until ORSOS updates are in place.
  - Surgeons report preference card chronically incorrect, resulting in waste and delay.

Perioperative Services > Operating Room – Intraoperative Care / Materials Management

Assessment

- Some surgeons reported that the circulator is always out of the room hunting for something.
- Case cart assembly begins in central processing, where sterile supplies are stored with cardboard boxes taken directly from the loading dock.

Deficiencies

- Value analysis processed for products selection not utilized.
- Excess supplies with minimum use of par levels.
- Sterile and non-sterile supply stored together.
- Cardboard boxes and materials from loading dock mixed with sterile items.

Recommendations

3.4.31 Update preference card and prepare for automation.

3.4.32 Establish par levels.

3.4.33 Ensure maximum number of items are on consignment.

3.4.34 Establish performance expectations for materials management personnel and OR.

Perioperative Services > Operating Room

Performance Measures

- OR suite utilization
  - Current 26%
  - Target 70%
- TOT
  - Current 29 min
  - Target 15 - 20 min average (reflects case complexity)
- Percentage of on time first case starts
  - Current 52%
  - Target 95%
- Occurrence of adverse events
  - Current not currently measured
  - Target 0
  - Adverse events include, but are not limited to:
    - Wrong site – wrong procedure.
    - Unscheduled return to the OR.
    - Postoperative infection.
    - Inaccurate instrument and sharp counts, resulting in unintentional retained objects.
    - Lost or mislabeled specimens.

Perioperative Services > Operating Room

Performance Measures

- Percentage of cases with an operative progress note entered into medical record immediately after a procedure.
  - Current not currently collected
  - Target 100%
- OR Productivity: Worked hours per case hour
  - Current not currently collected
  - Target TBD
- OR overtime as a percentage of worked hours
  - Current not currently collected
  - Target 2.00

Responsibility

- Medical Director
- CNO

Assessment

- All surgical outpatients, regardless of ASA classification, required to make in-person visit.
  - Mandatory visit described as burdensome and insensitive for patients who must miss work and depend on public transportation.
  - 1/22/05: Per Interim Chair, Anesthesia, some outpatients may bypass OSA, including:
    - Urgent and emergent outpatients
    - Vascular access for end stage renal patients
- Lack of communication between anesthesiologists cited as evidence of the irrelevance of OSA.
  - Attending anesthesiologist frequently cancels case the morning of surgery, despite clearance by OSA anesthesiologist.
- Current services provided in two locations (2A -15 and 3G) that are cramped, unclean and compromise HIPAA expectations.
  - Currently under Perioperative Nursing administration, leading to inefficiency.
  - Minimum preoperative testing guidelines reported as rarely used, resulting in confusion on the morning of surgery.

Perioperative Services > Outpatient Surgery Anesthesia

Deficiencies

- Lack of criteria for in-person OSA visits.
- All aspects of OSA area inadequate and unacceptable.

Recommendation

3.4.35 Relocate OSA to 3B.

Perioperative Services > Outpatient Surgery Anesthesia

Performance Measures

- Percentage of elective patient charts with a completed history and physical not less than 24 hours prior to day of surgery.
  - Current not currently collected
  - Target 95%
- Percentage of elective patient charts (with all completed preoperative documentation) reviewed prior to day of surgery
  - Current not currently collected
  - Target 95%

Responsibility

- CNO

Perioperative Services > Post Anesthesia Recovery

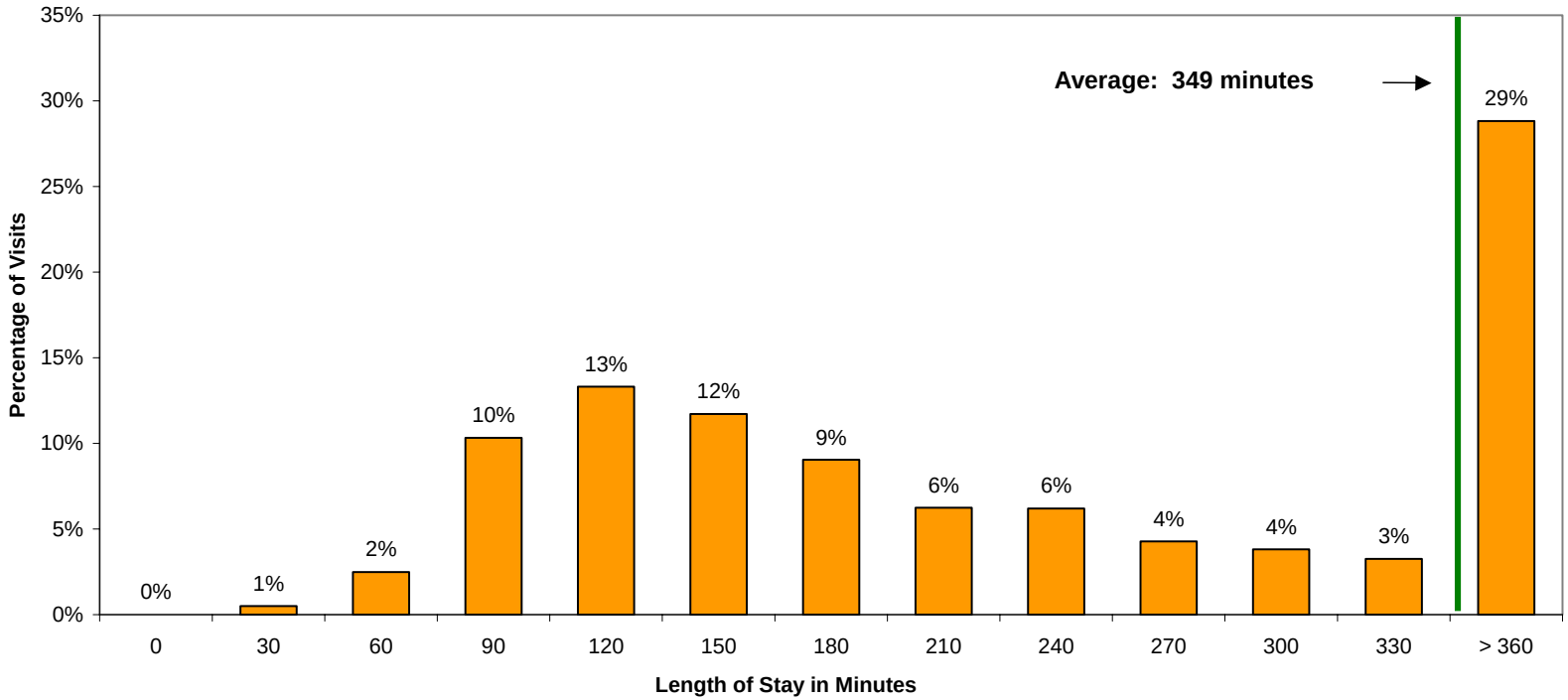
Assessment

- Unit cares for both pre and post surgical patients, including Phase II.
  - Six preoperative bays
  - Eleven postoperative bays
- Post Anesthesia Recovery (PAR) manager estimated one-third of all PAR patients admitted to unit intubated.
- Per Director of Perioperative Services, PAR discharge by anesthesia sign-off only.
  - Anesthesia provides Medical Director for this area.
  - Discharge delays due to anesthesia described as minimal.
- Aldrete scoring system used by PAR nurses to identify when an anesthesiologist is needed to review patient for discharge.
- PAR Manager stated PAR admission or discharge criteria non-existent.
- PAR reported as frequently serving as the de facto ICU.
- PAR overall appearance cluttered and noisy.
- Average LOS is 349 minutes, with 73% of all PAR visits over 120 minutes, maximum leading practice target.
- No patient data captured electronically.
- PAR patients may wait for up to 8 hours or overnight for a surgical bed, 24 -36 hours for an ICU bed.

Perioperative Services > Post Anesthesia Recovery

Assessment

PAR Length of Stay (LOS) Distribution
March 1, 2004 - September 30, 2004



- Current Performance: 73% of PACU visits have LOS > 120 minutes
- Target Performance: LOS does not exceed 90-120 minutes

Note: 2178 of 2377 visits analyzed

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Perioperative Services > Post Anesthesia Recovery

Assessment

- PAR manager estimated there are three to five overnight boarders in PAR weekly, due to lack of beds and patient condition.
- Variance in practice among anesthesiologists yields variance of LOS for like procedures.
- Estimated one-third of patients enter the PAR intubated – leading practice reflects extubation occurs in OR.

Deficiencies

- Prolonged LOS.
- Overnight stays.
- Intubated patients routine in PAR.

Recommendations

3.4.36 Capture PAR data electronically.

3.4.37 Compose and use PAR admission and discharge criteria.

3.4.38 Review practice variance in anesthesia and develop a plan of correction.

Perioperative Services > Post Anesthesia Recovery

Performance Measures

- PAR length of stay
  - Current 349 minutes
  - Target 90 – 120 minutes
- Percentage of patients admitted to PAR intubated
  - Current not currently collected, estimated to be 33%
  - Target < 2% total patients
- Percentage of patients who meet PAR admission criteria
  - Current not currently collected
  - Target 100%
- Percentage of patients who meet PAR discharge criteria before transfer to next LOC
  - Current not currently collected
  - Target 100%
- PAR Productivity: Worked hours per patient
  - Current not currently collected
  - Target TBD

Perioperative Services > Post Anesthesia Recovery

Responsibility

- CNO

Perioperative Services > Cath Lab

Assessment

- Digital bilateral Cath Labs, newest in LA County system.
- Department clean and well organized.
  - Staff spoke with pride of new unit and state-of-the-art equipment.
- Cinefilm still in use, consuming approximately 15 frames per second.
- Scope of service limited to diagnostic procedures and insertion of permanent pacemakers.
- Patients receive local sedation, monitored by staff RN.
  - Intervention by anesthesiologist rare.
- One team, comprised of a staff RN and a vascular technician, assigned to cases.
  - Team is not floated to other areas when there are no Cath Lab cases.
- Staff for two angio labs, located across the hallway, is separate from cath lab.
- Following removal of sheath, 15 minutes of direct pressure is applied for hemostatis, followed by up to six hours of sandbag pressure.
- Patients represent both inpatient and outpatient, who are frequently a same day admit, to ensure there is no post procedure bleeding.
- No weekend staffing or call requirements.

Perioperative Services > Cath Lab

Assessment

- NCI model considers the entire case volume and case hours, regardless of day or time case was completed, accomplished within available hours.
  - 52 weeks of case hours/50 weeks of available hours (to account for holidays).
- Current utilization suggests the capacity and staffing for approximately 641 additional cases, given the current available hours and staffing.

119	Total Cath Lab procedure volume
297	Total Cath Lab procedure hours
2.50	Average procedure length (hours)
150	Average procedure length (min)
2,000	Current available hours
396	Target available hours at 75% utilization
1,604	Excess available hours
641	Potential additional procedures (150 min in length)

Perioperative Services > Cath Lab

Assessment

- Suite Utilization, without TOT
  - Overall 15%
  - NCI Target 75%

Cath Lab						
week day	days	rooms open	hour open	hour close	hours available	hours per week
M-F	5	1	8:00 AM	4:00 PM	8.00	40.00
total hours per week						40.00
total hours per week * 50 weeks						**2,000**

297	total procedure hours
2,000	total available hours
15%	**overall utilization**

Source: Vidya Kaushik MD, Cardiology
Timeframe: January 1, 2004 - September 30, 2004 annualized.
Notes: Actual case length note measured. Per Dr. Kaushik, average case length including case length is 2.5 hours.

Deficiency

- Excess available hours given current volume.

Recommendations

3.4.39 Reduce available hours.

Perioperative Services > Cath Lab

Performance Measures

- Cath lab suite utilization
  - Current 15%
  - Target 75%
- Occurrence of adverse events
  - Current 0 (2004 YTD)
  - Target 0
  - Adverse events include, but are not limited to, the following:
    - Emergent surgical intervention
    - Postoperative infection
- Cath Lab Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD

Responsibility

- CNO

Perioperative Services > GI Lab

Assessment

- All patients referred to GI Lab Clinic via a consult.
- GI Lab attends to the entire spectrum of patient needs, from pre to post procedure care, all within the room where the procedure occurs.
  - Patient recovery period may be several hours in the procedure room, preventing the completion of other procedures to follow.
  - Backlog of patients suggest need to improve patient throughput and use procedure rooms for procedures – not recovery bays.
- GI Lab environment extraordinarily cramped, with inadequate space for the most essential items.
- Family members accompany patient pre and post procedure; and are subjected to all the challenging elements of a GI procedure room.
- All cases routinely staffed with two RNs, one to monitor conscious sedation and the other to provide assistance to physician, as needed.
- Additional patients could receive needed interventions if patients were not recovered in the GI procedure room.
- Custom ultrasonics scope washer and disinfector provides state-of-the-art cleaning.
  - Two scopes may be processed simultaneously in the 45 minute cycle.
  - Cidex OPA used, with daily testing, per manufacturer's direction.

Perioperative Services > GI Lab

Assessment

- Suite Utilization, without TOT
  - Overall 76%
  - NCI Target 75%
- Current utilization suggests available hours inadequate for procedure volume, as well as additional procedures.
- The procedure hours capture the period of scope-in to scope-out only – not the pre and post care that also occurs in the procedure room.

GI Lab						
week day	days	rooms open	hour open	hour close	hours available	hours per week
M,T,W	3	2	8:00 AM	4:30 PM	8.50	51.00
H,F	2	2	8:00 AM	12:00 PM	4.00	16.00
total hours per week						67.00
total hours per week * 50 weeks						**3,350**

2,549	total procedure hours
3,350	total available hours
76%	**overall utilization**

Source: D. Akerele, Manager
Timeframe: January 1, 2004 - September 30, 2004 annualized.
Notes: Procedure minutes = scope in to scope out.
Procedures minutes based on average case length by procedure.
Rooms: 1 & 2

Perioperative Services > GI Lab

Deficiencies

- GI Lab environment and patient care areas sub-committee.
- HIPAA compliance compromised as continual traffic from dermatology clinic patients passes both of the GI Lab procedure rooms occupied with patients. GI Lab patients must also use this narrow public hallway to go to the rest-room, passing other patients and their families.
- Patients recovered in procedure room.
- Gross debris on scopes removed in sink that is also used for hand washing.

Recommendations

3.4.40 Relocate GI Lab immediately to vacant or soon to be vacant unit.

Perioperative Services > GI Lab

Performance Measures

- Suite Utilization
  - Current 76%
  - Target 75%
- Occurrence of Adverse Events
  - Current not currently collected
  - Target 0
  - Adverse Events include, but are not limited to:
    - Perforation
    - Postoperative infection
    - Incomplete/inadequate scope processing
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD

Responsibility

- CNO

Perioperative Services > Cystoscopy

Assessment

- Cystoscopy procedures accomplished with moderate or local sedation, monitored by RN.
- Overall environment of procedure rooms sub-standard.
  - Grouted tile floor rather than sheet flooring.
  - Poisons and cleaning products stored with sterile supplies.
  - Laminate covering broken, revealing wooden shelving.
  - Cysto table drain appeared dirty and dust covered .
- Suite Utilization, without TOT
  - Overall 33%
  - NCI Target 75%

Cystoscopy						
week day	days	rooms open	hour open	hour close	hours available	hours per week
M-F	5	1	8:00 AM	4:30 PM	8.50	42.50
total hours per week						42.50
total hours per week * 50 weeks						**2,125**

701	total case hours
2,125	total available hours
33%	**overall utilization**

Source: ORSOS Download, Mary Villaflora, Medical Staff Coordinator.
Timeframe: January 1, 2004 - September 30, 2004 annualized.
Notes: **1/22/05 Per Dr. Datta, 657 procedures completed during this period.**
Rooms 3G-7 & 3G-9

Perioperative Services > Cystoscopy

Assessment

- NCI model considers the entire case volume and case hours, regardless of day or time case was completed, accomplished within available hours.
  - 52 weeks of case hours/50 weeks of available hours (to account for holidays).
- Current utilization suggests the capacity and staffing for approximately 1,488 additional cases, given the current available hours and staffing.

218	Total Cystoscopy procedure volume
272	Total Cystoscopy procedure hours
1	Average procedure length (hour)
48	Average procedure length (min)
2,125	Current available hours
388	Target available hours at 70% utilization
1,737	Excess available hours
2,165	Potential additional procedures (48 min in length)

Perioperative Services > Cystoscopy

Deficiencies

- Substandard cystoscopy suites that would require extensive renovation.
- Current volume of procedures do not warrant an area segregated from the operating room.

Recommendation

3.4.41 Renovate existing space, either in the operating room or cystoscopy suite, to accomplish cystoscopy volume.

Perioperative Services > Cystoscopy

Performance Measures

- Occurrence of Adverse Events
  - Current not currently collected
  - Target 0
  - Adverse Events include, but are not limited to, the following:
    - Perforation
    - Postoperative infection
    - Incomplete/inadequate scope processing

Responsibility

- CNO

Perioperative Services > Central Sterile

Assessment

- Instrument sets reported as frequently incorrect and incomplete.
  - Thoracic surgery keeps most specialized instrument sets, including bronchoscope, in own department for safekeeping.
- No performance expectations for staff as to how long it should take to assemble an instrument set
- At 10:00 AM, no less than 20 instrument sets were stacked on top of each other, awaiting assembly.
  - Delicate instruments did not appear protected.
  - Sets were used the day before or on the night shift.
- Contaminated instruments are picked up by central sterile two to three times a day.
  - These instrument sets remain in the hallway in the OR, covered only with a plastic bag.
  - Instruments are not in water or an enzyme product to prevent blood and tissue drying on the instruments.
- Extra instruments stored on pegboards in central sterile were soiled and stained.
  - No less than 50 individual instruments were suspected of having dried blood or rust on them, and were pulled for reprocessing only when cleanliness was challenged.
- Cart washer in place, but reported as broken, then described as, never has been used.
  - Detergent vessels appeared to hold fresh product, despite this report.

Perioperative Services > Central Sterile

Assessment

- Instrument sets appear heavy with excess instrumentation.
  - Genesis provides the following guidelines for full containers:
    - Full size containers 19 pounds of instruments.
    - Mid size containers 16 pounds of instruments.
    - Half size containers 13 pounds of instruments.

Deficiencies

- Contaminated instruments held in OR hallway for hours.
- No performance expectations to expedite instrument set turnaround.
- Soiled instruments stored with clean instruments.
- No provision to wash instrument carts.
- Trays exceeding acceptable weight limits.

Recommendations

3.4.42 Process instrument sets promptly and do not store contaminated items in hallway.

3.4.43 Set performance expectations for set completion and instrument inspection.

3.4.44 Compose plan to standardize instrument sets and ensure trays do not exceed weight.

Perioperative Services > Central Sterile

Performance Measures

- Inaccurate/incomplete instrument set composition
  - Current not currently collected
  - Target < 5 %
- Complete sterilization logs and related documentation
  - Current Unknown (the volume of logs precluded NCI validation)
  - Target 100%
- Productivity: Worked hours per adjusted discharge
  - Current not currently measured
  - Target TBD

Responsibility

- COO

Section IV – Medical Administration

NAVIGANT CONSULTING

Medical Administration > Interviews

• T. Yoshikawa, MD	Chair IM
• R. Peeks, MD	Medical Director
• F. Rutherford, MD	Assistant Medical Director
• M. Villaflor	Coordinator Medical Staff Affairs
• L. Knight, MD	Director Quality and Performance Improvement
• E. Bradley	Manager, Risk Management
• P. Rodriquez	Nursing Quality
• M. Willock, MD	Dean, Drew Medical School
• R. Edelstein, MD	Associate Dean, Drew Medical School
• K. Lewis, MD	Vice-Chair Anaesthesia, Director OR
• J. Jahr,MD	Acting Chair, Anesthesia
• G. Mallory, MD	Acting Chair, Psychiatry
• G. Gil, MD	Chair ENT
• G. Locke,MD	Chair, Neuroscience
• X. Bean, MD	Director Neonatology
• R. Hassan,MD	Vice-Chair OB/GYN, Director Women's Health Clinic
• L. Makim, MD	Acting Medical Director HHH Clinic
• L. Akhanjee, MD	Chair, Family Practice

Medical Administration > Interviews

• L. Robinson, MD	Chair, Pediatrics
• N. Datta, MD	Acting Chair, Surgery
• T. Fukushima,MD	Chair, OB/GYN
• E. Hardin, MD	Chair, Emergency Medicine
• H. Mohamed,MD	Chair, Pathology
• M. Sutjita, MD	Program Director, Infection Control
• J. Miller, MD	Program Director, Occupational Medicine
• S. Balasubramaniam, MD	Program Director, CME
• S. Viejo	Value Management
• D. Runke	Interim CEO
• F. Leaf	DHS COO
• A. Kapstrom, MD	Director, CRM
• L. Sharff	Quality Director, LA DHS
• J. Gutterman, MD	AMD, LADHS
• R. Casey, MD	Chair, Ophthalmology
• J. McQuirter, MD	Chair OMFS
• S. Ashley, MD	Director, GME programs
• R. Scott, MD	President, PSA

Medical Administration > Interviews

• V. Payne, MD	Acting Chair, Radiology
• D. Sanders, MD	Acting Chair, Orthopedics
• B. Franzreb	Medical Administration, Legal Affairs
• R. Mohrmann, MD	Pathologist
• B. Yee, MD	Pathologist
• L. Wand, MD	Pathologist
• J. Pachciarz, MD	Pathologist
• I. Tofler, MD	Psychiatrist
• R. Zokevitch, MD	Psychiatry
• P. Meade, MD	Director, Surgical ICU
• K. Arfai, MD	Chief Resident, Anesthesia
• A. Turner, MD	Radiology
• G. Nails, MD	IM Resident
• C. Nalls	Administrator, Ambulatory Care
• P. Packwood	COS, Director, LA Department of Health Services

Medical Administration > Prioritized Summary of Recommendations

Medical Administration – Clinical Practice Observations		
Short-term	4.3.01	Develop a clinical vision for KDMC which prioritizes patient care and service, and addresses the priority clinical needs of the local population.
Long-term	4.3.02	Implement an on-going clinical planning process to structure scope of services, clinical faculty expertise and clinical program development to achieve the vision.
Intermediate	4.3.03	Ensure adequate available clinical time to provide efficient, effective clinical care in all specialty areas.
Intermediate	4.3.04	Evaluate existing clinical capabilities and address concerns and/or gaps, e.g., immediate need for: intensivist coverage of all ICU patients; 24/7 ICU bed triage “czar”; after hours attending coverage for codes; cardiology on-call EKG review capability, etc.
Long-term	4.3.05	Recruit as indicated talented clinical staff to provide needed added service scope. Recruitment may be more effective if undertaken jointly with local academic partner program(s) in which case affiliation arrangements should be pursued.
Intermediate	4.3.06	Create effective practice support systems.
Long-term	4.3.07	Support development of a faculty practice plan to facilitate faculty recruitment.
Medical Staff Management		
Intermediate	4.5.01	Clarify the Medical Director role as responsible for overseeing the clinical practice at KDMC, eliminating direct reporting relationship to Dean of Drew Medical School but maintaining a strong (dotted line) collaborative interface with Drew.
Short-term	4.5.02	Work with the County to resolve the outstanding MD and AHP personnel issues and to develop a streamlined, effective process for resolving all MD personnel issues.
Urgent	4.5.03	Clean out office occupied by the former Associate Medial Director and allocate to two new Associate Medical Directors: AMD, Medical Staff Affairs and AMD UM and Clinical Programs.
Urgent	4.5.04	Streamline Medical Staff Management with formal and specific delegation to facilitate more effective management with clear responsibility areas.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Medical Administration > Prioritized Summary of Recommendations

Medical Staff Management		
Intermediate	4.5.05	Identify a limited clinical role for the Medical Director to enhance credibility and professional satisfaction; initially this might most appropriately relate to a role in UM given the challenges facing the facility currently.
Urgent	4.5.06	Develop/implement intensive Medical Director mentoring/professional development program; closely monitor.
Short-term	4.5.07	Manage to clear goals/objectives for remainder of the year; prioritization in context of institutional priorities, timelines and deliverables. Added significant projects or tasks would be negotiated to adjust established goals and objectives/deliverables.
Short-term	4.5.08	Conduct Medical Director performance review approximately 2/05 in context of interim goals developed 12/04.
Urgent	4.5.09	Create two Associate Medical Director positions – AMD for Medical Staff Affairs and AMD for UM and Clinical Programs.
Urgent	4.5.10	Define responsibilities for AMD Medical Staff Affairs.
Intermediate	4.5.11	Configure the following positions/programs to report to AMD for Medical Staff Affairs: Peer Review, MD Program Directors for Medical Education, Infection Control, and Occupational Medicine, and the GME Program Director.
Short-term	4.5.12	Remove supervision for OR scheduling from Medical Staff Coordinator and transition to the OR.
Urgent	4.5.13	Define responsibilities for the AMD UM and Clinical Programs to include CRM and PI/Quality, including RM.
Urgent	4.5.14	Configure the following positions/programs reporting to AMD for UM and Clinical Programs: MODs, Assistant Medical Director for Patient Safety, and two Directors – Director for CRM and Director for Performance Improvement.
Urgent	4.5.15	Eliminate current county CRM physician leader role, incorporating functions into the AMD for UM and Clinical Programs role.
Short-term	4.5.16	Identify strong candidates for these two AMD roles and fill. Current AMD should fill AMD Medical Staff Affairs role.
Intermediate	4.5.17	Create AMD for Medical Safety role to report to AMD for UM and Clinical Programs with responsibility for facilitating medical staff engagement, participation in, and leadership of patient safety initiatives.
Urgent	4.5.18	Define MOD role to include Physician Advisor responsibility for UM to work daily with Case Managers and Social Workers actively intervening with physicians to enhance care coordination. Charge role with responsibility of “clinical triage czar” to triage

Medical Administration > Prioritized Summary of Recommendations

Medical Staff Management		
Urgent	4.5.19	Appoint one or more individuals to fill the MOD role – more than one splitting the responsibility would seem preferable to ensure coverage. Some coverage to be provided by the additional AMD and Medical Director.
Intermediate	4.5.20	Recruit two experienced Directors to report to the AMD for UM and Clinical Programs: a Director of CRM and a Director of PI.
Urgent	4.5.21	Consolidate Case Management Social Service, and Bed Management and CRM staff" in a CRM department reporting to the Director of CRM. Insure data capability to support UM activities.
Urgent	4.5.22	Consolidate Quality, Medical Legal Affairs, and RM staff into a Quality department reporting to the Director of PI.
Intermediate	4.5.23	Define Chair and Division Chief goals and objectives, performance expectations, etc.
Intermediate	4.5.24	Identify clinical practice medical director or vice-chair to formally in each clinical department to oversee departmental clinical practice program – or chair can cover this role, which must include clear prioritization of efficient/effective clinical practice.
Intermediate	4.5.25	Develop a prioritization and timeline for recruitment of permanent chairs for 7 departments with Acting Chairs. Actively intervene and coordinate recruitment efforts with Drew to meet established timeline goals IT.
Intermediate	4.5.26	Streamline Surgical service management. Develop Director of Surgical Specialties role. Part-time (~.25 FTE), reporting to Medical Director and responsible for Chairs of Departments of Surgery, Ophthalmology, Orthopedics, OMFS, and ENT. Recruit to fill position.
Intermediate	4.5.27	Eliminate current OR Director role, and vest physician leadership responsibility for OR functioning in the Director of Surgical Specialties in collaboration with Chairs of Anesthesia, Neuroscience, and ObGyn.
Long-term	4.5.28	If/when there is a leadership transition, consider subdividing Neurosciences department, incorporating Neurology within IM, and Neurosurgery within the Surgical Specialties.
Intermediate	4.5.29	Assess Clinic (HHH & Dollarhide) Medical Director role and fill permanently
Short-term	4.5.30	Create Administrator Clinical Programs position, reporting to/partnering with Medical Director to oversee operational activities within clinical departments; transition this responsibility from COO area, but maintain dotted line relationship with the COO.

Medical Administration > Prioritized Summary of Recommendations

Medical Staff Management		
Intermediate	4.5.31	Organize accountabilities so clinical department directors (excluding ancillary departments – lab and radiology), while reporting to Chairs, have matrixed accountability to and oversite by Administrator Clinical Programs.
Intermediate	4.5.32	Review medical program director roles; consolidate/eliminate; develop/implement goals/objectives, timelines, accountabilities, etc.
Long-term	4.5.33	Consider development of additional program medical director roles as indicated by clinical or systems needs with small allocations of administrative time.
Intermediate	4.5.34	Reorganize Infection Control staff to report to the CNO, maintaining Medical Director role in an advisory capacity, reporting to the AMD UM and Clinical Programs.
Intermediate	4.5.35	Delegate reporting for the Program Director of Occupational Medicine to AMD for Medical Staff Affairs with a formal indirect reporting relationship with HR.
Short-term	4.5.36	Assign facilitation responsibility for each medical staff committee to a senior Medical Administration executive to ensure that agendas and committee process address priority items, follow-up and implementation is accomplished.
Intermediate	4.5.37	Assign single ICU director for each ICU with clear accountability for clinical oversite of unit, reporting via respective Department Chair to Medical Director.
Intermediate	4.5.38	Address critical clinical program gaps. Strongly consider implementation of remote ICU monitoring program to better ensure consistent high quality MD and RN intensivist coverage to supplement the on-site clinicians; Relocate PICU to better space.

Medical Administration > Prioritized Summary of Recommendations

Medical Staff Office		
Short-term	4.6.01	Consolidate medical staff support functions, reporting to Medical Staff Coordinator, including the medical photography function, and the Medical Staff Affairs staff.
Intermediate	4.6.02	Consolidate administrative functions reporting to Administrator Clinical Programs, including I&R dorm administrator, and Medical Staff Office manager.
Urgent	4.6.03	Address all regulatory deficiencies in medical staff bylaws, rules and regulations, policies and committee function by 12/31/04, and ensure BOD approval at the January 2005 meeting.
Short-term	4.6.04	Integrate peer review reports and malpractice, risk management, disciplinary information into medical staff credentialing process and files.
Short-term	4.6.05	Investigate benchmarks regarding specialty-specific privileging and proctoring/supervision approaches; integrate into KDMC medical staff, and departmental P&Ps. Complete full review and definition by department by 3/1/05.
Intermediate	4.6.06	Develop/reliably maintain easily accessible, preferably on-line, data repository to catalog privileging and proctoring and supervision requirements for medical staff, AHPs and residents.
Long-term	4.6.07	Develop annual medical staff performance review process for employed physicians and incorporate performance information (quality, risk, utilization, profiles, colleague and staff feedback, patient satisfaction scores, disciplinary actions, citizenship).
Long-term	4.6.08	Develop similar review for Allied Health Professionals, including compliance with supervisory requirements by both the AHP and their supervising/responsible physician.
Long-term	4.6.09	Identify training/development opportunities for Coordinator of Medical Staff Affairs to learn best practices and develop benchmarking contacts.
Short-term	4.6.10	Provide access for Medical Staff Coordinator to pertinent regulatory requirements, i.e., JACHO.
Long-term	4.6.11	Develop support/coordination role (AMD for Medical Staff Affairs) for medical staff and AHP recruitment, orientation and ongoing “personnel” support and (non-departmental) CME programming.
Intermediate	4.6.12	Orchestrate systematic review of HR, credentialing, privileging, RM, and peer review files and any available profiling or other data for current clinical staff to ensure problematic issues have been addressed.
Intermediate	4.6.13	Obtain independent external peer review to review clinical performance in any areas of concern.
Long-term	4.6.14	Develop system to integrate peer review, risk, quality, profiling information with credentialing and privileging activities and with performance review/management activities for employed clinicians.

Medical Administration > Prioritized Summary of Recommendations

Credentialing and Privileging		
Short-term	4.7.01	Complete and implement bylaw and rules/regulations revisions to ensure regulatory compliance.
Intermediate	4.7.02	Integrate peer review, malpractice, risk, disciplinary actions and feedback into credentialing/privileging processes.
Intermediate	4.7.03	Develop/implement clear criteria for approving and/or denying/deferring credentials or privileges, and apply to Credentials Committee review of applications and MEC review of Credentialing Committee recommendations.
Intermediate	4.7.04	Ensure that medical staff, resident, and AHP privileging policies are in reasonable compliance/congruence with specialty board and/or professional society scope of training and/or practice and/or generally accepted clinical practice standards locally or nationally.
Intermediate	4.7.05	Ensure that AHP supervision policies/practice are in reasonable compliance/congruence with specialty board and/or professional society scope of training and/or practice and/or generally accepted clinical practice standards locally or nationally.
Intermediate	4.7.06	Ensure that resident/medical student supervision/privileging policies and practice are in reasonable compliance/congruence with specialty board and/or professional society scope of training and/or practice and/or generally accepted clinical practice standards locally or nationally.
Intermediate	4.7.07	Use incident reports, risk, peer review, quality data to flag reviews regarding credentials/ privileges and/or performance (employed clinical staff) as appropriate.
Long-term	4.7.08	Ensure that clinical documentation is in place to capture service/diagnosis coding to accurately populate profiling databases.

Medical Administration > Prioritized Summary of Recommendations

Policies and Procedures		
Short-term	4.8.01	Ensure modifications as required to comply with regulatory bodies are enacted and implemented expeditiously.
Intermediate	4.8.02	Develop and implement clear progressive disciplinary programs for non-compliance.
Long-term	4.8.03	Integrate with credentialing/privileging activities and performance evaluations of employed physicians and AHPs.
Long-term	4.8.04	Systematically monitor for compliance and opportunities for improvement via incident reporting, peer review, IOP processes.
Long-term	4.8.05	Develop systematic approaches for monitoring and identifying outliers, and intervening Periodic review of all personnel/peer review files for aggregated concerns.
Long-term	4.8.06	Create a culture of safety re reporting of clinical errors or questionable activities/behaviors.
Intermediate	4.8.07	Collect and analyze sentinel events, RM case, root cause analyses, clinical screens for adverse outcomes or complications and develop and implement.
Intermediate	4.8.08	Identify a clinical leader to champion/facilitate medical staff patient safety efforts.

Medical Administration > Prioritized Summary of Recommendations

Governance and Committees		
Urgent	4.9.01	Actively integrate management of medical staff issues by elected representatives (Medical Staff Officers) and hospital line managers (Medical Director, etc).
Intermediate	4.9.02	Support exploration and development of Faculty Practice Program, if financially feasible.
Intermediate	4.9.03	Implement clear hospital policies as applicable to medical staff, e.g., public relations policy precluding medical staff interactions with the press except as overseen and approved by hospital executive leadership.
Intermediate	4.9.04	Continue to refine and streamline medical staff committee structure, specifying committee reporting and medical administration executive liaison and matching meeting frequency to intensity of needed work effort.
Intermediate	4.9.05	Consider combining Provision of Care Committee with IOP Committee. Consider Patient Safety & Infection Control Committees as subcommittees reporting to IOP. Integrate committee recommendations with operations of clinical areas.
Intermediate	4.9.06	Link results of committee review and deliberations with other related functions, e.g., results of residency reviews linked with appropriate hospital committees to address issues.
Intermediate	4.9.07	Establish medical directors as chairs, liaisons, or members of key committees, e.g., peer review, UM, IOP.
Long-term	4.9.08	Include active Committee participation in citizenship components of physician performance evaluations.
Productivity		
Intermediate	4.10.01	Perform complete physician work force analysis to identify FTEs and funding currently allocated, and explicitly being used, to cover various physician activities: clinical, teaching, research, administration.
Intermediate	4.10.02	Evaluate contract and moonlighting FTEs and cost to provide clinical care.
Intermediate	4.10.03	Assess clinical needs in each department and match clinical staffing to demand, 24/7.
Long-term	4.10.04	Measure and report clinical productivity regularly, compared to national benchmarks by specialty.
Long-term	4.10.05	Consider development of an incentive compensation system to incentivize physician performance.

Medical Administration > Prioritized Summary of Recommendations

Teaching and Resident Supervision		
Intermediate	4.11.01	Assess accreditation status and outstanding citations of existing residency and fellowship programs; identify approaches to address program gaps within KDMC and/or in partnership or collaboration with other local facilities.
Intermediate	4.11.02	Explicitly analyze/define GME monies currently expended to support residency programs and available funding from federal and other sources.
Intermediate	4.11.03	Assess role/contribution by specialty of residency and fellowship training programs.
Long-term	4.11.04	Develop and implement a future strategy appropriate for each training program.
Intermediate	4.11.05	Consider joint program pilots with UCLA and/or USC to begin collaborative process.
Long-term	4.11.06	In collaboration with whatever medical school(s) are involved, recruit talented junior faculty to staff.
Long-term	4.11.07	Require Board eligibility and certification for new faculty.
Long-term	4.11.08	Evaluate existing faculty in the context of future program needs; develop modified roles or transition plans.
Intermediate	4.11.09	Develop strategies to effectively recruit high-quality residency candidates, including Drew Med school graduates.
Intermediate	4.11.10	Resolve operational issues currently plaguing residency programs.
Intermediate	4.11.11	Transition GME Office to Medical Administration, with Director reporting to AMD for Medical Staff Affairs at KDMC.
Urgent	4.11.12	Complete residency supervision protocols by specialty by year and implement consistently.
Intermediate	4.11.13	Integrate tracking of medical students and residents/resident rotators, including supervision status/requirements with systems for medical staff tracking, and make available to facility staff.
Short-term	4.11.14	Develop/implement reliable/consistent programs to orient rotating students/residents to policies and procedures.
Short-term	4.11.15	Develop and implement strategies to enhance resident recruitment in all programs.

Medical Administration > Prioritized Summary of Recommendations

Peer Review and Clinical Quality Process		
Long-term	4.12.01	Develop Director of Clinical PI role reporting to Medical Director for UM and Clinical Programs.
Long-term	4.12.02	Consolidate clinical RM, clinical quality, patient safety, clinical legal affairs, and IOP activities to report to this Director.
Intermediate	4.12.03	Consolidate RM and Clinical Legal affairs activities under supervision of a single manager.
Long-term	4.12.04	Establish more robust clinical quality program.
Long-term	4.12.05	Establish Quality priorities set by regulatory agency agendas for quality/safety, institutional and/or county priorities, case finding by sentinel events, root cause analyses, incident reports, indicator reporting and monitoring, credentialing reviews, etc.
Short-term	4.12.06	Define peer review and departmental quality programs.
Long-term	4.12.07	Appoint departmental peer review committees.
Intermediate	4.12.08	Institute initial case peer review by a designated departmental clinical case reviewer who may or may not be the department chair. Serious or unclear cases would then be referred to a peer review committee for review and recommendations.
Intermediate	4.12.09	Address recommendations related to an individual's performance with the individual by the department Chair and the Medical Director, with all identified issues addressed and fully resolved.
Intermediate	4.12.10	Refer systems recommendations for follow-up action to the departmental quality committee.

Medical Administration > Prioritized Summary of Recommendations

Peer Review and Clinical Quality Process		
Intermediate	4.12.11	Complete root cause analyses on untoward event occurs involving multiple staff and/or a complex multi-departmental process and should include all interested/involved parties, leadership from relevant departments, a risk manager, and a clinical quality staff.
Intermediate	4.12.12	Identify, track and communicate all recommendations from root cause analyses to the individual departmental leadership (specific individual interventions recommended) and/or the QI/safety/risk committees as appropriate (systems issues).
Long-term	4.12.13	Appoint ad-hoc root cause committees to expeditiously review sentinel events, deaths, clinical incidents, etc.
Long-term	4.12.14	Develop methodology to ensure follow-up occurs for issues identified by peer review and/or root cause analyses.
Long-term	4.12.15	Require board certification for Board eligibility and after five years, board certification is required of all newly credentialed physicians.
Long-term	4.12.16	Target physician recruitment and retention efforts to gaps in specialty coverage for medical programs, prioritized to meet the community medical needs. Clinical programs are added or expanded based on this prioritization, and assuming adequate clinical coverage.
Long-term	4.12.17	Address facility, equipment, and infrastructure requirements to meet basic standards of medical care and regulatory requirements with sustaining procedures implemented to ensure on-going maintenance, replacement and/or upgrading.

Section IV – Medical Administration

3. Clinical Practice Observations

Clinical Practice Observations

Assessment

- Many dedicated, hard-working clinicians on the KDMC staff are committed to serving the needs of the underserved populations in the surrounding communities.
- Systems and process inefficiencies and inadequacies routinely impede efforts to deliver quality, effective, and efficient care.
- A day-to-day tolerance/complacency/frustration/hopelessness regarding errors, oversights, inconvenience, and inadequacies has developed in the face of these unremitting challenges.
- A crisis approach to care is pervasive with irregular attention to health maintenance, preventive care, and/or non-emergent, urgent, or routine interventions.
- Service excellence and continuity of care are not routinely delivered.
- A commitment to medical education, an important cornerstone of the provision of care in this environment, supports the mission of the facility to contribute to the development of clinicians to serve underserved populations.
- Academic pursuits may cloud the development of and accountability for providing efficient, service-oriented clinical care.
- Prioritized allocation of time and energies for clinical care can be problematic.

Clinical Practice Observations

Assessment

- Quality and systems issues are managed in a crisis mode with the result that policies can multiply but real, substantive, sustained improvement often does not occur.
- Triage of critical resources, e.g., ICU beds, is fragmented, inefficient and perhaps to some extent politically driven.
- Some clinical programs to address population needs are well developed (e.g., diabetes), and others are minimal or absent (e.g., comprehensive primary care and palliative care).
- In a one-month period in the OR, 29% of scheduled surgeries did not happen. There has been a recent committee discussion of how to recall patients who had been sent home when their surgeries were cancelled, but the replacement urgent case did not materialize.
- In the pre-op screening area on a recent day, patients were arriving up to 1+ hours late for appointments, delayed by having to visit other clinical areas collecting pre-op data and forms.
- A resident was thrilled to have charts for approximately two-thirds of the clinic patients one afternoon – great, but very unusual for such a high percentage to be available.
- Routinely 9 -11% of inpatient days are denied for payment by payers because of lack of clinical indications for the designated LOC.

Clinical Practice Observations

Assessment

- 48% of all positive blood cultures during a recent month were contaminants.
- A tally showed 24,000 radiology reports awaiting finalization by attending signature (this has since been resolved).
- A fairly recent consultant report documented average ER LOS of 14 hours; 80% of this time was spent waiting for something (but not for beds or staff!).
- In July 2004, 23% of the time blood type and cross was not ready when the patient was ready for surgery (benchmark is <5%).
- There are approximately two to three misidentifications/month for surgical patients; re: medical record numbers (MRNs).
- In a QI meeting there was discussion of patients becoming dizzy while waiting for prescriptions at the outpatient pharmacy – the problem, “no space for chairs for the waiting patients to sit” (versus improving processes to minimize waits).
- Outpatients routinely sit on the floor in some areas waiting for appointments.

Clinical Practice Observations

Deficiencies

- Care programs at KDMC fail to address substantive healthcare needs of the local community.
- Competing academic agendas without robust explicit resource allocation de-prioritize clinical care.
- Operational systems are substantively broken leading to inefficient, ineffective, chaotic care delivery.

Recommendations

4.3.01 Develop a clinical vision for KDMC which prioritizes patient care and service, and addresses the priority clinical needs of the local population – See Programs and Services, Section XI.

4.3.02 Implement an on-going clinical planning process to structure scope of services, clinical faculty expertise and clinical program development to achieve the vision.

4.3.03 Ensure adequate available clinical time to provide efficient, effective clinical care in all specialty areas.

Clinical Practice Observations

Recommendations

4.3.04 Evaluate existing clinical capabilities and address concerns and/or gaps. e.g., immediate need for: intensivist coverage of all ICU patients; 24/7 ICU bed triage “czar”; after hours attending coverage for codes; cardiology on-call EKG review capability, palliative care program, and urgent need for permanent department hairs in multiple departments.

4.3.05 Recruit as indicated talented clinical staff to provide needed added service scope.

- Recruitment may be more effective if undertaken jointly with local academic partner program(s) in which case affiliation arrangements should be pursued.
- Dedicated HR resource to assist with recruitment, especially contract and coverage physicians.

4.3.06 Create effective practice support systems:

- Prioritize remediation of infrastructure, systems and process issues: scheduling, throughput, results reporting, medical record availability.
- Develop effective clinical quality, risk management, and safety programs, creating a high-reliability system: QI plan and program, peer review, sentinel event and incident reporting, and effective root cause analysis.
- Reconfigure Clinical Resource Management functions into a single cohesive department including bed management oversight and proactive care and discharge planning.

4.30.7 Support development of a faculty practice plan to facilitate faculty recruitment.

Section IV – Medical Administration

5. Medical Staff Management

NAVIGANT CONSULTING

Medical Staff Management

Assessment

- The KDMC Medical Director reports to both the KDMC CEO and the Drew Medical School Dean; time and salary split is approximately 55/45.
- The Medical Director position is 100% administrative though the Medical Director would like to free up some time for limited clinical practice.
- The Medical Director has general goals and a generic “county” job description. To date (11 months tenure), no reviews, position-specific goal development, organized progress monitoring, or professional development discussions have occurred.
- There is no coordination between the two major components of the Medical Director role, and a significant percentage of time is spent fire-fighting, and responding to external missives and policy/info requests.
- In total, the Medical Director has 25-30 direct reports.
- An Assistant Medical Director (an Oral Surgeon) is also essentially 100% administrative; reports to the Medical Director and is responsible for trouble shooting clinical and utilization problems, Medical Staff issue resolution, and credentialing oversight.

Medical Staff Management

Assessment

- Three physicians rotate responsibilities as MOD and are variably effective in orchestrating patients' disposition. Responsibilities and accountabilities for this role are vague, as is time commitment, coverage times, and key interfaces. It is not clear whether this is a paid role or part of the base compensation for these physicians.
- Another full-time Medical Director is responsible for CRM, working with a masters prepared nurse administrator. This is a County sponsored role, matrixed to the KDMC Medical Director with responsibility for implementing County-wide clinical protocols and order sets. Formal CRM program implementation is in process, but slow.
- The chairs and several Program Medical Directors report to the Medical Director, as do Medical Staff Affairs and Risk Management, though not Case Management/ Social Service or Clinical Quality.
- The chairs, though formally reporting through the Medical Director to the Medical School Dean, are held directly accountable by the Dean with significant direct communication and decision making, often apparently by-passing the Medical Director.
- The Chairs, Medical Directors and Program Medical Directors all apparently lack formal detailed role descriptions, goals and objectives, or progress monitoring. Similarly there is little to no formal managerial professional development.

Medical Staff Management

Assessment

- Though interested in clinical medicine and committed to providing quality care, the chairs seem to place more emphasis on academic endeavor (teaching, research, faculty academic achievement, residency and medical student training, niche clinical programs, etc.) than on the efficient, effective operation of the inpatient and outpatient clinical practices.
- Similarly, discussions of new clinical programs at times seem to be more motivated by enhancing academic endeavor than prioritizing based on the most prevalent clinical needs of the surrounding community.
- Significant number of Program Medical Directors, several of whom are currently directly responsible for operational program oversight, also reports to the Medical Director. The necessity and effectiveness of these roles is quite variable.
- A single oversight role for ICU triage, a critical facility and patient care resource is lacking.
- The Medical Director lacks an administrative partner to facilitate operational change in the departments.

Medical Staff Management

Deficiencies

- Medical Staff Management is organized inefficiently with too many direct reports to the Medical Director, and too little formal delegation and accountability.
- The dual reporting relationship with Drew Medical School dilutes and confuses the needed focus on hospital and clinical practice operations.
- Administrative support is lacking within medical administration.

Medical Staff Management

Recommendations

4.5.01 Clarify the Medical Director role as responsible for overseeing the clinical practice at KDMC, eliminating direct reporting relationship to Dean of Drew Medical School but maintaining a strong (dotted line) collaborative interface with Drew.

4.5.02 Work with the County to resolve the outstanding MD and AHP personnel issues and to develop a streamlined, effective process for resolving all MD personnel issues.

4.5.03 Clean out office occupied by the former Associate Medial Director and allocate to two new Associate Medical Directors: AMD, Medical Staff Affairs and AMD UM and Clinical Programs.

4.5.04 Streamline Medical Staff Management with formal and specific delegation to facilitate more effective management with clear responsibility areas.

4.5.05 Identify a limited clinical role for the Medical Director to enhance credibility and professional satisfaction; initially this might most appropriately relate to a role in UM given the challenges facing the facility currently.

4.5.06 Develop/implement intensive Medical Director mentoring/professional development program; closely monitor.

Medical Staff Management

Recommendations

4.5.07 Manage to clear goals/objectives for remainder of the year; prioritization in context of institutional priorities, timelines and deliverables. Added significant projects or tasks would be negotiated to adjust established goals and objectives/deliverables.

4.5.08 Conduct Medical Director performance review approximately 2/05 in context of interim goals developed 12/04.

4.5.09 Create two Associate Medical Director positions – AMD for Medical Staff Affairs and AMD for UM and Clinical Programs.

4.5.10 Define responsibilities for AMD Medical Staff Affairs.

4.5.11 Configure the following positions/programs to report to AMD for Medical Staff Affairs: Peer Review, MD Program Directors for Medical Education, Infection Control, and Occupational Medicine, and the GME Program Director.

4.5.12 Remove supervision for OR scheduling from Medical Staff Coordinator and transition to the OR.

4.5.13 Define responsibilities for the AMD UM and Clinical Programs to include CRM and PI/Quality, including RM.

Medical Staff Management

Recommendations

4.5.14 Configure the following positions/programs reporting to AMD for UM and Clinical Programs: MODs, Assistant Medical Director for Patient Safety, and two Directors – Director for CRM and Director for Performance Improvement.

4.5.15 Eliminate current county CRM physician leader role, incorporating functions into the AMD for UM and Clinical Programs role.

4.5.16 Identify strong candidates for these two AMD roles and fill ASAP. Current AMD should fill AMD Medical Staff Affairs role.

4.5.17 Create AMD for Medical Safety role to report to AMD for UM and Clinical Programs with responsibility for facilitating medical staff engagement, participation in, and leadership of patient safety initiatives.

4.5.18 Define MOD role to include Physician Advisor responsibility for UM to work daily with Case Managers and Social Workers actively intervening with physicians to enhance care coordination. Charge role with responsibility of "clinical triage czar" to triage.

4.5.19 Appoint one or more individuals to fill the MOD role – more than one splitting the responsibility would seem preferable to ensure coverage. Some coverage to be provided by the additional AMD and Medical Director.

Medical Staff Management

Recommendations

4.5.20 Recruit two experienced Directors to report to the AMD for UM and Clinical Programs: a Director of CRM and a Director of PI.

4.5.21 Consolidate Case Management Social Service, and Bed Management and CRM staff" in a CRM department reporting to the Director of CRM. Insure data capability to support UM activities.

4.5.22 Consolidate Quality, Medical Legal Affairs, and RM staff into a Quality department reporting to the Director of PI.

4.5.23 Define Chair and Division Chief goals and objectives, performance expectations, etc.

4.5.24 Identify clinical practice medical director or vice-chair to formally in each clinical department to oversee departmental clinical practice program – or chair can cover this role, which must include clear prioritization of efficient/effective clinical practice.

4.5.25 Develop a prioritization and timeline for recruitment of permanent chairs for 7 departments with Acting Chairs. Actively intervene and coordinate recruitment efforts with Drew to meet established timeline goals IT.

4.5.26 Streamline Surgical service management. Develop Director of Surgical Specialties role. Part-time (~.25 FTE), reporting to Medical Director and responsible for Chairs of Departments of Surgery, Ophthalmology, Orthopedics, OMFS, and ENT. Recruit to fill position.

Medical Staff Management

Recommendations

4.5.27 Eliminate current OR Director role, and vest physician leadership responsibility for OR functioning in the Director of Surgical Specialties in collaboration with Chairs of Anesthesia, Neuroscience, and ObGyn.

4.5.28 If/when there is a leadership transition, consider subdividing Neurosciences department, incorporating Neurology within IM, and Neurosurgery within the Surgical Specialties.

4.5.29 Assess Clinic (HHH & Dollarhide) Medical Director role and fill permanently

4.5.30 Create Administrator Clinical Programs position, reporting to/partnering with Medical Director to oversee operational activities within clinical departments; transition this responsibility from COO area, but maintain dotted line relationship with the COO.

4.5.31 Organize accountabilities so clinical department directors (excluding ancillary departments – lab and radiology), while reporting to Chairs, have matrixed accountability to and oversite by Administrator Clinical Programs.

4.5.32 Review medical program director roles; consolidate/eliminate; develop/implement goals/objectives, timelines, accountabilities, etc.

4.5.33 Consider development of additional program medical director roles as indicated by clinical or systems needs with small allocations of administrative time.

Medical Staff Management

Recommendations

4.5.34 Reorganize Infection Control staff to report to the CNO, maintaining Medical Director role in an advisory capacity, reporting to the AMD UM and Clinical Programs.

4.5.35 Delegate reporting for the Program Director of Occupational Medicine to AMD for Medical Staff Affairs with a formal indirect reporting relationship with HR.

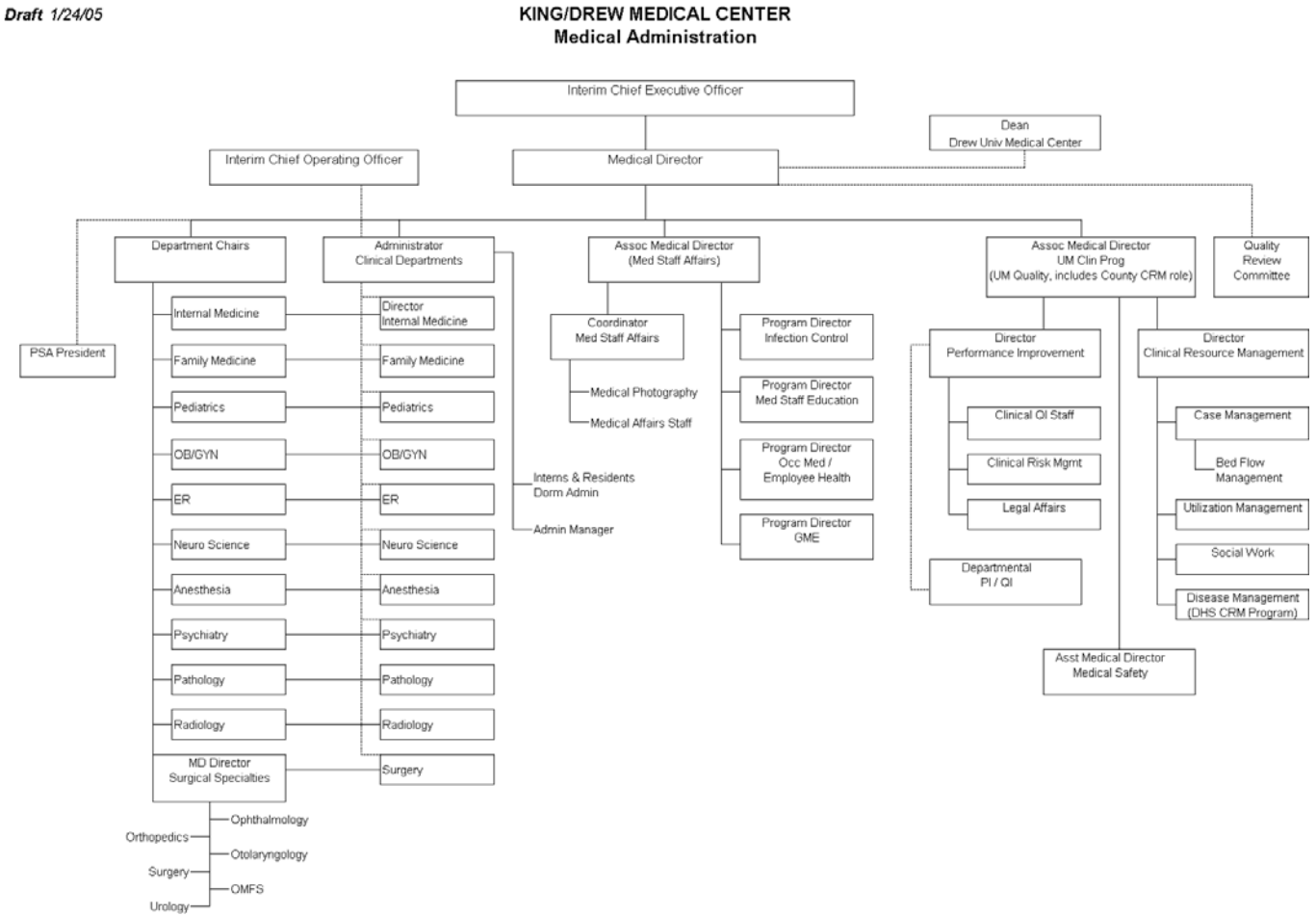
4.5.36 Assign facilitation responsibility for each medical staff committee to a senior Medical Administration executive to ensure that agendas and committee process address priority items, follow-up and implementation is accomplished.

4.5.37 Assign single ICU director for each ICU with clear accountability for clinical oversite of unit, reporting via respective Department Chair to Medical Director.

4.5.38 Address critical clinical program gaps. Strongly consider implementation of remote ICU monitoring program to better ensure consistent high quality MD and RN intensivist coverage to supplement the on-site clinicians; Relocate PICU to better space.

Medical Staff Management – Management/Structure

Proposed Organizational Chart: Medical Administration



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Medical Staff Management – Proposed Medical Staff Committee Liaisons

Draft *12/22/04*

KING/DREW MEDICAL CENTER
Medical Staff Committees Liaison

Administrative Liaison	Committee				
Medical Director	Bylaws	PSA	PSA Executive	OR Governance	ER Governance
AMD Med Staff Affairs	Physician Wellbeing	Credentials	Infection Control	CIDP	
AMD UM and Clin Prog	P&T	Ethics	ICU	Ambulatory Care	
Director CRM	UM	Blood Usage	Cancer / Tumor Board	Cardiac Arrest	
Director Performance Improvement	IOP	Provision of Care	Med Records	Disaster	
Asst Med Director, Medical Safety	Patient Safety	Medication Usage			

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Section IV – Medical Administration

6. Medical Staff Office

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Medical Staff Office

Assessment

- There is no link for ensuring that peer review, risk management or quality information is included in credentialing reviews.
- Little profiling data is collected to support credentialing/privileging decisions.
- Privileging information is not routinely readily available so that Nursing staff can access for procedure scheduling, or for proctoring (provisional staff), or supervision requirements (residents and applied health practitioners [AHPs]).
- AHP credentialing/privileging processes and procedures parallel those for Medical Staff, though specific scope of service criteria need clarification by specialty (in process), and required physician supervision is not clearly monitored.
- Individuals in this area report directly to the Medical Director; these responsibilities should be separated and reassigned as follows:
  - Medical Staff affairs, including credentialing/privileging, peer review, and PSA support.
  - Administrative, including admin support and dorm management.
  - Clinical quality, including clinical quality programs, risk management and medical legal affairs, streamlining managerial functions.

Medical Staff Office

Assessment

- For employed physician and AHP staff, performance reviews and efficient progressive disciplinary processes, linked to credentialing as appropriate, are not clearly present.
- There is no apparent organized support for departments for clinician recruitment and new physician orientation. New residents are oriented to the facility, but routine orientation of residents rotating to KDMC during the year is less clear.
- Professional Staff Association (PSA) support is appropriately coordinated by the Medical Staff affairs group.
- Policy and Procedures, Bylaws, and Rules and Regulations modifications to ensure regulatory compliance are in process but not yet finalized.

Deficiencies

- All functions currently report directly to the Medical Director with no formal delegation.
- Activities to support regulatory compliance are in process but not fully finalized.
- Committee support occurs but committees are not linked to senior management oversight to ensure effective, efficient functioning.

Medical Staff Office

Recommendations

4.6.01 Consolidate medical staff support functions, reporting to Medical Staff Coordinator, including the medical photography function, and the Medical Staff Affairs staff.

4.6.02 Consolidate administrative functions reporting to Administrator Clinical Programs, including I&R dorm administrator, and Medical Staff Office manager.

4.6.03 Address all regulatory deficiencies in medical staff bylaws, rules and regulations, policies and committee function by 12/31/04, and ensure BOD approval at the January 2005 meeting.

4.6.04 Integrate peer review reports and malpractice, risk management, disciplinary information into medical staff credentialing process and files.

4.6.05 Investigate benchmarks regarding specialty-specific privileging and proctoring/supervision approaches; integrate into KDMC medical staff, and departmental P&Ps. Complete full review and definition by department by 3/1/05.

4.6.06 Develop/reliably maintain easily accessible, preferably on-line, data repository to catalog privileging and proctoring and supervision requirements for medical staff, AHPs and residents.

Medical Staff Office

Recommendations

4.6.07 Develop annual medical staff performance review process for employed physicians and incorporate performance information (quality, risk, utilization, profiles, colleague and staff feedback, patient satisfaction scores, disciplinary actions, citizenship).

4.6.08 Develop similar review for Allied Health Professionals, including compliance with supervisory requirements by both the AHP and their supervising/responsible physician.

4.6.09 Identify training/development opportunities for Coordinator of Medical Staff Affairs to learn best practices and develop benchmarking contacts.

4.6.10 Provide access for Medical Staff Coordinator to pertinent regulatory requirements, i.e., JACHO.

4.6.11 Develop support/coordination role (AMD for Medical Staff Affairs) for medical staff and AHP recruitment, orientation and ongoing “personnel” support and (non-departmental) CME programming.

4.6.12 Orchestrate systematic review of HR, credentialing, privileging, RM, and peer review files and any available profiling or other data for current clinical staff to ensure problematic issues have been addressed.

Medical Staff Office

Recommendations

4.6.13 Obtain independent external peer review to review clinical performance in any areas of concern.

4.6.14 Develop system to integrate peer review, risk, quality, profiling information with credentialing and privileging activities and with performance review/management activities for employed clinicians.

Section IV – Medical Administration

7. Credentialing and Privileging

NAVIGANT CONSULTING

Credentialing and Privileging

Assessment

- Peer review, risk management, and profiling information is not routinely incorporated into the review process.
- Supervision/oversight policies for AHPs are not clearly articulated with processes for monitoring regularly.
- Privileging and proctoring criteria for new staff or for residents, by year - by specialty, have not been clearly articulated with policies and procedures or tools to support implementation.
- Credentialing/privileging information is only recently readily available to facility staff.
- Review of specialty/resident privileging programs for compliance with specialty training curricula is not formalized.

Deficiencies

- Absence of link for risk management, quality, profiling, peer review info to automatically be included in credentialing and privileging activities.
- Privileging and proctoring criteria and process/implementation supports for new staff, residents and AHPs are not clearly implemented so that Nursing or scheduling staff can verify as needed.

Credentialing and Privileging

Recommendations

4.7.01 Complete and implement bylaw and rules/regulations revisions to ensure regulatory compliance.

4.7.02 Integrate peer review, malpractice, risk, disciplinary actions and feedback into credentialing/privileging processes.

4.7.03 Develop/implement clear criteria for approving and/or denying/deferring credentials or privileges, and apply to Credentials Committee review of applications and MEC review of Credentialing Committee recommendations.

4.7.04 Ensure that medical staff, resident, and AHP privileging policies are in reasonable compliance/congruence with specialty board and/or professional society scope of training and/or practice and/or generally accepted clinical practice standards locally or nationally.

4.7.05 Ensure that AHP supervision policies/practice are in reasonable compliance/congruence with specialty board and/or professional society scope of training and/or practice and/or generally accepted clinical practice standards locally or nationally.

Credentialing and Privileging

Recommendations

4.7.06 Ensure that resident/medical student supervision/privileging policies and practice are in reasonable compliance/congruence with specialty board and/or professional society scope of training and/or practice and/or generally accepted clinical practice standards locally or nationally.

4.7.07 Use incident reports, risk, peer review, quality data to flag reviews regarding credentials/ privileges and/or performance (employed clinical staff) as appropriate.

4.7.08 Ensure that clinical documentation is in place to capture service/diagnosis coding to accurately populate profiling databases.

Section IV – Medical Administration

8. Policies and Procedures

NAVIGANT CONSULTING

Policies and Procedures

Assessment

- Policies and procedures/rules and regulations have been partially modified to ensure JACHO/CMS compliance, with additional revisions in process currently.
- Governing body approval has not yet been obtained but is scheduled for early January.
- Medical Executive Committee (MEC) / PSA indicated approval is either accomplished or in process.
- Systematic approaches for monitoring compliance and implementing remedial action/integrating adverse determinations into credentialing/privileging processes or progressive disciplinary activities are not consistently present.
- A culture-of-safety for reporting areas of concern, adverse events, and non-compliance has not been established.

Deficiencies

- Policy and procedure/rules and regulations/bylaws revisions not yet completed and approved to comply with regulators.
- Reluctance to report clinical concerns or incidents at times; a safe environment to encourage these activities must be created.

Policies and Procedures

Recommendations

4.8.01 Ensure modifications as required to comply with regulatory bodies are enacted and implemented expeditiously.

4.8.02 Develop and implement clear progressive disciplinary programs for non-compliance.

4.8.03 Integrate with credentialing/privileging activities and performance evaluations of employed physicians and AHPs.

4.8.04 Systematically monitor for compliance and opportunities for improvement via incident reporting, peer review, IOP processes.

4.8.05 Develop systematic approaches for monitoring and identifying outliers, and intervening Periodic review of all personnel/peer review files for aggregated concerns.

4.8.06 Create a culture of safety re reporting of clinical errors or questionable activities/behaviors.

4.8.07 Collect and analyze sentinel events, RM case, root cause analyses, clinical screens for adverse outcomes or complications and develop and implement corrective action.

4.8.08 Identify a clinical leader to champion/facilitate medical staff patient safety efforts.

Section IV – Medical Administration

9. Governance and Committees

NAVIGANT CONSULTING

Governance and Committees

Assessment

- Elected Medical Staff officers lead PSA activities, actively interfacing with the hospital executive team.
- The formal interface of elected leadership with CMO is less clear.
- A formal Medical Staff Committee structure exists with reasonably clear reporting relationships among the various Medical Staff bodies and activities.
- Committee charters are general, and meetings are variably productive, with sometimes less than rigorous follow-up on action items.
- Committee attendance can be variable as well.
- Committee recommendations can be idealized, failing to recognize potential impacts on operations.
- Applicability of hospital staff policies to Medical Staff has not always been clarified or implemented

Deficiencies

- Committee activities and scope need to be more clearly defined with attention to problem identification, planning to remedy, and follow-through on implementation with follow-up measurement or assessment to ensure effective intervention.
- Intent of hospital policies regarding Medical Staff needs to be clarified and implemented as applicable.

Governance and Committees

Recommendations

4.9.01 Actively integrate management of medical staff issues by elected representatives (Medical Staff Officers) and hospital line managers (Medical Director, etc).

4.9.02 Support exploration and development of Faculty Practice Program, if financially feasible.

4.9.03 Implement clear hospital policies as applicable to medical staff, e.g., public relations policy precluding medical staff interactions with the press except as overseen and approved by hospital executive leadership.

4.9.04 Continue to refine and streamline medical staff committee structure, specifying committee reporting and medical administration executive liaison and matching meeting frequency to intensity of needed work effort.

4.9.05 Consider combining Provision of Care Committee with IOP Committee. Consider Patient Safety & Infection Control Committees as subcommittees reporting to IOP. Integrate committee recommendations with operations of clinical areas.

Governance and Committees

Recommendations

4.9.06 Link results of committee review and deliberations with other related functions, e.g., results of residency reviews linked with appropriate hospital committees to address issues.

4.9.07 Establish medical directors as chairs, liaisons, or members of key committees, e.g., peer review, UM, IOP.

4.9.08 Include active Committee participation in citizenship components of physician performance evaluations.

Section IV – Medical Administration

10. Productivity

Productivity

Assessment

- Productivity is not systematically measured or reported or compared with external benchmarks.
- There are no productivity (or other) incentive programs.
- There is significant confusion and lack of rigor or accountability in defining the various components of physician work activity, and alignment with the components of compensation.
- Clinical time is, therefore, not accurately or consistently measured and/or accounted for.
- It is thus nearly impossible to match available clinical resource with demand to rationally plan clinical staffing complements.

Deficiencies

- There is no clear way to ensure that appropriate time is allocated for clinical or teaching/supervisory activities.

Productivity

Recommendations

4.10.01 Perform complete physician work force analysis to identify FTEs and funding currently allocated, and explicitly being used, to cover various physician activities: clinical, teaching, research, administration.

4.10.02 Evaluate contract and moonlighting FTEs and cost to provide clinical care.

4.10.03 Assess clinical needs in each department and match clinical staffing to demand, 24/7.

4.10.04 Measure and report clinical productivity regularly, compared to national benchmarks by specialty.

4.10.05 Consider development of an incentive compensation system to incentivize physician performance.

Section IV – Medical Administration

11. Teaching and Resident Supervision

Teaching and Resident Supervision

Assessment

- Residency training programs are in place in most specialty areas and there are fellowship programs in four medical sub-specialty areas. Training programs in surgery, radiology and neonatology have lost accreditation (the latter is under appeal).
- Medical students rotate at KDMC from Drew Medical School for their third year core clinical rotations and for a few months during their fourth year. A few medical students rotate at KDMC from other medical schools, usually for certain popular electives during their fourth year.
- Drew medical students, receive UCLA degrees, match to competitive training programs, and show a higher likelihood of pursuing practice opportunities in underserved areas than students graduating from other California medical schools.
- Several of the training programs are fully accredited, while three (family practice, orthopedics, and anesthesia) are on probation with up-coming reviews during the spring and summer of 2004. Many of the accredited programs have outstanding items raised at prior RRC reviews, and the overall GME program has cited concerns with a review due this winter.

Teaching and Resident Supervision

Assessment

- Criteria, content, and circumstances for resident supervision by department at KDMC are in the final development stages currently.
- Currently KDMC has approximately 333 filled residency positions.
- The sum of residency program requirements exceeds the clinical breadth of patients available at KDMC to successfully train the currently accepted residency complement for 2005.
- Despite adverse publicity, the numbers and commitment of residency candidates are high.
- The caliber of residents matching in several specialties has been problematic; despite this, programs try hard to fill rather than leaving vacancies and finding alternative approaches to covering resulting clinical care gaps.
- The retention of academic programs and opportunity (teaching and research) is critical to attracting and retaining quality Medical Staff at KDMC.

Teaching and Resident Supervision

Assessment

- Within reasonable limits, there seems to be commitment at the medical school and KDMC to implement teaching programs for all high volume specialties; tailored in size to match the clinical needs of the local community. Correction of cited concerns may require affiliation or partnership with other local training programs in some specialties.
- Residency program funds flow, true fully loaded costs, and relationship to funding levels is murky; with a particular lack of clarity currently around funding for RRC-required program support functions.
- Operational issues at KDMC and its affiliated facilities are negatively impacting the effectiveness of several residency programs and in some cases threatening accreditation.
- In selected areas the faculty depth and breadth, and scholarly and research activities are insufficient to support robust residency training.

Deficiencies

- Several programs are currently on probation, and additional programs are at risk given the current regulatory situation and lack of adequate clinical volume and/or faculty depth in certain areas.
- The absence of a surgical residency will make re-opening of a trauma center a challenge.

Teaching and Resident Supervision

Recommendations

4.11.01 Assess accreditation status and outstanding citations of existing residency and fellowship programs, and identify approaches to address any identified program gaps within KDMC and/or in partnership or collaboration with other local facilities.

4.11.02 Explicitly analyze and define GME monies currently being expended to support residency programs and available funding from federal and other sources.

4.11.03 Assess role/contribution by specialty of residency and fellowship training programs to:

- Provision of clinical care within scope identified for KDMC
- Institutional mission of developing clinicians interested and skilled in providing care for underserved populations

4.11.04 Develop and implement a future strategy appropriate for each training program: independent program; joint program with another facility or medical school; track or rotation within another facility or medical school program; or possible program elimination.

- Define size of each program by matching to clinical needs and scope of service/depth of faculty at facility as well as available funding (direct and indirect GME $)
- Include funding for required residency program supports in funding
- Prioritize departments which are currently on probation (anesthesia, FP, orthopedics) and with upcoming routine reviews

Teaching and Resident Supervision

Recommendations

4.11.05 Consider joint program pilots with UCLA and/or USC to begin collaborative process.

4.11.06 In collaboration with whatever medical school(s) are involved, recruit talented junior faculty to staff.

4.11.07 Require Board eligibility and certification for new faculty.

4.11.08 Evaluate existing faculty in the context of future program needs; develop modified roles or transition plans.

4.11.09 Develop strategies to effectively recruit high-quality residency candidates, including Drew Med school graduates.

4.11.10 Resolve operational issues currently plaguing residency programs.

4.11.11 Transition GME Office to Medical Administration, with Director reporting to AMD for Medical Staff Affairs at KDMC

4.11.12 Complete residency supervision protocols by specialty by year and implement consistently.

Teaching and Resident Supervision

Recommendations

4.11.13 Integrate tracking of medical students and residents/resident rotators, including supervision status/requirements with systems for medical staff tracking, and make available to facility staff.

4.11.14 Develop/implement reliable/consistent programs to orient rotating students/residents to policies and procedures.

4.11.15 Develop and implement strategies to enhance resident recruitment in all programs.

Section IV – Medical Administration

12. Peer Review and Clinical Quality Processes

NAVIGANT CONSULTING

Peer Review and Clinical Quality Processes

Assessment

- Clinical programs at times lack basic equipment, space, systems supports and/or facilities to deliver quality care
- Peer review processes and root cause analyses have been variably detailed with sometimes apparent lack of ownership of issues and suboptimal remediation plans
- Clinical coverage is at times provided by physicians whose background does not include formal “industry standard” subspecialty training and/or certification for the area being covered.
- Clinical quality programs are scattered among several functional areas.
- There is inconsistency of definitions, processes, accountability, and implementation/follow-up among the various program components.
- Case finding for quality reviews is variably implemented; using a variety of triggers somewhat inconsistently.
- Case managers are not consistently utilized as case finders with trigger lists to flag cases.
- Case review for quality concerns does occur but in a variety of formats, applied somewhat inconsistently, with variable diligence in regards to identifying true quality opportunities, root causes, and developing remediation plans.

Peer Review and Clinical Quality Processes

Assessment

- A culture of safety for reporting and openly analyzing and addressing quality concerns is lacking.
- Risk management processes lack a database to facilitate aggregate data review and intervention.

Deficiencies

- Clinical quality and risk management programs as they currently exist do not reliably identify and/or remediate clinical quality concerns or inadequate performance.
- Chronically inadequate systems and program development and/or failure to replace broken equipment or purchase needed supplies has impaired provision of quality care.
- Clinical quality reviews have not been robustly identified or dealt with all contributing concerns.
- Board eligible or board certified physicians in appropriate specialties are not always available to cover all clinical programs.

Peer Review and Clinical Quality Processes

Recommendations

4.12.01 Develop Director of Clinical PI role reporting to Medical Director for UM and Clinical Programs.

4.12.02 Consolidate clinical RM, clinical quality, patient safety, clinical legal affairs, and IOP activities to report to this Director.

4.12.03 Consolidate RM and Clinical Legal affairs activities under supervision of a single manager.

4.12.04 Establish more robust clinical quality program.

4.12.05 Establish Quality priorities set by regulatory agency agendas for quality/safety, institutional and/or county priorities, case finding by sentinel events, root cause analyses, incident reports, indicator reporting and monitoring, credentialing reviews, etc.

4.12.06 Define peer review and departmental quality programs.

4.12.07 Appoint departmental peer review committees.

4.12.08 Institute initial case peer review by a designated departmental clinical case reviewer who may or may not be the department chair. Serious or unclear cases would then be referred to a peer review committee for review and recommendations.

Peer Review and Clinical Quality Processes

Recommendations

4.12.09 Address recommendations related to an individual's performance with the individual by the department Chair and the Medical Director, with all identified issues addressed and fully resolved.

4.12.10 Refer systems recommendations for follow-up action to the departmental quality committee.

4.12.11 Complete root cause analyses on untoward event occurs involving multiple staff and/or a complex multi-departmental process and should include all interested/involved parties, leadership from relevant departments, a risk manager, and a clinical quality staff.

4.12.12 Identify, track and communicate all recommendations from root cause analyses to the individual departmental leadership (specific individual interventions recommended) and/or the QI/safety/risk committees as appropriate (systems issues).

4.12.13 Appoint ad-hoc root cause committees to expeditiously review sentinel events, deaths, clinical incidents, etc.

Peer Review and Clinical Quality Processes

Recommendations

4.12.14 Develop methodology to ensure follow-up occurs for issues identified by peer review and/or root cause analyses.

4.12.15 Require board certification for Board eligibility and after five years, board certification is required of all newly credentialed physicians.

4.12.16 Target physician recruitment and retention efforts to gaps in specialty coverage for medical programs, prioritized to meet the community medical needs. Clinical programs are added or expanded based on this prioritization, and assuming adequate clinical coverage.

4.12.17 Address facility, equipment, and infrastructure requirements to meet basic standards of medical care and regulatory requirements with sustaining procedures implemented to ensure on-going maintenance, replacement and/or upgrading.

Medical Administration

Performance Measures

- Residency match results and board performance/scores over time.
- Credentialing/privileging metrics.
- Performance compared to objectives on goals and objectives by medical managers.
- Malpractice settlement performance.
- IOP metrics by department.
- Hospital-wide quality metrics (national patient safety initiatives).
- Denied days or admissions, ALOS, admit rate.
- Appointment access, wait times in clinics.
- OR start/wait times to schedule.
- Average ER visit length and urgent care, average length of visit, percent LWBS after length of wait.
- Development of goals and objectives for medical directors, chairs, medical program directors, and selected physicians.
- Test result turnaround time, time to results on chart.
- Clinical department/unit performance metrics (HR measures, quality operational and utilization measures).

Responsibility

- Medical Director

Section V – Nursing Services

NAVIGANT CONSULTING

Nursing Services > Interviews

• M. Lang	Interim Director of Nursing
• P. Rodriquez	Interim Director Nursing Quality
• L. Barber	Manager, Staffing office
• C. Allmond	Manager, Nursing Education
• C. Taylor	Manager, Nursing Recruitment
• A. Lemus	Manager, Emergency room
• D. Akerele	Manager, Ambulatory Services
• P. Soltero	Manager, Pediatrics
• N. Haye	Manager, Labor and Delivery
• C. Duckworth	Interim Manager, ICU
• C. Duckworth	Manager, Telemetry
• A. Hilliard	Manager, CCU
• R. Taylor	Manager, NICU
• K. Thomas	Manager, Referral Center
• M. Sankey	Manager, Information services

Nursing Services > Interviews

• R. Scott, MD	President, PSA
• J. Jahr, MD	Interim Chair, Anesthesiology
• Z. Steffens, MD	Clinical Coordinator, Anesthesiology
• L. Sarff	Director Quality Improvement DHS
• L. Kidd	(former) interim Chief Nursing Officer
• L. Pascual	Manager, Psychiatric ED
• N. Smith	OR Manager and Assistant Director of Perioperative Services
• A. Bedhran	Assistant Nurse Manager, ED
• B. Patton	The Camden Group

Nursing Services > Prioritized Summary of Recommendations

Leadership / Management		
Urgent	5.4.01	Modify current organizational chart to reduce span of control of interim Clinical Nursing Director.
Urgent	5.4.02	Focus Nursing Director role on organization of budget, capital equipment planning and execution, orderly recordkeeping, development of systems, centralized nurse staffing, all other business functions for the Department of Nursing.
Intermediate	5.4.03	Hire Clinical Directors for medical surgical units, ICUs, ER, psychiatry and peri-operative with expertise in their specific fields and proven management skills to direct and upgrade care in all nursing units. Goals should include improvement in employee relations, behavior correction, establishment of typical nursing standards and clinical protocols.
Short-term	5.4.04	Develop and implement the tools necessary to operate nursing cost centers in a more business-like manner.
Intermediate	5.4.05	Establish as an expectation that Nurse managers have input into and adhere to the budget.
Intermediate	5.4.06	Analyze and re-set the manpower budgets in keeping with nationally recognized productivity measures so that managers can be expected to control their positions and work within parameters.
Urgent	5.4.07	Relocate manager offices to assigned units.
Short-term	5.4.08	Increase responsibilities of nurse managers to include quality measures and accountability.
Short-term	5.4.09	Re-evaluate charge nurse role.
Short-term	5.4.10	Provide formal ongoing education for management staff within nursing.
Short-term	5.4.11	Work with DHS administration, change the KDMC policy regarding manager pay structure to one of exempt, traditionally salaried management positions no longer subject to overtime pay. Retain all other provisions, including a compensation time clause, but desist paying managers for overtime work.
Urgent	5.4.12	Reinforce 24/7 responsibility and accountability of the Unit Manager.
Urgent	5.4.13	Increase management visibility and require monthly staff meetings all shifts.
Intermediate	5.4.14	Introduce the principles of shared governance/leadership to all employees over time. Establish an interdepartmental professional practice forum for the purposes of sharing and supporting practice changes, policy approval, joint decision-making and support for developing clinical programs.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Nursing Services > Prioritized Summary of Recommendations

Staffing / Productivity		
Long-term	5.5.01	Reduce number of Travelers so that ratios can be maintained at required levels while reducing excessive staffing.
Short-term	5.5.02	Rebalance staffing across similar units so that regular staff are in the majority.
Short-term	5.5.03	Upgrade systems available to the staffing office to improve recordkeeping and report production.
Short-term	5.5.04	Enlist cooperation from managers to be more timely in their requests and more diligent in scheduling activities, by developing a timetable that ensures accountability and timeliness. Incomplete schedules are not acceptable.
Short-term	5.5.05	Update staffing plans to work within ratios as well as acceptable industry standards.
Intermediate	5.5.06	Conduct a workshop with managers to develop scheduling techniques.
Intermediate	5.5.07	Establish a float pool to include resource/admissions nurses. Offer a variety of pay options to attract nurses to this work arrangement.
Intermediate	5.5.08	Evaluate current use of patient acuity tool, and make necessary improvements.
Patient Care Delivery Model		
Intermediate	5.6.01	Define patient care delivery system establishing care partners or dyad model.
Short-term	5.6.02	Establish Laboratory phlebotomist responsible for blood drawing for type/cross match and blood culture specimens.
Intermediate	5.6.03	Include charge nurses in management development and training programs specific to their areas of responsibility.
Short-term	5.6.04	Work with CMO office and individual services to develop progressive call plan that nursing staff can utilize effectively.
Intermediate	5.6.05	Develop plan for inter disciplinary care to model in one unit (4B) and roll out to other units as it is successful.
Intermediate	5.6.06	Develop formal shift to shift report and transferring unit to unit report tool.
Intermediate	5.6.07	Develop a plan to meet the physical therapy needs of patients across the continuum.

Nursing Services > Prioritized Summary of Recommendations

Clinical Practice		
Urgent	5.7.01	Assign members of interim management team as project leads working with KDMC nursing management to research, plan and execute all projects mentioned in the assessment statement.
Urgent	5.7.02	Prioritize items which have direct patient care implications.
Short-term	5.7.03	Recruit specialist nurses as required to initiate and sustain clinical programs.
Intermediate	5.7.04	Develop standards of care for patient populations.
Documentation / Technology		
Short-term	5.8.01	Fast-track documentation changes by utilizing existing examples and working directly with the forms vendor to modify as necessary. Customization will be minimized.
Short-term	5.8.02	Add a risk assessment to be done at time of admission and repeated as indicated clinically. As patients are identified at risk for falls, nutritional needs, skin integrity risk, in need of social services and complex discharge planning, automatic consultation to appropriate departments should be immediate so that no time is lost in obtaining services.
Short-term	5.8.03	Define what team members should chart depending on job descriptions and qualifications.
Short-term	5.8.04	Control access to chart and maintain compliance with HIPAA regulations, with the introduction of this new process.
Short-term	5.8.05	Operationalize multidisciplinary care planning and documentation in the record.
Short-term	5.8.06	Revise MAR documentation tool.
Training and Education		
Intermediate	5.9.01	Coordinate with recruiter to initiate new graduate orientation program and update content of program.
Intermediate	5.9.02	Lead effort towards improved selection of preceptors and charge nurses reflective of skill level required to be successful in their roles. Update training days in support of more consistent performance; offer on a regular basis.
Intermediate	5.9.03	Determine if ancillary departments have need of professional education staff. If the need exists, develop a plan to expand Nursing Education into a Staff Education department.
Intermediate	5.9.04	Evaluate need for onsite ICU training program, and in the interim, ensure that all ICU staff attend county offered program.
Short-term	5.9.05	Develop telemetry training program to meet the needs of KDMC.

Nursing Services > Prioritized Summary of Recommendations

Skill Verification and Competency		
Urgent	5.10.01	Organize all documentation of skills verification/competencies records in Nurse Staffing office under Clinical Director, Administration position.
Short-term	5.10.02	Establish accountability of Nurse Managers for timely completion of skills verification and competency training.
Intermediate	5.10.03	Review and revise as indicated the list of competencies required in nursing.
Intermediate	5.10.04	Plan an annual skills and competency fair in 2005 placing all units in an annual consistent schedule.
Orientation		
Intermediate	5.11.01	Evaluate length and content of orientation program and adjust accordingly.
Short-term	5.11.02	Member(s) of Nursing leadership team to meet and greet all new employees.
Intermediate	5.11.03	Examine the issue of not meeting staff needs through a focus group approach. Meet with hirees who have joined the organization within the last six months and gain insight into their needs. Adjust the program accordingly.
Patient Safety – Emergency Preparation/Response, Monitoring Patients, End of Life, Patient Identifiers, Communication		
Urgent	5.12.01	Immediately order replacement Code Blue pagers.
Short-term	5.12.02	Standardize members and response to Code Blues 24/7.
Short-term	5.12.03	Standardize code carts and their contents throughout the inpatient units, emergency room, OR and trauma center.
Short-term	5.12.04	Review current system of stocking carts and develop a comprehensive exchange cart plan.
Short-term	5.12.05	Remove code carts from clinic settings and replace with airway management box. Instruct staff to call 911 for code situations (excluding clinics which perform conscious sedation procedures).
Urgent	5.12.06	Assess effectiveness of codes on an on-going basis.
Intermediate	5.12.07	Update policy and procedure and implement changes as necessary. Define requirements of supporting documentation.
Short-term	5.12.08	Implement DNR/DNI document record, that is easily identifiable in the patients chart. This document should have a bright coloring to aid identification.
Intermediate	5.12.09	Review Ethics Committee membership and activities, and make necessary changes to improve utilization and decision support. Develop a palliative care program as a subset of the Ethics Committee.

Nursing Services > Prioritized Summary of Recommendations

Patient Safety – Emergency Preparation/Response, Monitoring Patients, End of Life, Patient Identifiers, Communication		
Urgent	5.12.10	Institute immediate training for all clinical personnel in Management of Assaultive Behavior techniques. Utilize nationally recognized training programs and certified instructors.
Urgent	5.12.11	Construct policies and procedures to clarify the actions to be taken by staff prior to a Code 9 call, roles and membership of the Code 9 response team, oversight and review of the team's work.
Short-term	5.12.12	Implement policy, procedures and process to meet the identification needs of the patient. This will involve Allergy alert bands and determining the hospital-wide color code for falls risk patients.
Short-term	5.12.13	Review Advance Directive policy and revise system and process accordingly.
Intermediate	5.12.14	Develop and implement Medical Interpreter services department reporting to case management leadership.
Intermediate	5.12.15	Revise current patient education system.
Recruitment and Retention		
Urgent	5.13.01	Expand the department to at least two full time recruiters and one support person.
Short-term	5.13.02	Write a program which includes student nurse hiring, recruitment in the nursing schools, scholarship availability.
Intermediate	5.13.03	Work with Human Resources to develop a workforce plan and adjust recruitment program accordingly.
Intermediate	5.13.04	Expand student nurse clinical site training contracts to include BSN programs.
Long-term	5.13.05	Educate the recruitment and retention committee members in contemporary techniques for recruitment. Incorporate findings of Leadership Institute training planned in first quarter 2005 into development of retention strategies.
Environment of Care		
Short-term	5.14.01	Initiate weekly rounds including COO, CNO and directors of Plant and Environmental Services with emphasis on the work list identified in the Assessment section.
Short-term	5.14.02	Clarify responsibility for cleaning medical equipment.
Short-term	5.14.03	Develop priority list for patient units and public areas that includes way finding, aesthetics, patient comfort, access and cleanliness.
Short-term	5.14.04	Add additional keys or keypads strongly recommended for use in the patient units.

Overview

- The following is a comprehensive list of nursing units at KDMC:
  - Emergency Room and Trauma Center
  - Critical Care units: ICU A & B, Cardiac Care unit, PICU, NICU
  - Medical Surgical units: 3A, 3C, 4A
  - Telemetry unit: 4B
  - Labor and Delivery & 3C
  - Pediatric Medical Surgical unit: 5G
  - Outpatient Clinics and Referral Center
- Labor Unions and contract.
  - Nursing department employees belong to SEIU. The contract was ratified recently.
- Agencies and Traveler company used.
  - The current travel company of choice is Fastaff. This is a County-held contract that was entered into in April of this year. Currently, 30 other companies are used by the department to provide coverage.
  - Examples of companies providing services are: All Star Staffing, AMN, Associated Health Professionals, ATC Travelers, Cross Country Staffing, Flex Nursing Service, HRN Services & Nurse Providers.

Section V – Nursing Services

4. Leadership / Management

NAVIGANT CONSULTING

Leadership / Management

Assessment

- The Nursing Department at KDMC is organized under a Chief Nursing Executive Officer, who reports directly to the CEO.
  - The department has been structured with one Clinical Nursing Director, who reports directly to the CNO.
  - The single Clinical Director holds responsibility for medical/surgical, critical care, emergency, peri-operative, psychiatric, maternal-child and ambulatory nursing.
  - Unit managers, the first line managers on nursing units, report to the Nursing Director. This rank is achieved by passing a civil service examination.
  - Supervising staff nurse roles exist in all areas, although a limited number have achieved this level. Supervising nurses work 50% clinical and 50% non-clinical to support the unit managers. They are non-exempt employees.
  - Charge nurse roles exist in all areas, on all shifts. These staff members ideally work outside of the ratios to provide break relief, make assignments, and carry out other very traditional functions. Not all charge nurses have taken the County exam to become a charge nurse.
- Titling issues exist within the organization.
  - For example, the Director of Quality is ranked at a nursing director level.
- The position of Nursing Director of Performance Improvement was initiated in April 2004 in response to non-compliance with regulatory requirements.
  - A basic program has been developed which focuses on Nursing quality issues.
  - The program is not completely JCAHO compliant.

Leadership / Management

Assessment

- All inpatient Nursing units, regardless of size, have a designated manager.
  - Span of control varies considerably within nursing (2-100 employees).
  - The ambulatory clinic managers are responsible for multiple clinics.
  - Some ambulatory clinics are also managed by inpatient managers, which contributes to inconsistencies.
  - Not all managers have office space located in their units. Some are housed on different floors.
  - Some managers have demonstrated personnel management problems; resulting in moves to other areas within nursing where they may not have specific clinical expertise. Common clinical protocols, which should be expected, are not in place. For example:
    - Telemetry unit does not have clearly-defined and usable protocols for the administration of high-risk, low-volume medications, such as dopamine.
    - The care of chronic ventilated patients is limited to the critical care unit.
    - Standards of care establishing nursing orders such as intake and output measurement or vital sign frequency are not in place. Physicians must order these parameters or risk not having data.

Leadership / Management

Assessment

- Managers have minimal business skills or typical tools needed to operate their areas in a business-like manner.
  - Management training and development has been historically lacking.
  - Managers do not receive monthly budget reports and are not responsible fiscally.
  - Managers have had little to no input into budget development.
  - There is no productivity system.
  - Managers do not appear to have ownership of their unit level quality data.
- There is generally a feeling of hopelessness within the management group regarding their ability to impact change or effect behavior changes in staff.
- Managers consistently voiced the challenges they encounter when trying to hold staff accountable or apply effective discipline without support from superiors.
  - Disciplinary actions are sometimes neglected.
  - Confrontation of staff to correct a behavior problem is avoided.
- Monthly staff meetings on all shifts are not presently being held.

Leadership / Management

Assessment

- An administrative policy was put in place several years previously which re-classified KDMC nursing managers as non-exempt, even though their job grade qualifies them for exempt status. Consequently:
  - They work shift hours (eight hour days).
  - Any time >eight hours is considered overtime and paid at premium rate.
  - Conflicts arise when overtime must be pre-approved.
  - Working under these circumstances, they are unavailable for staff on off shifts or problem-solving outside a strictly-enforced eight-hour day.
  - Lacking schedule flexibility, managers are not knowledgeable about their unit operations 24/7, which has lead to a lack of ownership for quality or personnel issues.
- Position control is non-existent. Lengthy investigation is required to determine what positions are budgeted in each cost center. Over time, positions have been moved in and out of nursing cost centers indiscriminately. Consequently, budgets, which are based on history, are inaccurate and not truly reflective of the department's needs.

Leadership / Management

Assessment

- Inter-departmental collaboration depends on individual personalities and personal relationships; and not on an established system of shared leadership and joint decision-making. Departments more often work in silos, independent of one another and, therefore, not benefiting from the input of other professional thinking.

Deficiencies

- Lack of administrative oversight for Nursing departments.
- Lack of quality driven decision-making, and accountability.
- Lack of management ethic amongst line managers.
- Inability of management to manage productivity of Nursing cost centers, due to lack of knowledge and systems.

Leadership / Management

Recommendations

5.4.01 Modify current organizational chart to reduce span of control of interim Clinical Nursing Director.

5.4.02 Focus Nursing Director role on organization of budget, capital equipment planning and execution, orderly recordkeeping, development of systems, centralized nurse staffing, all other business functions for the Department of Nursing.

5.4.03 Hire Clinical Directors for medical surgical units, ICUs, ER, psychiatry and peri-operative with expertise in their specific fields and proven management skills to direct and upgrade care in all nursing units. Goals should include improvement in employee relations, behavior correction, establishment of typical nursing standards and clinical protocols.

5.4.04 Develop and implement the tools necessary to operate nursing cost centers in a more business-like manner.

5.4.05 Establish as an expectation that Nurse managers have input into and adhere to the budget.

5.4.06 Analyze and re-set the manpower budgets in keeping with nationally recognized productivity measures so that managers can be expected to control their positions and work within parameters.

Leadership / Management

Recommendations

5.4.07 Relocate manager offices to assigned units.

5.4.08 Increase responsibilities of nurse managers to include quality measures and accountability.

5.4.09 Re-evaluate charge nurse role.

5.4.10 Provide formal ongoing education for management staff within nursing.

5.4.11 Work with DHS administration, change the KDMC policy regarding manager pay structure to one of exempt, traditionally salaried management positions no longer subject to overtime pay. Retain all other provisions, including a compensation time clause, but desist paying managers for overtime work.

5.4.12 Reinforce 24/7 responsibility and accountability of the Unit Manager.

5.4.13 Increase management visibility and require monthly staff meetings all shifts.

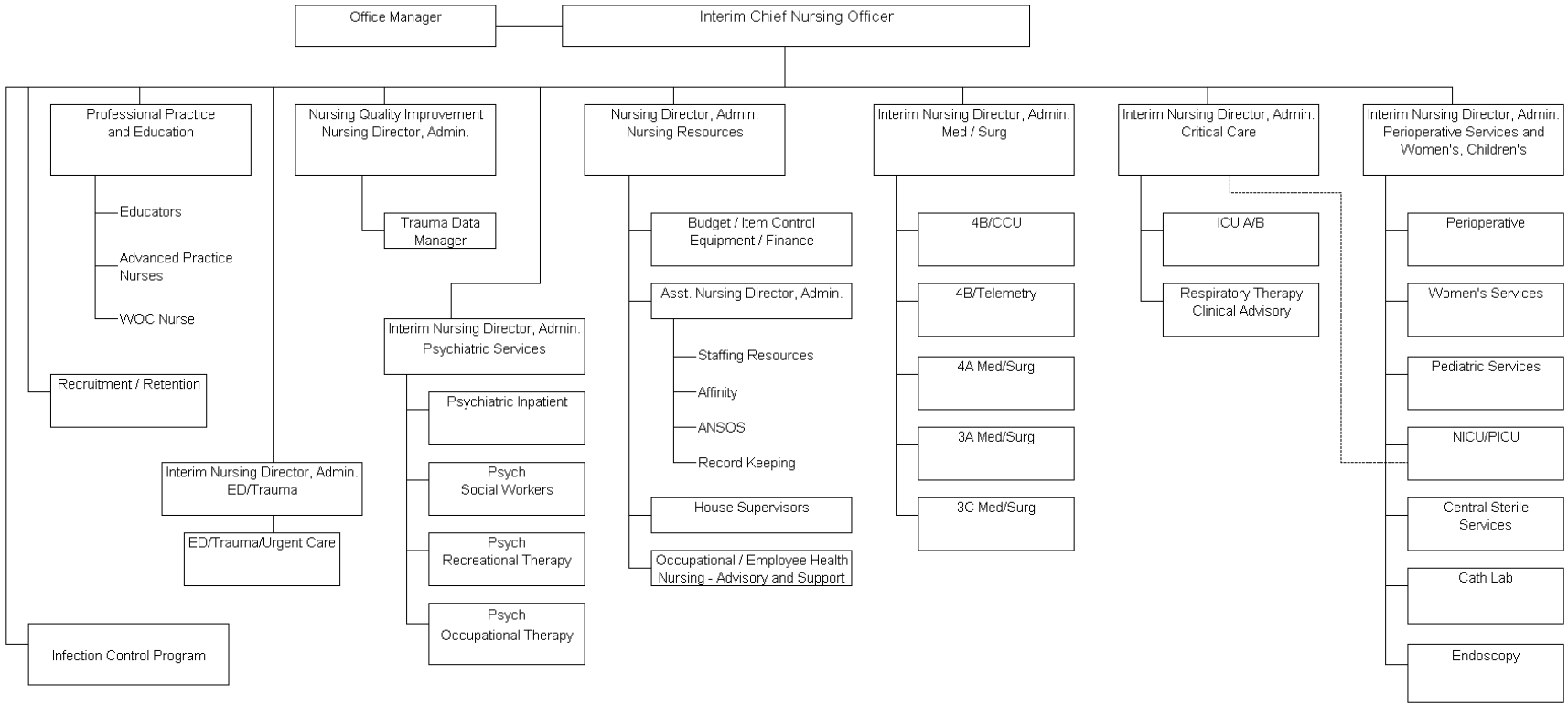
5.4.14 Introduce the principles of shared governance/leadership to all employees over time. Establish an interdepartmental professional practice forum for the purposes of sharing and supporting practice changes, policy approval, joint decision-making and support for developing clinical programs.

Management/Structure

Proposed Organizational Chart: Nursing Service

Draft *12/21/04*

KING/DREW MEDICAL CENTER
Nursing Services



NAVIGANT CONSULTING

Section V – Nursing Services

5. Staffing / Productivity

Staffing / Productivity

Assessment

- Nursing managers have recently assumed responsibility for creating their schedules and are on a learning curve.
  - Frequent changes are made to schedules and reconciliation is a significant challenge.
  - Uneven coverage exists on nursing units due to seniority and shift preferences.
  - Traveling nurses work almost exclusively 12-hour shifts, but regular staff more frequently work 8-hour shifts.
  - Managers submit incomplete schedules and expecting the staffing office to fill them in.
- Nursing resources, such as scheduling, attendance, recordkeeping of licensure, and competency maintenance has been scattered and incomplete.
  - Various citations from regulatory agencies have pointed out deficiencies of necessary records.
  - Systems are available but have not been fully installed or employees trained to utilize them.
- There is no automated time and attendance system making all recordkeeping manual.
- The level of coverage by regular staff at KDMC varies between 35-50%. The remaining coverage is provided by agency staff.

Staffing / Productivity

Assessment

- Currently, there are >100 travel nurses on KDMC staff. Contracts vary weekly.
- A staffing manager role was implemented in early 2004 in an attempt to organize agency orders, records, contracts, and assist managers with fulfilling schedule requirements. While the individual has made some impact on significant challenges, smoothly working systems are not yet in place.
  - Traveler orders continue to be chaotic, with many units giving very short-term notice of their needs to the staffing office.
- With the addition of traveler nurses, KDMC is maintaining nurse:patient ratios as required by California law. However, units are often over-staffed due to almost non-existent flexing and a set schedule, which accommodates agency staff with contract requirements.
  - Shift reports illustrate ratios varying 1:3 or 1:4 consistently on medical/surgical units, which require minimum ratio of 1:6.
  - Regular staff object to being flexed down when volumes are low, while agency nurses stay on duty.
  - The 12-hour agency staff object to changing assignments after 8 hours as an accommodation to regular staff.

Staffing / Productivity

Assessment

- There is no float pool or resource/admissions nurses to aid in flexing staff, filling call-in vacancies, or being available for a temporary increase in workload; such as, higher than usual numbers of admissions, returns from OR, patient in crisis, etc.
  - Nursing supervisors adjust staffing every shift by floating staff to areas of similar competency requirements.
- A patient classification tool is utilized, the system in use is Elivaysis.
- There is no method for demonstrating staffing effectiveness currently.
- Agency Contracts:
  - Travel company of choice is Fastaff, contracted in April 2004. Other companies are also utilized, but to a lesser extent.
  - The company is contracted to provide 44 hours of nursing care, per week, per person.
  - The company has deployed a full-time, on-site manager to the hospital. She endeavors to meet requests from the staffing office as expeditiously as possible. This contract is held at the County level.
  - Multiple staffing agencies are used by the staffing office. There is no discounted contractor of choice or specialized contracts at the present time.

Staffing / Productivity

Deficiencies

- Outdated scheduling system and lack of process to monitor licenses and skills.
- Lack of ownership and accountability from line managers.
- A grid to determine the cost per agency of each level of staff is currently not in place.
- Multiple registry agencies are not prioritized by quality, reliability, or cost.

Recommendations

5.5.01 Reduce number of Travelers so that ratios can be maintained at required levels while reducing excessive staffing.

5.5.02 Rebalance staffing across similar units so that regular staff are in the majority.

5.5.03 Upgrade systems available to the staffing office to improve recordkeeping and report production.

5.5.04 Enlist cooperation from managers to be more timely in their requests and more diligent in scheduling activities, by developing a timetable that ensures accountability and timeliness. Incomplete schedules are not acceptable.

Staffing / Productivity

Recommendations

5.5.05 Update staffing plans to work within ratios as well as acceptable industry standards.

5.5.06 Conduct a workshop with managers to develop scheduling techniques.

5.5.07 Establish a float pool to include resource/admissions nurses. Offer a variety of pay options to attract nurses to this work arrangement.

5.5.08 Evaluate current use of patient acuity tool, and make necessary improvements.

Section V – Nursing Services

6. Patient Care Delivery Model
   - Collaboration with Other Disciplines

Patient Care Delivery Model

Assessment

- The model at KDMC can be described as modified team nursing on general care units and total patient care in critical care areas.
  - Obstetrics unit follows AWHONN guidelines, which reflect California ratio levels.
- In all areas, a charge nurse is available on all shifts and generally does not begin the shift with an assignment but may assume one as volume changes.
  - A charge nurse duty is to cover the assignments of staff nurses while they are on breaks.
  - The charge nurse role may be filled by a Supervising Staff Nurse 1 although there are insufficient nurses in that classification to fulfill all charge nurse assignments.
  - Charge nurse is a variable assignment for a staff nurse and is frequently rotated among many nurses on a unit.
  - Charge nurses have poorly developed delegation or personnel management skills as demonstrated by the frequency of complaints from staff.
- The RN who holds the highest level license by virtue of education and training and also holds most accountability for the delivery of care to a group of patients, has not been clearly established as the professional leader of the patient care team.

Patient Care Delivery Model

Assessment

- LVNs take patient assignments and are supervised by RNs. This system fulfills legal requirements but is not currently functioning well as a cohesive team model.
- LVNs may also act as team leaders depending on the current staffing need and are thereby acting as substitute RNs without the same license level.
- CNAs deliver direct patient care, transport, perform blood glucose monitoring, and help take vital signs. Interviewees stated that there is a lack of trust between the licensed nursing staff and the CNA group on most units.
- Units generally have clerks on their day shifts. However, coverage is limited on evening shifts.
  - Clerks generally carry out all clerical duties as assigned and order supplies.
- Nurses draw approximately half the blood specimens on their units, including blood cultures and type, and cross specimens.

Deficiencies

- No clearly articulated model of care, leading to role confusion and performance issues.

Patient Care Delivery Model

Recommendations

5.6.01 Define patient care delivery system establishing care partners or dyad model.

- Assignments will consistently place the RN as team leader with a group of no more than 6 patients. LVNs and CNAs will be assigned to the RN, not directly to patients, and will deliver direct patient care under the direct supervision of the nurse.
- RNs will pass all medications, discuss cases with physicians, set the patient plan of care, design the education plan, contribute to the discharge plan working with case management, and generally perform all professional level activities.
- RNs will do patient assessments on admission and every shift. Team members will contribute data, e.g., vital signs/weights but will not be responsible for any systems review.
- The LVN role will be modified from one of team leader with RN oversight to one of team member with responsibility for direct care.
- In the instance of insufficient RNs on duty, which cannot be rectified through the use of the float pool or other staff adjustments, an RN-LVN team can be assigned to as many as 10 patients. Assignments can be varied within the dyad to meet the patients' needs.
- At any time, an RN may function as a direct caregiver or team member.
- RNs and LVNs will be accountable for vital signs and blood glucose monitoring.

5.6.02 Establish Laboratory phlebotomist responsibility for blood drawing for type and cross match and blood culture specimens.

5.6.03 Include charge nurses in management development and training programs specific to their area of responsibility. The goal should be to stabilize this assignment for better continuity and development.

Patient Care Delivery Model > Collaboration with Other Disciplines

Assessment

- Physician:
  - The relationship between Medical Staff and Nursing is not cohesive or collaborative in nature. While there are some areas that work well together, overall the relationship is fragmented.
  - Interviews and direct experience demonstrated that nursing staff are unsure of the chain of command, do not have trust in having pages returned; and as a result have developed alternative work arounds.
- Pharmacy:
  - Relations between Nursing and pharmacy are fragmented. Both areas work in silos when making changes to policies, procedures, etc.
- Ancillary Services:
  - The relationship held between Nursing and nutrition is collaborative and cohesive. Examples of team work are readily available, especially around committee work-related to intake and output measurement, etc.
  - Perceived lack of available resources in PT exists, with managers unable to relate if their specific unit has an assigned therapist.
  - Orders for PT are not encouraged due to perceived lack of available services.

Patient Care Delivery Model > Collaboration with Other Disciplines

Assessment

- Care Management:
  - Case managers are assigned to nursing units. However, planned and systematic communication does not appear to exist.
  - Managers and staff were unable to articulate a clear disposition plan for patients even though care management resources were available.
- Nursing to Nursing:
  - Interviews and direct observation verified that a lack of teamwork exists within the department internally.
  - Communication in and between Nursing units is limited and has an effect on patient care.
    - Reports on patient transfers from unit to unit are generally disorganized.
    - Treatment delays occur on patients admitted from the ED due to inpatient units willingness to accept the patient or perceived disrespect between nurses in the departments.

Deficiencies

- Lack of inter-disciplinary communication and teamwork.

Patient Care Delivery Model > Collaboration with Other Disciplines

Recommendations

5.6.04 Work with CMO office and individual services to develop progressive call plan that nursing staff can utilize effectively.

5.6.05 Develop plan for inter disciplinary care to model in one unit (4B) and roll out to other units as it is successful.

5.6.06 Develop formal shift to shift report and transferring unit to unit report tool.

5.6.07 Develop a plan to meet physical therapy needs of patients across the continuum.

Section V – Nursing Services

7. Clinical Practice

Clinical Practice

Assessment

- There is a lack of professionally-driven clinical programs which can be expected in any community hospital and certainly in an academic medical center. Programs which should be in place and functioning at a high-level include, but are not limited to:
  - Skin care and breakdown prevention program.
  - Palliative Care Program.
  - Restraint-free environment with sitter alternatives, e.g., safe beds concept.
  - Aggressive weaning protocols jointly with Respiratory Care and Nursing.
  - Care of chronic ventilators outside of critical care bed space.
  - Pain management program.
  - Measurement of pain management effectiveness.
  - Clinical research at minimum at the level of clinical inquiry.
  - Standards of nursing care which support critical thinking skills and customize care to the needs of the patient.
  - On-going comprehensive readiness program for JCAHO, CMS or any other regulatory agency compliance.
  - Professional development program.

Clinical Practice

Deficiencies

- Lack of programs to meet needs of patient populations.

Recommendations

5.7.01 Assign members of interim management team as project leads working with KDMC nursing management to research, plan and execute all projects mentioned in the assessment statement.

5.7.02 Prioritize items which have direct patient care implications.

5.7.03 Recruit specialist nurses as required to initiate and sustain clinical programs.

5.7.04 Develop standards of care for patient populations.

Section V – Nursing Services

8. Documentation / Technology

Documentation / Technology

Assessment

- Nursing does not utilize the principles of charting by exception. The currently used SOAPIE system can be characterized as causing excessive narrative charting and is not a contemporary documentation system.
  - Managers have been working on documentation changes to implement the FDAR system for about six months.
  - The FDAR system still requires narrative charting and is not far different from SOAPIE. It is also not considered a contemporary charting system.
  - Multiple sub-committees exist, each working on an aspect of documentation improvement. The lack of collaboration, redundant efforts, and poor communications among these groups is demonstrated by the lack of implementation of new chart forms following six months of uncoordinated work.
- Care plans for patients do not reflect current practices or utilize best practice models. The lack of care plans, which correlate with the care being received, has been cited by recent regulatory agency surveyors as inadequate.
- All documentation for the patient is kept in one medical record with no immediate care record available, decreasing the usability of the record.
- All charting is done at the central desk area, is not timely and is a cause of excessive overtime.

Documentation / Technology

Assessment

- Clinical documentation on ED patients awaiting inpatients beds is not at the same level or the same forms as the inpatient units, resulting in inconsistent records, delays in discharge planning, delays in treatment planning, and loss of vital patient information.
- Flow charting is not used outside of the ICU setting.
- The initial assessment tool is currently six pages, leading to decreased compliance.
- Nursing employs a manager in the role of nursing informaticist. This person does not hold an advanced nursing informatics degree.
- Lack of technology is pervasive throughout the department. Many systems are paper driven.
- One unit did have computerized nurse charting for a short time. When this unit was closed, the experiment ended.
- Multi-disciplinary care planning and documentation is not demonstrable in the record. This is an area of non-compliance, which must be improved.

Deficiencies

- Outdated documentation and care planning systems.

Documentation / Technology

Recommendations

5.8.01 Fast-track documentation changes by utilizing existing examples and working directly with the forms vendor to modify as necessary. Customization will be minimized.

5.8.02 Add a risk assessment to be done at time of admission and repeated as indicated clinically. As patients are identified at risk for falls, nutritional needs, skin integrity risk, in need of social services and complex discharge planning, automatic consultation to appropriate departments should be immediate so that no time is lost in obtaining services.

5.8.03 Define what team members should chart depending on job descriptions and qualifications.

5.8.04 Control access to chart and maintain compliance with HIPAA regulations, with the introduction of this new process.

5.8.05 Operationalize multidisciplinary care planning and documentation in the record.

5.8.06 Revise MAR documentation tool.

Section V – Nursing Services

9. Training and Education

Training and Education

Assessment

- Director of Education reports directly to the CNO and is committed to the Education department as a full-time employee.
- Education staff have varying levels of competence and educational backgrounds. There is one advance practice nurse who will be leaving soon. Some, but not all members of the department, have graduate educations. Job descriptions for instructors do not require more than bachelor's preparation.
- Several positions are vacant. The multiplicity of needs to upgrade and professionalize Nursing are discussed throughout this report. APNs and nurse educators with graduate education and specific skill sets will be needed to support multiple projects and act as role models for Nursing staff.
- Resources appear to be unevenly distributed throughout the various specialty areas.
  - Educators report to director but are assigned to work with managers on specific units.
  - Three of four educators for the department are currently assigned to critical care.

Training and Education

Assessment

- A downstream effect of the lengthening of orientation programs on the scheduling and maintenance of regular classes has been identified.
  - In anticipation of new program development and documentation changes, the education department has been asked to keep the schedule of classes open until further planning can be done in first quarter 2005.
- Performance-based development system (PBDS) is used for new hires and travel nurses during orientation. Improvements in this program over the last year have met with approval by regulatory agencies.
- A new graduate training program was developed two years ago, but has not been implemented due to lack of applicants.
- ICU training programs occur at another County institution and are not regularly attended by KDMC staff.
- There is a lack of appropriate preceptor staff available for new hire orientation as relayed by both Education and Nursing management in interviews.
  - Preceptor training, as well as an appropriate selection process, is inconsistent at best.

Training and Education

Assessment

- Charge nurses do not attend a charge nurse class, nor are refresher classes offered on an annual basis.
- Newly promoted managers and managerial staff are not provided with readily accessible classes on site.
- It is unclear whether ancillary departments have any professional educator hours available or if department management provides the necessary competency training.

Deficiencies

- Variation exists in both content knowledge and principles of teaching and learning.

Training and Education

Recommendations

5.9.01 Coordinate with recruiter to initiate new graduate orientation program and update content of program.

5.9.02 Institute improved selection of preceptors and charge nurses reflective of skill level required to be successful in their roles. Update training days in support of more consistent performance; offer on a regular basis.

5.9.03 Determine if ancillary departments have need of professional education staff. If the need exists, develop a plan to expand Nursing Education into a Staff Education department.

5.9.04 Evaluate need for onsite ICU training program, and in the interim, ensure that all ICU staff attend county offered program.

5.9.05 Develop telemetry training program to meet the needs of KDMC.

Section V – Nursing Services

10. Skill Verification and Competency

Skill Verification and Competency

Assessment

- There is no uniform or coordinated system for skill verifications and competencies tracking. Nursing' staffing, education, and administration are presently tracking various items.
- There is no one owner of both licenses and competencies within the department.
- Currently, over 60 competencies are tracked using the ANSOS system. However, all of these are not updated due to a disjointed approach to documentation of these competencies.
- Reports are not readily available to leadership and management regarding licensure and competency (ACLS, BLS) expiration dates.
- Clear documentation of competency expectations per unit does not exist.
- Competencies on certain high-risk, low-volume medications are not in place.
- Both Nursing education and management state that the systems in place for skills verification have not worked. There is a lack of compliance and accountability from staff nurses and nursing managers for the return of self-learning modules.
  - Initial Assessment self-learning modules were due for return from units on October 18, 2004. As of December 2, 2004, not all units had returned their packets.
- An annual skills and competency fair has not been done in the last one to two years, but the department reports former success with this approach.

Skill Verification and Competency

Deficiencies

- Lack of uniform system, process and ownership.

Recommendations

5.10.01 Organize all documentation of skills verification/competencies records in Nurse Staffing office under Clinical Director, Administration position.

5.10.02 Establish accountability of the Nurse Managers for timely completion of skills verification and competency training.

5.10.03 Review and revise as indicated the list of competencies required in nursing.

5.10.04 Plan an annual skills and competency fair in 2005 placing all units in an annual consistent schedule.

Section V – Nursing Services

11. Orientation

Orientation

Assessment

- During the past year, the length and content of Nursing orientation has changed frequently. Currently, it is five days for all new hires including travel staff. It is perceived to be excessive in length.
- Staff who had recently joined the department also voiced that this was excessive and the content did not meet their needs.
- This has resulted in stretched resources within the Education department.
- Preceptors are not readily available. Training for preceptors is planned for early 2005.
- Accountability for monitoring of new hire retention and satisfaction is not assigned in a formal way. The current recruiter tries to meet this need when possible.
- Nursing leadership do not meet and greet new employees during orientation.

Orientation

Deficiencies

- Length of orientation is excessive and does not meet the needs of the department.

Recommendations

5.11.01 Evaluate length and content of orientation program and adjust accordingly.

5.11.02 Member(s) of Nursing leadership team to meet and greet all new employees.

5.11.03 Examine the issue of not meeting staff needs through a focus group approach. Meet with hirees who have joined the organization within the last six months and gain insight into their needs. Adjust the program accordingly.

Section V – Nursing Services

12. Patient Safety
    - Emergency Preparation and Response
    - Monitoring of Patients
    - End of Life Care
    - Management of Assaultive Behavior
    - Patient Identifiers
    - Communication
    - Patient Education

Patient Safety > Emergency Preparation and Response – Code Blue (Cardiac Arrest team)

Assessment

- Code Blue team responses are not consistent. Multiple interviews and direct experience verified this during the assessment phase.
- It is unclear of whom the team consists.
  - In one mock Code Blue, multiple physicians arrived.
  - It is also unclear who the team leader is for Code Blue situations.
- Code Blue team members do not all carry pagers. Some have been lost over the years and not replaced. Currently, the operator calls some of the team members on their non-code pagers, which may lead to slow response times.
- Anesthesia does not respond to codes. They are called if others are unable to intubate.
- Standard code carts do not exist on inpatient units. There are at least three different types in use. Unit staff are responsible for re-stocking the cart also causing non-standard supplies.
- Non-standard code carts exist in all outpatient clinic areas.

Deficiencies

- Lack of standard Code Blue team response.
- Lack of standard Code Blue supplies.

Patient Safety > Emergency Preparation and Response – Code Blue (Cardiac Arrest team)

Recommendations

5.12.01 Immediately order replacement Code Blue pagers.

5.12.02 Standardize members and response to Code Blues 24/7.

5.12.03 Standardize code carts and their contents throughout the inpatient units, emergency room, OR and trauma center.

5.12.04 Review current system of stocking carts and develop a comprehensive exchange cart plan.

5.12.05 Remove code carts from clinic settings and replace with airway management box. Instruct staff to call 911 for code situations (excluding clinics which perform conscious sedation procedures).

5.12.06 Assess effectiveness of codes on an on-going basis.

Patient Safety > Monitoring of Patients

Assessment

- Telemetry unit does not have portable telemetry transmitters. Currently, it uses hardwire system only. This is not community standard for this population.
  - Example: If patient has bathroom privileges, he/she is removed from the cardiac monitor while in bathroom.
- NICU and Labor & Delivery do not currently have a security system in place, nor a patient tracking system. Discussion with the safety officer and nurse managers revealed that some had been reviewed, but the decision was made not to move forward due to cost constraints.
- A policy for conscious sedation monitoring is unavailable. This is in direct violation of JCAHO standard.

Deficiencies

- Lack of appropriate technology system to monitor telemetry population, placing risk on KDMC.
- Lack of regulatory requirement to monitor infant population, decreasing their safety and placing risk on KDMC.
- Lack of policy on conscious sedation.

Patient Safety > End of Life Care

Assessment

- Do Not Resuscitate or Do Not Intubate (DNR/DNI) forms do not exist. Currently, the orders are written as any other physician orders in the medical record; may be missed or not well-supported in the progress notes as required. This can and apparently does result in a breakdown in support of patients' rights. This is not within community standards.
- The level of physician who can actually write orders to withhold or withdraw treatment is not clear within KDMC.
- Ethics committee is not utilized by staff appropriately. It has not been seen as instrumental in aiding decisions around patients' end of life care. Its role is advisory at best.
- Currently there is no programmatic approach to palliative care.

Deficiencies

- Lack of appropriate documents to provide effective DNR/DNI documentation places KDMC at risk.
- Ethics committee is not functioning optimally.
- Patients are not appropriately supported through end of life decision making.

Patient Safety > End of Life Care

Recommendations

5.12.07 Update policy and procedure and implement changes as necessary. Define requirements of supporting documentation.

5.12.08 Implement DNR/DNI document record, that is easily identifiable in the patients chart. This document should have a bright coloring to aid identification.

5.12.09 Review Ethics Committee membership and activities, and make necessary changes to improve utilization and decision support. Develop a palliative care program as a subset of the Ethics Committee.

Patient Safety > Management of Assaultive Behavior

Assessment

- Current approach to management of assaultive behavior is inconsistent. Has lead to inappropriate handling of patients with violent responses on the part of law enforcement once called to the event. There is confusion as to what techniques are standard and workable and abrogation by the clinical team of their responsibility for controlling the situation and causing the least harm to patient and staff.
- Role confusion, lack of training, absent leadership and confusion about the response team membership have contributed to the problems.
- Medical Staff have heretofore not participated in the Code 9 response team membership even though resident physicians on psychiatric units and ED are present at nearly all times.
- Lack of skills by the nursing staff in how to perform appropriate de-escalation techniques has contributed to an excessive number of Code 9 calls, which then involve other untrained or unskilled personnel and add to the general confusion and poor handling of aggressive behaviors.
- Patient injuries have resulted, largely as the result of taser incidences by the OPS force. Governmental agencies have strongly objected to this technique in the handling of patients and have demanded immediate changes to policy and training.

Patient Safety > Management of Assaultive Behavior

Deficiencies

- Lack of a take-down team with clear directions and skills training.
- Lack of an organized and efficient process for the management of assaultive behaviors.

Recommendations

5.12.10 Institute immediate training for all clinical personnel in Management of Assaultive Behavior techniques. Utilize nationally recognized training programs and certified instructors.

5.12.11 Construct policies and procedures to clarify the actions to be taken by staff ` prior to a Code 9 call, roles and membership of the Code 9 response team, oversight and review of the team's work.

Patient Safety > Patient Identifiers

Assessment

- Name bands are used for all patients. However, allergy bands and fall risk bands are not used.
- Advance Directive Forms and their usage are unclear, without real ownership and accountability.

Deficiencies

- Lack of appropriate identification of patient risk factors may lead to decreased safety of patients.

Recommendations

5.12.12 Implement policy, procedures and process to meet the identification needs of the patient. This will involve Allergy alert bands and determining the hospital-wide color code for falls risk patients.

5.12.13 Review Advance Directive policy and revise system and process accordingly.

Patient Safety > Communication

Assessment

- Currently AT&T language line service is in place. Interviewees within nursing stated that staff in many areas are not sure how to use the system
- A formal interpreter department does not exist. Some staff members are paid a stipend for this service.
  - Staff utilized in this way are not trained as medical interpreters.
  - Managers voiced that this informal system does not work in general, as most staff interpreters are involved in direct patient care and are unable to respond timely to requests.

Deficiencies

- Lack of understanding of Nursing staff on how to utilize AT&T system.
- Lack of formal interpreter services.

Recommendations

5.12.14 Develop and implement Medical Interpreter services department reporting to case management leadership.

Patient Safety > Patient Education

Assessment

- Micromedics is the system currently in place in Nursing. Managers voiced that staff are unsure how to access this system. Staff also have computer access limitations.
- Education materials do not exist in Spanish. A contract is not currently in place with a provider of educative materials.

Deficiencies

- Lack of readily available patient education documents.

Recommendations

5.12.15 Revise current patient education system.

Section V – Nursing Services

13. Recruitment and Retention

Recruitment / Retention

Assessment

- KDMC is significantly challenged in recruitment and retention due to both market forces and KDMC image.
- KDMC nursing recruitment does not have an individual budget but is reliant on a centralized budget for all expenditures, which was relayed as challenging in interviews with the recruiter.
- Recruitment for new graduates is focused on local associate degree programs in community colleges. There appears to be no preference for BSN graduates.
- Students in local programs are rotated through KDMC as part of their program.
  - Recently, one rotation was cancelled at late notice to the college due to internal constraints. This caused upset to students.
  - There is no active hiring program for student nurses while in school or to expand their job description as they progress through school.
- Currently, one recruiter is in place for Nursing with one support staff person.
  - This recruiter returned from retirement on a limited basis to meet the needs of the department.
  - An experienced recruiter has been hired to build the recruitment and retention efforts.

Recruitment / Retention

Assessment

- A workforce plan does not exist. Hiring is determined for the postings requested by managers, but not necessarily in support of new program areas or future predictions of staff availability.
- Managers are not currently held accountable for individual unit turnover or trends, nor rewarded for retention efforts.
- Incentive programs are not currently in place; limited by County regulations.
- A Recruitment and Retention Committee is in place. Membership is limited to some staff persons working with management staff. Education of this group, regarding factors which contribute to positive recruitment and retention efforts, is not evident.
- Recognition of employees is currently not a priority. A major example is that Nurses' Week has not been celebrated for at least two years.

Recruitment / Retention

Deficiencies

- Lack of budget and strategic planning to meet both recruitment and retention needs.

Recommendations

5.13.01 Expand the department to at least two full time recruiters and one support person.

5.13.02 Write a program which includes student nurse hiring, recruitment in the nursing schools, scholarship availability.

5.13.03 Work with Human Resources to develop a workforce plan and adjust recruitment program accordingly.

5.13.04 Expand student nurse clinical site training contracts to include BSN programs.

5.13.05 Educate the recruitment and retention committee members in contemporary techniques for recruitment. Incorporate findings of Leadership Institute training planned in first quarter 2005 into development of retention strategies.

Section V – Nursing Services

14. Environment of Care
    - Patient Care Units

Environment of Care > Patient Care Units

Assessment

- The overall work environment of the patient care areas is in need of structural and organizational improvement.
- Clean, supply, and soiled rooms are very small and do not meet current needs.
- There are, at most, two keys to the locked areas with the exception of the medication room, which has a newly-installed keypad lock.
  - Seeking keys, obtaining supplies, and returning keys creates additional steps and time by staff and has the potential for delaying care.
- On each unit a patient room is being used as an equipment storage area (beds, IV poles, blanket warmers, infusion pumps, bedside tables, etc). Both clean and soiled equipment is found in the area along with medical equipment requiring repair.
- The cleaning responsibility of medical equipment is an unresolved issue and therefore neglected. Environmental staff claim that they are not qualified to clean some equipment. Nursing and Biomedical say that the environmental staff are responsible for cleaning.
- There is no consistent orientation of environmental staff as to the unit's needs and the services required. Additionally, environmental staff rotate quite often among units; causing unfamiliarity with units.

Environment of Care > Patient Care Units

Assessment

- Corridor door signs are incorrect in many areas.
- Corridor wall mounted mask and glove containers are mounted too close to the sidewall handrails. The required 12-inch clearance does not exist.
- The ceilings in the patient units and in other areas of the hospital are of an antiquated style no longer available. Replacement of damaged tiles (old style tongue-in-groove) is accomplished by using standard two-by-four foot lay-in panels that accommodate the same size light fixtures. Replacement of the old style ceiling tile would improve lighting and appearance of the units, make access for inspection and repair above the ceiling more efficient as well as safer (less dust and debris).
- Cleaning of ventilation grilles is problematic from the standpoint of dirty ductwork. Until the ductwork is cleaned on a routine basis, the grilles will continue to become dirty and the air being circulated will create a potential respiratory contamination risk.

Environment of Care > Patient Care Units

Deficiencies

- The root cause of the issues identified above is management inattention to safe environmental standards, patient aesthetics and comfort, way finding and general space adequacy.
- There has been a lack of clarity regarding responsibility for cleaning medical equipment among Biomedical Engineering, Environmental Services and Nursing.

Recommendations

5.14.01 Initiate weekly rounds including COO, CNO and directors of Plant and Environmental Services with emphasis on the work list identified in the Assessment section.

5.14.02 Clarify responsibility for cleaning medical equipment.

5.14.03 Develop priority list for patient units and public areas that includes way finding, aesthetics, patient comfort, access and cleanliness.

5.14.04 Add additional keys or keypads strongly recommended for use in the patient units.

Nursing Services

Performance Measures

- Turnover
  - Current <10% overall
  - Target 5-7% average
- Retention rate
  - Current not currently collected
  - Target TBD
- Percentage of agency staff per manager
  - Current not currently collected
  - Target steady decline each month to 0 use within a year
- Skin breakdown occurrences (nosocomial)
  - Current 11.4, range 6 -19 (2004 10-month average)
  - Target 0
- Aspiration occurrences
  - Current not currently collected
  - Target 0
- Fall occurrences
  - Current 8.1, range 1-17 (2004 10-month average)
  - Target 0

Nursing Services

Performance Measures

- Rate of medication administration errors
  - Target 22.1 (2004 10-month average), range 10 -78, rate not available
  - Target <0.3% rate med errors/all meds administered
- Unexpected return to a critical care area
  - Current not currently collected
  - Target 0
- Restraints incident occurrences
  - Current not currently collected
  - Target steady decline monthly to 0 use in one year
- Percentage of effectiveness of pain management per patient perception
  - Current not currently collected
  - Target >90% patient satisfaction with pain management
- Delay in treatment
  - Current 8.2 (2004 10-month average), range 1-17
  - Target 0

Nursing Services

Performance Measures

- Percentage of Code 9 resulting in restraints
- Percentage of Code 9 resulting in police action
- Percentage of debriefing after all Code 9
  - Current 100%
  - Target 100%
- Percentage of incidents with appropriate documentation
  - Current not currently collected
  - Target 100%
- Productivity (by unit)
  - Current not currently collected
  - Target TBD

Responsibility

- CNO

Section VI – Psychiatric Services

NAVIGANT CONSULTING

Psychiatric Services > Interviews

• L. Pascual	Nurse Manager, Inpatient and PES Unit
• B. Allmond	Nurse Manager
• M. Lang	Nursing Administration
• M. Richardson	Utilization Management
• L. Cruz	Supervisor
• G. Mallory, MD	Interim Chair of the Department of Psychiatry
• F. Pinder, MD	Chief of Inpatient/PES
• I. Toefler, MD	Chief Consultation & Liaison Service
• J. Williams	Supervisor, Social Worker
• J. Ching	Supervisor, Occupational Therapy
• J. Lawless	Supervisor, Recreational Therapy
• L. Erickson	Psychologist
• K. Thomas	Psychiatry Administrator

Psychiatric Services > Prioritized Summary of Recommendations

Psychiatric Services – Management		
Short-term	6.4.01	Consolidate the position of Chief Medical Director and Chief of Inpatient/PES.
Urgent	6.4.02	Replace present Nurse Manager.
Short-term	6.4.03	Institute regular multidisciplinary Psychiatric Services Management meetings with the goal of developing and implementing therapeutic programming.
Urgent	6.4.04	Develop a treatment model for care in PES.
Short-term	6.4.05	Develop a patient education plan.
Staffing and Scheduling		
Urgent	6.5.01	Institute 7-day a week coverage of Occupational and Recreational Therapy and Social work services to all units.
Immediate	6.5.02	Relocate Social Workers and Occupational Therapy supervisors from King and have them report to the Clinical Director and carry case loads.
Urgent	6.5.03	Ensure Registered OT conduct initial assessments on all patients.
Urgent	6.5.04	Revise the standards of care for PES consistent with the inpatient units.
Urgent	6.5.05	Evaluate the caseload of the Chief of Inpatient (if role not consolidated with Chief Medical Director). Hold accountable for the care and treatment provided to patients and to provide supervision to physicians.
Urgent	6.5.06	Provide permanent unit assignments for staff for continuity.
Urgent	6.5.07	Close nursing office in psychiatry area. Supervisory coverage will be provided by the psychiatric nursing management and house supervisors from the nursing department at King.
Urgent	6.5.08	Assign the SSN1 to permanent charge nurse positions on the units.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Psychiatric Services > Prioritized Summary of Recommendations

Delivery Model		
Urgent	6.6.01	Establish consistent coverage of all disciplines throughout the service.
Urgent	6.6.02	Increase OTR coverage to complete assessments and develop plan of care that OTAs can follow.
Short-term	6.6.03	Revamp the group schedule with input from all disciplines.
Short-term	6.6.04	Develop a plan to create a therapeutic milieu.
Short-term	6.6.05	Establish nurse leaders for all groups.
Urgent	6.6.06	Ensure Occupational Therapy is doing Activities of Daily Living Assessments.
Urgent	6.6.07	Enhance collaboration amongst the disciplines leading to an integrated plan of care.
Urgent	6.6.08	Establish daily rounds integrating utilization management at least once weekly to assist in throughput.
Urgent	6.6.09	Increase number of family/significant other meetings with Social Workers which may provide some assistance in placement.
Short-term	6.6.10	Establish and appropriate program of therapeutic groups with all disciplines involved.
Clinical Practice		
Urgent	6.7.01	Establish a dedicated Triage staff. Call the physician with the disposition.
Short-term	6.7.02	Develop performance standards and hold staff accountable for meeting them.
Urgent	6.7.03	Establish an environment for patient privacy at triage.
Short-term	6.7.04	Establish a permanent charge nurse in place that reports directly to the Nurse Manager.
Intermediate	6.7.05	Restructure the PES unit as an inpatient unit, calling it a forensic unit or an intensive treatment unit.
Urgent	6.7.06	Ensure all disciplines provide services to the “new” PES unit so that an integrated plan of care is developed.
Intermediate	6.7.07	Appoint one physician as chief of PES with responsibility and accountability for the clinical care provided.
Short-term	6.7.08	Maintain a separate holding area for minors and transfer when a a bed opens up at an appropriate facility. May use beds in Pediatrics to hold minors with psychiatric coverage and 1:1 provided by Psychiatric services.
Urgent	6.7.09	Educate and train staff regarding restraint policy and hold them accountable for compliance.

Psychiatric Services > Prioritized Summary of Recommendations

Documentation/Technology		
Short-term	6.8.01	Evaluate the documentation system and develop a more integrated record.
Performance and Quality Improvement		
Short-term	6.9.01	Develop QA/PI plan with all disciplines involved that will be integrated with hospital plan.
Short-term	6.9.02	Monitor items pertinent to psychiatry.
Skill Verification and Competency		
Short-term	6.10.01	Re-evaluate all staff for competency because the validation is questionable.
Training and Education		
Intermediate	6.11.01	Develop a training/education plan integrating specific psychiatric skills for all staff.
Intermediate	6.11.02	Develop training module for charge nurse development.
Orientation		
Short-term	6.12.01	Assess the completeness of the orientation.
Short-term	6.12.02	Develop an orientation packet on medication administration for psychiatry.
Short-term	6.12.03	Use consistent preceptors.
Recruitment and Retention		
Intermediate	6.13.01	Develop a recruitment strategy for psychiatry.
Environment of Care		
Urgent	6.14.01	Develop and implement a plan to address environment of care issues.

Overview

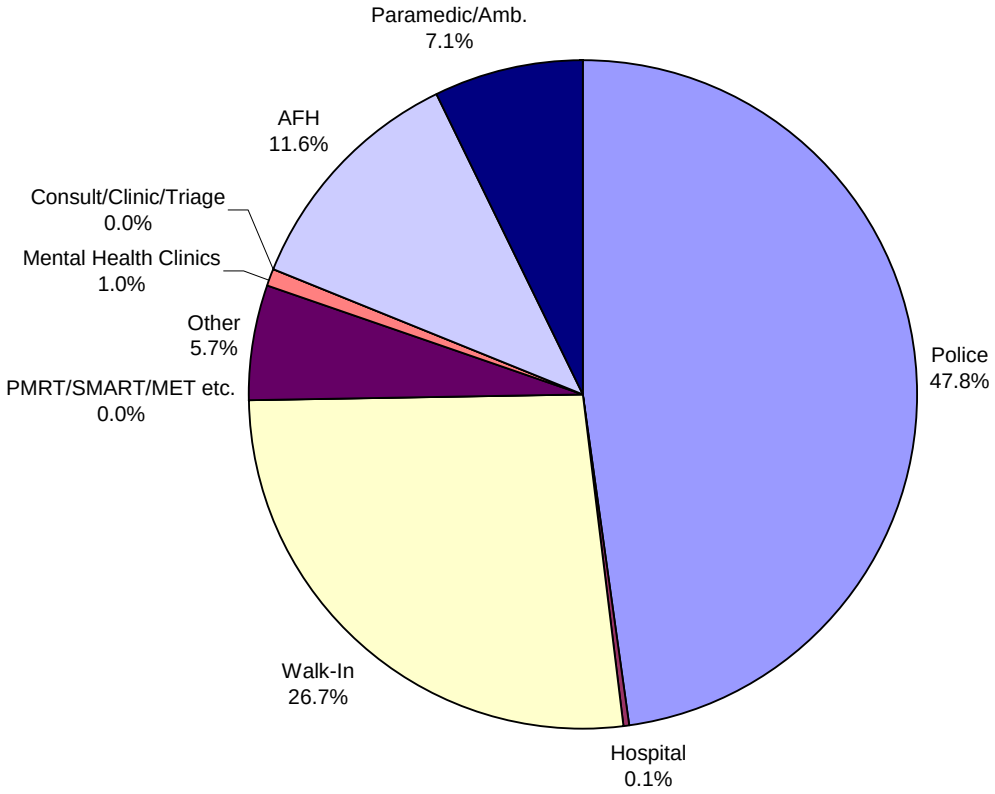
- Located on 2nd floor of the Augustus Hawkins Building.
- 76 licensed beds – 40 to 44 filled at any one time.
- Service Includes:
  - Triage:
    - Intake area (patient registration, evaluation, and medical clearance done here).
  - Psychiatric Emergency Services (PES). Portal of entry for psychiatric inpatient units.
    - 12 bed capacity - average daily census 19 -22.
    - Inpatient units:
      - Unit D 11+1
      - Unit F 10+1
      - Unit B 10+1 (closed presently for refurbishing)

Overview

- Average length of stay:
  - PES 24-32 hours
  - Inpatient units 16 days
  - Disposition Issues: not enough resources in the community or in state facilities. Patients difficult to place.
- 50% of patients are free care uninsured, 45% Med Cal, 5% insurance/Medicare.
- July 2003 - July 2004 triage had 4,308 visits; 2,480 brought in by the Police.

Overview

Psych ED



Patient Source (August 2004 – October 2004)

NAVIGANT CONSULTING

Section VI – Psychiatric Services

4. Leadership/Management

Leadership/Management

Assessment

- The Department Chair and clinical director have overall responsibility for managing psychiatric inpatient and PES services.
- The Chair of the department has been with KDMC since it opened. He is very committed to the organization and knows what needs to be done, but is no longer working full-time.
- The Chief Medical Director attempts to address the issues but fails to follow through to resolution.
- Nurse manager covers all three inpatient units. Her responsibilities include the day-to-day management of the unit, staffing, ensuring quality care delivery, and ensuring that all staff are compliant with mandatory training. Nurse manager retired recently. She was unable to grasp the seriousness of the situation as evidenced by:
  - Inability to manage fiscally and the use of Travelers and Registry personnel.
  - Numerous deficiencies identified by the JCAHO surveyors that still have not been addressed.
- An interim manager is in place.

Leadership/Management

Assessment

- No attempt to develop a QA plan for the service in collaboration with other disciplines. Data is collected but deficiencies are not addressed.
- The Chief of Inpatient and PES does not carry a case load and fills in where necessary. He does not address issues with physicians and fails to provide supervision and leadership around therapeutic milieu.
- Disciplines providing services to psychiatry (social workers, occupational therapists, recreational therapists and psychology) do not have a direct reporting relationship to the Chief Medical Director, the Nurse Manager or the interim Clinical Director.

Deficiencies

- Excessive use of Travelers and Registry personnel and overtime.
- Management does not provide leadership in ensuring quality care.
- Deficiencies are not proactively identified and resolution plans are not implemented.
- Staff are not compliant with mandatory trainings.
- Lack of therapeutic programming.

Leadership/Management

Deficiencies

- Leadership has made no attempt to work with the staff to develop a treatment model for PES.
- No patient education plan developed in response to JCAHO.
- Physician leadership ineffective.
- Reporting relationships of ancillary staff permits fragmentation, lack of collaboration and accountability.

Recommendations

6.4.01 Consolidate the position of Chief Medical Director and Chief of Inpatient/PES.

6.4.02 Replace present Nurse Manager.

6.4.03 Institute regular multidisciplinary Psychiatric Services Management meetings with the goal of developing and implementing therapeutic programming.

6.4.04 Develop a treatment model for care in PES.

6.4.05 Develop a patient education plan.

Section VI – Psychiatric Services

5. Staffing and Scheduling

Staffing and Scheduling

Assessment

- There is a nurse who functions doing performance management work on the deficiencies. Her responsibilities include working on PES decompression, educating staff on patient assessments, and patient rights. She has become the Interim Nurse Manager for psychiatric services.
- Staffing includes:
  - Four supervising staff nurses who work as supervisors.
  - Nineteen RNs, nine LVN, and twenty NAs.
  - Eleven travelers
  - Six clerks
  - Uneven coverage exists due to travelers who work 12-hour shifts, while KDMC staff work 8-hour shifts.
- The RN to patient ratio is 6:1, which meets the California standards.
- Productivity is currently 11.4 worked hours per patient day on the inpatient units.
- Physicians:
  - There are six full-time psychiatrists (one does not carry case load, one psychiatrist works 20 hours on weekends and 10 hours on holidays) and one internal medicine physician.
  - One PhD, who runs groups three times weekly, does psychological assessments, neuro cognitive screening, intelligence measurement, personality inventory, and research.
  - Four psychology interns and three psychology externs.
  - Seven to nine psychiatric residents.

Staffing and Scheduling

Assessment

- Ancillary staffing:
  - One social worker supervisor, who does not carry a case load.
  - Three masters prepared social workers and two medical case workers.
  - One registered occupational therapist (housed at KDMC and has other duties).
  - Three occupational assistants.
  - One recreational therapy supervisor, who does not carry a case load (housed at KDMC) and has other duties.
  - Three recreational therapists
    - Two from 8:00 AM to 4:30 PM, Monday through Friday.
    - One from 11:00 AM to 7:00 PM, Tuesday through Saturday.
  - One utilization management nurse; works 40 hours.
- Schedules are done through ANSOS for a four-week period for Nursing.
- Minimal flexing occurs within the Nursing. It is usually accomplished by requesting staff to come to work or not come to work. They can use earned time.
- Decisions on staffing needs made using the Evalisys Patient Classification System.
- Staff float between three units; no continuity.

Staffing and Scheduling

Deficiencies

- The same standard of care is not provided throughout the service.
- Lack of multi-disciplinary care on PES.
- Little collaboration between disciplines; no integrated plan of care.
- Lack of occupational therapy and social worker coverage on weekends and holidays.
- Unwillingness of other disciplines, other than psychology and recreational therapy, to run groups.

Staffing and Scheduling

Recommendations

6.5.01 Institute 7-day a week coverage of Occupational and Recreational Therapy and Social work services to all units.

6.5.02 Relocate Social Workers and Occupational Therapy supervisors from King and have them report to the Clinical Director and carry case loads.

6.5.03 Ensure Registered OT conduct initial assessments on all patients.

6.5.04 Revise the standards of care for PES consistent with the inpatient units.

6.5.05 Evaluate the caseload of the Chief of Inpatient (if role not consolidated with Chief Medical Director). Hold accountable for the care and treatment provided to patients and to provide supervision to physicians.

6.5.06 Provide permanent unit assignments for staff for continuity.

6.5.07 Close nursing office in psychiatry area. Supervisory coverage will be provided by the psychiatric nursing management and house supervisors from the nursing department at King.

6.5.08 Assign the SSN1 to permanent charge nurse positions on the units.

Section VI – Psychiatric Services

6. Delivery Model

Delivery Models

Assessment

- A modified team nursing model is used to deliver care.
- Nursing staff move among the three units.
- RNs do assessments, referrals, blood draws, and medication administration.
- LVNs do medication administration charting.
- NAs do vital signs and bathing.
- OT provides service to Units D and F only.
- Recreational therapy provides services to all units and runs most of the groups.
- Social services provides service to all units but they do not do assessments on patients here <23 hours on PES.
- The UM nurse provides service to the inpatient units but does not go to PES.
- Psychology runs one group a day for the patients on Unit D and F. Also do testing; MMPI, neuro-cognitive, and intelligence depression.
- Inter-disciplinary treatment teams meet two to three times weekly (daily on PES called discharge rounds).
- Minimal collaboration exists among disciplines.

Delivery Models

Deficiencies

- Standards of care are not consistent across the service.
- Program schedule does not meet the therapeutic needs of the patients.
- Lack of continuity of Nursing staff on each unit promotes lack of ownership and accountability.
- Occupational therapists do not assess activities of daily living (ADL).
- Few family/significant other meetings occur with social workers.

Delivery Models

Recommendations

6.6.01 Establish consistent coverage of all disciplines throughout the service.

6.6.02 Increase OTR coverage to complete assessments and develop plan of care that OTAs can follow.

6.6.03 Revamp the group schedule with input from all disciplines.

6.6.04 Develop a plan to create a therapeutic milieu.

6.6.05 Establish nurse leaders for all groups.

6.6.06 Ensure Occupational Therapy is doing Activities of Daily Living Assessments.

6.6.07 Enhance collaboration amongst the disciplines leading to an integrated plan of care.

6.6.08 Establish daily rounds integrating utilization management at least once weekly to assist in throughput.

6.6.09 Increase number of family/significant other meetings with Social Workers which may provide some assistance in placement.

6.6.10 Establish and appropriate program of therapeutic groups with all disciplines involved.

Section VI – Psychiatric Services

7. Clinical Practice
   - Triage
   - Psychiatric Emergency Services

Clinical Practice

Assessment

- Medical needs of the patients are assessed by an internist 8:00 AM - 4:30 PM, Monday through Friday.. After hours and on weekends this is done by a resident. If there is a medical emergency, 911 is called and the patient is transported to KDMC by ambulance or gurney.
- The use of tasers by County Police is an issue.
- The units look like psychiatric units of the 1960s; no pictures, not colorful.
- Lack of all discipline involvement has lead to a lack of integrated plans of care.
- There is an absence of therapeutic milieu. Patients sit in straight back chairs in day room and eat off trays in their laps because there is not enough room at the table.
- There is little interaction between patient and staff.
- Policies regarding restraints are not followed. Patients not monitored in room by staff but monitored from nurses' station on video.

Clinical Practice > Triage

Assessment

- All patients must go through triage to be evaluated for admission to PES or for disposition to another program (i.e., urgent care).
- The ED at KDMC may be the initial entry point for psychiatric patients. Patients who come into the ED have a psychiatric consult; disposition is made and if admission is necessary they are transferred to PES directly.
- Triage is a cumbersome process in which the patient may wait from 30 minutes to 4 hours to be seen.
- The physician from PES does the intake and makes the disposition. During evenings and nights a resident performs these duties with an attending as backup by phone.
- There is a breech of patient confidentiality based on the physical set-up of triage, anyone going by the area can look in the windows and see the patient being interviewed. Patients are held in an open area waiting for triage.

Deficiencies

- Patients are not expedited through triage in a timely manner.
- Patient confidentiality is compromised by the physical set up of the triage area.

Clinical Practice > Triage

Recommendation

6.7.01 Establish a dedicated Triage staff. Call the physician with the disposition.

6.7.02 Develop performance standards and hold staff accountable for meeting them.

6.7.03 Establish an environment for patient privacy at triage.

Clinical Practice > Psychiatric Emergency Services

Assessment

- Nurse manager manages the PES as well as the two inpatient units.
- Nursing staff ratios on PES are 4:1. This standard has been met with the use of agency nurses.
- Two physicians share the lead position. Another psychiatrist does UM on the unit.
- Overall responsibility for care delivery belongs to the Chief of Inpatient and PES.
- Minors are placed with the adults on this unit.
- OT does not service this unit. Social workers only do assessments on patients that have been on the unit >23 hours and on minors. The UM nurse does not service this unit.
- 95% of all patients coming to PES have a legal status, usually 5150.

Deficiencies

- PES is functioning as an inpatient unit rather than a crisis stabilization unit.
- Staff are not dispositioning patients quickly.
- There are some physician responsibility/accountability issues for care delivery on unit.
- Nursing leadership is not stable.
- Minors are admitted to PES.

Clinical Practice > Psychiatric Emergency Services

Recommendations

6.7.04 Establish a permanent charge nurse in place that reports directly to the Nurse Manager.

6.7.05 Restructure the PES unit as an inpatient unit, calling it a forensic unit or an intensive treatment unit.

6.7.06 Ensure all disciplines provide services to the “new” PES unit so that an integrated plan of care is developed.

6.7.07 Appoint one physician as chief of PES with responsibility and accountability for the clinical care provided.

6.7.08 Maintain a separate holding area for minors and transfer when a a bed opens up at an appropriate facility. May use beds in Pediatrics to hold minors with psychiatric coverage and 1:1 provided by Psychiatric services.

6.7.09 Educate and train staff regarding restraint policy and hold them accountable for compliance.

Section VI – Psychiatric Services

8. Documentation/Technology

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Documentation / Technology

Assessment

- Different charting tools are used by each discipline. The record does not flow well. Continually have to go back and forth to see progress of the patient.
- Nurses document on the patient progress note using the DAR system (data, assessment, response).

Deficiencies

- Lack of integrated patient record.

Recommendation

6.8.01 Evaluate the documentation system and develop a more integrated record.

Section VI – Psychiatric Services

9. Performance and Quality Improvement

Performance and Quality Improvement

Assessment

- There is no QA/PI plan in place for unit which reflects all disciplines involved.
- Audits are done on charts but information regarding deficiencies is not communicated to staff.
- Staff need to monitor issues pertinent to the psychiatric areas, i.e., high-risk meds.
- Staff has focused on limiting the average time in restraints.

Deficiencies

- QA/PI plan not in place.
- Deficiencies not communicated to staff.
- Monitoring items not pertinent to psychiatry

Recommendations

6.9.01 Develop QA/PI plan with all disciplines involved that will be integrated with hospital plan.

6.9.02 Monitor items pertinent to psychiatry.

Section VI – Psychiatric Services

10. Skill Verification and Competency

Skill Verification and Competency

Assessment

- Skills and competency validation is done in orientation and evaluated annually in performance review.
- Staff use checklists and self assessments to document.
- For new procedures or skills, a trainer will evaluate competency.
- Compliance is recorded at 100%, which seems questionable after observing actual practice and preliminary interviews with staff.

Deficiencies

- Forms do not cover all the competencies (i.e., medication administration).

Recommendations

6.10.01 Re-evaluate all staff for competency because the validation is questionable.

Section VI – Psychiatric Services

11. Training and Education

Training and Education

Assessment

- Little training or educating has taken place on the units.
- Rely on outside resources to provide training.
- Workforce Development of LA County has contracted El Camino Junior College to do training.
- Psychiatry has not had an educator for some time.
- Charge nurses need training on their role.

Deficiencies

- Lack of formal education/training plan.
- Lack of programs that will enhance the quality of patient care.
- Lack of educator for psychiatry.

Recommendations

6.11.01 Develop a training/education plan integrating specific psychiatric skills for all staff.

6.11.02 Develop training module for charge nurse development.

Section VI – Psychiatric Services

12. Orientation

Orientation

Assessment

- All staff go through three-week orientation.
  - One week in the general hospital and two weeks in psychiatry.
- A buddy system in place. Preceptor is not consistent. Preceptors do not attend formal classes.
- Goals and objectives for orientation are defined and measurable.
- Achievement is consistently documented. New employee is evaluated every month for the first six months.
- Travelers have a five-day orientation.
- Goals and objectives for travelers orientation are the same as for the regular staff as well as the documentation.

Deficiencies

- There is not a consistent preceptor for the orientees.
- Lack of training for preceptors

Recommendation

6.12.01 Assess the completeness of the orientation.

6.12.02 Develop an orientation packet on medication administration for psychiatry.

6.12.03 Ensure the use of consistent preceptors.

Section VI – Psychiatric Services

13. Recruitment and Retention

Recruitment and Retention

Assessment

- There are 7.5 RN vacancies and very few applicants. This is due in part to the market and to the reputation of KDMC.
- Many of the staff have ten or more years of service.
- Most staff leave within the first year. RN turnover rate is 7.94%.
  - They leave because of the patient population or the work environment.
  - Nothing has been done to manage this, resulting in the use of more agency and registry staff.
- There are no recruitment/retention strategies in place.

Deficiencies

- Lack of recruitment/retention strategy.

Recommendation

6.13.01 Develop a recruitment strategy for psychiatry.

Section VI – Psychiatric Services

14. Environment of Care

Environment of Care

Assessment

- The overall condition of the mental health area is sub-standard and subject to serious censure by any authority having jurisdiction that should inspect the area.
- Housing the types of patients described and observed requires a much higher degree risk-minimized environment than currently exists, even in so-called remodeled areas.
- Typical un-remodeled patient room issues:
  - Electrical over-bed lights (mostly damaged) that should be removed.
  - Closet doors are removable and can be used as weapons.
  - Washrooms with numerous grab bars, faucet, exposed plumbing pipe, toilet tissue holder hazards.
  - Removable ceiling tiles; should be solid ceiling.
  - Electrical outlets on wall should be blanked over with tamperproof screws.
- Ward D remodeled rooms:
  - Washrooms with plumbing piping and faucet handle hazards.
  - Mirror not recessed and removable from wall.
  - Closet doors are removable and can be used as weapons.
  - Removable ceiling tiles; should be solid ceiling.
  - Knobs on both bathroom and inside room doors.
  - Electrical outlets on wall should be blanked over with tamperproof screws.

Environment of Care

Assessment

- Restraint room occupied as a patient room.
  - Room should be available for restraint without removal of another resident.
  - Access panel in ceiling with edges loose.
- Other observations:
  - Ward F doors to ramp without security locks to prevent elopement.
  - Room 2075 without breakaway cubical curtain suspension.
  - Fire extinguishers should be kept inside nurse's stations.
  - Security magnets on some exterior doors impede on the required 6"-8" required egress height.
  - The location of the nurse's station does not maximize the observational requirements of the patient area corridors.

Environment of Care

Deficiencies

- Overall condition of the service is sub-standard and subject to any authority having jurisdiction that would inspect the units, i.e., restraint bed has head and foot rails, bathrooms with plumbing exposed, removable tiles in the ceilings, handles on closet doors, nurses station situated in such a way that it minimizes observation of the patients in the corridors.
- Environment of care not meeting standards.

Recommendations

6.14.01 Develop and implement a plan to address environment of care issues.

Psychiatric Services

Performance Measures

- Percentage of patients with an Occupational Therapist assessment
  - Current not currently collected
  - Target 100%
- Percentage of patients with an activities of daily living assessment
  - Current not currently collected
  - Target 100%
- Percentage of RN Turnover
  - Current 7.94%
  - Target TBD
- Percentage of Travelers to Total RN staff
  - Current 58%
  - Target 0%
- Percentage of staff with documented competencies
  - Current 100%
  - Target 100%

Psychiatric Services

Performance Measures

- Falls
  - Current not currently collected
  - Target TBD
- Percentage of re-admissions to the psych area within 30 days of discharge
  - Current 3% (January – December 2004)
  - Target TBA
- Percentage of traveler staff with documented orientation and competencies
  - Current 100%
  - Target 100%
- Medication administration errors
  - Current not currently collected
  - Target TBD
- Inpatient length of stay
  - Current 16 days
  - Target 6 days

Psychiatric Services

Performance Measures

- LOS - PES
  - Current 24-32 hours
  - Target 6-8 hours
- Productivity: Worked hours per patient day – Inpatient Units
  - Current not currently collected
  - Target TBD
- Percentage of documented compliance with restraint policy
  - Current not currently collected
  - Target TBA
- Number of elopements
  - Current not currently collected
  - Target TBD
- Percentage of documented compliance with the Suicide Policy
  - Current not currently collected
  - Target 100%
- Number of tasers incidents
  - Current not currently collected
  - Target 0

Psychiatric Services

Responsibility

- CNO
- Director of Psychiatry
- Medical Director

Section VII – Information Technology

NAVIGANT CONSULTING

Interviews

• M. McClure	CIO, KDMC Medical Center
• M. Cheng	Director Data Administration, KDMC IS
• J. Tuggle	Help Desk and Affinity System Manager, KDMC IS
• J. Christian	Director, Telecommunications, KDMC IS
• T. Hasan	HIPAA Compliance Officer, KDMC IS
• P. Appel	Laboratory Information Manager, KDMC IS
• A. Karim	Manager of Applications, KDMC IS
• R. Tan	Manager of Network and Operations, KDMC IS
• A. Richardson	Information Systems Coordinator, KDMC
• A. Kapstrom, MD	Clinical Resource Management
• C. Bartlett	Clinical Resource Management
• C. Griner	Clinical Resource Management IS
• A. Gray	CFO, KDMC
• E. Hardin, MD	Chief, EM Department, KDMC
• R. Peeks, MD	Chief Medical Officer, KDMC
• T. Yoshikawa, MD	Chair, Internal Medicine, Drew School of Medicine and KDMC

Interviews

• H. Mohamed, MD	Chair, Pathology, KDMC
• J. Keys	CEO, Hubert Humphrey Comprehensive Health Center
• L. Makam, MD	Medical Director, Hubert Humphrey Comprehensive Health Center
• W. Laker	CIO, Alverno Information Services
• F. Pecaitis	Sr., Vice President, Quadramed
• E. Files	Regional Vice President, Quadramed
• S. Williams	Vice President, Quadramed
• G. Groves	Client Manager, Quadramed
• R. Dunn	Vice President, MedQuist
• R. Matthews	Regional Director, MedQuist
• M. Morgan	CIO, Harbor UCLA
• J. Guterman, MD	Medical Director DHS
• S. Nelson	Director Information Services KDMC

Information Technology > Prioritized Summary of Recommendations

Overview – Scope and Governance		
Short-term	7.4.01	Restructure the reporting of the HIM Department in the organizational structure.
Short-term	7.4.02	Restructure the reporting of HIPPA in the organizational structure.
Short-term	7.4.03	Change sequencing of enterprise level implementations to address MLKD critical needs or run concurrent implementations and resource appropriately.
Short-term	7.4.04	Identify two physicians who can champion the use of Information Systems with other physicians.
Short-term	7.4.05	Involve key senior hospital executives in supporting Information Systems activities.
Strategic Alignment		
Short-term	7.5.01	Revise implementation timeframes and sequencing to ensure IT support is available for addressing critical issues on a timely basis.
Urgent	7.5.02	Ensure proper resources are available to carry out a more rapid implementation.
Structure and Management		
Short-term	7.6.01	Develop a training program for key management positions. Use this as a way to improve department performance and effectiveness.
Short-term	7.6.02	Develop performance measures and benchmark data that will assist management in directing the efforts of their people.
Intermediate	7.6.03	Relocate all servers at MLKD to the data center raised floor.
Intermediate	7.6.04	Relocate IT staff currently on raised floor to office areas.
Applications and Infrastructure		
Short-term	7.7.01	Implement Plan of Care (POC) for nursing services.
Urgent	7.7.02	Continue immediate upgrade to ANSOS.
Intermediate	7.7.03	Continue with the hardware upgrade to OMNI cell.
Urgent	7.7.04	Re-implement, properly staff, and train users regarding the ORSOS surgery scheduling system.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Information Technology > Prioritized Summary of Recommendations

Overview – Staffing and Spending		
Short-term	7.9.01	Revise the planned timeframes to acquire needed information systems quicker.
Urgent	7.9.02	Divide the Information Systems section into Operations/Technical Support (18 items) and Customer Services (13 items).
Intermediate	7.9.03	Align job classifications and pay scales to be more inline with other IT organizations allowing MLKD to be more competitive for IT resources.

Overview

- DHS and KDMC Information Services Department have implemented and supported many state-of-the-industry computer applications, particularly in the area of supporting patient care.
- Their Planning processes are in line with recommendations by JCAHO.
- The plans they are working on will further enhance the ability to support patient care activities.
- The staff at KDMC is experienced and seems qualified to carry out the assignments they have.
- Based upon budgetary constraints, sufficient staff is not available to implement systems at the rate that is needed.
- Staff should be better trained to provide a more effective project management activity that is required to implement available systems in a more timely manner.
- There seems to be competition for knowledgeable technical expertise among the various Information Technology departments throughout DHS.
- If it is the intent of DHS to consolidate resources and systems at an enterprise level. that effort should move ahead quickly so that systems can be implemented more rapidly to assist KDMC.

Section VII – Information Technology

4. Scope and Governance

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Scope and Governance

Assessment

- There are three organizations involved in providing Information Technology services at KDMC:
  - LA County Internal Services Department (ISD) Information Technology Services (ITS).
    - Supports pharmacy, human resources (CWTAPPS), plant management, and mental health outpatient systems.
  - Department of Health Services (DHS)
    - Provides centralized patient billing.
  - KDMC Information Services Department (i.e., Southwest Area Health Services of LA County).
- The strategic direction of information technology is to continue with the acquisition of enterprise solutions at the DHS level.
- In addition to providing enterprise application solutions, DHS also sets Information Technology standards (e.g., for networking, communications, system acquisition, web) that must be complied with by all LAC healthcare facilities.
- DHS negotiates most of Information Technology contracts for all LAC healthcare facilities.
- The KDMC-Information Services Department ISD today provides most applications, however, this may change as the DHS-wide enterprise application standards are established and implemented.

Scope and Governance

Assessment

- In addition, KDMC-ISD also provides:
  - Telecommunications
  - Local application and desktop support including help desk services.
  - Security services (including building security systems).
  - Health information management
  - Implementation support for local systems.
  - Implementation and support of interfaces.
  - Report creation.
  - Systems and support for the entire Southwest Area.
- There are correspondingly two formal levels of governance:
  - DHS level anchored by an Information Technology Steering Committee (IMTS).
  - Membership includes CIOs from the six DHS healthcare campuses and Public Health.
  - This committee sets system acquisition and implementation priorities for enterprise level (i.e., DHS-wide Mysis for lab and pharmacy) applications.
  - In addition, DHS appoints executive sponsors for each enterprise level application and the executive sponsor appoints a project director. For example, the KDMC pharmacy director is the project director for the enterprise pharmacy solution.

Scope and Governance

Assessment

- Local KDMC planning is anchored by the Information Functional Committee.
  - Members are: risk management, utilization management, information systems, library services, radiology, HIM, nursing services, pharmacy, plant management, and HIPAA.
  - This committee recommends Information Technology projects to hospital administration. The exception is the Enterprise Information Technology projects. These are handled by DHS.
- While the strategic direction of moving to enterprise-level applications to: leverage IT investments; enhance patient centric functionality; improve patient services; and quality of care where appropriate - current implementation plans will not allow KDMC to address critical issues (e.g., pharmacy) within the required timeframes needed.

Scope and Governance

Deficiencies

- The procurement and implementation process is too lengthy and cumbersome resulting in extensive delays in being able to take advantage of technological advances, patient safety, and accreditation issues that assist patient care givers.
- Extensive CIO time is being spent on non-CIO activities.

Recommendations

7.4.01 Restructure the reporting of the HIM Department in the organizational structure.

7.4.02 Restructure the reporting of HIPPA in the organizational structure.

7.4.03 Change sequencing of enterprise level implementations to address MLKD critical needs or run concurrent implementations and resource appropriately.

7.4.04 Identify two physicians who can champion the use of Information Systems with other physicians.

7.4.05 Involve key senior hospital executives in supporting Information Systems activities.

Section VII – Information Technology

5. Strategic Alignment

Strategic Alignment

Assessment

- There is a process that is followed on an annual basis for identifying information technology needs at the local (i.e., KDMC) level. This process currently involves surveying hospital/clinic departments and formulating the Information Technology plan based on survey results by ISD.
- The Information Management Functional Committee reviews the recommendations in the Information Technology plan. It is then forwarded for approval to the hospital IPO and then for approval to DHS and County Board.
- The plan is strategic in direction, but details are lacking in the areas of:
  - An organization and human resources plan that identifies the number and experience required to fulfill the plan.
  - A management process plan that identifies the ongoing planning process and project management process.
  - An investment plan that identifies the cost of hardware, software, supplies, and human resources required.
  - An education and training plan that identifies the needs for educating the users, technicians, and management.
  - An implementation plan that identifies the precise timeframes that meet the organization's needs and objectives.

Strategic Alignment

Assessment

- While the plan is comprehensive and technically sound in its direction, the specified timeframes for implementing new systems are too elongated (e.g., pharmacy, and Nursing Plan of Care module), especially given the critical issues that need to be addressed by KDMC.
- DHS has a very robust strategic application directions plan to provide information systems on an enterprise level. Included in these plans are:
  - Enterprise Pharmacy
  - Laboratory
  - Electronic Medical Record
  - Data Repository
  - Web services
  - Voice over IP
  - Document Imaging
  - Unique Unified Patient Identifier
- Many of these systems are needed immediately at KDMC, in particular the pharmacy system.

Strategic Alignment

Deficiencies

- Although the plans for both KDMC and DHS are comprehensive the ability to resource to fulfill the plans within the needed time frames is difficult to accomplish due to the extensive approval times.

Recommendations

7.5.01 Revise implementation timeframes and sequencing to ensure IT support is available for addressing critical issues on a timely basis.

7.5.02 Ensure proper resources are available to carry out a more rapid implementation.

Section VII – Information Technology

6. Structure and Management

NAVIGANT CONSULTING

Structure and Management

Assessment

- The Chief Information Officer (CIO) reports directly to the CEO of KDMC.
- The KDMC data center houses and supports most of the servers at KDMC. However, there are servers housed outside the data center (i.e., pharmacy, PACS, and plant management). These servers should be housed in the secure, climate controlled data center environment where normal IT data center functions, such as system backup, and power backup are available.
- The department is organized by function:
  - Data Administration – 4 FTEs
  - HIPAA Compliance – 2 FTEs
  - Information Systems Application Implementation & Support – 13 FTEs
  - Technical Support – 9 FTEs
  - Network & Operations – 9 FTEs
  - Telephone Communications – 17 FTEs
  - HIM-medical records – 86 FTEs
- Most management personnel in KDMC-ISD. have long tenure, while this allows for strong institutional knowledge and continuity it means that there may be lack of new ideas and energy. Also, many near retirement (e.g., CIO will retire in five years) and there needs to be succession planning.

Structure and Management

Deficiencies

- There is a lack of management development.
- Non-IS activities consumes a large portion of CIO's attention.
- There is a lack of performance measures for the services being provided by the Information Services Department.
- Servers are located outside the controlled data center environment.

Recommendations

7.6.01 Develop a training program for key management positions. Use this as a way to improve department performance and effectiveness.

7.6.02 Develop performance measures and benchmark data that will assist management in directing the efforts of their people.

7.6.03 Relocate all servers at MLKD to the data center raised floor.

7.6.04 Relocate IT staff currently on raised floor to office areas.

Section VII – Information Technology

7. Applications and Infrastructure

Applications and Infrastructure

Assessment

- Overall, the applications and infrastructure environment at KDMC is technically sound. DHS and/or the hospital has selected state-of-the-industry solutions.
- Major Systems:
  - QuadraMed suite of applications systems (Affinity) is a robust solution however, it is not yet fully implemented.
  - Affinity has been installed at KDMC since 1997, but much of the functionality is not being fully-used, particularly in the Nursing areas.
  - There is currently no Physician Order Entry being used in the system. Of the 533 physicians who have passwords, some do inquiries. Plans are being made to move KDMC toward Physician Order Entry.
  - Affinity software is currently being upgraded from version M2 to M3. This is scheduled for February 2005.
- Supporting Systems:
  - Mysis for Lab has been providing appropriate support for the acute hospital and clinics.
  - McKesson Pharm2000 for outpatient pharmacy is in the process of an upgrade to the newest version.
  - CW-TAPPS for payroll and human services is an internally developed system and may need to be replaced in the near future. DHS should research the market to determine an appropriate direction.

Applications and Infrastructure

Assessment

- Supporting Systems:
  - McKesson OMNI CELL for medication dispensing has a hardware upgrade in process.
  - ANSOS for nurse staffing and tracking is in the process of upgrading to the “One Staff” module as an Enterprise application.
  - ORSOS for Surgery Scheduling is in need of redirection. The system is being used in a retrospective manner. Data is entered after the procedure has been completed. This should be re-implemented as prospective system so that surgery can take full advantage of its capabilities. This is currently being upgraded to a newer software and hardware version.
- Infrastructure:
  - The network installed is a fully-functioning, multi-protocol one linking all of the campus buildings with high speed capability. There is a $1.2 million project currently underway to improve the wiring throughout the campus. There is currently no wireless networking in place although there is talk of utilizing one in the future.

Applications and Infrastructure

Deficiencies

- There is no Computerized Physician Order Entry (CPOE) at KDMC.
- There are no online nurse care plans being used.
- The current version of the ANSOS system makes extensive use of symbols that is cumbersome for nurses to use where the newer version eliminates the use of symbols.
- The Nursing Plan Of Care Affinity module, although available, is not being used.
- The Vital Signs and Intake/output Affinity module, which interfaces with monitoring equipment and available, is not being used at KDMC.

Applications and Infrastructure

Recommendations

7.7.01 Implement Plan of Care (POC) for nursing services.

7.7.02 Continue immediate upgrade to ANSOS.

7.7.03 Continue with the hardware upgrade to OMNI cell.

7.7.04 Re-implement, properly staff, and train users regarding the ORSOS surgery scheduling system.

Section VII – Information Technology

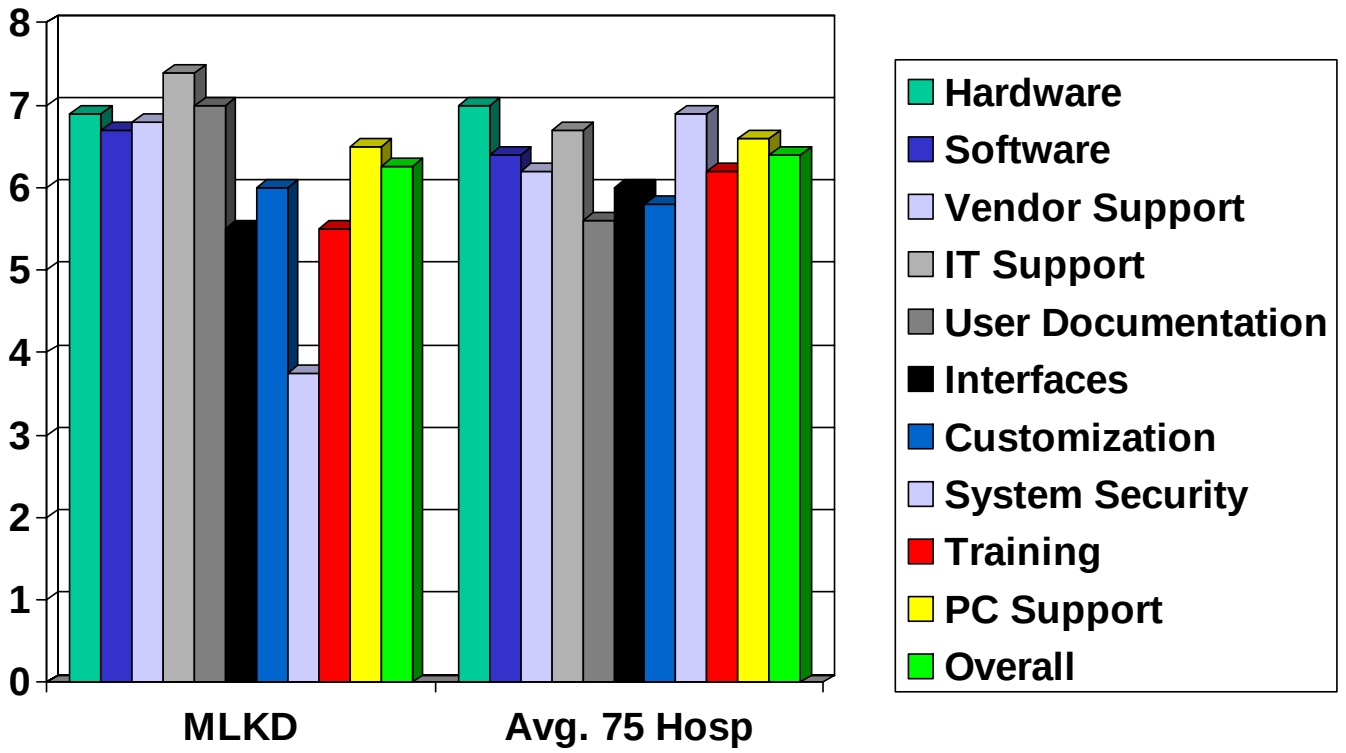
8. Service

Service

Assessment

- Surveyed 9 key users of Information Services services and achieved an overall rating of 6.25 on a scale of 10.
- The highest rating was 7.4 for the support received from the Information Services Department. The lowest rating was 3.75 for systems security. Based upon a survey conducted in 75 hospitals the comparative data for these categories were 6.4 overall, 6.7 for Information Services support, and 6.9 for systems security, (refer to the graph on following page).
- Some comments made are:
  - Color printers would enhance graphic capability.
  - Would like the capability to use Microsoft Project for project management.
  - IT support people need training in better customer relations.
  - Network is often too slow - the performance is deplorable.
  - Passwords expire too often.
  - Getting new systems acquired and operational takes too long.
  - The PC network is down too often.
  - Need authorization to be able to download training material for resident's program.
  - Need to reduce the time for availability of lab results in the ED.

Selected Customer Survey (9)



Section VII – Information Technology

9. Staffing and Spending

NAVIGANT CONSULTING

Staffing and Spending

Assessment

- The department is organized by function:
  - Department Administration – 2 items.
  - Data Administration – 4 items.
  - HIPAA Compliance – 2 items.
  - Information Systems – 33 items.
  - Telephone Communications – 17 items.
  - HIM –medical records – 86 items.
- The Information Services section should be divided into operations/technical support (18 items) and customer services (13 items). This would raise the level of customer support to a more visible level.
- The expenditure level for KDMC on Information Technology is approximately $4.4 million per year. This equates to about 1.1% of the total operating budget. Based upon industry benchmarks a standalone community hospital averages approximately 2.0% in operating expenses and multi-hospital Integrated Delivery Systems (IDSs) average 3%.

Staffing and Spending

Assessment

- The staffing level for the Information Services Department Information Technology function alone is 37 FTEs.
  - Based upon 62 hospital assessments the Information Technology FTE count should be between 7.5 FTEs per 100 Adjusted Occupied Beds (AOBs) and 11 FTEs per 100 AOBs.
  - Based upon 253.5 adjusted occupied beds (average daily census as of September 2004 and adjustment factor from FY03/04), the Information Technology FTE count should be between 19 - 28 FTEs.
  - It should be noted that KDMC's adjustment factor, provided by OSHPD, is "skewed to inpatient volume" due to LA County's all-inclusive charge master, therefore the optimal IT FTE level may be higher than above-mentioned.

Deficiencies

- There is too large a concentration of Information Technology FTEs and functions under a single section supervisor.
- The expense levels for Information Technology are below industry benchmarks for this size organization.
- The staffing complement for Information Technology people is below industry benchmarks.

Staffing and Spending

Recommendations

7.9.01 Revise the planned timeframes to acquire needed information systems quicker.

- For Pharmacy, Computerized Physician Order Entry, Nursing Care Plans, and the Electronic Medical Record.

7.9.02 Divide the Information Systems section into Operations/Technical Support (18 items) and Customer Services (13 items).

7.9.03 Align job classifications and pay scales to be more inline with other IT organizations allowing MLKD to be more competitive for IT resources.

Information Technology

Performance Measures

- Productivity: Worked hours per adjusted discharge
  - Current currently not collected
  - Target TBD
- Service Measures

Responsibility

- CEO
- CIO

Section VIII – Health Information Management

NAVIGANT CONSULTING

Interviews

• M. McClure	Chief Information Officer
• H. Jones	Director, Health Information Management
• V. Brown	Assistant Director, Health Information Management
• J. Richie	Assistant Director, Augustus F. Hawkins (AFH) HIM Department
• J. Bustamante	Assistant Director, HIM File Room
• J. Wilson	Supervisor, Coding
• H. Solomon	Supervisor, Release of Information
• V. Smith	Supervisor, Transcription Services
• E. Bell	Supervisor, Radiology File Room
• A. Kuvhenguhwa, MD	Chairman, Medical Record Committee
• L. Akhanjee, MD	Chief, Family Practice, Hubert Humphrey's Clinic
• L. Dubose	Chief Radiology Technician

Health Information Management > Prioritized Summary of Recommendations

Management		
Short-term	8.4.01	Provide customer awareness training to HIM staff. Utilize customer awareness training products developed by HIM previously.
Short-term	8.4.02	Establish an interdisciplinary team to enable problem resolution and buy-in from other managers and staff.
Short-term	8.4.03	Develop a department quality improvement program with communication to the department and employees performing the functions.
Short-term	8.4.04	Identify action plans for employees that are not performing at standard.
Short-term	8.4.05	Obtain necessary resources to comply with patient privacy regulations and provide quality services.
Short-term	8.4.06	Establish an administrative assistant position allowing more time for planning and development of longer term solutions to problems.
Short-term	8.4.07	Develop streamlined presentation materials and trend reports for presentations to the Medical Staff committee chairman and committees.
Short-term	8.4.08	Decrease turnaround times for coding of II/P and O/P records through improved record control procedures.
Short-term	8.4.09	Assess skills, performance and abilities of support managers and develop corrective action plans.
Short-term	8.4.10	Reorganize management staff to support new HIM functions.
Short-term	8.4.11	Continue to provide support for File Room Manager to obtain adequate staffing and resources in the file area and continue recognized success. Encourage manager to further education and career path.
Short-term	8.4.12	Reinstitute OVERT program when feasible.
Governance		
Short-term	8.5.01	Assist new Medical Record Committee Chairman to improve HIM communications with Medical Staff and to coordinate initiatives to improve clinical pertinence of the medical record. Coordinate meetings, electronic reports, scheduled email messages and develop
Short-term	8.5.02	Develop a subcommittee of the Medical Staff to perform a more comprehensive clinical pertinence review.
Short-term	8.5.03	Develop a tracking and feedback mechanism back to the Medical Records Committee and other Hospital IOP committees as needed including action plans for deficiencies noted.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

NAVIGANT CONSULTING

Health Information Management > Prioritized Summary of Recommendations

Overview – Coding		
Short-term	8.6.01	Perform comprehensive coding assessment for both inpatient and outpatient coders.
Short-term	8.6.02	Provide coder education related to deficiencies identified during coding assessment and 2005 ICD-9 and CPT-4 regulatory changes.
Urgent	8.6.03	Establish quality review results by coder with formalized reporting to HIM Director on a monthly basis.
Intermediate	8.6.04	Perform comparative analysis of facility DRG pairs for the most recent fiscal year with national data to determine potential areas for improved inpatient coding compliance and reimbursement.
Intermediate	8.6.05	Analyze APC groups to determine areas for improved outpatient coding compliance and reimbursement.
Long-term	8.6.06	Perform high-level review of facility CDM to determine potential areas for improvement of hard coded services.
Urgent	8.6.07	Relocate O/Ps, same day surgery and ED coding function to the HIM for coding consistency and compliance.
Intermediate	8.6.08	Review county coder item structure and facility recruiting efforts for certified coder positions. Determine competitive compensation package.
Intermediate	8.6.09	Review performance standards for coder trainees. Develop action plan to integrate those not meeting performance measures into other vacant technical positions.
Transcription		
Urgent	8.6.10	Determine contractual quality performance measures in MedQuist contract and compare current performance. Discuss findings with MedQuist reps and request implementation of immediate action plan for improvement.
Urgent	8.6.11	Provide feedback to Phil Valenzuela and John Wallace on quality issues with MedQuist.
Urgent	8.6.12	Hire 2-3 FTEs for radiology transcription in the interim while resolving the interface issue.
Short-term	8.6.13	Ensure that updated MedQuist software is installed immediately for radiology transcription.
Urgent	8.6.14	Further quantify reasons for MedQuist interface issues and identify solutions.
Urgent	8.6.15	Further evaluate quality of MedQuist transcription documents. Report to MedQuist executives and request monitoring and a formal action plan for improvement to be reported to HIM management on a weekly basis.
Intermediate	8.6.16	Review feasibility of physician dictation and transcription of ED records or other automated solution.
Short-term	8.6.17	Review “Buck Sheet” process and develop new procedure with the assistance of surgical service.

Health Information Management > Prioritized Summary of Recommendations

Overview – Release of Information		
Short-term	8.6.18	Review Smart Corporation contract, determine revenue and cost to Smart for current billable workload, meet with executive representatives to determine if additional work can be completed by Smart Corporation employees.
Short-term	8.6.19	Revise policy and procedure for storage of Risk Management department records with department managers.
Urgent	8.6.20	Develop a report that specifies number of records requested and number of records released on a weekly basis for use with staffing analysis.
Urgent	8.6.21	Install a security code lock for the ROI department door.
Urgent	8.6.22	Remodel Decedent Affairs area using adjacent two offices that are not frequently used. Establish a waiting area for visitors to the area with a service window and install a security code lock for the Decedent Affairs department door.
Short-term	8.6.23	Study ROI process for clinic patients, meet with clinic managers, develop a more patient friendly approach.
Short-term	8.6.24	Determine number of ambulance billing requests for 2002-2003; develop action plan for completion of requests.
Urgent	8.6.25	Determine reasons for delay or inability to retrieve medical records by the File Keepers storage company.
Short-term	8.6.26	Meet with ED physicians to discuss/develop a P&P for completion of required reports on injured patients.
Information Storage and Retrieval		
Short-term	8.6.27	Revise staffing to workflow and productivity standards.
Urgent	8.6.28	Develop a plan to resolve missing record issues related to File Keepers storage company.
Urgent	8.6.29	Log, box and check into computer system the 1979 – 1980 records and submit to File Keepers for storage.
Short-term	8.6.30	Relocate discharge processing functions to subsequently available space (Central Discharge Unit).
Urgent	8.6.31	Develop process to file lab and radiology reports on the inpatient records while patient is in-house.
Short-term	8.6.32	Eliminate clinic shadow chart system.
Urgent	8.6.33	Improve record controls to increase chart availability to patient care areas.
Long-term	8.6.34	Continue efforts with U2PI RFP and installation to improve duplicate medical record issue. Assess process in registration to determine if improvements are possible there with revised procedures and additional staff training.
Urgent	8.6.35	Implement solutions to the patient privacy issues in main file room.
Short-term	8.6.36	Training physicians to improve understanding of the Affinity system.
Short-term	8.6.37	Monitor workload in the radiology file room and reallocate staff to other areas where possible.

Health Information Management > Prioritized Summary of Recommendations

Overview – Clinic Operations		
Short-term	8.6.38	Perform comprehensive review of each on-site and off-site clinic to determine patient flow, record control, scheduling, financial screening, space and clinic support personnel issues. Develop an action plan to correct identified problems.
Long-term	8.6.39	Implement use of electronic progress notes in General Surgery clinic using available Health Notes module in Affinity. Implement second signature requirement.
Urgent	8.6.40	Improve record control and availability in clinics through implementation of successful record control pilot project in remaining clinics.
Short-term	8.6.41	Eliminate use of shadow charts.
Short-term	8.6.42	Identify implement effective process for patient financial screening and implement.
Short-term	8.6.43	Provide medical/clinic staff training in use of existing Affinity scheduling module.
Urgent	8.6.44	Determine clinic clerical support requirements, recruit and hire replacements for these open positions.
Tumor Registry		
Short-term	8.6.45	Review salary requirements for CTR professional.
Short-term	8.6.46	Recruit certified/registered Tumor Registrar to meet ACS standard.
Deficiency Control		
Urgent	8.6.47	Develop multidisciplinary team to discuss closed chart review process and clinical pertinence issues. Develop new process with more involvement by the medical and clinical staff.
Urgent	8.6.48	Monitor process and workflow; gradually decrease number of clerks in post discharge deficiency area. When concurrent deficiency program is completely implemented, much of the work should be performed prior to discharge.
Short-term	8.6.49	Add a feature to the deficiency system so that the physician's deficiencies appear when they log into Affinity.
Urgent	8.6.50	Assess process for obtaining anesthesia signatures. Determine a more effective way of processing these records.
Urgent	8.6.51	Assign duties and responsibilities to the unit clerks to assist with record completion and filing on the nursing units.
Urgent	8.6.52	Implement concurrent review process on nursing units.
Short-term	8.6.53	Review the current admitting and registration procedure and make recommendations for improving the duplicate record and AKA patient record combination process.

Overview

- The HIM Department is located on the lower level of KDMC with a satellite office for psychiatric records in the Augustus F. Hawkins building. The department is staffed with eight managers and 71 employees providing the following HIM services:
  - Coding – inpatient medical records are coded and processed for billing.
  - Decedent Affairs Office – medical information is processed and provided to families, the Coroner's office and others authorized and requiring information.
  - HIM File Room – outpatient and inpatient records are retrieved and maintained for patient care and others authorized to review medical information.
  - Medical Audit – records are reviewed for deficiencies and tracked until complete.
  - Release of Information – records are released to providers, insurance companies, attorneys and others authorized to receive medical information.
  - Tumor Registry – medical information in processed and tracked for cancer patient follow-up and research statistics.
  - X-ray File Room – x-ray films are retrieved and maintained for patient care.

Overview

- The HIM department is part of the patient care support team and is represented at many hospital operations and Medical Staff committees.
- The goals and objectives for HIM are to provide medical information to those who are authorized with a need to know, and to maintain proper security of patient information as is required by law.
- HIM is the custodian of the medical record and is responsible for monitoring the completion of the record and ensuring that the record is clinically pertinent for use during patient care services provided by KDMC healthcare practitioners.

Section VIII – Health Information Management

4. Management

Management

Assessment

Staffing				
Management	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
HIM Director	1	1	0	0
Assistant Director King/Drew	1	1	0	0
Assistant Director AFH	1	1	0	0
Supervisor -x-ray File Room	1	1	0	0
Supervisor File Room	1	1	0	0
Administrative Assistants	2	2	0	0
Blind Transcriptionist	1	1	0	0
Total	**8**	**8**	**0**	**0**

Management

Assessment

- Competency evaluation of HIM Director reflects:
  - Well-educated HIM Director with BS Degree in Health Information Management and subsequent RHIA credentials.
  - Well-organized and successfully develops policies and procedures required to effectively manage the department.
  - Extremely creative in problem solving abilities and quickly identifies workable solutions to daily issues. However, due to resource and staffing issues, much of management's time is utilized in solving urgent problems.
  - Well-liked and respected by employees. Provides effective leadership within the department. Effectively communicates information and discusses issues with employees as needed. Problems related to non-performance by employees appears to be related to HR policy rather than a hesitation to find a permanent solution.
  - Very effective at multi-tasking during periods where several priorities must be handled at once.
  - Possesses exceptional understanding of JCAHO, State of California and CMS standards. Able to quote many standards during discussions and has no problem locating those needing further reference.

Management

Assessment

- The HIM process improvement program, One Voice Employee Response Team (OVERT) was developed to involve staff in setting standards, goals, and quality indicators for their areas. It was discontinued due to staffing issues.
- A Continuous Quality Improvement Process is in place and includes quality indicators related to HIM policies and procedures as well as inter-departmental issues.
  - Process is working well.
  - Issues are presented and discussed at monthly meetings. Resolutions are identified and implemented.
  - Process lacks quality indicators related to accuracy of the work being done by individuals within the department.
- There is a strong, recently-hired file room manager.

Management

Deficiencies

- Need to replace positions and purchase resources needed to effectively operate the department.
- Third-party reimbursement has not been a focus at the facility.
- There is not a focus on quality of job performance within the department.
- Lack of necessary resources for the department, such as, equipment or remodeling required to accommodate patient privacy standards.
- Salary classifications for management positions not competitive with other LA County facilities.
- Support management staff often lacks responsiveness and follow-through.

Management

Recommendations

8.4.01 Provide customer awareness training to HIM staff. Utilize customer awareness training products developed by HIM previously.

8.4.02 Establish an interdisciplinary team to enable problem resolution and buy-in from other managers and staff.

8.4.03 Develop a department quality improvement program with communication to the department and employees performing the functions.

8.4.04 Identify action plans for employees that are not performing at standard.

8.4.05 Obtain necessary resources to comply with patient privacy regulations and provide quality services.

8.4.06 Establish an administrative assistant position allowing more time for planning and development of longer term solutions to problems.

8.4.07 Develop streamlined presentation materials and trend reports for presentations to the Medical Staff committee chairman and committees.

8.4.08 Decrease turnaround times for coding of inpatient and outpatient records through improved record control procedures.

Management

Recommendations

8.4.09 Assess skills, performance and abilities of support managers and develop corrective action plans.

8.4.10 Reorganize management staff to support new HIM functions.

8.4.11 Continue to provide support for File Room Manager to obtain adequate staffing and resources in the file area and continue recognized success. Encourage manager to further education and career path.

8.4.12 Reinstitute OVERT program when feasible.

Section VIII – Health Information Management

5. Governance

Governance

Assessment

- Medical Staff governance of HIM department is performed by the Medical Record Committee.
- Medical Record Committee chairman is involved and provides excellent support to department.
- Communications from the Medical Record Committee to the PSA Committee are the responsibility of medical administration and are performed routinely.
- The Medical Record Committee does not provide adequate oversight of the clinical pertinence review of the medical record.

Deficiencies

- Insufficient clinical pertinence reviews of the medical record.

Governance

Recommendations

8.5.01 Assist new Medical Record Committee Chairman to improve HIM communications with Medical Staff and to coordinate initiatives to improve clinical pertinence of the medical record. Coordinate meetings, electronic reports, scheduled email messages and develop

8.5.02 Develop a subcommittee of the Medical Staff to perform a more comprehensive clinical pertinence review.

8.5.03 Develop a tracking and feedback mechanism back to the Medical Records Committee and other Hospital IOP committees as needed including action plans for deficiencies noted.

Section VIII – Health Information Management

6. Functions
   - Coding
   - Transcription
   - Release of Information
   - Information Storage and Retrieval
   - Clinic Operations
   - Tumor Registry
   - Deficiency Control

Functions > Coding

Assessment

Staffing				
Coding	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
Supervisor	1	1	0	0
Contract DRG Coder	0	0	1	0
AFH coder	1	1	0	0
Trainee Coder	6	6	0	0
Contract non-Medicare Coder/Trainer	0	0	3	0
Contract Part-time 24 hr/week	0	0	2	0
Total	**8**	**8**	**6**	**0**

Functions > Coding

Assessment

- Inpatient coding is performed within the HIM department.
- Outpatient and same day surgery coding is performed by the Ambulatory Services.
  - Not all outpatient, same day surgery or ED records are coded due to a record control issue in the patient care areas.
- ED coding is performed by the Admitting.
- Internal audit results in HIM indicate issues with coding consistency and compliance.
- Staff includes one contract certified coder. Remaining coders are not certified.
- Area is over staffed due to trainee coders that are part of the LA County coder training program.
- Coder training on annual coding changes and coding compliance issues is not performed by outside trainers.
- Coding quality review is performed by coding supervisor periodically with feedback to the responsible coder. A weekly review schedule is planned for the near future. Results of quality review indicate need for additional training.
- An outside coding audit was previously requested but not approved.

Functions > Coding

Assessment

- Recruiting and retention is an issue due to competitive salary issues.
- A periodic coding newsletter is published by the coding manager that outlines coding issues identified during the internal audit process.

Deficiencies

- Need for a formalized coding quality review process with feedback to HIM Director.
- Coder retention issues related to competitive salary scales.
- Lack of enforced performance standards and timeframes for coder trainee positions.
- Need for coding audit and subsequent training by outside coding professionals.

Functions > Coding

Recommendations

8.6.01 Perform comprehensive coding assessment for both inpatient and outpatient coders.

8.6.02 Provide coder education related to deficiencies identified during coding assessment and 2005 ICD-9 and CPT-4 regulatory changes.

8.6.03 Establish quality review results by coder with formalized reporting to HIM Director on a monthly basis.

8.6.04 Perform comparative analysis of facility DRG pairs for the most recent fiscal year with national data to determine potential areas for improved inpatient coding compliance and reimbursement.

8.6.05 Analyze APC groups to determine areas for improved outpatient coding compliance and reimbursement.

8.6.06 Perform high-level review of facility CDM to determine potential areas for improvement of hard coded services.

8.6.07 Relocate O/Ps, same day surgery and ED coding function to the HIM for coding consistency and compliance.

8.6.08 Review county coder item structure and facility recruiting efforts for certified coder positions. Determine competitive compensation package.

8.6.09 Review performance standards for coder trainees. Develop action plan to integrate those not meeting performance measures into other vacant technical positions.

Functions > Transcription

Assessment

Staffing				
Transcription	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
Transcription Supervisor	1	1	0	0
Transcription Clerks	1	1	0	0
Total	**2**	**2**	**0**	**0**

Functions > Transcription

Assessment

- MedQuist maintains the contract for medical transcriptions in all LA County facilities.
- There is a 56% error rate for delivery of reports through the interface in radiology.
- The accuracy rate is 97% for HIM transcription. Contractual agreement is 99%.
- MedQuist has been unable to quantify and resolve the complex set of issues related to the radiology interface.
- Discussions have occurred with facility and County contract and grants managers.
- The MedQuist transcription service has not achieved the targeted contractual turnaround times for HIM transcription. Service is required to turnaround reports in 24 hours. This is monitored by HIM. Phone calls and written notification have been made to the service when there are delays. No further action has been taken.
  - For example, the turnaround time for History & Physicals and Operative Reports for the week ending 11/26/04 was at least four days. H&P transcription turnaround was cited by JCAHO the same week.
- Quality of transcription in the HIM area is being evaluated by the transcription supervisor, who reviews reports for accuracy.

Functions > Transcription

Assessment

- Quality of the radiology transcription is not acceptable with frequent errors such as typing one patient's report with another patient's demographic information.
- A comprehensive assessment of the radiology transcription issues has been initiated. Issues relate to errors by transcriptionists, KDMC staff and physicians, equipment and, interface software between MedQuist and Affinity.
- A technical evaluation by IT at MedQuist and KDMC is planned. An action plan for resolution is being formulated.
- Surgical Request forms, Buck Sheets, are typed by the surgeons to let various departments know that a surgery is scheduled. The process is cumbersome and inefficient for surgeons trying to schedule surgical procedures.

Deficiencies

- Poor quality radiology transcription.
- Radiology reports dictated are not available for patient care.
- HIM transcription reports are not available within 24 hours per contract with MedQuist.

Functions > Transcription

Recommendations

8.6.10 Determine contractual quality performance measures in MedQuist contract and compare current performance. Discuss findings with MedQuist reps and request implementation of immediate action plan for improvement.

8.6.11 Provide feedback to Phil Valenzuela and John Wallace on quality issues with MedQuist.

8.6.12 Hire 2-3 FTEs for radiology transcription in the interim while resolving the interface issue.

8.6.13 Ensure that updated MedQuist software is installed immediately for radiology transcription.

8.6.14 Further quantify reasons for MedQuist interface issues and identify solutions.

8.6.15 Further evaluate quality of MedQuist transcription documents. Report to MedQuist executives and request monitoring and a formal action plan for improvement to be reported to HIM management on a weekly basis.

8.6.16 Review feasibility of physician dictation and transcription of ED records or other automated solution.

8.6.17 Review “Buck Sheet” process and develop new procedure with the assistance of surgical service.

Functions > Release of Information

Assessment

Staffing				
Release of Information	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
Supervisor	1	1	0	0
Clerks	6	6	0	0
AFH ROI Clerk	1	0	0	1
Contract	0	1	0	0
Decedent Affairs (not included in ROI average)	2	2	0	0
Medico-Legal	2	2	0	0
Contract - Smart corporation (makes copies only for non-billable - processes all billable)				
Total	**12**	**12**	**0**	**1**

Functions > Release of Information

Assessment

- The Smart Corporation contract is in place for billable release of information services. Record photocopy service only for non-billable requests. Contractual obligations are met by Smart.
- Risk Management maintains records in a locked area. Original records are released for patient care providing opportunities for alteration of the records by facility staff.
- Workload information should be improved for staffing analysis purposes.
- Flow of patients from the clinic to the Release of Information (ROI) area is not effective. Patients travel to basement area from the clinic and are told that the record is in the clinic and not currently available.
- Patient privacy issues exist in ROI area with unauthorized employees entering area.
- Patient privacy issues also exist in Decedent Affairs office. Small area does not allow sufficient room for patient families, nursing, police officers, coroners office employees, etc., after a patient death. Medical records of patients are in plain view of visitors in the area due to small space available.

Functions > Release of Information

Assessment

- Current backlog of ambulance billing from 2002 and 2003 is pending completion.
- File Keepers storage company has been unsuccessful in producing a significant number of facility records for the ROI area.
- Doctor's First reports are not completed by ED physicians resulting in additional manpower to get them completed by the ROI area at a later date.

Deficiencies

- Lack of detailed workload information for staffing analysis.
- Ineffective patient flow from the clinic to the ROI area.
- Patient privacy issues in ROI area with unauthorized employees entering area.
- Patient privacy issues in Decedent Affairs office. Inadequate space record security and privacy.
- Inadequate performance by File Keepers storage company.
- Lack of proper reporting for injuries resulting in additional manpower requirements.

Functions > Release of Information

Recommendations

8.6.18 Review Smart Corporation contract, determine revenue and cost to Smart for current billable workload, meet with executive representatives to determine if additional work can be completed by Smart Corporation employees.

8.6.19 Revise policy and procedure for storage of Risk Management department records with department managers.

8.6.20 Develop a report that specifies number of records requested and number of records released on a weekly basis for use with staffing analysis.

8.6.21 Install a security code lock for the ROI department door.

8.6.22 Remodel Decedent Affairs area using adjacent two offices that are not frequently used. Establish a waiting area for visitors to the area with a service window and install a security code lock for the Decedent Affairs department door.

8.6.23 Study ROI process for clinic patients, meet with clinic managers, develop a more patient friendly approach.

Functions > Release of Information

Recommendations

8.6.24 Determine number of ambulance billing requests for 2002-2003; develop action plan for completion of requests.

8.6.25 Determine reasons for delay or inability to retrieve medical records by the File Keepers storage company.

8.6.26 Meet with ED physicians to discuss/develop a P&P for completion of required reports on injured patients.

Functions > Information Storage and Retrieval

Assessment

Staffing				
Information Storage & Retrieval (File Room)	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
File Clerks	29	29	0	0
Clerk NC (No position - temp employee)	0	2	0	0
AFH File Clerk	2	2	0	0
Total	**31**	**33**	**0**	**0**

Staffing				
Information Storage & Retrieval (Radiology File Room)	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
File Clerks	12	12	3.75	0

Functions > Information Storage and Retrieval

Assessment

- File room historically understaffed. Replacement positions were not approved. Recently, overtime utilized to purge records in overcrowded shelves and file backlogged loose filing.
- Average chart return rate from the clinics was 50% earlier this year. After initiating a pilot project in two clinics; the current rate is 85% for the pilot clinics.
- Clinic shadow charts are utilized in clinics to store copies and some originals of clinic progress notes due to retrieval issues.
- Discharged medical record process is performed in multiple locations resulting in difficult access for those needing records. Record control is difficult and manpower requirements are increased due to logistics.
- Records dated 1979-1980 are shelved in the basement. Space is needed for central discharge unit to improve logistics of discharged records.
- Laboratory and radiology reports are not consistently available for patient care.
- Reduction of duplicate medical record numbers is a County-wide initiative (U2PI project). An RFP is being developed to select a system for County hospitals.
- Patient privacy regulations exist due to file room access issues. Non-HIM staff performing chart review must walk through the file area to access records. Remodeling plan is complete.

Functions > Information Storage and Retrieval

Assessment

- Physicians require additional training in the Affinity system. Lack of training results in decreased access to patient records and scheduling information.
- Radiology file room area has a dwindling workload due to PACS radiology image software.

Deficiencies

- Average chart return rate is improving for pilot clinics, remaining clinics need improvement.
- Clinic shadow charts are utilized in clinics to store copies and some originals of clinic progress notes.
- The discharged medical record process is performed in multiple locations resulting in difficult access for those needing records.
- Records dated 1979-1980 are shelved in the basement and should be placed in long term storage.
- Laboratory and radiology reports are not consistently available for patient care.
- Patient privacy issues exists due to file room access issues.
- Lack of physicians training in the Affinity system resulting in decreased access to patient records and scheduling information.

Functions > Information Storage and Retrieval

Recommendations

8.6.27 Revise staffing to workflow and productivity standards.

8.6.28 Develop a plan to resolve missing record issues related to File Keepers storage company.

8.6.29 Log, box and check into computer system the 1979 – 1980 records and submit to File Keepers for storage.

8.6.30 Relocate discharge processing functions to subsequently available space (Central Discharge Unit).

8.6.31 Develop process to file lab and radiology reports on the inpatient records while patient is in-house.

8.6.32 Eliminate clinic shadow chart system.

8.6.33 Improve record controls to increase chart availability to patient care areas.

8.6.34 Continue efforts with U2PI RFP and installation to improve duplicate medical record issue. Assess process in registration to determine if improvements are possible there with revised procedures and additional staff training.

8.6.35 Implement solutions to the patient privacy issues in main file room.

8.6.36 Training physicians to improve understanding of the Affinity system.

8.6.37 Monitor workload in the radiology file room and reallocate staff to other areas where possible.

Functions > Clinic Operations

Assessment

- Dollarhide and Hubert Humphrey clinics chart retrieval, storage, and completion processes require immediate evaluation. Off-site clinics were recently added to the HIM area of responsibility and comprehensive assessments have not been completed.
- Patient flow in General Surgery Clinic is ineffective due to block scheduling and inadequate space.
- Shadow charts are utilized to ensure chart availability decreasing the continuity of the medical record.
- Scheduling system in affinity is not fully utilized by physicians and staff due to training issues.
- OR scheduling system is not accessible to surgeons who are unable to view their surgical schedule. Surgeons are unable to easily reschedule patients.
- Financial screening of surgical patients is not effective. Preoperative workups are performed and surgery is cancelled due to non-coverage by insurance company. Preoperative review for medical necessity based on regulatory requirements is not performed.
- Clerks are not available in all clinics. Nurses are attempting to answer phones, schedule appointments and provide other clerical support.

Functions > Clinic Operations

Deficiencies

- Urgent record control and availability exist at Dollarhide and Hubert Humphrey clinics.
- Patient flow in general surgery clinic is ineffective due to block scheduling and inadequate space.
- Shadow charts are utilized to ensure chart availability decreasing the continuity of the medical record.
- Scheduling system in affinity is not fully utilized by physicians and staff due to training issues.
- OR scheduling system is not accessible to surgeons attempting to view their surgical schedule.
- Financial screening of surgical patients is not effective.
- Clerks are not available in all clinics.

Functions > Clinic Operations

Recommendations

8.6.38 Perform comprehensive review of each on-site and off-site clinic to determine patient flow, record control, scheduling, financial screening, space and clinic support personnel issues. Develop an action plan to correct identified problems.

8.6.39 Implement use of electronic progress notes in General Surgery clinic using available Health Notes module in Affinity. Implement second signature requirement.

8.6.40 Improve record control and availability in clinics through implementation of successful record control pilot project in remaining clinics.

8.6.41 Eliminate use of shadow charts.

8.6.42 Identify implement effective process for patient financial screening and implement.

8.6.43 Provide medical/clinic staff training in use of existing Affinity scheduling module.

8.6.44 Determine clinic clerical support requirements, recruit and hire replacements for these open positions.

Functions > Tumor Registry

Assessment

Staffing				
Tumor Registry	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
Registered Tumor Registry Clerk (contract)	0	0	0	1
Tumor Registry Clerks	2	2	0	1
Tumor Registry Clerk Part-time: 20-24	1	1	0	1
Total	**3**	**3**	**0**	**3**

Functions > Tumor Registry

Assessment

- Tumor registry does not have a certified tumor registrar (CTR) and, therefore, does not meet American College of Surgeons standards for certification.
- Coding backlog is developing in tumor registry.
- Salaries are not competitive for CTR professionals.

Deficiencies

- No certified tumor registrar (CTR).

Recommendations

8.6.45 Review salary requirements for CTR professional.

8.6.46 Recruit certified/registered Tumor Registrar to meet ACS standard.

Functions > Deficiency Control

Assessment

Staffing				
Deficiency Control	**Available Positions**	**Current FTEs**	**Contract FTEs**	**Vacant Positions**
Concurrent Review Staff	3	3	0	0
Discharge Area Deficiency Staff	4	4	0	0
Contract	0	0	7	0
Total	**7**	**7**	**7**	**0**

Functions > Deficiency Control

Assessment

- HIM was cited by JCAHO and CMS because of medical record deficiencies such as:
  - H&Ps and operative notes not recorded in the record within 24 hours.
    - However, there is an extensive monitoring, tracking and feedback process in HIM to assist the Medical Staff in completion of these reports. Great strides have been made in this regard.
  - Delinquent record count 50% or below the average monthly discharges (JCAHO noted that delinquent records did not meet standard for the fourth quarter of 2003. However, Medical Record Committee minutes indicate that delinquent records were within standard for the fourth quarter of 2003).
  - Inconsistent medical record information.
  - Missing clinical information from the medical record.
- Currently, approximately 35 KDMC employees, classified as nursing assistants, are waiting conversion to unit clerk status. They are currently available on each nursing unit to perform clerical functions.
- Concurrent deficiency review was recently implemented in order to address the deficiencies cited by JCAHO related to lack of dictation, signatures, and other clinical information required for patient care during the patient stay.

Functions > Deficiency Control

Assessment

- Physicians are not using their number stamp or writing in their numbers and credentials next to their names. This makes it difficult to identify attending physicians, residents, and medical students.
- Assess feasibility of adding new feature to the deficiency system so that the physician's deficiencies appear when they log into Affinity.
- It is difficult to determine which attending physician should co-sign for anesthesia residents. Currently, the Anesthesia Department Chairman is signing most of the records after discharge; and has been encouraging the residents to indicate who the attending is when they write a note.

Deficiencies

- Inconsistent medical record information within the medical record.
- Missing clinical information in the medical record.
- Physicians are not using their assigned numbers to identify themselves in the medical record.

Functions > Deficiency Control

Recommendations

8.6.47 Develop multidisciplinary team to discuss closed chart review process and clinical pertinence issues. Develop new process with more involvement by the medical and clinical staff.

8.6.48 Monitor process and workflow; gradually decrease number of clerks in post discharge deficiency area. When concurrent deficiency program is completely implemented, much of the work should be performed prior to discharge.

8.6.49 Add a feature to the deficiency system so that the physician's deficiencies appear when they log into Affinity.

8.6.50 Assess process for obtaining anesthesia signatures. Determine a more effective way of processing these records.

8.6.51 Assign duties and responsibilities to the unit clerks to assist with record completion and filing on the nursing units.

8.6.52 Implement concurrent review process on nursing units.

8.6.53 Review the current admitting and registration procedure and make recommendations for improving the duplicate record and AKA patient record combination process.

Health Information Management

Performance Measures

Coding

- Percent inpatient records not coded > 5 days post discharge
  - Current
    - August 0.13%
    - September 0.75%
    - October 0.94%
    - November 5.01%
  - Target 5.00%
- Inpatient records pending coding that have not been received from nursing units
  - Current 8
  - Target 0
- Records coded per day per FTE
  - Current 3.5
  - Target 24

Health Information Management

Performance Measures

Release of Information

- Percentage of ROI requests pending > 14 days
  - Current not currently collected
  - Target 95%
- Percentage Birth Certificates mailed/complete 11 days after birth
  - Current not currently collected
  - Target 95%

Transcription

- Percentage H&Ps transcribed in 24 hours
  - Current not currently collected
  - Target 100%
- Percentage Operative Reports transcribed in 24 hours
  - Current not currently collected
  - Target 100%
- Percentage Discharge Summaries transcribed in 24 hours
  - Current not currently collected
  - Target 100%

Health Information Management

Performance Measures

Information Storage and Retrieval

- Percentage Clinic charts available for patient care
  - Current 81%
  - Target 95%
- Percentage Correspondence/loose reports filed within 30 days
  - Current 81%
  - Target 95%
- Percentage Charts pending from clinic (average/day)
  - Current 30%
  - Target 0%
- Percentage Charts pending from nursing units (average/day)
  - Current 3%
  - Target 0%

Health Information Management

Performance Measures

Deficiency Control

- Percentage of records completed within 14 days
  - Current 26.9%
  - Target <50%

Tumor Registry

- Percentage Tumor Registry coding within six months post discharge
  - Current not currently collected
  - Target 90%
- Percentage Tumor Registry patients lost to follow-up
  - Current 11%
  - Target 10%

Responsibility

- Director, Health Information Management

Section IX – Human Resources

NAVIGANT CONSULTING

Interviews

• S. Hamai	Administrative Director, DHS
• K. Edmundson	Acting Director, DHS Human Resources
• D. Jackson	Business Operations, Compliance Audits, DHS
• L. Barber	Nurse Manager
• M. Lang	Nursing Director
• E. Bolden	Director of Material Management
• T. Payne	Director of Physical Therapy
• H. Mohamed,MD	Director, Pathology Department
• A. Gray	Chief Finance Administrator, Finance Department
• A. Gutierrez	Director, Pharmacy Department
• N. Darling	Occupational Therapy Chief
• P. Price	Interim CNO
• D. Ashton	Interim Assistant Chief, HR Services Division
• B. Kikkawa	Departmental Civil Services Representative, Performance Management Section of KDMC Human Resources

Interviews

- K. Ochoa Director, SEIU, Local 660
- R. Leonard Director, Health Division I, SEIU, Local 660
- P. Valenzuela Administrator for Ancillary and Rehab Services
- Union delegates from SEIU and Local 660
- Group interview with members of the KDMC Human Resources and DHS Human Resources

Human Resources > Prioritized Summary of Recommendations

Human Resources – Service Delivery Strategy		
Intermediate	9.5.01	Re-evaluate the centralized HR model, which provides HR service support to KDMC as a shared services strategy for efficiency and effectiveness. The KDMC HR professional staff should be assigned to specific departments for clarity of assignment.
Short-term	9.5.02	Complete a thorough and disciplined review of work processes to define the scope and purpose of the KDMC HR function in relationship to DHS and County specific HR programs and services.
Organization, Staffing and Management		
Urgent	9.6.01	Establish new positions for KDMC HR.
Short-term	9.6.02	Assess the current needs of its customers to address service gaps in strategic leadership, management training, organizational development, recruitment and retention and human resources performance metrics to measure service and organizational impact of the function.
Intermediate	9.6.03	Develop the necessary information systems capabilities to capture critical human resources data and establish ongoing reports for decision support on turnover, budgeted FTEs (items), workforce demographics & trends and JCAHO/CMS compliance.
Short-term	9.6.04	Benchmark and compare data to healthcare industry performance benchmarks from organizations such as ASHHRA (American Society for Healthcare Human Resources Administration, (UHC) University Health Consortium as well as private sector human resources performance metrics from SHRM (Society for Human Resources Management) or The Saratoga Institute.
Technology		
Short-term	9.7.01	Identify performance criteria to evaluate the new HRIS system acquired for use in the Medical Center.
Short-term	9.7.02	The HR Department should evaluate end user`s (managers) needs to insure that this system provides the necessary information tools to enable managers to manage their human resources in a shared services environment.
Intermediate	9.7.03	Continue the plan for installation of a new HRIS system and design specific ad hoc reports that can be developed through CWTAPPS until a decision is made about acquiring a new HRIS package.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Human Resources > Prioritized Summary of Recommendations

Policies and Procedures		
Urgent	9.8.01	Establish a Medical Center-wide task force to develop a comprehensive HR Policies and Procedures Manual for KDMC, which can be periodically monitored for possible updates and revisions in policy.
Performance Management		
Urgent	9.9.01	Establish criteria and triage cases based on severity of the alleged offense, potential risk to patients, staff, etc., and establish time limits to bring these cases to closure.
Short-term	9.9.02	Establish performance goals for the Performance Management Unit to include customer satisfaction, case turnaround times, trend analysis and reporting and organizational effectiveness.
Urgent	9.9.03	Increase communication and improve case management coordination between the Performance Management Unit and responsible supervisors or managers to clarify Investigative procedures, delineate organizational roles and responsibilities in the investigative process and produce measurable results which address both management and employee advocacy objectives.
Recruitment and Retention		
Short-term	9.10.01	Assist with the follow up and communication of the results of the Service Excellence Survey being conducted and to use the data to identify those issues of employee dissatisfaction which may be adversely affecting patient satisfaction.
Short-term	9.10.02	Maintain, trend and analyze turnover statistics and investigate causal effects of “unhealthy” turnover in the organization.
Intermediate	9.10.03	Conduct periodic employee opinion surveys to elicit employee input, identify problem areas and develop specific action plans to address these concerns as part of a proactive and positive Employee Relations strategy. These organization-specific survey results should be compared to healthcare industry benchmarks such as MSA (Management Science Associates) AON Consulting healthcare workforce commitment index, etc.

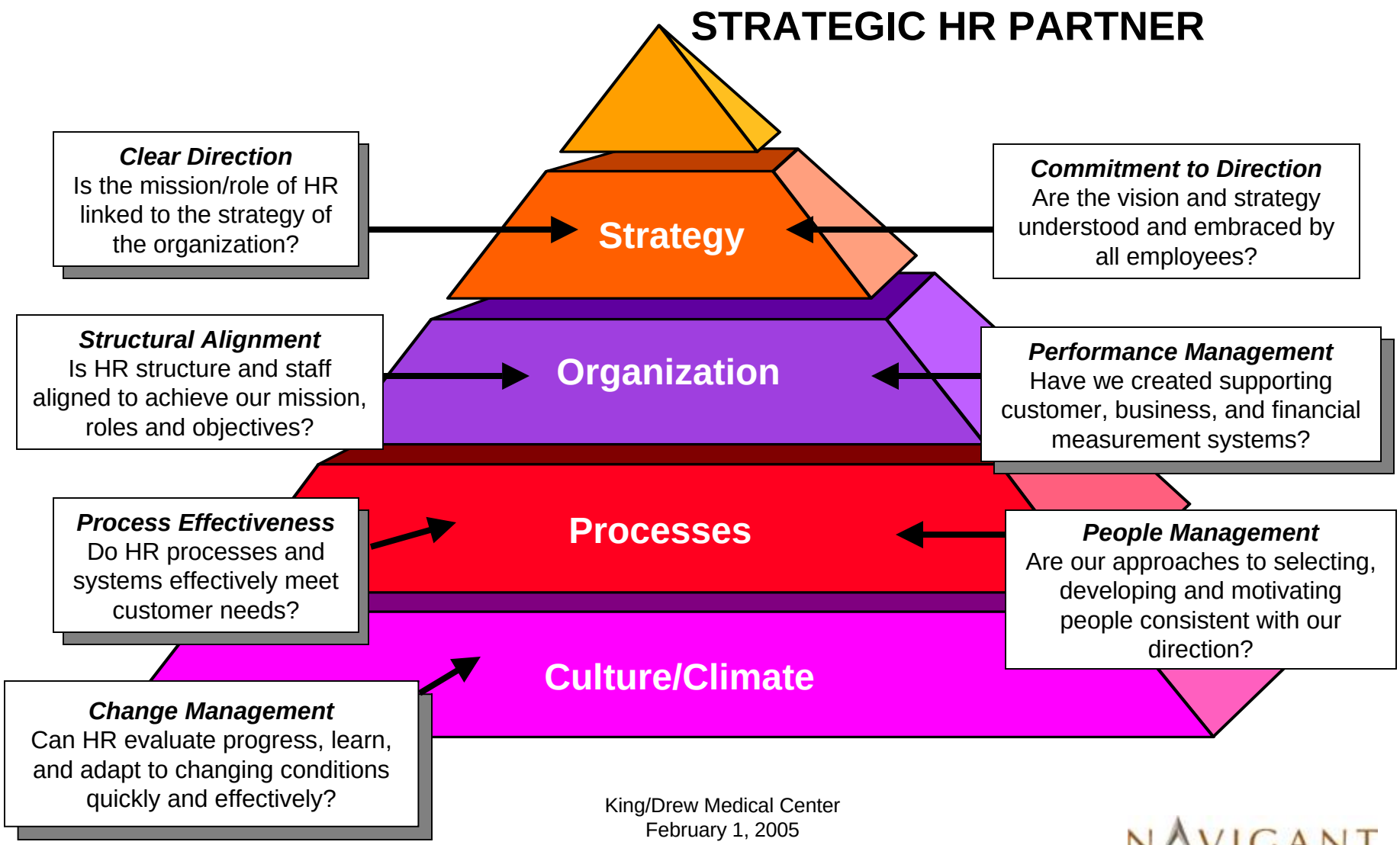
Human Resources > Prioritized Summary of Recommendations

Compliance Reporting		
Urgent	9.11.01	Add an on-site HR Compliance Coordinator and one administrative support staff person.
Short-term	9.11.02	Establish HR as the primary point of organizational contact in coordinating agency and travelers orientation to the facility and accountable for completion of documentation on professional competencies.
Urgent	9.11.03	Obtain appropriate software and/or reporting systems to track and trend compliance issues specific to the healthcare industry and established regulatory requirements.
Short-term	9.11.04	Re-evaluate structure, process and representation (including HR representation) of the KDMC Improving Organizational Performance Committee (IOP) to insure it functions as an effective compliance oversight mechanism, with appropriate accountabilities tied back to Medical Center leadership.
Urgent	9.11.05	Establish organization-wide performance criteria for the JCAHO Management of HR standards for all managers as part of their annual performance evaluations at KDMC.
Compensation and Benefits		
Short-term	9.12.01	Conduct an analysis of the compensation and benefits program compared to healthcare industry trends to evaluate it's competitiveness and quality for recruitment/retention for high vacancy areas.
Employee Labor Relations		
Short-term	9.13.01	Identify corrective plans as issues are identified from these grievances
Short-term	9.13.02	Design and present a comprehensive Management Training Program, which provides skill development and training in positive employee/labor relations, communication skills, employee survey techniques, conflict resolution, progressive discipline and other key topics.
Payroll		
Short-term	9.14.01	Develop an RFP for a fully automated payroll system which, in its design and functionalities, will achieve both payroll and HR objectives for the organization. This process has started in DHS and should continue into year 2005 to establish a timetable for a buy decision and implementation schedule for both a payroll and HRIS package..

Human Resources > Prioritized Summary of Recommendations

Training and Organizational Development		
Short-term	9.15.01	An OD function should be established at the DHS level, which provides on-site support to the Medical Centers.
Intermediate	9.15.02	Conduct a needs assessment to determine the depth and scope of OD interventions so that an appropriate and cost-effective staffing model can be developed and implemented to support the Medical Centers' needs in this area.
Health, Safety and Workers Comp		
Short-term	9.16.01	Integrate the Employee Health Service into the HR Department at KDMC to better coordinate the employee hire and orientation process and to support improved on-site management of KDMC workers' compensation cases.
Urgent	9.16.02	Conduct a thorough audit of all its workers compensation cases and develop a plan to manage these cases to resolution by a specified timetable.

Assessment Framework



NAVIGANT CONSULTING

Organizational Profile

- 2,600 employees, which is the workforce specific to KDMC (an additional 1,000 employees are from other affiliate facilities like Southwest CHC/Health Centers being included in the workforce count of the County).
  - Approximately 83% of the current medical center workforce are full-time employees, 17% are either temporary full-time or part-time employees.
  - Approximately 80% of KDMC`s workforce is unionized, representing 14 separate bargaining units in both direct patient care, ancillary support, and service/technical support positions.
  - 50% of the Nursing staff is comprised of contingency (travelers and agency) staff.
  - The overall turnover rate for KDMC is 6.5% (DHS turnover report).
  - The overall vacancy rate is 26% (DHS vacancy report).
  - Nursing vacancy rate is approximately 35%. Pharmacy has a 50% vacancy rate.
  - Approximately 8% (195) of the workforce is on workers' compensation, (source: Open Claims Report for KDMC from DHS).
  - Approximately 61% of the workforce is Female, 39% is Male, 51% is African-American, 11% is Hispanic, 1% is Asian (workforce profile report for KDMC from DHS).
  - Average annual employee base salary: $43,400 (DHS workforce profile report).
  - Average length of employee service at KDMC is 16.0 years (DHS workforce profile report).

Service Delivery Strategy

Assessment

- The Human Resources (HR) at KDMC has evolved from a hospital-based department to a County centralized service delivery model, maintaining limited on-site staff. Provide transaction-based services in personnel processing, training/orientation, performance management, and return to work.
- DHS supports KDMC in some areas, e.g., JCAHO compliance, with other traditional HR functions administered at the County level, e.g., recruitment, collective bargaining, etc. The objectives of the move to a centralized HR model was to achieve more consistency in administering and interpreting HR policies and procedures and improving technology to enable on-site users to manage human resource transactions directly and more efficiently.
- KDMC HR functions work collaboratively with DHS and the County level HR Department in a distributive or corporate-divisional relationship in providing services.
- There is little evidence of defined service requirements in these relationships or metrics on service performance or quality indicators.
- KDMC HR function was largely dysfunctional for seven years before DHS intervened to redefine and restructure services.

Service Delivery Strategy

Deficiencies

- The organizational structure and service delivery strategy does not represent a true shared services model that is customer-driven in articulating the scope of services provided with clearly identified service contacts, and a clear delineation of service roles between KDMC HR and DHS/County level services.
- Although the HR technology, which supports HR and management at KDMC, is not sophisticated and user-friendly enough in providing both standing reports and related data for decision supports by departments. On-line access to item (position) control, current hiring lists, became available in March 2004. Approval for access was required by the CEO who significantly limited that access.

Recommendations

9.5.01 Re-evaluate the centralized HR model, which provides HR service support to KDMC as a shared services strategy for efficiency and effectiveness. The KDMC HR professional staff should be assigned to specific departments for clarity of assignment.

9.5.02 Complete a thorough and disciplined review of work processes to define the scope and purpose of the KDMC HR function in relationship to DHS and County specific HR programs and services.

Organization, Staffing and Management

Assessment

- KDMC HR is comprised of 21 staff who coordinate basic services in:
  - Training Unit – three
  - JCAHO Compliance – five
  - Operations – five and one student worker
  - Performance Management – seven

  * this does not include other HR support staff that is off-site, which includes full-time dedicated staff for payroll, return to work, etc.
- They are supported by a centralized HR function through DHS. According to staff, the KDMC HR function was largely dysfunctional for about seven years, creating significant problems, which central DHS has been working on over the last year.
- The current service delivery model is more of a corporate/division model than a true shared services function for KDMC.
- The current ratio of KDMC HR staff to employees at KDMC is 1:158 (includes all hospital positions, Comprehensive Health Center positions and the Health Center Positions - 3, 229 for FY 2004-05) Industry benchmarks are 1:100 for private sector human resources and 1:180 for healthcare human resources.

Organization, Staffing and Management

Assessment

- There is currently no permanent, on-site senior HR management position at KDMC, which functions as a generalist and internal consultant.

Deficiencies

- The present HR staffing resources allocated to the KDMC are inadequate in proportion to the urgent HR issues and ongoing service/strategy needs.
- Departmental customers cite slow or non-response to service inquiries, a lack of clarity in understanding who to contact in HR for which services and the management of employee discipline is a lengthy and cumbersome process.
- Access to on line reporting tools has been limited by the prior CEO. There is a lack of understanding and use of the full capabilities of the system.
- There is no on-site, permanent senior HR director to lead the function to focus on these deficiencies and rebuild/refocus the function to meet customer needs in developing a KDMC-specific HR strategy.

Recommendations

9.6.01 Establish the following positions in addition to the current HR staff at KDMC:

- An HR associate director to provide direct, on-site supervision of the staff and develop a Medical Center-specific HR strategy while managing provision of daily operations. This position(item) should report directly to the COO of KDMC, with a dotted line report to DHS.
- A full-time on-site HR Compliance Coordinator.
- A Recruitment Specialist with emphasis on Allied Health Recruitment., providing additional support to Nursing Services in nurse recruitment as needed.
- Two additional administrative support staff (one for general administrative support and one to assist the HR Compliance Coordinator position).

Organization, Staffing and Management

Recommendations

9.6.02 Assess the current needs of its customers to address service gaps in strategic leadership, management training, organizational development, recruitment and retention and human resources performance metrics to measure service and organizational impact of the function.

9.6.03 Develop the necessary information systems capabilities to capture critical human resources data and establish ongoing reports for decision support on turnover, budgeted FTEs (items), workforce demographics & trends and JCAHO/CMS compliance.

9.6.04 Benchmark and compare data to healthcare industry performance benchmarks from organizations such as ASHHRA (American Society for Healthcare Human Resources Administration, (UHC) University Health Consortium as well as private sector human resources performance metrics from SHRM (Society for Human Resources Management) or The Saratoga Institute.

Technology

Assessment

- At present, the County-wide personnel information system, CWTAPPS provides personnel information and data reporting for KDMC.
- This system is not particularly user friendly and needs to be manipulated to generate certain types of reports, which should be part of a standing reporting package for a contemporary HRIS (Human Resources Information System), e.g., distribution of timely performance evaluations, budget reporting of positions(items) by cost center, etc.
- DHS is currently reviewing a vendor package for an updated HRIS, which should have improved capabilities to meet its information needs. The estimated time frame to make a buy decision is on or before February, 2005. Timing of implementation is much further out.

Technology

Deficiencies

- The current system is not user friendly and needs to be manipulated to generate certain types of reports.
- There is a lack of focus and initiative taken among KDMC staff to define HRIS needs in designing the data base and determining what kinds of reporting information is needed to support customers.

Recommendations

9.7.01 Identify performance criteria to evaluate the new HRIS system acquired for use in the Medical Center.

9.7.02 The HR Department should evaluate end user`s (managers) needs to insure that this system provides the necessary information tools to enable managers to manage their human resources in a shared services environment.

9.7.03 Continue the plan for installation of a new HRIS system and design specific ad hoc reports that can be developed through CWTAPPS until a decision is made about acquiring a new HRIS package.

Policies and Procedures

Assessment

- There are no updated HR policies and procedures manual specific to KDMC.
- The facility is relying essentially on County-wide HR policies and procedures to address performance management and other human resources issues.
- Policies are suitable as generic HR policies at the County level, a set of healthcare oriented HR policies and procedures should be developed for KDMC, as well as an ongoing mechanism for policy review and update.

Deficiencies

- No site-specific HR policies or procedures, which leads to inconsistency of application and interpretation of policy and subsequent management decision affecting employees.

Recommendations

9.8.01 Establish a Medical Center-wide task force to develop a comprehensive HR Policies and Procedures Manual for KDMC, which can be periodically monitored for possible updates and revisions in policy.

Performance Management

Assessment

- KDMC HR has a performance management unit, which is responsible for consulting with managers in assisting them to address employee performance/discipline issues.
- There are approximately 300 performance management cases on file at KDMC, which are being investigated and brought to some form of closure by this unit. Approximately 50% of these cases have been brought to some form of closure.
- While this unit records the dates that cases are logged in for investigation and closed out, they do not track or measure the average length of time it takes to complete a case investigation. They also do not categorize or prioritize these cases for investigation by severity of the alleged offense, e.g., patient care issue or policy violation or urgency of response needed.
  - As an example, an investigation involving an alleged verbal abuse of a patient in the ED was initiated almost 60 days ago, yet to date, appears unresolved.

Performance Management

Deficiencies

- The performance management unit displays limited effectiveness in the areas of case management in coordinating investigation with affected staff, communication and establishing performance metrics in achieving timely resolution of cases.

Recommendations

9.9.01 Establish criteria and triage cases based on severity of the alleged offense, potential risk to patients, staff, etc., and establish time limits to bring these cases to closure.

9.9.02 Establish performance goals for the Performance Management Unit to include customer satisfaction, case turnaround times, trend analysis and reporting and organizational effectiveness.

9.9.03 Increase communication and improve case management coordination between the Performance Management Unit and responsible supervisors or managers to clarify Investigative procedures, delineate organizational roles and responsibilities in the investigative process and produce measurable results which address both management and employee advocacy objectives.

Recruitment/Retention

Assessment

- There are approximately 559 budgeted vacant positions at KDMC, or 26% of the workforce. Approximately 227 of these are in the Nursing services area, (source: DHS Vacancy Report).
- Employee recruitment at KDMC is performed largely at the County level as candidates apply on-line through the County-wide employment website.
- KDMC HR does not play an active role in this part of the process, but does perform post-hire processing of new employees, including administering the new hire orientation program.
- They do not perform the traditional role of a full-service employment specialist or staff recruiter, nor do they maintain related statistics or metrics such as requisition lapse time and cost per hire data.
- There is no formal exit interview process for separating employees at KDMC at this time.

Recruitment/Retention

Deficiencies

- Limited participation or involvement by the KDMC HR function in its ability to impact on recruitment/retention issues due to delineation of roles and organization of recruiting at the DHS County level.

Recommendations

9.10.01 Assist with the follow up and communication of the results of the Service Excellence Survey being conducted and to use the data to identify those issues of employee dissatisfaction which may be adversely affecting patient satisfaction.

9.10.02 Maintain, trend and analyze turnover statistics and investigate causal effects of "unhealthy" turnover in the organization.

9.10.03 Conduct periodic employee opinion surveys to elicit employee input, identify problem areas and develop specific action plans to address these concerns as part of a proactive and positive Employee Relations strategy. These organization-specific survey results should be compared to healthcare industry benchmarks such as MSA (Management Science Associates) AON Consulting healthcare workforce commitment index, etc.

Compliance Reporting

Assessment

- KDMC HR was tasked to coordinate resolution and response to the following compliance deficiencies, as identified through the JCAHO and CMS accreditation reviews:
  - Lack of timely performance evaluations, performance evaluations do not address ages of populations of patients served.
  - Assessment of agency staff. Responsibility and oversight of staff and agency competency not clearly defined and carried out.
  - Lack of training in assaultive behavior, medical record documentation system.
  - Incomplete agency staff orientation.
- Based on October 2004 reporting data, 92% of performance evaluations due for October were late. Therefore, KDMC is still non-compliant on this issue.
- KDMC has developed a comprehensive, criterion-based performance evaluation tool, which captures required information on competency assessment. The organization is compliant on this issue.
- KDMC has not sufficiently clarified and delineated the scope of responsibilities between itself and the various agencies on who is responsible for competency assessment of agency staff and, therefore, is still non-compliant on this issue.

Compliance Reporting

Assessment

- While KDMC has made significant progress in completing training in dealing with assaultive behaviors, the personnel files do not accurately and consistently reflect documentation of such training. Given the recent CMS citation, the organization is non-compliant on this issue.
- Agency staff do not receive appropriate and consistent orientation to KDMC, compared to the regular two-day program that regular staff attend.
- There are documentation issues in the personnel files accurately reflecting orientation participation and documentation of staff competencies. Therefore, KDMC is still non-compliant on this issue.

Deficiencies

- There is currently no dedicated on-site HR staff responsible for coordinating ongoing HR compliance activity for JCAHO, CMS, etc. at KDMC.
- There is a serious lack of management accountability to manage compliance as part of the managers' overall performance responsibilities at KDMC.

Compliance Reporting

Recommendations

9.11.01 Add an on-site HR Compliance Coordinator and one administrative support staff person.

9.11.02 Establish HR as the primary point of organizational contact in coordinating agency and travelers orientation to the facility and accountable for completion of documentation on professional competencies.

9.11.03 Obtain appropriate software and/or reporting systems to track and trend compliance issues specific to the healthcare industry and established regulatory requirements.

9.11.04 Re-evaluate structure, process and representation (including HR representation) of the KDMC Improving Organizational Performance Committee (IOP) to insure it functions as an effective compliance oversight mechanism, with appropriate accountabilities tied back to Medical Center leadership.

- HR should serve on this committee so they can be a more effective liaison between the committee and the Medical Center in coordinating compliance on HR issues and advancing standards for quality improvement in HR performance.

9.11.05 Establish organization-wide performance criteria for the JCAHO Management of HR standards for all managers as part of their annual performance evaluations at KDMC.

Compensation and Benefits

Assessment

- Compensation and benefits is managed at the County level for KDMC employees.
- There is not a traditional on-site compensation and benefits function at KDMC, which provides analytical support, surveys market trends, and actually plays a proactive role in designing and implementing compensation and/or benefit programs. The County sets and implements compensation policy through the office of the Chief Administrative Officer (CAO).
- The County benefits program, while generally comprehensive and competitive compared to similar public sector employers, is not specific enough to healthcare industry benefits trends, operational issues, and employee needs.
- The current compensation program at the County level reflects a traditional civil service, time in grade progression model, and does not significantly reflect or address healthcare industry compensation market issues or trends, e.g., recruitment/retention bonuses, salary market equity adjustments, performance incentives, career ladders in Nursing, and allied health positions, etc.
- There has been some interest expressed at DHS in becoming more involved with compensation and benefits planning; playing a more active role in developing strategy to support the KDMC's recruitment and retention strategy.

Compensation and Benefits

Deficiencies

- Current compensation is believed to be a barrier for KDMC recruitment and retention.

Recommendations

9.12.01 Conduct an analysis of the compensation and benefits program compared to healthcare industry trends to evaluate its competitiveness and quality for recruitment/retention for high vacancy areas.

Employee/Labor Relations

Assessment

- Since 80% of the KDMC's workforce is unionized across 14 separate bargaining units, the major activity in this area is more traditional labor relations, e.g., grievance handling, labor contract interpretation and administration and interface with the union representatives.
- The actual union contracts are negotiated at the County level, where most final settlement or impasse decisions are made by the CAO.
- Management training is needed in the KDMC to improve managers' skills in working with employees, handling grievances in working with union delegates, interpreting and administering the union contracts, etc.

Employee/Labor Relations

Deficiencies

- Lack of an on-site presence at KDMC HR to significantly impact on labor relations at the facility level; and lack of a comprehensive management training program in positive and proactive employee/labor relations.

Recommendations

9.13.01 Identify corrective plans as issues are identified from these grievances which may require follow up or intervention with responsible managers.

9.13.02 Design and present a comprehensive Management Training Program, which provides skill development and training in positive employee/labor relations, communication skills, employee survey techniques, conflict resolution, progressive discipline and other key topics.

Payroll

Assessment

- The payroll function is administered by HR, to the extent that they are responsible for coordinating the collection of payroll data for the organization, which is then sent on for processing and actual production of paychecks.
- The part of the payroll process performed by HR is largely manual, paper driven, and antiquated.

Deficiencies

- Lack of a state-of-the-art automated payroll function with effective interface with a comprehensive HRIS.

Recommendations

9.14.01 Develop an RFP for a fully automated payroll system which, in its design and functionalities, will achieve both payroll and HR objectives for the organization. This process has started in DHS and should continue into year 2005 to establish a timetable for a buy decision and implementation schedule for both a payroll and HRIS package..

Training and Organizational Development

Assessment

- Some basic training is provided by KDMC HR to staff in the organization. Nursing education provides more specific clinical education programs.
- There is also no formal organizational development (OD) function on-site (or at the DHS level either) with a continuing focus on and organizational responsibility for such areas as leadership development, managing change, team building, succession planning, aligning organizational culture with strategy, etc.
- While the size of KDMC may may not necessitate having a dedicated, on-site OD function, there are OD issues, which should be addressed either through a DHS level OD function or perhaps through an outsourced contractual service model.

Training and Organizational Development

Deficiencies

- While some training and a formal new employee orientation program is conducted on-site, there is not a comprehensive management training program which helps healthcare professionals transition effectively from the role of practitioner or specialist to manager.

Recommendations

9.15.01 An OD function should be established at the DHS level, which provides on-site support to the Medical Centers.

9.15.02 Conduct a needs assessment to determine the depth and scope of OD interventions so that an appropriate and cost-effective staffing model can be developed and implemented to support the Medical Centers' needs in this area.

Health, Safety and Workers' Compensation

Assessment

- The employee health services function at KDMC operates separately from HR, with coordination of information and services as needed for managing new employee orientation, medical leave of absence processing, etc.
- Approximately 8% of all employees at KDMC are currently on workers' compensation status.

Deficiencies

- Lack of a coordinated and effective workers' compensation management strategy at KDMC to assess and manage resolution of existing workers' compensation liability claims, resulting in significant costs in money and lost productivity to the organization.

Recommendations

9.16.01 Integrate the Employee Health Service into the HR Department at KDMC to better coordinate the employee hire and orientation process and to support improved on-site management of KDMC workers' compensation cases.

9.16.02 Conduct a thorough audit of all its workers compensation cases and develop a plan to manage these cases to resolution by a specified timetable.

Human Resources

Performance Measures

Workforce

- Turnover rate
  - Current 6.5 %
  - Target 10% or less
- Percentage of unscheduled absences of regular hours worked (breakdown of sick versus AWOP)
  - Current 10.3 % (DHS Report on Sick Time Hours Taken by KDMC Employees, 2004)
  - Target < 5%
- Number and percentage of Disability and Workers' Compensation incidents
  - Current 195/8%
  - Target < 5%
- Percentage of late performance reviews (defined as 30 days past due from the end of the employees evaluation period)
  - Current 92%
  - Target < 5%
- Total number of active third level employee grievances
  - Current 52
  - Target 5% or less of workforce involved with grievances (N=130)
- Percentage of delinquent performance reviews
  - Current Definition to be determined
  - Target none

Human Resources

Performance Measures

Department

- Time to fill a position from the initial request time of the manager
  - Current not currently collected
  - Target 75 - 90 days (exempt/professional positions)
    60 - 90 days (nonexempt/hourly positions)
- Time of request to initiated disciplinary actions
  - Current not currently collected
  - Target 30 days or less
- Percentage of staff with documented attendance at orientation
  - Current not currently collected
  - Target 95%
- Percentage of agency and traveler staff with documented attendance at orientation
  - Current not currently collected
  - Target 95%
- Percentage of discipline cases to total employee population
  - Current not currently collected
  - Target TBD

Responsibility

- County HR Administrator

Section X – Ancillary Services

NAVIGANT CONSULTING

Section X – Ancillary Services

1. Radiology
   - Interviews
   - Prioritized Summary of Recommendations
   - Overview

Radiology > Interviews

• P. Venezeula	Administrator Ancillary Services
• V. Payne, MD	Medical Director
• H. Tate, MD	Clinical Director
• L. Dubose	Chief Radiologic Technologist
• Y. McKenzie	Clerical Supervisor
• A. Minor	Diagnostic Radiology Supervisor
• C. Potts	Nuclear Medicine Supervisor
• M. Srestapunte	Nursing Supervisor
• A. Todd	Report Processing Supervisor
• J. Wheeler	Radiology Information System Supervisor

Radiology > Prioritized Summary of Recommendations

Radiology		
Short-term	10.1.01	Conduct a review of staffing needs to determine where personnel should be assigned and with what responsibilities.
Short-term	10.1.02	Evaluate for opportunities for cross training amongst modalities.
Urgent	10.1.03	Identify a solution to improve transportation issues.
Urgent	10.1.04	Form a departmental advisory committee to develop methods of reducing on-the-job accidents.
Short-term	10.1.05	Provide educational opportunities, including the provision of instruction for staff development.
Urgent	10.1.06	Work with current transcription vendor to identify and improve problems in the process.
Intermediate	10.1.07	Evaluate the use of an in-house transcription program.
Urgent	10.1.08	Evaluate the ability to configure the order entry system to mandate the ordering of required laboratory tests.
Short-term	10.1.09	Compile a full listing of equipment for replacement and/or reconditioning.
Short-term	10.1.10	Inventory and remove unused equipment. Salvage and sell to dealers of used radiographic equipment.
Urgent	10.1.11	Integrate the equipment maintenance program with the hospitals.
Short-term	10.1.12	Complete a departmental review of the allocation of space.
Short-term	10.1.13	Redesign and make available several additional managerial reports.
Short-term	10.1.14	Update policies and procedures to address issues related to improved technology and some hospital policies that affect the department to insure that measures related to infection control, isolation management, departmental cleanliness, etc., are properly addressed.
Short-term	10.1.15	A systematic review of existing policies should be conducted to ensure they are current and based on existing technology.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Radiology > Prioritized Summary of Recommendations

Radiology		
Urgent	10.1.16	Monitor compliance with the JCAHO recommendation that all radiographic reports filed in the patient's medical record be signed by a radiologist, develop an action plan as appropriate.
Short-term	10.1.17	Ensure that films and studies are formally read by the radiologist during the shift on which they are performed.
Urgent	10.1.18	Ensure that mammography service conforms to applicable FDA standards.
Short-term	10.1.19	Consider addition of new modalities aligned with the KDMC scope of services, e.g. PET scan.
Intermediate	10.1.20	Implement voice recognition technology to facilitate immediate transcription, editing, and signature of radiology reports.
Short-term	10.1.21	Adjust staffing to match testing demand and supply (testing and reading capacity) by time of day and day of week. Supply must factor in time for equipment maintenance, repair, and updating.
Short-term	10.1.22	Implement radiology teaching rounds for other clinical services to review results and test indications.
Intermediate	10.1.23	Reduce film usage to a minimum based on impact of PACS which now provides digital storage of imaged procedures.

Radiology > Overview

Assessment

- The Radiology Department consists of the following divisions:
  - Main Radiology (tomography and overflow)
  - Trauma Radiology, including
    - Diagnostic Radiology
    - Mammography
    - Computed Tomography (CT)
    - Ultrasound
    - Magnetic Resonance (MR)
    - Nuclear Medicine
    - Radiation Oncology
- The department is fragmented with main radiology being on the first floor, which is seldom used for patient care (used for tomography and overflow examinations). Other divisions are physically located in various areas of the hospital.
  - Emergency Department
  - Trauma Radiology
  - Computed Tomography (CT)
  - Magnetic Resonance (MR)
  - Nuclear Medicine
  - Radiation Oncology

Radiology > Overview

Assessment

- Hours of operation:
  - Emergency Department (24/7)
    - Three rooms / three machines / two mobile units
  - Trauma Radiology (8 AM - 4:30PM, Monday thru Friday)
    - Nine rooms / nine machines
  - Trauma Bay (24/7)
    - Two mobile units
  - Ultrasound
    - Four machines (8 AM - 5 PM, Monday thru Friday, and one machine 5 PM - 8 AM, Monday thru Friday)
    - One machine 24/7 Saturday and Sunday
  - Computed Tomography (CT)
    - One machine 24/5, Monday thru Friday
    - One machine 24/7
  - Nuclear Medicine (7 AM - 6 PM, Monday thru Friday, and Saturday & Sunday on-call
    - Three rooms
  - Magnetic Resonance (MR)
    - One machine (7 AM -7 PM 24/5, 8 AM - 4 PM Saturday, and Sunday on-call

Radiology > Overview

Assessment

- Hours of operation: (cont)
  - Radiation Oncology (8 AM – 6 PM, Monday thru Friday)
  - Special Procedures (8 AM – 4:30 PM, Monday thru Friday, 4:30 PM – 8 AM and Saturday & Sunday on-call)
    - Three rooms
  - Surgery (one to three technologists dedicated 24/7) – special procedure personnel cover surgery
  - Mammography (8 AM – 4:30 PM, Monday thru Friday)
    - Three technologists
- The department of radiology serves as a clinical affiliate of the Drew Imaging Technology Program, with programs in radiography, ultrasound, and nuclear medicine. Approximately 20 students from these programs may be in the department performing their clinical rotation. Each student is assigned to a qualified technical person while in the department.
- Radiologists staff the department from two different sources; one group is employed by the County of Los Angeles, another group is contracted separately through an outside source. Both groups work together in providing interpretation of radiographic examinations.

Radiology

Assessment

- Leader Management
  - The Interim Medical Director has been in his position for 10 weeks as of the end of December 2004.
  - The departmental managerial structure consists of the Chief Radiologic Technologist, who manages supervisors for nuclear medicine/radiation oncology, computed tomography/magnetic resonance, trauma radiology, the ED, and the evening shift.
  - Radiologist staffing is provided by both County employees and a group of radiologists contracted to provide services.
  - An affiliated residency program was recently terminated causing some problems of manpower to cover all days/shifts required. The technical staff has complained that radiologists sometimes do not report to work (particularly between 4 PM and 8 PM) and sometimes refuse to provide interpretations if they are assigned to another division of the department.

Radiology

Assessment

- There has been a decrease in volume in the average number of examinations performed per day, from 485 to a current average of 296 per day, however, 80 -100% of the staffing remains in place.
- Average daily volumes by modality:
  - Trauma Radiology (Diagnostic Radiology) – 198/day
  - Mammography – 5/day
  - Computed Tomography – 47/day
  - Magnetic Resonance – 11/day
  - Nuclear Medicine – 5/day
  - Ultrasound – 30/day
- Patients managed in radiation oncology are treated at a nearby hospital and are not included in the above statistical information.
- The department has recently installed a picture archival communications system (PACS), which has improved technology from film/screen radiology to digital radiology.
- Extensive policies exist in the department, however, many are in need of being updated due to the addition of new technologies, i.e., PACS.

Radiology

Assessment

- Currently trauma/ED patients take priority over inpatients.
- The dictation process is done via MedQuist.
- After dictation the transfer back to the Affinity RIS (Radiology Information System) has a major typographic/reject issue.
- An estimated 30-45% of dictated reports do not get back to the Affinity system due to typographic and other transcription errors.
- This is a problem because the manual matching process used is inherently slow and arduous, but due to the lack of skilled employees in the department the problem is even worse.
  - It also appears that the company providing transcription services, MedQuist, never meets the terms of the existing contract for accuracy of reports.
- There are no metrics for machine utilization, staff utilization, productivity, report turnaround times, or patient waiting time.
- The process whereby reports are generated in medical records is very confusing and inefficient.

Radiology

Assessment

- Equipment in the department seems to be “OK” according to the Chief Radiologic Technologist. One CT scanner is 10 years old and, due to increasing workload, could be an area of concern in the near future.
- There is a general lack of documentation of medical necessity for ordering radiographic examinations in ED, resulting in the physicians ordering “everything.” This causes patient delays due to many potentially unnecessary procedures in the queue, and potentially unnecessary radiation exposure to patients and staff.
- An inordinate number of portable examinations are ordered by ED physicians.
- No reports available for tracking metrics for response to order, complete to report, or order to report.
- Manual logs were implemented to identify deficiencies in throughput, but inconsistent data was received. No report complete time was available. To complete this area would require multiple logs and intensive manual collection.
- Manual log showed an inpatient MR ordered on November 28, 2004 but not completed until December 1, 2004. Unsure if the cause of delay was a medical condition or availability of modality.

Radiology

Assessment

- Methodologies to assess the frequency of specific types of examinations ordered and the documentation of medical necessity will soon be implemented.
  - Results and recommendations will be communicated to the departments being assessed.
- The lack of sufficient patient transportation has been cited by virtually everyone interviewed as a seemingly insurmountable problem.
- There are a minimal number of managerial reports available to the department director, and even those that are available are seldom shared with supervisory personnel.
- Many issues exist where distribution of information regarding patient management seem to be negatively affecting patients.
- Patients are often asked to carry reports or other information from department to department when this information is readily available on the hospital information system.
- The dictation/transcription problems are causing approximately 40-60% of the reports from getting to the referring physicians, or nursing units, in a timely manner.
- Some reports are held for several weeks due to a flaw in the dictation system, whereby, any single piece of misinformation that is entered throws the report into a hold position that must be researched and gets severely backlogged.

Radiology

Assessment

- Critical laboratory values medically necessary for the proper management of specific types of radiological examinations are not being provided by the nursing units.
- Much of the equipment in the department is technologically acceptable. Both CT scanners are very old (one is 10 years old) and the purchase of a new scanner is underway. This is currently complicated in an effort to update the existing proposal to a newer technology that has recently become available.
- There are many pieces of equipment in the department that are no longer used. Similarly, many rooms within the department are no longer used and are sitting empty, often used for storage, or for nothing at all.
- There is no dedicated RIS, but rather the hospital information system (HIS) has a radiology module that is felt to be inadequate for modern radiology management.
- A recent JCAHO recommendation cited the equipment management program maintained within the department, as it is not currently a part of the hospital-wide program.
- A list of equipment has been provided to biomedical services for this purpose, it has not been implemented.

Radiology

Assessment

- Also, a second JCAHO recommendation was that all radiographic reports filed in the patient's medical record must be signed by a radiologist. Although it is felt that this problem was isolated and unique, a follow-up survey should be performed to document improvement. A quality improvement study will be conducted to determine the extent of this problem, along with resolution if indicated.

Deficiencies

- Staffing (professional, technical, and clerical) not appropriately matched to patient flow and volume.
- There exists a high number of personnel industrial accidents.
- Limited educational opportunities.
- A large number of radiographic procedures are routinely ordered without sufficient documentation of medical necessity.
- The inability or unwillingness of personnel to provide patient transport produces negative effects on productivity.

Radiology

Deficiencies

- Problems with report transcription related to appropriate turnaround times and accuracy.
- Lack of a comprehensive equipment inventory and replacement plan.
- Equipment maintenance plan is not integrated into the hospital plan.
- Existing policies and procedures are not current and up-to-date with technology.

Recommendations

10.1.01 Conduct a review of staffing needs to determine where personnel should be assigned and with what responsibilities.

10.1.02 Evaluate for opportunities for cross training amongst modalities.

10.1.03 Identify a solution to improve transportation issues.

10.1.04 Form a departmental advisory committee to develop methods of reducing on-the-job accidents.

10.1.05 Provide educational opportunities, including the provision of instruction for staff development.

Radiology

Recommendations

10.1.06 Work with current transcription vendor to identify and improve problems in the process.

10.1.07 Evaluate the use of an in-house transcription program.

10.1.08 Evaluate the ability to configure the order entry system to mandate the ordering of required laboratory tests.

10.1.09 Compile a full listing of equipment for replacement and/or reconditioning.

10.1.10 Inventory and remove unused equipment. Salvage and sell to dealers of used radiographic equipment.

10.1.11 Integrate the equipment maintenance program with the hospitals.

10.1.12 Complete a departmental review of the allocation of space.

10.1.13 Redesign and make available several additional managerial reports.

10.1.14 Update policies and procedures to address issues related to improved technology and some hospital policies that affect the department to insure that measures related to infection control, isolation management, departmental cleanliness, etc., are properly addressed.

10.1.15 A systematic review of existing policies should be conducted to ensure they are current and based on existing technology.

Radiology

Recommendations

10.1.16 Monitor compliance with the JCAHO recommendation that all radiographic reports filed in the patient's medical record be signed by a radiologist, develop an action plan as appropriate.

10.1.17 Ensure that films and studies are formally read by the radiologist during the shift on which they are performed.

10.1.18 Ensure that mammography service conforms to applicable FDA standards.

10.1.19 Consider addition of new modalities aligned with the KDMC scope of services, e.g., PET scan.

10.1.20 Implement voice recognition technology to facilitate immediate transcription, editing, and signature of radiology reports.

10.1.21 Adjust staffing to match testing demand and supply (testing and reading capacity) by time of day and day of week. Supply must factor in time for equipment maintenance, repair, and updating.

10.1.22 Implement radiology teaching rounds for other clinical services to review results and test indications.

10.1.23 Reduce film usage to a minimum based on impact of PACS which now provides digital storage of imaged procedures.

Radiology

Performance Measures

- Time from ED order - procedure completion
  - Current not currently collected
  - Target 75% within 1 hour; 100% within 2 hours
- In Patient Stat: Time from order to procedure completion
  - Current not currently collected
  - Target 75% within 1 hour; 100% within 2 hours
- In Patient Routine: Time from order to procedure completion
  - Current not currently collected
  - Target 80% within 6 hours; 100% within 16 hours
- Procedure completion to report completion (on record)
  - Current not currently collected
  - Target 90% stat within 3.5 hours; 90% routine within 24 hours
- Percentage of radiology reports in patient charts signed by the radiologist
  - Current not currently collected
  - Target 100%
- Percentage of portable orders
  - Current not currently collected
  - Target TBD

Radiology

Performance Measures

- Radiographic report completion of examination to report available to physician
  - Current 1 - 3 months
  - Target 90% stat within 3 hours; 90% routine within 24 hours
- Mammography productivity: Worked hours per procedure
  - Current not currently collected
  - Target 0.50 hours
- CT productivity: Worked hours per procedure
  - Current not currently collected
  - Target 0.75 hours
- CT Backlog:
  - Current not currently collected
  - Target 12 – 18 hours routine; 1 hour stat
- Special Procedures productivity: Worked hours per procedure
  - Current not currently collected
  - Target 1 – 3 hours

Radiology

Performance Measures

- Diagnostic Radiology productivity: Worked hours per procedure
  - Current not currently collected
  - Target 0.50 hours
- Ultrasound productivity: Worked hours per procedure
  - Current not currently collected
  - Target 0.60 hours
- MRI productivity: Worked hours per procedure
  - Current not currently collected
  - Target 0.60 hours
- Nuclear Medicine productivity: Worked hours per procedure
  - Current not currently collected
  - Target 1 to 2 hours

Responsibility

- Chief Radiology Technologist

Section X – Ancillary Services

2. Laboratory/Pathology
   - Interviews
   - Prioritized Summary of Recommendations
   - Overview
   - Management and Support
   - Information Technology
   - Processes
     - Pre-Analytical and Post-Analytical
     - Turnaround Time
     - Critical Test Result Notification
   - Blood Component Transfusion
   - Histopathology
   - Proficiency Testing (CAP) and Accreditation
   - Point of Care Testing
   - Efficiency and Productivity
   - Clinical Competency

Laboratory/Pathology > Interviews

• H. Mohamed, MD	Chair, Department of Pathology
• M. Gretz,	Laboratory Manager
• A. Baldwin	Supervisor, Quality Assurance
• D. Williams	Supervisor, Blood Bank
• G. Nassar	Supervisor, Chemistry
• N. Menes	Supervisor, Hematology
• D. McClam	Supervisor, Microbiology
• S. Bankhead	Supervisor, Phlebotomy
• G. Albritton	Acting Supervisor, Central Receiving
• N. Wilson	Supervisor, Point of Care Testing
• S. Misenas	Supervisor, Special Chemistry
• C. Nguyen	Supervisor, MTII, Evening and Night
• F. Fidel	Supervisor, Night
• P. Bacon	Supervisor, Transcription
• A. Marshall	Supervisor, Arterial Blood Gases
• A. Clinton	Information Systems
• P. Appel	Information Systems

Laboratory/Pathology > Interviews

• P. Valenzuela	Director, Operations
• J. Pachciarz, MD	Pathologist
• L. Wang, MD	
• R. Mohrmann, MD	
• T. Loya, MD	
• B. Yee, MD	

Laboratory/Pathology > Prioritized Summary of Recommendations

Management and Support		
Short-term	10.2.01	Initiate formal coaching/mentoring of supervisors (1:1) on an ongoing basis.
Short-term	10.2.02	Create a suite of monthly management reports.
Intermediate	10.2.03	Develop lab employee recognition program.
Urgent	10.2.04	Form an interdisciplinary Laboratory Advisory Committee.
Long-term	10.2.05	Develop a laboratory strategic plan with defined objectives for future operations, including services provided to other KDMC clinics.
Short-term	10.2.06	Consolidate laboratory departments into a centralized operation; eliminate departmental segmentation.
Information Technology		
Urgent	10.2.07	Initiate a lab IT service request form to monitor demand; plan lab staff training accordingly.
Short-term	10.2.08	Activate IT functionality to support manifests and bar-code labels when ordering lab requests.
Short-term	10.2.09	Evaluate the feasibility of using Affinity to order blood products on line.
Short-term	10.2.10	Upgrade arterial blood gas equipment. At a minimum consider using Affinity/Mysis to order blood gases and enter test results on-line/LIS.
Short-term	10.2.11	Evaluate the operational logistics in place for the physician review and attestation of completed laboratory reports. Consider printing reports remotely to the requesting physician and/or the electronic attestation of reports with specific monitoring tools in place.
Urgent	10.2.12	Conduct a formal study to determine availability of lab reports in charts (I/P and O/P); validate changes in reporting process.
Urgent	10.2.13	Initiate planned orders in Affinity; adjust workflow to meet 100% compliance.
Long-term	10.2.14	Interface cytopathology test results with commercial vendor – this is limited by a county-wide contract with PathNet, which is expected to be revisited at the end of 2005.
Urgent	10.2.15	Conduct a study to review pending lab orders purged from computer w/o manual intervention or supervisory review.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Laboratory/Pathology > Prioritized Summary of Recommendations

Processes – Pre-Analytical		
Urgent	10.2.16	Relocate phlebotomy draw station.
Urgent	10.2.17	Revamp patient registration/check in process for blood collection; incorporate home collected specimen drop off.
Short-term	10.2.18	Initiate phlebotomy services for psychiatry.
Urgent	10.2.19	Initiate phlebotomy services for blood product transfusion to the phlebotomy team.
Urgent	10.2.20	Transfer responsibility to collect blood cultures to the phlebotomy team; remove responsibility from nursing personnel.
Short-term	10.2.21	Conduct a wait time and workload study in the phlebotomy department; align resources accordingly.
Short-term	10.2.22	Create core (centralized) 'Client Services Unit' to host/support: specimen receiving/processing; phlebotomy headquarters; telephone support, send out processing, tracking, and customer service. Include a MT rotation in this department to provide technical expertise.
Urgent	10.2.23	Develop patient instruction hand outs and educational materials.
Short-term	10.2.24	Define strict STAT test ordering guidelines; redefine STAT test menu.
Short-term	10.2.25	Conduct root-cause analysis of reasons for specimen rejections; implement corrective action.
Urgent	10.2.26	Provide additional staff training and implement a monitoring mechanism for the timely and adequate processing of send out specimens.
Short-term	10.2.27	Initiate internal and external customer satisfaction survey of lab services.
Processes – Post-Analytical		
Short-term	10.2.28	Conduct study to demonstrate duplicate test requests; incorporate trend in IOP; implement corrective action.
Short-term	10.2.29	Re-evaluate and modify accordingly the existing protocols for notifying physicians of critical and STAT test results.
Urgent	10.2.30	Consolidate incident report forms and standardize the incident report documentation process.
Short-term	10.2.31	Initiate root-cause analysis, trending, and corrective action of incidents.

Laboratory/Pathology > Summary of Prioritized Recommendations

Turn Around Time		
Short-term	10.2.32	Consolidate chemistry and special chemistry test menus; offer therapeutic drug monitoring services during the evening and night shifts.
Short-term	10.2.33	Conduct workload study by shift; re-align staff accordingly.
Urgent	10.2.34	Expand number of tests included in TAT studies; adjust performance indicators to include and monitor at least three times, including test order, specimen collection, and resulting.
Critical Test Result Notification		
Urgent	10.2.35	Evaluate STAT test availability in outpatient clinics; implement immediate corrective action.
Urgent	10.2.36	Evaluate cause of delays in notifying ER of critical test results.
Short-term	10.2.37	Conduct a formal evaluation of STAT test request logistics and processes with a target 50% reduction in turn around time.
Intermediate	10.2.38	Evaluate the status of the pneumatic tube system; activate if appropriate.
Blood Component Transfusion		
Urgent	10.2.39	Clarify patient identification (AKA) policies; continue efforts with IOP/Blood Usage Committee
Histopathology		
Intermediate	10.2.40	Re-evaluate the existing pathology dictation equipment; install an upgraded system.
Short-term	10.2.41	Conduct study to determine amended report frequency; plan corrective action if appropriate.
Urgent	10.2.42	Immediately order new tissue processor (already approved in 2004 budget).
Point of Care Testing		
Long-term	10.2.43	Develop a POCT strategic plan; create a multi-disciplinary advisory committee. The plan strategically organizes new instrument acquisitions and their roll out process; data integration protocols; non-compliance action protocols; POCT menus; as well as all policies and protocols.
Urgent	10.2.44	Increase POCT staffing (using internal resources) to sustain the program.
Urgent	10.2.45	Expedite obtaining a laptop computer and tissue processor.

Laboratory/Pathology > Summary of Prioritized Recommendations

Efficiency and Productivity		
Short-term	10.2.46	Evaluate the laboratory test menu options in Affinity to support physician needs; enhance test ordering options to include various CBCs, hemoglobin and hematocrit, as well as reflex tests, among others.
Short-term	10.2.47	Reduce the number of lab tests outsourced to commercial laboratories; expand in-house test menu.
Long-term	10.2.48	Evaluate and validate laboratory billing and reimbursement process and accuracy.
Intermediate	10.2.49	Strategically plan staff cross training, beginning with most critical areas, such as blood bank.
Clinical Competency		
Urgent	10.2.50	Immediately plan Affinity training for all laboratory personnel.
Additional Recommendations		
Short-term	10.2.51	Evaluate the existing system; identify missing speakers and faulty equipment and upgrade accordingly.
Short-term	10.2.52	Develop a sound preventive maintenance program (PMI) that includes ongoing preventive maintenance of each unit in service; an inventory of units in use; disposal documentation of units discontinued; and competency training records of nursing personnel using the equipment.
Short-term	10.2.53	Re-institute lab provided in-services; re-validate competency.
Urgent	10.2.54	Discontinue the practice allowing patients to carry KDMC-collected blood specimens to hematology/oncology.
Short-term	10.2.55	Re-arrange the physical layout and adjust the work flow of the pathology transcription and administrative areas; separate administration from transcription operations.

Laboratory/Pathology > Overview

- KDMC operates a full-service clinical laboratory in various specialties, averaging approximately 650,000 billable tests/year.
- The test volume has decreased by approximately 50% in the last few years, mainly due to the closure of various clinics and lower bed census.
- Approximately 20% of the tests are outsourced to commercial labs, mainly in the areas of genetics, cytology, and esoteric procedures, which is a common practice at County hospitals.
- KDMC serves as a reference laboratory for some outside County clinics, such as Hubert Humphrey.
- The laboratory has a staff of 110, including five pathologists, and other technical and non-technical personnel. Most staff have a long tenure working with the County.
- Approximately 10% - 15% of the staff are under some sort of unresolved HR status, administrative leave, long-term disability, and medical restrictions.
- The laboratory operates three shifts, seven days a week.
- The laboratory is accredited by the College of American Pathologists (CAP) and is enrolled in CAP proficiency testing programs (recognized by JCAHO).
- Clinical performance appears sound, based on proficiency result records and other quality indicators, which were evaluated during this assessment.

Laboratory/Pathology > Management and Support

Assessment

- A Medical Director leads KDMC's clinical lab operations.
- A lab coordinator reports directly to the Medical Director. Each specialty is managed by department supervisors, including chemistry, hematology, blood bank, microbiology, transcription, central receiving, phlebotomy, and point of care. Lab staff includes assistants, runners, phlebotomists, MT I, MT II, and other support personnel.
- A team of six pathologists provides clinical oversight to all departments, including POCT.
- Until recently, the laboratory operated under full control of a lab manager with a tenure of 25+ years. Upon her retirement, a new laboratory coordinator (manager) transferred from another County hospital in July 2004. A number of early improvements have been made in a short period of time, including providing some structure and accountability to the system. Both the coordinator and Medical Director are capable and willing to improve overall operations.
- The Laboratory Manager and the Medical Director are capable and willing to drive change to improve overall operations.
- Laboratory leadership holds meetings regularly, including: supervisor, pathology department, and monthly inter-departmental staff meetings.
- Coaching/mentoring meetings with individual supervisors are informal.

Laboratory/Pathology > Management and Support

Assessment

- Inter and multi-disciplinary representation by pathologists and lab leadership is sound. But, there is no laboratory advisory committee in place to handle inter-disciplinary laboratory-specific issues.
- There is no strategic business plan or a formal plan to capitalize on services provided to outside outside clinics.
- Department supervisors are promoted from within or transfer from other County facilities, but promotions are based on civil service rules, not outstanding performance.
- Several supervisors lack an adequate level of experience and/or the skills to run their departments, thus requiring extensive mentorship. Managerial training and accountability is limited.
- The use of monthly management reports is limited despite the extensive reporting capabilities of the lab computer system.
- The physical layout of the laboratory is segmented, thus overall operations are highly inefficient. Previous efforts by lab administration to make the necessary improvements have gone unattended by hospital administration.
- Overall departmental productivity is approximately 45%, as calculated based on workload reports, test volume, billable tests and other reports available.

Laboratory/Pathology > Management and Support

Deficiencies

- Several supervisors lack the necessary managerial training.
- Monthly management reports are not used to manage each department.
- Inter-disciplinary relations/communication with other parts of KDMC are insufficient.
- Departmental fragmentation within the lab is excessive; thus causing a highly inefficient operation, as well as service delays and duplication of efforts.
- The laboratory operates without clear direction for future operations that considers a plan and strategy for growth, quality and productivity improvement, and control cost.

Recommendations

10.2.01 Initiate formal coaching/mentoring of supervisors (1:1) on an ongoing basis.

10.2.02 Create a suite of monthly management reports.

10.2.03 Develop lab employee recognition program.

10.2.04 Form an interdisciplinary Laboratory Advisory Committee.

10.2.05 Develop a laboratory strategic plan with defined objectives for future operations, including services provided to other KDMC clinics.

10.2.06 Consolidate laboratory departments into a centralized operation; eliminate departmental segmentation.

Laboratory/Pathology > Information Technology

Assessment

- The laboratory department uses a combination of state-of-the-art information systems that interface with Affinity.
  - Mysis, used by the clinical lab.
  - Co-Path used in pathology.
- Standard management reports in Mysis are available, but not used.
- Tools available with the existing IT infrastructure are not used to capacity to improve operations. For example, the current work flow prevents the activation of barcode labels, blood collection manifests, and planned orders; thus leading to double-labeling of blood specimens, while creating opportunities for errors.
- Two FTEs from the IT department are based at the lab 100% of the time.
- IT staff spend the majority of their time putting out fires with limited time for system development and improvements.
- Blood bank orders are not handled on-line.
- Phlebotomists do not receive electronic notification or blood collection manifests to handle their work.

Laboratory/Pathology > Information Technology

Assessment

- Planned orders are not handled on-line, thus test results are merged manually between Mysis and Affinity. Most planned orders are entered in directly in Mysis, not Affinity, thus test result reporting (and billing-related transactions) are suspect.
- Results of Arterial Blood Gases (ABGs) and other Point of Care (POC) tests are handled manually.
- Although test results are available immediately on-line upon completion, physicians do not normally review test results on-line and hard copies of reports do not print back at the units. Reports are filed in patient charts without physician attestation.
- A process does not existing to monitor on-line physician review and attestation of completed test results, both routine and STAT (critical) test results.
- Nurses and physicians are able to view test results on-line, but do not receive paper reports for the most part (remote printing capabilities are not active).
- Pap smear results are not interfaced to the hospital computer system.
- Unattended lab orders are purged out of the system after 7–10 days without documented action.

Laboratory/Pathology > Information Technology

Assessment

- Future orders for lab work (planned orders) are handled manually, thus creating bottlenecks in specimen collection and leading to significant delays in result reporting. Frequently, manual intervention is required to process such results and present them on-line.
- Cytopathology results from commercial laboratories must be typed in the Laboratory Information System (LIS). Interface considerations are hindered by a County-wide contract with PathNet, which is expected to be reconsidered in 2005.

Deficiencies

- Manual processes are causing inefficiencies throughout the laboratory, as well as opportunities for error.
- Manual processes are creating delays in specimen collection, processing, and result reporting.
- Results are available on-line, but not attested prior to filing.
- The lack of system interfaces in some areas prevent on-line access to test results. This in turn cause JCAHO concerns and creates doubts about the accuracy of billing.

Laboratory/Pathology > Information Technology

Recommendations

10.2.07 Initiate a lab IT service request form to monitor demand; plan lab staff training accordingly.

10.2.08 Activate IT functionality to support manifests and bar-code labels when ordering lab requests.

10.2.09 Evaluate the feasibility of using Affinity to order blood products on line.

10.2.10 Upgrade arterial blood gas equipment. At a minimum consider using Affinity/Mysis to order blood gases and enter test results on-line/LIS.

10.2.11 Evaluate the operational logistics in place for the physician review and attestation of completed laboratory reports. Consider printing reports remotely to the requesting physician and/or the electronic attestation of reports with specific monitoring tools in place.

10.2.12 Conduct a formal study to determine availability of lab reports in charts (I/P and O/P); validate changes in reporting process.

10.2.13 Initiate planned orders in Affinity; adjust workflow to meet 100% compliance.

10.2.14 Interface cytopathology test results with commercial vendor – this is limited by a county-wide contract with PathNet, which is expected to be revisited at the end of 2005.

10.2.15 Conduct a study to review pending lab orders purged from computer w/o manual intervention or supervisory review.

Laboratory/Pathology > Processes – Pre-Analytical

Assessment

- The laboratory operates a central receiving unit and phlebotomy services. Runners are also in place to pick up specimens from the units. Runners and phlebotomists often duplicate efforts.
- Phlebotomist have scheduled pick-up times for routine work and are paged when STAT pick-ups are needed. After-hours phlebotomists report to each unit, every so often to see if their services may be needed. Phlebotomists are often unaccounted for throughout the day.
- The only blood draw area to support outpatients is located on the 4th floor. The area is unsafe and creates concerns with confidentiality, CAP compliance, and is not conducive of an efficient operation. The same prevents the laboratory from making significant operational enhancements to improve overall operations.
- The patient registration process, planned orders, and other logistics; such as, double labeling of blood vials are outdated and do not support safety, quality, or good customer service.
- The phlebotomy team does not support the psychiatry unit. At times, psychiatry care patients are escorted to the outpatient lab draw station for lab work creating and unsafe environment for visitors and patients.

Laboratory/Pathology > Processes – Pre-Analytical

Assessment

- The blood collection station work schedule is not aligned to meet patient needs.
- Although STAT service for outpatients is available, a nurse or at times the patient must carry specimens to the laboratory.
- Patients do not receive clear or written instructions to prepare for lab tests and specimens collected at home are delivered back to the clinics; thus affecting the stability of specimens and increasing specimen rejections. STAT orders are unlimited and the STAT test menu is too broad. Thus, the STAT rate ranges between 40-83% between the day and evening shift, accordingly.
- Approximately 500 specimens are rejected each month, including: QNS, hemolysis, clotting, and other causes.
- Blood culture contamination rate ranges between 5-7%.
- Outpatient blood collection schedule is not aligned with clinic hours.
- Patients do not receive written instructions to prepare for lab tests, thus leading to unacceptable specimens.
- Lab specimens collected at home are not returned directly to the laboratory.
- The psychiatry unit does not receive phlebotomy support.
- The frequency of duplicate test requests appears high; further validation is necessary.

Laboratory/Pathology > Processes – Pre-Analytical

Deficiencies

- Unsafe phlebotomy area with compromised efficiency and workflow.
- Phlebotomy services are inefficient resulting in delays.
- The use of manual labels.
- Inadequate patient registration process.
- Inadequate logistics/preparation for home collected specimens.
- Large numbers of rejected specimens due to insufficient quantity, hemolysis, clotted blood, and improper labeling among others.
- Patients handling their own blood specimens.
- High blood culture contamination rates with contaminants introduced at the time of specimen collection.

Laboratory/Pathology > Processes – Pre-Analytical

Recommendations

10.2.16 Relocate phlebotomy draw station.

10.2.17 Revamp patient registration/check in process for blood collection; incorporate home collected specimen drop off.

10.2.18 Initiate phlebotomy services for psychiatry.

10.2.19 Initiate phlebotomy services for blood product transfusion to the phlebotomy team.

10.2.20 Transfer responsibility to collect blood cultures to the phlebotomy team; remove responsibility from nursing personnel.

10.2.21 Conduct a wait time and workload study in the phlebotomy department; align resources accordingly.

10.2.22 Create core (centralized) 'Client Services Unit' to host/support: specimen receiving/processing; phlebotomy headquarters; telephone support, send out processing, tracking, and customer service. Include a MT rotation in this department to provide technical expertise.

Laboratory/Pathology > Processes – Pre-Analytical

Recommendations

10.2.23 Develop patient instruction hand outs and educational materials.

10.2.24 Define strict STAT test ordering guidelines; redefine STAT test menu.

10.2.25 Conduct root-cause analysis of reasons for specimen rejections; implement corrective action.

10.2.26 Provide additional staff training and implement a monitoring mechanism for the timely and adequate processing of send out specimens.

10.2.27 Initiate internal and external customer satisfaction survey of lab services.

Laboratory/Pathology > Processes – Post-Analytical

Assessment

- Even though test results are available on-line immediately upon completion, physician not always retrieve them from Affinity. Auto-printing of completed results to the ordering unit/provider does not exist; thus HIM techs pick up batched reports from the laboratory each morning and transport the same to medical records.
- Although the laboratory follows sound protocols to notify physicians of completed test results, frequently it is difficult to reach physicians or nurses in the ER, trauma, and after discharge.
- The documentation of incident reports is handled on a wide variety of forms and documentation is inconsistent. Also, root-cause analysis of incidents is not done, thus limiting opportunities for corrective action.
- Hard copies of lab reports are handled differently by different departments. Physicians frequently complain of missing reports.
- Frequently, laboratory test results are filed in patient charts without physician review or attestation; other times results are unaccounted for in patient charts.

Laboratory/Pathology > Processes – Post-Analytical

Deficiencies

- Physicians frequently do not retrieve laboratory results from Affinity; reports are filed without physician attestation.
- Difficulty in reaching physicians with critical test results, and hard copies of the same results are not printed until the following day.
- Incident report documentation is inconsistent, not standardized, and without actionable corrective action.

Recommendations

10.2.28 Conduct study to demonstrate duplicate test requests; incorporate trend in IOP; implement corrective action.

10.2.29 Re-evaluate and modify accordingly the existing protocols for notifying physicians of critical and STAT test results.

10.2.30 Consolidate incident report forms and standardize the incident report documentation process.

10.2.31 Initiate root-cause analysis, trending, and corrective action of incidents.

Laboratory/Pathology > Processes – Turnaround Time

Assessment

- The laboratory monitors turnaround time (TAT) for five tests commonly ordered STAT and three routine tests and reports to an IOP committee. STAT, TAT monitoring is limited to the time when specimens arrive at the lab averaging between 39–79 minutes, depending on the test. The true TAT from actual order to completion is close to three hours.
- A STAT menu is not well-defined or enforced. Providers are able to order any test on a STAT basis, even procedures not clinically needed on an urgent basis.
- The laboratory refers out therapeutic drug monitoring (TDM) after hours, but offers the service during the day shift.
- STAT services frequently are not available for outpatient clinics.

Deficiencies

- Unnecessary STAT orders overwhelm the system, thus true STAT requests are delayed.
- STAT, TAT performance indicators only monitor the analytical component and disregard overall TAT monitoring.

Laboratory/Pathology > Processes – Turnaround Time

Recommendations

10.2.32 Consolidate chemistry and special chemistry test menus; offer therapeutic drug monitoring services during the evening and night shifts.

10.2.33 Conduct workload study by shift; re-align staff accordingly.

10.2.34 Expand number of tests included in TAT studies; adjust performance indicators to include and monitor at least three times, including test order, specimen collection, and resulting.

Laboratory/Pathology > Processes – Critical Test Result Notification

Assessment

- Specimens collected for urgent requests are physically transported to lab by a runner. At times, runners are not available, thus delaying the process. A pneumatic tube system is no longer in use.
- The laboratory notifies physicians of critical test results, but frequent delays are experienced (15 minutes or more) particularly when calling results to the ER.
- The laboratory does not print a hard copy of critical (or STAT) test results until the next day. Physicians are expected to pull the results from Affinity either by monitoring their completion or when notified by phone.
- A process exists to prevent clerical errors when calling test results by telephone; the nurse/physician is expected to read back the results to secure adequate documentation. The lab documents read-backs 75% of the time (target 100%).

Deficiencies

- Delays in transporting urgent specimens to the laboratory.
- Delays when notifying the ER of critical lab results.
- Compliance with read-back is below target.
- Sub-optimal review and attestation of lab test results.

Laboratory/Pathology > Processes – Critical Test Result Notification

Recommendations

10.2.35 Evaluate STAT test availability in outpatient clinics; implement immediate corrective action.

10.2.36 Evaluate cause of delays in notifying ER of critical test results.

10.2.37 Conduct a formal evaluation of STAT test request logistics and processes with a target 50% reduction in turn around time.

10.2.38 Evaluate the status of the pneumatic tube system; activate if appropriate..

Laboratory/Pathology > Blood Component Transfusion

Assessment

- The laboratory obtains blood products from the Red Cross located a few miles from KDMC. The cost is approximately $45K/month.
- Blood bank orders are handled using paper forms.
- Phlebotomists and nurses share blood draw responsibilities, but JCAHO has recommended a change in this area.
- The department performs basic blood bank functions to include ABO, Rh typing, and antibody screening; antibody identification is only done during the day. Performance indicators are in place to monitor excellence.
- Staff members from other departments assist blood bank when unforeseen emergencies occurs and to run the lab after hours.
- Blood product waste is approximately 2.7% (slightly above target) mainly due to used blood products, which can not be returned. At times wastage occurs due to patient identification issues, surgery cancellations, etc. Blood Bank is working with the IOP/Blood Usage Committees to address these issues.
- Delays exist delivering blood products immediately for trauma cases.
- Specimen rejections are approximately 6.75%, of which 47% is due to hemolysis mainly when specimens are collected by non-lab personnel.

Laboratory/Pathology > Blood Component Transfusion

Assessment

- Transfusion-related complications, due to clinical reactions, is under 0.5%.
- The preventive maintenance and competency documentation of nursing proficiency involving blood warmers is suspect and at risk for additional citations.

Deficiencies

- High specimen rejection rate mainly due to specimen collection errors, mainly hemolysis.
- Orders for blood bank are handled using manual forms and may lead to delays and errors.
- Delays in the transportation of blood in trauma cases.
- Excessive blood wastage.
- Lack of a sound blood warmer unit maintenance and inventory and competency documentation program.

Recommendations

10.2.39 Clarify patient ID (AKA) policies; continue efforts with IOP/Blood Usage Committee.

Laboratory/Pathology > Histopathology

Assessment

- Histology handles approximately 10,200 cases/year. Approximately 98.6% of the cases evaluated match the surgeon's pre-op diagnosis. TAT is monitored and kept under three days.
- Concerns exist with an outdated tissue processor, without any backup.
- Pap smears are outsourced to PapNet; results are manually entered in KDMC's computer system.
- Performance and quality improvement metrics for histology are in place to include a 10% case review rate, among other quality programs.
- Cyto-histo correlation process for cytology and histology specimens seems to be in accordance with good quality practices.
- Written policies are in place to support amended reports.
- Dictation system is outdated.
- Operational set up of the transcription department and pathology administration support is obsolete.

Laboratory/Pathology > Histopathology

Deficiencies

- Reporting delays occur with tissue specimens collected on weekends and holidays.
- Prolonged turnaround time and reports are not reaching patient charts.
- Inefficiencies exist in the pathology administration support and transcription areas, thus creating room for errors.

Recommendations

10.2.40 Re-evaluate the existing pathology dictation equipment; install an upgraded system.

10.2.41 Conduct study to determine amended report frequency; plan corrective action if appropriate.

10.2.42 Immediately order new tissue processor (already approved in 2004 budget).

Laboratory/Pathology > Proficiency Testing (CAP) and Accreditation

Assessment

- The laboratory is accredited by the College of American Pathologists and the State of California. CAP accreditation fulfills JCAHO and CLIA requirements.
- The laboratory participates in CAP proficiency programs and consistently scores 100%.
- The laboratory has corrected most CAP recommendations rendered at the June 2004 CAP inspection, except in the outpatient phlebotomy department.

Deficiencies

- Poor outpatient phlebotomy department layout and operational logistics.

Laboratory/Pathology > Point of Care Testing

Assessment

- The laboratory is responsible for a Point of Care Testing (POCT) program, which offers limited testing in some of the departments, including glucose, urine dipsticks, pregnancy testing, and hemoglobin.
- The overall POCT program lacks structure and standardization. The program has been kept afloat by one FTE.
- Non-compliance on the nurses part has led to the discontinuance of POCT in some departments, while other areas require extensive hands-on oversight from the laboratory.
- POCT automation upgrades are planned, including data integration, but IT specifications have not been reviewed and any implementation plan is unclear. Also, new equipment may or may not have been ordered at some units; while other departments, i.e., hematology/oncology have purchased equipment for other POCT, yet the laboratory is not part of the process.
- Although CAP has cited the program for lack of data analysis, the laptop computer ordered to support the program is still in the purchasing black hole.
- The POCT is not robust enough to accommodate any growth.
- POCT results are not available on line. Also, it is unknown if any billing functions take place.

Laboratory/Pathology > Point of Care Testing

Deficiencies

- Lack of data integration, lack of computer equipment, and inadequate staffing level.
- Lack of overall structure is creating inconsistencies throughout POCT operations.

Recommendations

10.2.43 Develop a POCT strategic plan; create a multi-disciplinary advisory committee. The plan strategically organizes new instrument acquisitions and their roll out process; data integration protocols; non-compliance action protocols; POCT menus; as well as all policies and protocols.

10.2.44 Increase POCT staffing (using internal resources) to sustain the program.

10.2.45 Expedite obtaining a laptop computer and tissue processor.

Laboratory/Pathology > Efficiency and Productivity

Assessment

- The laboratory operates with 110 FTEs and 6 pathologists performing 650,000 billable tests/year.
- Productivity index ranges from 30-60% depending on the department (average is 45%).
- The laboratory is equipped with state-of-the-art analyzers for the most part; but a significant delay has been experienced obtaining a tissue processor for pathology. The order is pending processing through materials management, which may take 6+ months.
- Excess capacity exists up to 60% of the time in some departments. Staffing is off balance in some shifts. Staff have been observed reading newspapers and magazines due to the lack of work.
- The laboratory refers 800+ tests/month (15-20%) to Quest Diagnostics, Focus Technologies, and genetic screenings at an average cost of $70K/month. Over 300 cytology smears are also referred out; one FTE is on staff to process 13-20 Pap smears/day.
- Results from commercial laboratories are interfaced to the LIS, except Pathnet (Pap smears). The lack of an interface requires one FTE to manually enter Pap results on line.

Laboratory/Pathology > Efficiency and Productivity

Assessment

- Operational systems are inefficient. Departments are fragmented with limited inter-departmental communication. For example, the hematology department reviews over 40% of the cell count smears (<20% in other markets), yet the only option to physicians is to order complete cell counts. Reflex protocols are non-existent in urinalysis. Therapeutic tests, which are commonly needed on a STAT basis, are done only during the day; after hours the tests are sent to a commercial lab simply due to the way the departments are established.
- Management seems unprepared to accommodate any market shifts. For example, the lab volume has decreased by over 50% in the last two years; yet staff has remained unchanged.
- Overall, the laboratory is overstaffed, supervisors need training and development, and staffing is excessive with the current test volume.
- The laboratory is unsure of the billing/collection accuracy due to the lack of data.

Laboratory/Pathology > Efficiency and Productivity

Deficiencies

- Limited staff productivity. Inefficiencies are built in throughout the system, which increases markedly after hours.
- Highly fragmented operation is not conducive of adequate staff cross-training.
- Unnecessary use of FTEs to support cytology send-outs.
- High number of staff is either out of work or is not productive for the reasons previously mentioned in this report.
- Difficulty in obtaining necessary equipment.
- Poorly defined test menu.
- Send-out tests are excessive.
- Laboratory lacks billing, collection, and reimbursement data.

Laboratory/Pathology > Efficiency and Productivity

Recommendations

10.2.46 Evaluate the laboratory test menu options in Affinity to support physician needs; enhance test ordering options to include various CBCs, hemoglobin and hematocrit, as well as reflex tests, among others.

10.2.47 Reduce the number of lab tests outsourced to commercial laboratories; expand in-house test menu.

10.2.48 Evaluate and validate laboratory billing and reimbursement process and accuracy.

10.2.49 Strategically plan staff cross training, beginning with most critical areas, such as blood bank.

Laboratory/Pathology > Clinical Competency

Assessment

- Clinical competency of the laboratory technical personnel, specifically those involved in the analysis of clinical specimens, appears to be robust.
- All medical technologists and pathologist are duly licensed by the State of California. They also hold national accreditation for the most part from the American Society of Clinical Pathology and other reputable organizations.
- Successful laboratory accreditation by CAP, as well as the recent certification obtained from the American Association of Blood Bank (AABB).
- All licensed personnel are required to complete a minimum of 12 hours of CEU/CME each year in order to maintain their license.
- Competency records of ongoing training and monitoring of individual staff performance are well documented, including annual competency evaluation of existing personnel and twice a year for new staff.
- Daily quality control of equipment and preventive maintenance records are available and in target with acceptable standards. Correlation studies are well documented for changes in technology, new test kits, and changes in test menu.
- Surgical pathology peer review programs with 10% surgical pathology case review, extra department consultations, and frozen section correlations.
- The blind testing of unknown specimens provided by the College of American Pathologists is done quarterly; performance has consistently met 100% satisfactory ratings in all specialties.

Laboratory/Pathology > Clinical Competency

Deficiencies

- Generalist Medical technologists lack cross-training in various clinical specialties. This is particularly important to support evening, night, and weekend operations.
- The majority of staff, including supervisors, do not use the Affinity hospital system.

Recommendations

10.2.50 Immediately plan Affinity training for all laboratory personnel.

Additional Recommendations (Overall)

Recommendations

10.2.51 Evaluate the existing system; identify missing speakers and faulty equipment and upgrade accordingly.

10.2.52 Develop a sound preventive maintenance program (PMI) that includes ongoing preventive maintenance of each unit in service; an inventory of units in use; disposal documentation of units discontinued; and competency training records of nursing personnel using the equipment.

10.2.53 Re-institute lab provided in-services; re-validate competency.

10.2.54 Discontinue the practice allowing patients to carry KDMC-collected blood specimens to hematology/oncology.

10.2.55 Re-arrange the physical layout and adjust the work flow of the pathology transcription and administrative areas; separate administration from transcription operations.

Laboratory/Pathology

Performance Measures

- STAT requests
  - Current 40% - 83%
  - Target <20%
- Productivity index based on test volumes, workload reports, and billable tests
  - Current 45% average (ranges from 30% - 60%)
  - Target 80% - 90%
- Productivity: Worked Hours per Billed Test
  - Current .44
  - Target .12 - .16
- STAT TAT – Received at the Lab to verify time
  - Current 72 minutes
  - Target under 1 hour
- TAT from the time test is ordered
  - Current 3 hours
  - Target < 1.5 hours

Laboratory/Pathology

Performance Measures

- Ratio of type and cross match to transfusion
  - Current 1.8
  - Target 2.0 is an acceptable market standard
- Blood transfusion incidents
  - Current <1%
  - Target <2%
- Blood product waste rate
  - Current 2.7%
  - Target <2%
- Critical result read-back documentation
  - Current 75%
  - Target 100%
- Specimen rejection
  - Current < 1% (approximately 500 specimens/month*)
  - Target < 1.5%

* Although the overall specimen rejection in on target specific targets for reasons for rejection will need to be established.

Laboratory/Pathology

Performance Measures

- Number of incidents
  - Current Not currently collected
  - Target < 2%
- Blood culture contamination rate
  - Current 6% - 7%
  - Target < 3%
- Outpatient wait times
  - Current Not currently collected
  - Target 5 minutes or less 75% of the time
- Customer satisfaction rating – external
  - Current 90% (based on a hospital wide survey in which the OP lab is included)
  - Target 80% or higher
- Customer satisfaction rating – internal
  - Current Not currently collected
  - Target 80% or greater

Responsibility

- Laboratory Medical Director

Section X – Ancillary Services

3. Pharmacy Services
   - Overview
   - Prioritized Summary of Recommendations
   - Comparative Analysis
   - Pharmaceutical Care Outcomes Initiatives (PCOI)
     - Leadership/Management
     - Governance
     - Information System
     - Medication Procurement & Storage
     - Medication Distribution
     - Clinical Services
     - Staffing and Productivity
       - Orientation and Training
       - Staff Competency
     - Environment

Pharmacy Services > Interviews

• A. Gutierrez, PharmD	Director of Pharmacy
• K. Weissman, PharmD	IP Pharmacy Supervisor (Acting AD)
• E. Okeke, PharmD	IP Pharmacy Supervisor
• M. Kim, PharmD	Hawkins Pharmacy Supervisor (acting)
• H. Roh, PharmD	IP Pharmacy Supervisor
• J. Han, PharmD	Controlled Substance Safe Pharmacist
• F. Al-Khayat, PharmD	IP Pharmacist
• V. Kim, PharmD	OP Pharmacy Supervisor
• C. Duckworth	ICU Nurse Manager
• S. Taylor, MD	Chair of P&T, Pediatrics
• K. Lewis, MD	Anesthesiology
• D. Ogunyemi, MD	OB/GYN
• R. Leathers, DDS	Oral Surgery
• S. Myint, MD	Surgery
• P. Valenzuela	Administrator, Ancillary Services

Pharmacy Services > Prioritized Summary of Recommendations

Pharmacy – Leadership/Management		
Urgent	10.3.01	Devote DOP full-time to KDMC Pharmacy Services.
Urgent	10.3.02	Structure clear reporting dynamics between DOP and Administration.
Urgent	10.3.03	Initiate structured weekly Pharmacy Management team meetings and staff meetings.
Urgent	10.3.04	Revise process for analyzing patient safety issues; hold management team and staff accountable.
Governance		
Short-term	10.3.05	Restructure P&T Committee, including membership, chair appointment, and accountabilities.
Short-term	10.3.06	Develop and incorporate a Dashboard as a standing monthly agenda item for the P&T Committee to review and analyze, identifying issues/problems and providing stewardship to develop and implement plans for resolution.
Short-term	10.3.07	Determine optimal role of County level P&T Committee involvement in KDMC P&T Committee.
Information System		
Urgent	10.3.08	Build and install GE PIS.
Urgent	10.3.09	Revise medication labels so that appropriate information is included.
Urgent	10.3.10	Revise MAR.
Medication Procurement and Storage		
Urgent	10.3.11	Install surveillance cameras.
Short-term	10.3.12	Restructure procurement staffing, taking into account appropriate skill mix and state requirements.
Short-term	10.3.13	Review sample policy; may be more appropriate to better utilize Patient Assistance Programs (where available).
Urgent	10.3.14	Improve storage of medications in the ED.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Pharmacy Services > Prioritized Summary of Recommendations

Medication Distribution		
Long-term	10.3.15	Redesign IV room to adhere to USP Chapter 797 regulation.
Urgent	10.3.16	Move Omnicell server to IS Department.
Urgent	10.3.17	Move ED scanner server from desk-top to main server in IS Department.
Urgent	10.3.18	Establish on-going Nursing/Pharmacy Practice Group.
Urgent	10.3.19	Work with nursing to resolve controlled substance waste documentation.
Urgent	10.3.20	Repackage bulk liquids into UD containers (appropriate medications).
Long-term	10.3.21	Restructure medication delivery process; plan to increase use of OmniCell.
Clinical Services		
Long-term	10.3.22	Restructure clinical services.
Urgent	10.3.23	Complete a competency assessment of pharmacists and individualized improvement plans.
Long-term	10.3.24	Develop a strategy for additional clinical services, in collaboration with nursing and prescribers.
Long-term	10.3.25	Secure reimbursement for cognitive services.
Staffing and Productivity		
Urgent	10.3.26	Revise policies and procedures to reflect current industry competency standards.
Urgent	10.3.27	Revise orientation process to improve documentation.
Urgent	10.3.28	Work with registry providers to better ascertain competency.
Intermediate	10.3.29	Develop appropriate productivity documentation tools.
Urgent	10.3.30	Evaluate alternatives for improving quality, patient safety and service delivery, including outsourcing.
Environment		
Long-term	10.3.31	Identify and implement a plan to correct pharmacy environment.

Pharmacy Services > Overview

- Main pharmacy in basement, with minor revisions to floor plan from original.
  - Provides 24/7 services.
  - Traditional cart fill.
  - Full IV additive.
  - Chemotherapy
- NICU Satellite
  - Provides 8/7 services.
  - NICU and some pediatric coverage.
- ICU Satellite
  - Provides 8/7 services.
  - ICU coverage only.
  - TPNs for entire house.
- OP Pharmacy on first floor, original in size and design to the building.
  - Open 7 days/week.
  - Limited service on weekends and holidays (limited to discharge prescriptions).
  - Psychiatric pharmacy housed in Humphrey Building

Pharmacy Services > Comparative Analysis

KDMC Comparative Assessment
2002 to 2004 data
N= 19 hospitals
ADC range 176 - 228

Hospital Data	King Drew Medical Center (LA) FY03-04 (obtained Nov 2004)	Averages	75th %'tile	50th %'tile	25th %'tile
Drug Purchases and Revenues					
Total Purchases	$10,516,023	$7,043,368	$8,104,644	$5,755,329	$4,556,972
Inpatient Purchases	$5,023,010	$6,754,263	$7,626,801	$5,618,535	$4,556,972
Purchases/Inpatient Day	$67	$94	$101	$85	$66
Purchases/Occupied Bed	$24,623	$33,597	$36,289	$30,871	$23,670
Purchases / admission	$444	$558	$582	$489	$388
Purchases/APD	$127	$76	$80	$70	$50

NAVIGANT CONSULTING

Pharmacy Services > PCOI

- Unable to complete class specific analysis utilization
- Based on Cardinal Distribution spend for inpatient pharmacy.

Total Cardinal Spend	$3,891,639	
Antimicrobials	$1,667,506	42.8%
Misc	$978,043	25.1%
Cardiology	$481,249	12.4%
Anesthesiology	$374,993	9.6%
Psych	$146,288	3.8%
Antiemetics	$132,057	3.4%
EPO	$95,235	2.4%
CSF	$16,268	0.4%

Pharmacy Services > PCOI – Leadership/Management

Assessment

- Overall responsibility for management of the pharmacy is the Director of Pharmacy.
- The Director of Pharmacy is assigned as DHS Interim Pharmacy Director 50% time.
- The performance expectations for this role are not reflective of current industry standards.
- Due to subordinate supervisor managerial skill level, the director can not always delegate in a consistent manner.
  - Non-licensed staff assigned scheduling for runners
  - Supervisors should be part of issues/vendors that pertain to their assigned areas and equipment issues
- Due to the number of CMS and JCAHO surveys in the past year, the supervisor meetings have been placed on hold.
- Director functions in crisis management mode.

Pharmacy Services > PCOI – Leadership/Management

Assessment

- Assume leadership role in patient safety issues.
  - Medication safety issues are not always reported to the director in a timely manner
  - Director is aware that the hospital process for reporting patient safety issues is fractioned
  - Unable to consistently find complete documentation of process improvement for patient safety issues related to medication
    - Each incident should contain FMEA, root cause analysis, recommendations for improvement, as well as follow-up documentation in one location.
- Finance and administration do not include the department director in the budget process
  - DOP understands most of the principles of a budget but has not been required to submit or adhere to one Infuse fiscal reality into management decisions.
  - Unable to ascertain if department is within budget, given there is no budget.
- Assume responsibility to complete assignments.
  - In attending committee meetings and reviewing P&T Committee meeting minutes for 2003 – 2004, the Director attended consistently (is P&T secretary), but does not lead consistently and does not follow-through on outstanding issues.
  - Department does not use metrics for reporting.
    - Trending, summaries, conclusions, recommend change, and follow-up.

Pharmacy Services > PCOI – Leadership/Management

Assessment

- Utilize proactive problem solving skills.
  - Lack of support in solving staffing issues other than to request additional registry personnel or approve overtime.
    - DOP stated, in the past, operational change suggestions and requests have been denied by administration.
    - Some staffing issues are due to survey reports and media coverage.
    - Competency issues with pharmacist have been noted for many years.
      - Pharmacy-specific clinical competency not assessed annually.
      - No plan for performance improvement.
    - Documentation of disciplinary action for non-licensed staff is lacking.
      - Attendance issues and reticent staff attitude.
- Ensure pharmacy services reflect leading practice in policies and procedures and daily practice.
  - Not current with all regulations.
    - USP Chapter 797 clean room for IV preparation.
    - Pharmacy Information System does not have a clinical component.
    - Difficult to ensure all medication orders are appropriate for specific disease state.
    - Pharmacist review of all non-urgent medication orders prior to administration.

Pharmacy Services > PCOI – Leadership/Management

Deficiencies

- Current state of Pharmacy Services suggest the current division of responsibilities of the Director of Pharmacy has led to:
  - Sub-optimal oversight of services provided.
  - Ineffective management and decision-making.
- Lack of administration guidance.

Recommendations

10.3.01 Devote DOP full-time to KDMC Pharmacy Services.

10.3.02 Structure clear reporting dynamics between DOP and Administration.

10.3.03 Initiate structured weekly Pharmacy Management team meetings and staff meetings.

10.3.04 Revise process for analyzing patient safety issues; hold management team and staff accountable.

Pharmacy Services > PCOI – Governance

Assessment

- Pharmacy & Therapeutics (P&T) Committee:
  - The P&T Committee identified as the formalized venue for governance issues.
    - Meets monthly, at least 10 times per year.
  - Director of Pharmacy serves as Secretary of P&T Committee.
  - No formal charter for sub-committees.
    - Drug Use Evaluation (DUE)
    - Adverse Events (AE)
  - Sub-committee recommendations presented to P&T Committee for comment, revision and approval.
  - Key performance indicators, such as AE and drug misadventures appear in meeting minutes throughout 2003 and 2004. No specific improvement plan with timeline, expected decisions, and actions.
  - County level P&T Committee dictates some issues at facility level.
- Committee members and attendance:
  - Committee consists of representatives from medical staff, nursing, and pharmacy.
  - Physician membership does not include all pertinent practice areas.
  - Historical lack of physician and nursing attendance.

Pharmacy Services > PCOI – Governance

Assessment

- Prioritization of issues:
  - Lack of planning on part of Director of Pharmacy and P&T Chair prior to meeting.
  - P&T Committee does not appear to prioritize and bring issues to conclusion.
    - Slight improvement noted in CY2004 minutes.
  - Lack of summarized results and concise recommendations for approval.
  - Meetings were cancelled due to multiple CMS and JCAHO surveys.

Deficiency

- Sub-optimal governance structure.

Recommendations

10.3.05 Restructure P&T Committee, including membership, chair appointment, and accountabilities.

10.3.06 Develop and incorporate a Dashboard as a standing monthly agenda item for the P&T Committee to review and analyze, identifying issues/problems and providing stewardship to develop and implement plans for resolution.

10.3.07 Determine optimal role of County level P&T Committee involvement in KDMC P&T Committee.

Pharmacy Services > PCOI – Information System

Assessment

- Current Pharmacy Stock Control & Audit System (PSCAS) developed by County in response to diversion.
  - An inventory system.
  - No clinical component.
  - Potential for order entry errors.
  - MAR print can only be done once per day.
- KDMC IS supports hardware and internet.
- County ISD supports software.
- County has agreed to move to GE system for all County facilities.
  - Order of install places KDMC third of five facilities (anticipate 2006).
- Outpatient pharmacy has additional system – McKesson Pharmacy 2000.
  - Installed 1999 and has not been upgraded since.
  - State Board of Pharmacy investigated dispensing error (2003) and system upgrade was recommended by DOP as result of root cause analysis.
    - Pending final spec quote from vendor and approval of purchase order by materials management.

Pharmacy Services > PCOI – Information System

Assessment

- Inpatient pharmacy patient-specific medication labels are confusing.
  - Label only prints two places to the right of the decimal; NICU doses are three to four decimal places.
  - Large volume additives (250ml and above) print as the IV fluid in bold and the medication prints in the “sig” field.

Deficiencies

- PSCAS does not provide appropriate clinical component.
  - Multiple safety concerns
- Confusing medication labels.
- An updated printed MAR is not available on demand.

Recommendations

10.3.08 Build and install GE PIS.

10.3.09 Revise medication labels so that appropriate information is included.

10.3.10 Revise MAR.

Pharmacy Services > PCOI – Medication Procurement and Storage

Assessment

- Registry technician responsible for day-to-day order process.
- County requires manual input of order receipt for inventory and control purposes.
- Official buyer position filled by a pharmacist.
  - Recent hire in position as of October 2004.
  - Unsure of the purpose of position.
  - Buyer has not been oriented to Cardinal Distribution system.
  - Buyer is not knowledgeable of inventory control techniques.
- Order sent to LAC-USC for approval and transmittal to Cardinal Distribution (or other vendor).
- Drug diversion has occurred in past.
  - DOP recommended installation of surveillance cameras.
  - Staff has limited access to store room.
  - Pharmacy areas submit order to store room on daily basis.

Pharmacy Services > PCOI – Medication Procurement and Storage

Assessment

- Sample policy states samples allowed in ambulatory clinics.
  - Unsure of control and tracking process.
  - Samples not found in inpatient care areas.
- Control of medication in the ED lacking.
  - ED Blue Team patients are considered inpatients and receive 24 hour cart fill.
  - Patient specific medication bins are to be stored in medication room.
  - ED is not equipped for 24 hour cart exchange.

Pharmacy Services > PCOI – Medication Procurement and Storage

Deficiency

- Historical drug diversion and gaps in the system creating the potential for further diversion.
- Failure to install surveillance cameras
- Potential issues with sample medications.
- Poor storage of medication in the ED.

Recommendations

10.3.11 Install surveillance cameras.

10.3.12 Restructure procurement staffing, taking into account appropriate skill mix and state requirements.

10.3.13 Review sample policy; may be more appropriate to better utilize Patient Assistance Programs (where available).

10.3.14 Improve storage of medications in the ED.

Pharmacy Services > PCOI – Medication Distribution

Assessment

- ED and 2B orders scanned to pharmacy.
- All other orders hand delivered to pharmacy.
  - Utilize pharmacy runners.
  - Delays in TAT.
- Omnicell SureMed® automated dispensing cabinets used for controlled substances and floor stock.
  - Cabinets are not updated with most recent software.
  - Server resides in inpatient pharmacy.
- Traditional cart fill utilized for 24 hour medication distribution. Not all oral liquid medications are unit dose (UD) for specific dose prescribed.
- There is a full IV additive and chemotherapy service.
- Runners scheduled to deliver medications to patient care units on hourly basis.
  - Excessive sick calls and scheduled time off leads to multiple delays.
- Appropriate and timely documentation of controlled substance waste by nursing in SureMed® is lacking.

Pharmacy Services > PCOI – Medication Distribution

Assessment

- USP Chapter 797 clean room for IV preparation and requirement for laminar flow room or glove box for IV preparation. There is limited access and restricted traffic flow area.
- Misleading medication labeling for compounded medications for NICU/PICU/ped patients, due to PSCAS constraints.

Deficiency

- IV room is not compliant with USP Chapter 797 regulation.
- ED scanning process not optimal (server issues).
- Manual delivery of orders to pharmacy suboptimal.
- Missing controlled substance waste is in violation of DEA and state laws.
- Omnicell server backup procedure issues.
- All medications required to be UD.
- Time delays in delivery of medications to patient care units noted (cart exchange excluded).
- Lack of formal communication with nursing.

Pharmacy Services > PCOI – Medication Distribution

Recommendation

10.3.15 Redesign IV room to adhere to USP Chapter 797 regulation.

10.3.16 Move Omnicell server to IS Department.

10.3.17 Move ED scanner server from desk-top to main server in IS Department.

10.3.18 Establish on-going Nursing/Pharmacy Practice Group.

10.3.19 Work with nursing to resolve controlled substance waste documentation.

10.3.20 Repackage bulk liquids into UD containers (appropriate medications).

10.3.21 Restructure medication delivery process; plan to increase use of OmniCell.

Pharmacy Services > PCOI – Clinical Services

Assessment

- Clinical programs placed on hold since May.
  - Daily IV to oral streamlining.
  - Renal dosing.
  - Patient teaching (diabetes, anticoagulation).
  - Staff inservices
  - Pharmacy newsletter.
- Clinical pharmacists have been reassigned to meet CMS and JCAHO requirements and recommendations.
- Current staff competency in clinical areas is lacking.
- 35% of inpatient pharmacy pharmacists are Registry.

Deficiency

- Clinical services non-existent.

Pharmacy Services > PCOI – Clinical Services

Recommendations

10.3.22 Restructure clinical services.

10.3.23 Complete a competency assessment of pharmacists and individualized improvement plans.

10.3.24 Develop a strategy for additional clinical services, in collaboration with nursing and prescribers.

10.3.25 Secure reimbursement for cognitive services..

Pharmacy Services > PCOI – Staffing and Productivity

Assessment

- There is excessive use of Registry; 35% inpatient staff and 100% outpatient staff.
  - Currently utilize three separate registry providers.
    - Registry pharmacists paid $79/hour (recently increased in order to obtain more competent and consistent staff).
    - KDMC pharmacists paid an average of $42/hour.
  - Registry staff dictate schedule (only work days).
  - Full-time staff moved to 2nd & 3rd shifts.
    - Has lead to resignations of more competent staff.
  - Clinical pharmacists cover shifts.
- There are excessive sick calls.
  - Crisis management for shift coverage.
  - Utilize more Registry to cover sick calls.
- There are no IP productivity statistics tracked or available.
- There are multiple reports of medication errors.

Pharmacy Services > PCOI – Staffing and Productivity

Assessment

- Orientation and training:
  - Documentation of hospital-specific orientation for Registry staff is lacking.
  - Incomplete documentation of required annual orientation of FT full-time staff.
- Staff competency:
  - Many of the staff lack critical thinking skills.
  - Competencies in job descriptions are not current with industry standards.
    - Unknown when pharmacist skills/competency validation checklist last updated.
    - Self-assessment for delineated critical elements not part of process.
    - Individual staff competency records not available.
    - Unable to ascertain Registry staff competency.

Pharmacy Services > PCOI – Staffing and Productivity

Deficiencies

- Department-specific policies and procedures are poorly written and inconsistently followed.
- Lack of documentation of orientation.
- There is a sub-standard competency assessment.
- No IP productivity statistics maintained or managed.
- Limited performance measures tracked.

Recommendations

10.3.26 Revise policies and procedures to reflect current industry competency standards.

10.3.27 Revise orientation process to improve documentation.

10.3.28 Work with registry providers to better ascertain competency.

10.3.29 Develop appropriate productivity documentation tools.

10.3.30 Evaluate alternatives for improving quality, patient safety and service delivery, including outsourcing.

Pharmacy Services > PCOI – Environment

Assessment

- Overall pharmacy areas (excluding the psychiatric facility) are not optimally designed.
  - Cluttered
  - IV additive and chemotherapy rooms are not optimally arranged with traffic flow issues.
  - Lack of work space in inpatient pharmacy may lead to medication errors.
  - Clinical pharmacist area is designed for two desks maximum (have five desks).
  - Medication procurement and storage areas not maximally secured.
  - Outpatient pharmacy designed for volumes of 200-300 scripts per day (average 850-900).

Deficiency

- Overall condition of the pharmacy areas is sub-standard.

Recommendation

10.3.31 Identify and implement a plan to correct pharmacy environment.

Pharmacy Services > Performance Measures

Performance Measures

- Patient information (i.e., height, weight, allergy history, age) available prior to dispensing
  - Current not currently collected
  - Target 95%
- Indication for use is available for each medication ordered
  - Current not currently collected
  - Target 100%
- All high-risk medications have documented double-check process
  - Current not currently collected
  - Target 100%
- Turn around time for STAT orders
  - Current not currently collected
  - Target 100%
- Turn around time for regular orders
  - Current not currently collected
  - Target 100%

Pharmacy Services > Performance Measures

Performance Measures

- Percentage of compliance with documented tracking of controlled substance utilization in the anesthesia setting
  - Current tracking is incomplete
  - Target 100%
- Adverse drug events per 100 medication orders per month
  - Current not currently collected
  - Target < 3
- Dispensing errors
  - Current not currently collected
  - Target Zero
- Security of medication in the inpatient pharmacy, outpatient pharmacy, and pharmacy satellites
  - Current not currently collected
  - Target TBD
- Productivity: worked hours per weighted unit of service
  - Current not currently collected
  - Target TBD

Pharmacy Services > Performance Measures

Performance Measures

- Dispensing pharmacists per 100 occupied beds
  - Current not currently collected
  - Target TBD
- Clinical pharmacists per 100 occupied beds
  - Current pending
  - Target 3.12
- Drug spend per IPD
  - Current $67
  - Target TBD
- Drug spend per APD
  - Current $127
  - Target TBD

Responsibility

- Director of Pharmacy
- Pharmacy Supervisors

Section X – Ancillary Services

4. Electrodiagnotic
   - Interviews
   - Prioritized Summary of Recommendations
   - Cardiology
   - Neuroscience
   - Neurology

Electrodiagnostic > Interviews

- Y. Kaushik, M.D. — Medical Director, Chief of Cardiology
- L. Smith — Department Manager
- J. Smith — Administrative Representative
- C. Rosario, M.D. — Medical Director, Neurologist
- H. Vary — Department Director, EEG Technician

Electrodiagnostic > Prioritized Summary of Recommendations

EKG/Holter Laboratory		
N/A	10.4.01	Ensure the availability of a registered nurse, when one is clinically necessary.
N/A	10.4.02	Identify a process for all EKGs performed anywhere in the hospital to be sent to the cardiology for physician interpretation.
N/A	10.4.03	Identify a process to ensure that a final report be placed in each patient's medical record along with a preliminary report (when one exists).
N/A	10.4.04	Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.
N/A	10.4.05	Identify and recruit the required physician complement.
N/A	10.4.06	Enlarge the waiting room (or relocate) and refurnish.
Stress Testing Laboratory		
N/A	10.4.07	Provide additional personnel; a registered nurse should be available at all times when one is clinically necessary. This could be an additional position to the staff or increased availability of Nursing support.
N/A	10.4.08	Replace existing treadmill.
N/A	10.4.09	Provide transport services to and from the department.
N/A	10.4.10	Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.
Echocardiology Laboratory		
N/A	10.4.11	Replace existing equipment.
N/A	10.4.12	Provide transport services to and from the department.
N/A	10.4.13	Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.

Urgent: By February 28; Short-term: By June 30; Intermediate: By October 31; Long-term: Through 2006

Electrodiagnostic > Prioritized Summary of Recommendations

Electrodiagnostics – EMG Laboratory		
N/A	10.4.14	Assess for the need of intraoperative monitoring and implement appropriately.
N/A	10.4.15	Establish an appropriate departmental continuing education program.
N/A	10.4.16	Refurbish the patient waiting area.
N/A	10.4.17	Relocate the existing storage closet into the janitor's closet.
N/A	10.4.18	Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.
EEG Laboratory		
N/A	10.4.19	Identify required professional and technical resources to accommodate patient needs.
N/A	10.4.20	Enhance the existing space.
N/A	10.4.21	Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.

Electrodiagnostic > EKG/Holter Laboratory

Assessment

- Hours of operation are 8:00 AM - 4:30 PM, Monday through Friday.
- Daily clinics:
  - Monday – General Medicine
  - Tuesday – Cardiology & General Medicine
  - Wednesday – Hypertension, Chest, and General Medicine
  - Thursday – Cardiology and General Medicine
  - Friday (8:00 AM – 12:00 PM) Preoperative and General Medicine
- Patient sources are from the ED, inpatients, outpatients, and various clinics.
- Current equipment:
  - Currently have two Marquette/GE EKG units that are two years old and in reasonably good operating condition that perform the standard 12-lead EKG procedure.
  - There are approximately 22 EKG units throughout the hospital; in ED and in various nursing units.

Electrodiagnostics > EKG/Holter Laboratory

Assessment

- Equipment needs:
  - The 22 EKG units throughout the hospital are obsolete and need to be replaced at a cost of $7 K each, for a total of $154 K.
  - Only the two units located in the EKG laboratory have computer capabilities that allow for automatic reporting.
    - The medical director, states that all other units located throughout the hospital need to be replaced in order to standardize the technology and to allow for processing of reports uniformly throughout the hospital.
  - A software option needs to be purchased that will allow cardiologists to interpret EKGs remotely.
- The existing waiting room used for cardiology clinics is inadequately furnished and much too small for patient volume.
- Current personnel:
  - Four technicians with two existing vacancies.
  - Four cardiologists.

Electrodiagnostics > EKG/Holter Laboratory

Deficiencies

- Some procedures performed require the services of a registered nurse, but there is no position on the staff for this nurse.
- No record being made in the medical record that the EKG was ever performed or a preliminary EKG is put into the patient's chart and never replaced with a final (physician interpreted) EKG.
- Waiting room is inadequate for patient needs.

Recommendations

10.4.01 Ensure the availability of a registered nurse, when one is clinically necessary.

10.4.02 Identify a process for all EKGs performed anywhere in the hospital to be sent to the cardiology for physician interpretation.

10.4.03 Identify a process to ensure that a final report be placed in each patient's medical record along with a preliminary report (when one exists).

10.4.04 Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.

10.4.05 Identify and recruit the required physician complement.

10.4.06 Enlarge the waiting room (or relocate) and refurnish.

Electrodiagnostics > EKG/Holter Laboratory

Performance Measures

- Length of study
  - Current 10 -15 minutes
  - Target 10 minutes
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target
- Scheduling Backlog (OP)
  - Current 3 months
  - Target 24-48 hours

Electrodiagnostic > Stress Testing Laboratory

Assessment

- Hours of operation are 8:00 AM – 4:30 PM, Monday through Friday.
- Patient source is ED, inpatients, outpatients, and andrious clinics.
- Current equipment:
  - One 20 year old treadmill.
- Equipment needs:
  - The existing treadmill needs to be replaced with a state-of-the-art piece of equipment. The new equipment will provide reporting capabilities as a component of the equipment.
- Current personnel:
  - Four technicians with two existing vacancies.
  - Four cardiologists.

Electrodiagnostic > Stress Testing Laboratory

Deficiencies

- Stress tests are currently performed using obsolete equipment.
- Lack of transport support services requires departmental staff to spend time transporting patients which should be spent performing technical procedures while patients are transported to and from the department.

Recommendations

10.4.07 Provide additional personnel; a registered nurse should be available at all times when one is clinically necessary. This could be an additional position to the staff or increased availability of Nursing support.

10.4.08 Replace existing treadmill.

10.4.09 Provide transport services to and from the department.

10.4.10 Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.

Electrodiagnostic > Stress Testing Laboratory

Performance Measures

- Procedure time
  - Current 1 hour
  - Target no change
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD
- Scheduling Backlog (OP)
  - Current 3 months
  - Target 24 - 48 hours

Electrodiagnostic > Echocardiology Laboratory

Assessment

- Hours of operation are 7:00 AM – 5:00 PM, with some overtime
- Patient source:
  - ED, inpatients, outpatients, and various clinics.
- Current equipment:
  - Eight-year old echocardiology equipment (the manufacturer will no longer provide a maintenance contract after July 2005 due to equipment age).
- Equipment needs:
  - Replace existing echocardiology equipment.
- Current personnel:
  - One echocardiology technician.
  - Registered nurse that assists when possible from the staffing of the cardiac catheterization laboratory.

Electrodiagnostic > Echocardiology Laboratory

Deficiencies

- Existing equipment is obsolete.
- Backlog of outpatients is extensive.
- Lack of transport support services requires departmental staff to spend time transporting patients, which should be spent performing technical procedures while patients are transported to and from the department.

Recommendations

10.4.11 Replace existing equipment.

10.4.12 Provide transport services to and from the department.

10.4.13 Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.

Electrodiagnostic > Echocardiology Laboratory

Performance Measures

- Length of procedure
  - Current 45 – 60 minutes
  - Target 30 – 45 minutes
- Productivity: Worked hours per procedure
  - Current
  - Target
- Scheduling Backlog (OP)
  - Current 6 months
  - Target 24 – 48 hours

Electrodiagnostic > EMG Laboratory

Assessment

- Hours of operation are 7:00 AM – 5:00 PM, Monday through Friday
- Patient Source: ED, inpatients, outpatients, and various clinics.
- Current equipment:
  - One EMG machine that is 10 years old.
- Equipment needs:
  - Replace existing obsolete unit with two new laptop-type machines at $18 K each.
- Current personnel:
  - One neurologist (no technical support).

Electrodiagnostic > EMG Laboratory

Deficiencies

- The department does not perform intraoperative monitoring, although the physician in charge of the department is capable of providing this service.
- There is no equipment to provide for intraoperative monitoring.
- There is no continuing education program in the department.
- The existing patient waiting room is poorly furnished and lighting is inadequate.
- A large storage closet in the patient waiting area causes clutter and is an obstacle to patient transport.

Recommendations

10.4.14 Assess for the need of intraoperative monitoring and implement appropriately.

10.4.15 Establish an appropriate departmental continuing education program.

10.4.16 Refurbish the patient waiting area.

10.4.17 Relocate the existing storage closet into the janitor's closet.

10.4.18 Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.

Electrodiagnostic > EMG Laboratory

Performance Measures

- Procedure Length
  - Current 30 – 40 minutes
  - Target No change
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD
- Scheduling Backlog (OP)
  - Current 4 months
  - Target 24 – 48 hours

Electrodiagnostic > EEG Laboratory

Assessment

- Hours of operation are 6:00 AM – 4:30 PM, Tuesday through Friday.
- On-call Requirements:
  - Three neurologists take call for two-week periods of time on a rotational basis.
- Patient Source is ED, inpatients, outpatients, and various clinics.
- Current equipment:
  - Two EEG machines that are four to five years old; do not currently need replacement.
- Equipment needs:
  - One additional EEG machine needs to be purchased to provide for mobile inpatient services.
  - Additionally, the department needs updated dictation equipment for report production and all examination rooms need numerous additional electrical outlets to provide for convenient and safe operation of equipment.
- Current space:
  - Two rooms are currently used for EEG procedures, both of which are too small and require doors to remain open as stretchers/cribs extend out of the room into the hallway.
- Current personnel:
  - One EEG technician.
  - One secretary

Electrodiagnostic > EEG Laboratory

Deficiencies

- Existing number of personnel, both professional and technical, are not adequate to provide for patient needs.
- The existing space is inadequate for appropriate management of patients while performing technical procedures.

Recommendations

10.4.19 Identify required professional and technical resources to accommodate patient needs.

10.4.20 Enhance the existing space.

10.4.21 Evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes.

Electrodiagnostic > EEG Laboratory

Performance Measures

- Procedure length
  - Current 2 hours
  - Target No change
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD
- Scheduling Backlog (OP)
  - Current 2 months
  - Target 24 – 48 hours

Responsibility

- Administrative Representative
- Medical Director

Ambulatory Services

NAVIGANT CONSULTING

Ambulatory > Interviews

• A. Funnye, M.D.	Division Chief, General Internal Medicine
• L. Nelson, M.D.	Physician, Neuroscience
• D. Ogunyemi, M.D.	Division Chief, Obstetrics
• R. Leathers, D.D.S.	Chief Oral and Maxillofacial Surgery Outpatient Services
• L. Jackson, D.D.S.	Interim Director, General Practice Residency, Dentistry
• A. Faye Singleton, M.D.	Pediatric Outpatient Medical Director
• H. Djalilian, M.D.	
• L. Lundy, M.D.	Chief, Division of General Surgery
• N. Datta, M.D.	Interim Chair, Department of Surgery
• R. Peeks, M.D.	Chief Medical Officer
• C. Nalls	Ambulatory Care Administrator
• P. Price, R.N.	Interim Chief Nursing Officer
• J. Keys	Interim Chief Executive Officer, Hubert H. Humphrey Comprehensive Health Center
• I. Carbins, R.N.	Nursing Director, Hubert H. Humphrey Comprehensive Health Center

Ambulatory > Interviews

• L. Makam, M.D.	Medical Director, Hubert H. Humphrey Comprehensive Health Center
• A. Kuvhenguhwa, M.D.	Chair of Medical Records Committee
• S. Brown	Administrative Program Director, Department of Otolaryngology
• R. Scott, M.D.	PSA President
• L. Madison	Supervising Typist Clerk, Dollarhide Health Clinic
• D. Smith	Interim Nurse Manager, Dollarhide Health Clinic
• D. Akerele	Nurse Manager
• T. Saunders	Charge Nurse, Orthopedic Clinic
• C. Vipapcon	Charge Nurse, Pediatric Subspecialty
• Singleton, M.D.	Pediatric Subspecialty, Pediatric Urgent Care, POP
• C. Mendez	Charge Nurse, Hematology/Oncology
• Chillar, M.D.	Hematology/Oncology
• Nihaua, M.D.	GYN Oncology
• P. Wauls	Associate Administrator, Hubert H. Humphrey Comprehensive Health Center
• Multiple nurses and staff	

Ambulatory Care > Prioritized Summary of Recommendations

Leadership/Management		
N/A	11.1.01	Streamline the financial screening process.
N/A	11.1.02	Place CHP workers strategically throughout KDMC with easy access for patients.
N/A	11.1.03	Design a set of management reports that track utilization of resources (both human and materials), cost of items, cost per patient visit, etc.
N/A	11.1.04	Develop ambulatory value and process improvement team to standardize processes.
N/A	11.1.05	Assign someone from the administrative level to work with IT to correct reports. Develop reports at the cost center level, and in a roll-up by department. Train managers and medical directors to read reports, and analyze data.
N/A	11.1.06	Define the roles of vice president, nurse manager, and medical director.
N/A	11.1.07	Develop a conflict resolution process for issues arising in ambulatory care.
N/A	11.1.08	Establishment of a KDMC vice president for ambulatory and community programs with responsibility and accountability for campus and community- based ambulatory care services, reporting directly to the KDMC CEO.
N/A	11.1.09	Develop a staff recognition program.
Access		
N/A	11.2.01	Eliminate all block scheduling.
N/A	11.2.02	Enforce the use of the automated scheduling system.
N/A	11.2.03	Develop policy and enforce the practice of scheduling patient visits in increments based on the specialty and type of patient being seen.
N/A	11.2.04	Assess the current Affinity scheduling module, and redesign the screens and menus to improve the efficiency of the scheduling process.
N/A	11.2.05	Adjust clerical staffing in the clinical areas to support expeditious patient registration.
N/A	11.2.06	Evaluate the need for selected elective services.
N/A	11.2.07	Develop a plan to rightsize medical staff and mid level provider support.
N/A	11.2.08	Develop a plan to improve collection of data at registration.

Ambulatory Care > Prioritized Summary of Recommendations

Patient Throughput		
N/A	11.3.01	Implement an effective appointment scheduling process.
N/A	11.3.02	Redesign front desk processes.
N/A	11.3.03	Establish alignment of appointments and staff to maximize productivity.
N/A	11.3.04	Evaluate and redesign hours of operation to optimize utilization.
N/A	11.3.05	Evaluate and redesign space based on clinical requirements.
N/A	11.3.06	Develop effective pre-operative process.
N/A	11.3.07	Develop a referral process to manage incoming and outgoing referrals.
HIM		
N/A	11.4.01	Improve medical record retrieval for clinics.
N/A	11.4.02	Eliminate shadow charts in clinics.
N/A	11.4.03	Improve completeness of medical records.
N/A	11.4.04	Ensure maximum utilization of information systems and electronic solutions.
N/A	11.4.05	Resolve space issues for filing dental films.
N/A	11.4.06	Implement new process to shred medical records at HHHCHC.
N/A	11.4.07	Utilize available space in another part of the clinic to increase the number of files for medical records at Dollarhide.
N/A	11.4.08	Ensure test result availability and system to flag available test results for clinicians.

Ambulatory Care > Prioritized Summary of Recommendations

Radiology		
N/A	11.5.01	Replace radiographic units.
N/A	11.5.02	Fill existing personnel vacancies.
N/A	11.5.03	Address issues related to industrial accidents.
N/A	11.5.04	Recruit the a permanent Department Manager to replace the current acting department manager.
N/A	11.5.05	Add a Clinical Nurse Attendant.
N/A	11.5.06	Add a Darkroom Technician.
N/A	11.5.07	Resolve issues complicating the scheduling of referred patients.
N/A	11.5.08	Reduce report turnaround time to be within 24-hours.
N/A	11.5.09	Provide managerial training to the department manager.
N/A	11.5.10	Create additional managerial reports to assist in analysis of specific improvement activities.
N/A	11.5.11	Expand scope of services provided to include fluoroscopic and IVP procedures.
Laboratory		
N/A	11.5.12	Review and update all laboratory policies to ensure they reflect current operational processes.
N/A	11.5.13	Establish a sound client support process/service that includes adequate staffing and sufficient phone lines.
N/A	11.5.14	Develop a formal POCT program with formal supervision and controls in place.
N/A	11.5.15	Allow only duly licensed/credentialed personnel to perform POCT, including those procedures requiring skin puncture.
N/A	11.5.16	Work with HR and administration to review the status of staff on disability; consider allowing the use of temporary staff where appropriate.
N/A	11.5.17	Provide the necessary computer training to all laboratory personnel.
N/A	11.5.18	Consider measuring physician and patient satisfaction, including wait times.
N/A	11.5.19	Consider using monthly management reports to manage the operation.
N/A	11.5.20	Consider providing the laboratory with a full time clerical support assistant.

Ambulatory Care > Prioritized Summary of Recommendations

Laboratory		
N/A	11.5.21	Add at least 2 phlebotomists/processors to support the test volume, particularly during peak times.
N/A	11.5.22	Immediately institute a short-term plan with the necessary space-related provisions in place to support the current patient volume in phlebotomy; adjust workflow accordingly.
N/A	11.5.23	Use the Affinity computer system to print labels (a computer and bar-code label printer may be necessary) and discontinue double labeling of specimens.
N/A	11.5.24	Initiate long-term planning efforts to renovate the phlebotomy area.
N/A	11.5.25	Develop patient instructions for home collected tests and/or for tests requiring preparation.
N/A	11.5.26	Immediately remove the patient waiting chairs from the clinical laboratory; identify other temporary ways to accommodate patient volume.
N/A	11.5.27	Expedite purchasing a new urinalysis analyzer.
N/A	11.5.28	Identify performance metrics and implement the necessary tracking systems.
N/A	11.5.29	Validate MT competency documentation and processes to handle CAP proficiency surveys.
N/A	11.5.30	Re-evaluate the process in place to outsource specimens, for tests not performed by KDMC's lab, to commercial laboratories. Consider sending specimens directly to the contracted lab instead of re-routing them through KDMC.
N/A	11.5.31	Evaluate the signage in place in the laboratory area; update it accordingly.
N/A	11.5.32	Consider implementing a different process to improve employee safety in the laboratory for services rendered after hours and weekends.
N/A	11.5.33	Consider a different process to improve safety, after hours, in the laboratory for patients seen after hours.
N/A	11.5.34	Develop a tracking process, either using copies of requisition forms, a logbook or a similar process in the short term to ensure reports are received for every Pap and other outsourced tests; consider an electronic tracking process in the long term.
N/A	11.5.35	Implement incident report documentation and tracking process; consider sharing some of the forms recently implemented at KDMC.
N/A	11.5.36	Further evaluate the cyto/histo correlation process in place for abnormal Pap smear results.

Ambulatory Care > Prioritized Summary of Recommendations

Physician/Academic		
N/A	11.6.01	Ensure compliance with ACGME requirements.
N/A	11.6.02	Establish an office immediately for the GPR program director.
N/A	11.6.03	Complete a full scale analysis of physician compensation by mission, including financial support, academic requirements and administrative responsibilities.
N/A	11.6.04	Define mid-level provider performance expectations.
N/A	11.6.05	Define administrative support staff needs for faculty.
Staffing		
N/A	11.7.01	Complete a full staffing analysis when valid data is available.
N/A	11.7.02	Develop a care model and redesign staff roles and responsibilities.
N/A	11.7.03	Develop and implement Case Manager performance measures.
N/A	11.7.04	Implement new reporting structure in each clinic that reports to the designated Nurse Manager.
Information Technology		
N/A	11.8.01	Improve electronic access to patient data for providers and staff.
N/A	11.8.02	Identify required Affinity functionality updates and implement.
N/A	11.8.03	Develop a IT plan for ambulatory care.
N/A	11.8.04	Streamline the OR scheduling process.
Facilities		
N/A	11.9.01	Replace all broken and unsafe furniture.
N/A	11.9.02	Complete a full facility and space analysis.
N/A	11.9.03	Relocate red plugs in those areas where they are inappropriately placed.
N/A	11.9.04	Ensure minimum standards are met for housekeeping services in ambulatory care.
N/A	11.9.05	Move clinical interviewing of patients to the exam room to alleviate violations of patient confidentiality.

Ambulatory Care > Prioritized Summary of Recommendations

Equipment/MM		
N/A	11.10.01	Replace malfunctioning equipment.
N/A	11.10.02	Purchase necessary equipment.
N/A	11.10.03	Develop a three year equipment purchase and replacement plan.
N/A	11.10.04	Streamline the materials management process.
Quality and Service		
N/A	11.11.01	Develop a customer service program.
N/A	11.11.02	Develop policies and tools to ensure compliance with minimum standards of care.
N/A	11.11.03	Develop and implement a process for follow up of all patient lab and diagnostic test results.
N/A	11.11.04	Improve availability of pertinent patient educational information including Spanish versions.
N/A	11.11.05	Improve relationships with KDMC providers and outside agencies and providers.
Regulatory		
N/A	11.12.01	Complete analysis of structural needs to maintain patient confidentiality.
N/A	11.12.02	Ensure compliance with Title IV Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.
N/A	11.12.03	Develop Ambulatory Care Infection Control Plan.
N/A	11.12.04	Ensure compliance with Patient Safety standards.
N/A	11.12.05	Evaluate and redesign documentation tools.

Overview

- Ambulatory care consists of a set of primary care and specialty clinics on the KKMC campus and at two satellite locations – Hubert H. Humphrey Comprehensive Health Center (HHHCHC) and Dollarhide Health Center.
- Ambulatory visit volumes for FY05 are projected at 264,560 – a decrease of 14.1% from FY04.
- Ambulatory care is currently staffed with 136.7 support staff FTEs (excludes dentists, physicians, residents and mid-level providers). This does not include the Dollarhide Health Center.
- In addition, 43.2 physicians, 6.7 dentists, and 4.8 mid-level providers are employed in ambulatory care.

Overview

- There are currently 20 distinct clinic programs on the King Drew Medical Center campus

Orthopedic	1F14
Pediatric Continuity and Subspecialties	1C-8
Pediatric OP Clinic (POP)	Denzel Washington Pediatric Pavilion
Hematology/Oncology	2A
Community Health Plan (Adult)	2B
Obstetrics/Gynecology	2H2
Perinatal Diagnostic Center	2023
Surgery	3G
Otolaryngology (ENT)	4G
Dermatology	4I
Gastroenterology, inc. Endoscopy	4I
Neuroscience	4J
Oral and Maxillofacial Surgery	4L
General Practice Residency in Dentistry	4L
Internal Medicine, including Subspecialties	4M
Hub Program (Foster Child Care)	Trailer 6
Pediatrics Continuity and Subspecialties	Trailer 6
Community Health Plan (Peds)	Trailer 6
Ophthalmology	Trailer 12
Oasis Clinic	Lot C

Overview

In addition, there are two satellite clinic locations:

- Hubert H. Humphrey Comprehensive Health Center was the first comprehensive health center in the country, and was originally designed to accommodate over 1,800 patients per day. It is located in the Southeast Health District, and provides services in:
  - Adult Medicine
  - Urgent Care
  - Family Medicine
  - Main Street Clinic
  - Women's One Stop
  - Obstetrics/Gynecology
  - Pediatrics
  - Specialty Clinics, currently only Ophthalmology
  - Clinical Laboratory
  - Diagnostic Radiology
- Dollarhide Health Center is located in the Compton Health District, and provides services in:
  - Obstetrics/Gynecology
  - Pediatrics
  - Family Medicine

Leadership/Management

1. Leader Management

Leadership/Management

Assessment

- The ambulatory care organization is fragmented, with the nurse manager of KDMC reporting to the CNO, the interim ambulatory care administrator reporting to the COO, the Interim CEO of HHHCHC reporting to the CEO.
  - Effective February 1, 2005, the Nurse Manager for Clinics at KDMC will report directly to the Interim Ambulatory Care Administrator, and will have a dotted line reporting relationship with the Clinical Nursing Director.
  - A Nurse Manager who was unassigned at KDMC has been assigned to pick up the responsibilities of some ambulatory clinics. The clinics she will be covering have not been determined.
  - There exists no coordination of ambulatory care programs between KDMC and the satellites. In fact, their relationship can be considered adversarial as both are competing for limited resources.
  - HHHCHC has a robust administrative structure with an Interim CEO, Associate Administrator, Nursing Director, Assistant Nursing Director/Education, 4 Nurse Managers, and 5 Nursing Supervisors (and an additional 2 Nursing Supervisors on IA).
  - There is an additional Business Office Supervisor and Interim Nurse Manager at Dollarhide Health Center.

Leadership/Management

Assessment

- Management reports are inconsistently available, and when they are available, they are erroneous and lack credibility.
- Physicians are unable to treat patients who chose KDMC for care if they are privately insured, or willing to pay cash.
- There is no infrastructure to assist patients with converting their HMO coverage to Community Health Plan (CHP). The county has also requested they not market CHP to patients.
- KDMC has lost 50% of service contracts with community providers over the last 2 years for unknown reasons.
- There is a perception that an aggressive campaign is required to reverse the public image of KDMC.
- There exists significant ambiguity in Trailer 6 where the HUB program coexists with CHP and Pediatric Clinics. The Pediatric Outpatient Medical Director has responsibility for the Pediatric programs, but no authority to manage those programs.

Leadership/Management

Assessment

- Customer survey boxes are located in each clinical area. There is not an effort to collect responses. There is little to no awareness on how to acquire a survey to fill out.
- There are no guidelines, or organizational support, to discharge patients from the practice. Patients can be consistently abusive, threatening, hostile and non-compliant, but physicians are still expected to treat them.
- Conflict between administrative personnel at KDMC and HHHCHC.
  - It is a perception that they are competing for the same patients, and are directly taking resources from each other.
  - HHHCHC believes that programs and support have been diverted to KDMC from HHHCHC without reason or cause.
  - HHHCHC believes their decreased volume is related to KDMC suspending appointment reminder letters to patients.
- HHHCHC Urgent Care Medical Director does not respond to the direction of the HHHCHC Medical Director or CEO. He says he reports directly to the Associate Dean.
- There is an environment of blaming the providers at HHHCHC.
- A physician identified there exists a "culture of secrecy."

Leadership/Management

Assessment

- Management staff had no formal education or training in practice management. They have been promoted through the ranks, and feel they do not know what "best practices" are.
- There is an overwhelming desire among the management staff to be successful.

Deficiencies

- Lack of information precipitates poor decision making.
- Faculty feel demoralized by their limited ability to treat patients who ask for their services.
- Inaccurate and incomplete management reports.
- Ineffective mechanism to complete financial screening for patients.
- Lack of role clarity, level of authority and lines of accountability.
- Community Health Plan (CHP) is underutilized.

Leadership/Management

Recommendations

11.1.01 Streamline the financial screening process.

11.1.02 Place CHP workers strategically throughout KDMC with easy access for patients.

11.1.03 Design a set of management reports that track utilization of resources (both human and materials), cost of items, cost per patient visit, etc.

11.1.04 Develop ambulatory value and process improvement team to standardize processes.

11.1.05 Assign someone from the administrative level to work with IT to correct reports. Develop reports at the cost center level, and in a roll-up by department. Train managers and medical directors to read reports, and analyze data.

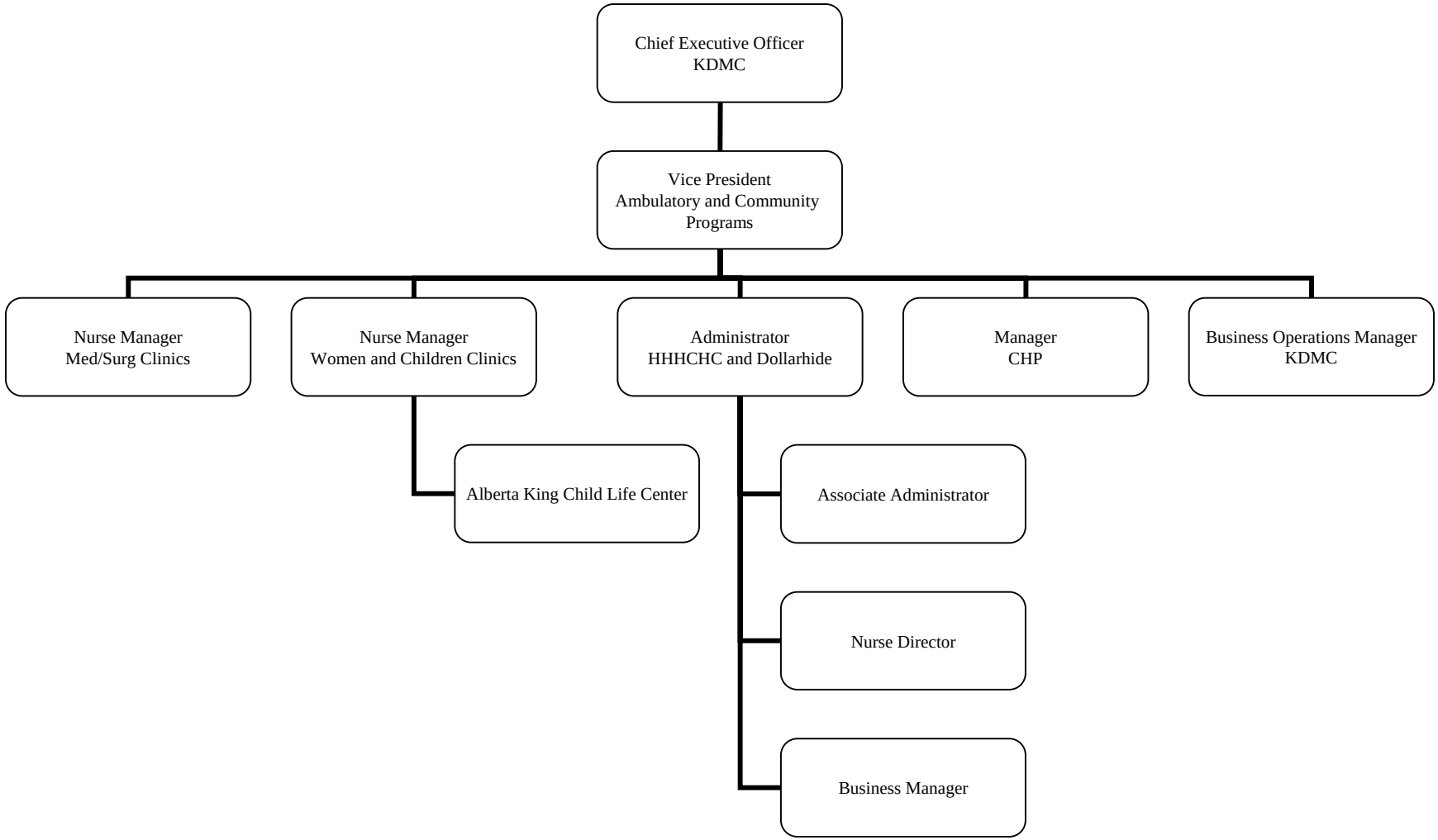
11.1.06 Define the roles of vice president, nurse manager, and medical director.

11.1.07 Develop a conflict resolution process for issues arising in ambulatory care.

11.1.08 Establishment of a KDMC vice president for ambulatory and community programs with responsibility and accountability for campus and community-based ambulatory care services, reporting directly to the KDMC CEO.

11.1.09 Develop a staff recognition program.

Leadership/Management



NAVIGANT CONSULTING

Access

2. Access

Access

Assessment

- Block scheduling is utilized by many of the onsite clinics resulting in patient flow and space issues.
- Otolaryngology does not use block scheduling, and is considered one of the most efficient clinics by others.
- Handwritten appointments are given to the patients without accessing the automated scheduling system.
- 4M clinic is bottlenecked due to several sub clinics occurring at the same time (diabetes, cardiology, renal).
- The Affinity scheduling module in the current form is inefficient and difficult to use.
- Everyone in the organization can schedule a patient appointment in a clinic which may or may not be correct.
- Patient routinely fight in the clinical area because they are so overcrowded. Patient had a space on the floor, and went to the bathroom. When the patient returned, his seat on the floor was taken, and a fight ensued.
- Physician at KDMC sending referrals back denied to HHHCHC.
- Patient volume in Affinity does not balance patient log volume.

Access

Assessment

- Nursing Director at HHHCHC wants to change Urgent Care to 12 hours, Monday through Friday, excluding holidays.
- KDMC provides fertility services to the uninsured.
- KDMC provides contact lens services to the uninsured.
- Lack of available patient appointments is one of the greatest dissatisfiers for physicians.
- Community clinic referrals are going to Harbor or Children's Hospital for Pediatric Surgery, Pediatric Endocrinology, Podiatry, Pediatric Rheumatology.
- Community clinic referrals for Adult Rheumatology and Cardiac Surgery are going to LAC-USC since no services are available at KDMC.
- Pediatrician at Dollarhide sent a request in October 2004 for an Urgent Pediatric Urology appointment to the Referral Center—still awaiting an appointment on January 25th.
- Current functionality in Affinity Patient Scheduling and Registration system cannot search on 1st available appointment for a service. The system requires you to search by provider.

Access

Assessment

- Registration staff frequently do not verify patient demographic information in the registration process. Patient address in Affinity was different from address documented in patient medical record since November 2004.
- Patients seen in the specialty clinics do not require specialty services any longer, but have no PCP to send the patient back to.
- It is the perception of staff at HHHCHC that volume is down because: patients have more options for care, the wait time to appointment is excessive and KDMC stopped sending out reminders letters.
- HHHCHC specialty care support has dwindled over the last year, with only Ophthalmology remaining.
- There is no systematic planning to match clinic service "supply" to patient demand.
- There is a high no show rate with minimal strategy apparent for addressing.

Access

Deficiencies

- Overbooking, block scheduling, and poor patient flow all contribute to excessive wait times in the clinic.
- Inaccurate patient data in scheduling/registration system.
- The automated scheduling process is ineffective.
- No services for Rheumatology (adult and pediatric), Pediatric GI, Pediatric Sickle Cell, Pediatric Surgery and Cardiothoracic Surgery.
- Appointment availability data is inaccurate. Data was pulled three times with different results, and was not validated upon telephone call. Results are incongruent with what physicians are experiencing.
- No matching of supply and demand.
- No telephone access metrics.
- The availability of primary care services do not meet the community medical needs.

Access

Recommendations

11.2.1 Eliminate all block scheduling.

- Clinics would have the option of scheduling by provider, by clinical specialty, or by room.
- Appointments must be spread out over the entire clinic time.

11.2.02 Enforce the use of the automated scheduling system.

11.2.03 Develop policy and enforce the practice of scheduling patient visits in increments based on the specialty and type of patient being seen.

11.2.04 Assess the current Affinity scheduling module, and redesign the screens and menus to improve the efficiency of the scheduling process.

11.2.05 Adjust clerical staffing in the clinical areas to support expeditious patient registration.

11.2.06 Evaluate the need for selected elective services.

11.2.07 Develop a plan to rightsize medical staff and mid level provider support.

11.2.08 Develop a plan to improve collection of data at registration.

Patient Throughput

3. Patient Throughput

Patient Throughput

Assessment

- CHP and Perinatal diagnostic services are efficient and effective.
- 4M patient flow is cumbersome. The clerk has to walk each patient chart from one end of the clinic to the other end of the clinic to give to the nurse.
- 4M staff do not schedule follow up appointments for patients if there are patients waiting to be registered. They tell them to call for an appointment.
- 4M have 6 providers sharing the same workroom approximately 160 square feet.
- 4M patients are scheduled and arrive at 12 noon, the providers arrive at 1pm, but the first patient does not get into an exam room until 1:10 pm. On one observation, it took almost 30 minutes before each provider had a patient in the exam room (there were 63 scheduled for 12 noon).
- 4J Neuroscience registration area was so cluttered and full, that you could barely get the door open.
- 4I Dermatology uses numbers to call patients. The registration clerk and the nurse pick what time they will start to call patients, the clerk gives number to each patient when they arrive beginning with "1", the nurse starts to call patients at the designated time, and they keep calling patients until no one responds.

Patient Throughput

Assessment

- The narcotics for GI Endoscopy are located in another clinic. The nurse must leave the patient treatment area to acquire narcotics for administration. In addition, the narcotic count and signature logs are located in a different room from the narcotic box.
- Patients have to jump through hundreds of hoops to get anything accomplished.
- Patient flow is driven by what is convenient to nurses and physicians, not what is convenient to patients.
- Physicians do not always have at least 2 exam rooms to see patients in.
- Exam rooms are not always supplied with the appropriate medical supplies.
- 3G patient medication refill requests require the patient to come to the clinic to pick it up. They do not mail prescriptions or call in refills.
- Patients are asked to reschedule appointments when the doctor does not get to them during the clinic session.
- Patients from fast track and ED frequently show up at the clinic with appointment slip in hand, and no appointment in the system.

Patient Throughput

Assessment

- When patients present to the clinic, they are logged into a computer, and a clerk verifies insurance status; Patients must present with photo identification and insurance card.
- Patient signs a general consent form for each visit.
- Clinics routinely start later than scheduled even though physicians are available to see patients. The long lines at the registration desk delay starting on time.
- Patients at HHHCHC are financially screened at every visit, creating a bottleneck during registration despite the financial screening being valid for 3 months.
- It can take hours to get diagnostic tests scheduled, the patient waits until they are given a date and time.
- Patient Resource Worker validates MediCal coverage at the time of every visit.

Patient Throughput

Deficiencies

- Block scheduling, handwritten appointments and ineffective patient registration leads to excessive wait times, overcrowding of waiting rooms, loss of control of patient flow, and angry patients.
- Duplicate, unnecessary work being done.
- Structural barriers in some areas hinder effective patient flow.
- Incoming referrals are slowly and consistently coordinated with poor follow-up to referring providers.
- Outgoing patient referrals are often not coordinated for the patient.

Recommendations

11.3.01 Implement an effective appointment scheduling process.

11.3.02 Redesign front desk processes.

11.3.03 Establish alignment of appointments and staff to maximize productivity.

11.3.04 Evaluate and redesign hours of operation to optimize utilization.

11.3.05 Evaluate and redesign space based on clinical requirements.

11.3.06 Develop effective pre-operative process.

11.3.07 Develop a referral process to manage incoming and outgoing referrals.

HIM

4. HIM

HIM

Assessment

- HIM department delivers medical records in the morning and retrieves them in the afternoon. Records include both outpatient visits and inpatient stays.
- Documentation is not standardized.
- Summary lists are not included in the medical record for HUB clinic patients; CHP clinic utilizes an HIM-generated form that includes past diagnosis only.
- HIM chart availability has improved over the recent months. However continued tracking and trending is required to reach the HIM goal of 95% availability in each clinic.
- Shadow charts are utilized in many clinics as back up in case the unit record is not received.
- Progress notes are handwritten and sent to HIM as separate loose filing at some point after the clinic visit.
- There are documents stored in the shadow chart which are not in the central medical record.
- Charts are delayed in arriving in the clinical setting and are often incomplete.

HIM

Assessment

- Physicians feel shadow charts are helpful because patient data is available when needed.
- Filing of panorex films on site is problematic because of space constraints.
- Otolaryngology has developed the most sophisticated and accurate encounter form to capture physician activity and patient acuity.
- Dictation services are not being used, and there is a perception that they are not "allowed" to explore this option.
- Physicians have no templates for documentation.
- There is no chart prep prior to the patient visit.
- Test results and reports inconsistently reach physicians an are often delayed when they do arrive.
- Physicians receive no notification when report results are available.

HIM

Assessment

- HHHCHC:
  - Loose correspondence is backlogged and adequate staff is not available to eliminate backlog.
  - Confidential records are placed in the trash instead of shredding at HHHCHC.
  - Temporary folders are created for patients in addition to the unit medical record. Temporary folders are often pulled for clinic instead of the unit record.
  - HIM department schedules do not permit adequate time to retrieve charts in time for clinic start.
  - Record control is inadequate and records are not consistently delivered to or retrieved from the clinics.
  - Coding and billing is backlogged due to lack of working scanners and staffing issues.
- Dollarhide Health Center:
  - There is inadequate filing space for medical records.
  - Affinity HIM modules are underutilized.
  - Physicians would benefit from the "patient charting" module of Affinity for electronic progress notes

HIM

Deficiencies

- The unit medical record is not readily available for all scheduled clinic visits.
- The complete unit medical record is often not available for clinic visits.
- Clinic progress notes are not submitted to HIM after each clinic visit.
- Charts do not contain most recent clinical information, documents are not filed at the time of the visit.
- HIM staff have inadequate Affinity skills.
- Patient confidentiality is compromised due to lack of shredding procedures.
- Late billing of visits.
- Release of information and chart tracking is not streamlined at Dollarhide.
- HIM area is overcrowded at Dollarhide.

HIM

Recommendations

11.4.01 Improve medical record retrieval for clinics.

11.4.02 Eliminate shadow charts in clinics.

11.4.03 Improve completeness of medical records.

11.4.04 Ensure maximum utilization of information systems and electronic solutions.

11.4.05 Resolve space issues for filing dental films.

11.4.06 Implement new process to shred medical records at HHHCHC.

11.4.07 Utilize available space in another part of the clinic to increase the number of files for medical records at Dollarhide.

11.4.08 Ensure test result availability and system to flag available test results for clinicians.

Ancillary Services

5. Ancillary Services
   - Radiology
   - Lab
   - Pharmacy

Ancillary Services > Radiology – HHHCHC

Assessment

- Hours of operation are 7:30 AM – 12:00 AM.
- Patient Source: Clinic Outpatients
- Equipment current:
  - Four radiographic units/rooms without fluoroscopy
  - Two ultrasound units/rooms
  - One mammogram unit/room
- Equipment
  - All radiographic rooms are in excess of 10 years old. Those that did once have fluoroscopic capabilities have had that modality disabled; fluoroscopic and intravenous pyelography (IVP) procedures are not performed at the center.
  - Both ultrasound units are fairly new and are in good working condition.
  - The mammography unit is three years old and has been labeled a “lemon.”
    - However, during the past 2 months the unit has been working very well. The manufacturer has acknowledged the “lemon” status of the equipment, but the county has decided not to pursue replacement due to the bureaucracy involved. The center has planned to replace the mammography unit with a new unit.

Ancillary Services > Radiology – HHHCHC

Assessment

- Personnel includes:
  - Department Manager
  - Six staff Technologists
  - Two Transcriptionist
  - One Clerk (vacant)
  - Two Sonographers
- Five members of the staff (30%) are out on extended industrial accident leaves.
- Radiographic report turnaround time is currently three days.
- 90 to 100 Diagnostic examinations performed per day.
- 10 to 12 Ultrasounds performed per day.
- 20 to 24 Mammographies per day.

Ancillary Services > Radiology – HHHCHC

Deficiencies

- Patients referred to KDMC for radiology services not provided at the center must follow-up with a phone call to insure that the referral was received.
- Much of the existing equipment is obsolete and should be replaced.
- The staff is negatively affected by a very high number of industrial accident cases.
- Fluoroscopic and IVP studies are not performed at the center.

Ancillary Services > Radiology – HHHCHC

Recommendations

11.5.01 Replace radiographic units.

11.5.02 Fill existing personnel vacancies.

11.5.03 Address issues related to industrial accidents.

11.5.04 Recruit the a permanent Department Manager to replace the current acting department manager.

11.5.05 Add a Clinical Nurse Attendant.

11.5.06 Add a Darkroom Technician.

11.5.07 Resolve issues complicating the scheduling of referred patients.

11.5.08 Reduce report turnaround time to be within 24-hours.

11.5.09 Provide managerial training to the department manager.

11.5.10 Create additional managerial reports to assist in analysis of specific improvement activities.

11.5.11 Expand scope of services provided to include fluoroscopic and IVP procedures.

Ancillary Services > Radiology – HHHCHC

Performance Measures

Diagnostic Radiology

- Length of Procedure
  - Current 10 – 20 minutes
  - Target No change
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD
- Scheduling Backlog
  - Current No backlog
  - Target No backlog

Ancillary Services > Radiology – HHHCHC

Performance Measures

Ultrasound

- Length of procedure
  - Current 20 – 30 minutes
  - Target 15 – 20 minutes
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD
- Scheduling Backlog
  - Current 2 weeks
  - Target 24 hours

Ancillary Services > Radiology – HHHCHC

Performance Measures

Mammography

- Length of procedure
  - Current 20 – 30 minutes
  - Target 15 – 20 minutes
- Productivity: Worked hours per procedure
  - Current not currently collected
  - Target TBD
- Scheduling Backlog
  - Current 2 months
  - Target 24 hours
- Report turnaround
  - Current 3 days
  - Target 24 hours

Ancillary Services > Laboratory – HHHCHC

Assessment

- The laboratory department supports approximately 25 physicians and mid-level providers, 10 clinics, as well as Urgent Care and its corresponding physicians.
- The laboratory is open from 7:30 a.m. until the time the last patient leaves the clinic around 12 AM.,7 days/week, including holidays.
- The laboratory performs approximately 42,000 test/month and refers out 3,900 tests/month to KDMC.
- The laboratory operates as a highly complex (non-waived) operation under the Clinical Laboratory Improvement Amendment of 1988 (CLIA '88), and it is accredited by College of American Pathologists (CAP). Test menu reflects the services of a moderate complex operation. The laboratory was last inspected in November 2003 and given satisfactory grades; however there are obvious areas of concern as listed in this report.
- The laboratory leadership includes a Laboratory Manager, one full-time Supervisor I, and one full-time Tech II. The Laboratory Manager is new to Humphrey. The laboratory's medical director retired in March 2004, but he continues to assist the laboratory on a voluntary basis. The Laboratory Manager also reports to the clinic's medical director.

Ancillary Services > Laboratory – HHHCHC

Deficiencies

- Policies and procedures seem to be outdated in some instances and may not reflect current laboratory operations.
- Some policies and procedure manuals have not been updated since the mid 1990s.
- Client/customer support, including telephone support, seems to be marginal.
- Point of Care Testing (POCT) lacks structure and formal oversight.
- Point of Care tests are performed by personnel who are not duly certified (in some instances) in accordance with State law.
- Several lab staff members (approximately 20% - 30% of the total staff) are on some sort of disability and/or have work limitations.
- Not all staff are able to use the Affinity computer system due to lack of training.
- Internal customer satisfaction is not measured or monitored.
- Laboratory management reports are not available, except for workload statistics.

Ancillary Services > Laboratory – HHHCHC

Recommendations

11.5.12 Review and update all laboratory policies to ensure they reflect current operational processes.

11.5.13 Establish a sound client support process/service that includes adequate staffing and sufficient phone lines.

11.5.14 Develop a formal POCT program with formal supervision and controls in place.

11.5.15 Allow only duly licensed/credentialed personnel to perform POCT, including those procedures requiring skin puncture.

11.5.16 Work with HR and administration to review the status of staff on disability; consider allowing the use of temporary staff where appropriate.

11.5.17 Provide the necessary computer training to all laboratory personnel.

11.5.18 Consider measuring physician and patient satisfaction, including wait times.

11.5.19 Consider using monthly management reports to manage the operation.

11.5.20 Consider providing the laboratory with a full time clerical support assistant.

Ancillary Services > Laboratory – Pre-Analytical – HHHCHC

Assessment

- Inadequate staffing levels and distribution of job functions in the phlebotomy and processing areas.
- Inadequate and unsafe space to handle the volume of patients in the phlebotomy area; confidentiality is of concern.
- Inadequate workflow systems, including patient registration, phlebotomy, specimen processing, and double labeling of blood specimens.
- Lack of systems to track tests submitted to outside laboratories, including Pap smears.
- Patient instructions for home collected specimens do not exist; on-site urine collection signs and instructions are not available.
- Patient safety is an area of concern when patients must wait inside the laboratory due to the limited space.

Ancillary Services > Laboratory – Pre-Analytical – HHHCHC

Deficiencies

- Insufficient staff and space.
- Lack of work processes.
- Inefficient sharing of job responsibilities.

Recommendations

11.5.21 Add at least 2 phlebotomists/processors to support the test volume, particularly during peak times.

11.5.22 Immediately institute a short-term plan with the necessary space-related provisions in place to support the current patient volume in phlebotomy; adjust workflow accordingly.

11.5.23 Use the Affinity computer system to print labels (a computer and bar-code label printer may be necessary) and discontinue double labeling of specimens.

11.5.24 Initiate long-term planning efforts to renovate the phlebotomy area.

11.5.25 Develop patient instructions for home collected tests and/or for tests requiring preparation.

11.5.26 Immediately remove the patient waiting chairs from the clinical laboratory; identify other temporary ways to accommodate patient volume.

Ancillary Services > Laboratory – Analytical – HHHCHC

Assessment

- Laboratory equipment is outdated in some specialties without a back up in place.
- Performance indicators are not in place to monitor the department's operating systems/processes.
- Staff proficiency documentation and validation system is unclear. For example, unable to validate if all Med Techs and all shifts are involved in completing CAP proficiency surveys.
- The process in place to outsource specimens to commercial laboratories is redundant; it delays test results while increasing the opportunity for errors.
- Signage throughout the laboratory department, particularly in patient waiting areas, is sub-optimal.
- A safety concern exists when urgent care patients are directed to the laboratory after hours (and weekends), while a single lab tech is on duty in a remote area of the clinic.

Ancillary Services > Laboratory – Analytical – HHHCHC

Deficiencies

- Outdated equipment.
- Inefficient outsourcing process.
- Lack of performance indicators.

Recommendations

11.5.27 Expedite purchasing a new urinalysis analyzer.

11.5.28 Identify performance metrics and implement the necessary tracking systems.

11.5.29 Validate MT competency documentation and processes to handle CAP proficiency surveys.

11.5.30 Re-evaluate the process in place to outsource specimens, for tests not performed by KDMC's lab, to commercial laboratories. Consider sending specimens directly to the contracted lab instead of re-routing them through KDMC.

11.5.31 Evaluate the signage in place in the laboratory area; update it accordingly.

11.5.32 Consider implementing a different process to improve employee safety in the laboratory for services rendered after hours and weekends.

11.5.33 Consider a different process to improve safety, after hours, in the laboratory for patients seen after hours.

Ancillary Services > Laboratory– HHHCHC

Performance Measures

- Specimen rejection
  - Current:: Data not available
  - Target: < 1.5%
- STAT requests
  - Current: Data not available
  - Target: To be determined upon further evaluation
- Productivity index based on test volumes, workload reports, and billable tests
  - Current: Not available
  - Target: 80% - 90%
- Productivity: Worked Hours per Billed Test
  - Current: Not available
  - Target: .12 - .16
- STAT TAT – Received at the Lab to verify time
  - Current: Not available
  - Target: < 1 hr
- TAT from the time test is ordered
  - Current:: Not available
  - Target: < 1.5 hr

Ancillary Services > Laboratory – Post-Analytical – HHHCHC

Assessment

- The laboratory does not track Pap smears, which are outsourced to PathNet. These reports are submitted directly from PathNet to the physician's office.
- Pap smear results are not interfaced; it is unclear how the cyto-histo correlation process is done.
- Incident reports are not documented, tracked, and improvement programs are unclear.
- The tracking process of other outsourced tests, and turn around time monitoring, is unclear.

Ancillary Services > Laboratory – Post-Analytical – HHHCHC

Deficiencies

- Lack of send out test monitoring.
- Unavailable incident report documentation.

Recommendations

11.5.34 Develop a tracking process, either using copies of requisition forms, a logbook or a similar process in the short term to ensure reports are received for every Pap and other outsourced tests; consider an electronic tracking process in the long term.

11.5.35 Implement incident report documentation and tracking process; consider sharing some of the forms recently implemented at KDMC.

11.5.36 Further evaluate the cyto/histo correlation process in place for abnormal Pap smear results.

Ancillary Services > Pharmacy – HHHCHC

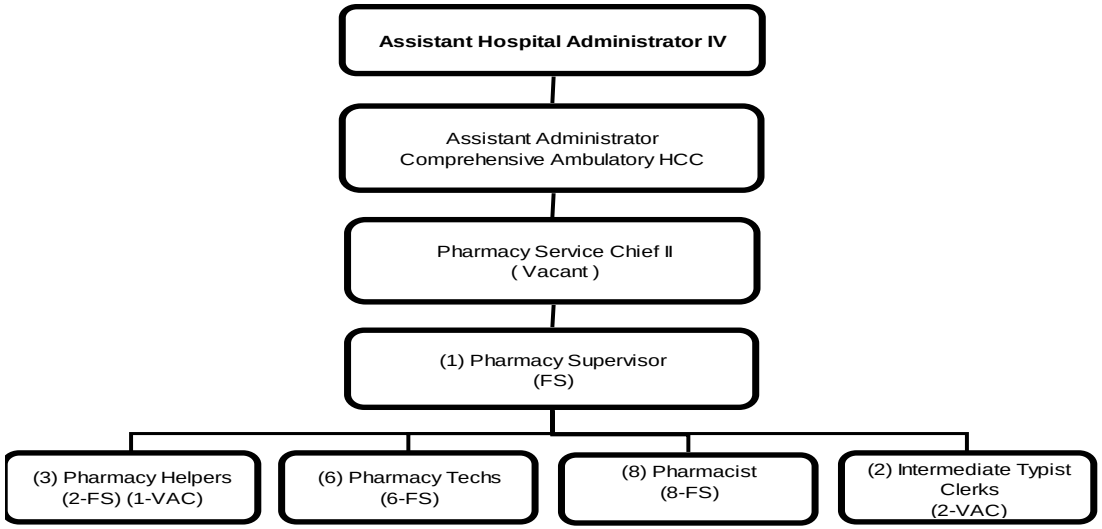
Assessment

- Provides pharmacy services 16 hours per day, 7 days per week.
- Organizational Chart:

County of Los Angeles Department of Health Services

Southeast Area
Hubert H. Humphrey CHC

Pharmacy



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Ancillary Services > Pharmacy – HHHCHC

Assessment

- Current Statistics (based on CY2004 data):
  - Average 1,133 prescriptions per day.
  - Based on 5 RPh staffing per day, average 226.6 prescriptions per RPh per day.
  - Based on 16-hour day, average 14.2 prescriptions per hour (4.24 minutes per prescriptions).
  - Average wait time is 2.5 to 3.5 hours.
- Currently purchase all medications on 340B pricing.
- Do not currently bill for medications dispensed.
  - Only CHC within LAC that does not bill for medications dispensed.
- 1115 waiver expires in June 2005.
- FQHC status pending.
- Unknown impact on ability to continue to procure medications on 340B pricing.
- Plans for remodeling the pharmacy have been drafted and approved.
- Plans for purchase of McKesson Pharmacy 2000 information system.

Ancillary Services > Pharmacy – HHHCHC

Deficiencies

- Chief II position vacant.
- One budgeted supervisor position for 16-hour days.
- Current average RPh daily staffing lower than optimal.
- None noted as plans have been developed for improvement.
- Plans are on hold.

Recommendations

- Fill Chief II position as soon as possible.
- Increase Supervisor to two budgeted positions (one for each eight-hour shift).
- Increase staff RPh to nine budgeted positions.
  - This will lead to average RPh per day staffing to 6.5 which will decrease workload average to 10.9 prescriptions per RPh per hour (5.51 minutes per prescription).
- Ascertain ability to bill for medications.
  - Will increase demand on cashiers.
- Ascertain impact of FQHC status and relationship with KDMC on 340B pricing.
- Proceed with pharmacy remodeling.
- Proceed with purchase and installation of McKesson Pharmacy 2000 information system.

Physician and Academic Issues

6. Physician and Academic Issues

Physician and Academic Issues

Assessment

- Physicians stay at KDMC because of the mission in this community.
- Physicians are concerned about the lack of support and resources for the academic mission. No infrastructure, no time, no support for curriculum development, no research.
- Internal Medicine residents get no experience completing pelvic exams. All these patients are referred to OB Gyn.
- GPR Program Director does not have an office because two clerical staff who have a "personality conflict" cannot be in the same room, therefore, the Director's office was taken away.
- Obstetrics and Gynecology residency program is at risk of accreditation because of decreasing volume.
- Existing providers are unable to adequately service patient loads in some clinics
- There are no guidelines for physician production and compensation.
- There are limited (or no) stipends for medical administration, Division Chief differentials, or on-call coverage.

Physician and Academic Issues

Assessment

- There are 53.4 FTE mid level provider support at KDMC with no targets or measurements for production.
- Physicians believe they are working at capacity, and there is no where to go.
- Mid Level Provider utilization is not measured, and standards are inconsistent.
- Some physicians are concerned that the only measurement of their productivity is volume, which does not measure their true activity. They believe RVU data would be more reflective of their efforts.
- Physician have little administrative support. Many departments have physicians typing their own letters, photocopying, etc.
- Los Angeles County does not cover the costs of physician recruitment, therefore all potential recruits pay 100% of expenses to visit KDMC.
- No department or hospital support for CME. Physicians are responsible for 100% funding for all CME activities.
- Physicians see all patients that are seen by a mid level provider.
- There is a belief that some physicians do not routinely spend 40 hour a week on site when they are considered full-time.

Physician and Academic Issues

Deficiencies

- Inadequate availability of clinical time to manage current patient load in some specialties.
- Lengthy wait times occur. Patients are sent away unseen and asked to return on another day.
- No mechanism to measure physician production, subsequently making it difficult to assess resource allocation and utilization for program expansion or reduction.
- Clinics may be cancelled on short notice by clinicians with little or no apparent supervisory oversight or procedures.

Recommendations

11.6.01 Ensure compliance with ACGME requirements.

11.6.02 Establish an office immediately for the GPR program director.

11.6.03 Complete a full scale analysis of physician compensation by mission, including financial support, academic requirements and administrative responsibilities.

11.6.04 Define mid-level provider performance expectations.

11.6.05 Define administrative support staff needs for faculty.

Staffing

7. Staffing

Staffing

Assessment

- GPR residents perform all oral hygiene services on patients.
- There is no county job classification for Medical Office Assistant, who is trained in clinical and clerical responsibilities.
- Request from Cerritos Community College to have KDMC serve as an Student Externship in Speech Pathology with the Department of Otolaryngology was denied by DHS.
- OB/Gyn clinical staffing frequently has one nurse covering three exam rooms at a time.
- Surgery clinic requires additional staff to provide case management functions for the pre and post operative patients.
- Clerical staff is unavailable for many of the clinics.
- Physicians want nursing staff who are appropriately prepared and trained to take care of patients, and recognize what patients need.
- 4M had 63 patients scheduled for 12 noon with only one registration clerk. It took 2.5 hours to register all the patients.
- 3G Nursing staff filing in shadow records.

Staffing

Assessment

- Staff take breaks regardless of the activity in the clinic. They are not delayed, or curtailed based on patient need.
- HHHCHC has Case Managers that cover all the services. These BSN prepared Case Managers are in addition to the clinic staffing.
- Licensed nursing staff performed many clerical duties.
- RN staff performing activities not required of RN staff, such as rooming patients, taking vital signs, and chaperoning physical exam.
- RN staff perform very little triage.
- Very few unlicensed care providers, leaving the RN staff to do many technical, rather than professional duties.
- General consensus that they need more staff, both nursing and clerical staff.
- Activity of the clerical staff is too fragmented. Each person performs one task.
- Cannot determine the staffing needs of these clinics because there is no data currently available and accurate to determine that activity level in ambulatory care.

Staffing

Assessment

- Current staffing (FTEs) by job function:

	KDMC	HHHCHC	Dollarhide
Administration	2.4	6.2	Not Avail
Medical Receptionist	28.05	1.61	Not Avail
Medical Records	Not Avail	Not Avail	Not Avail
Registered Nurses	21.00	25.00	Not Avail
Licensed Vocational Nurses	5.27	8.60	Not Avail
Med Asst, Nsg Asst, Techs	19.77	18.80	Not Avail
Contract Support Staff			Not Avail
TOTAL FTE	**76.5**	**60.2**	

Staffing

Deficiencies

- Misuse of RN staff.
- Fragmented clerical responsibilities.
- Lack of unlicensed patient care providers to perform technical tasks.
- Lack of Dental Hygienist in dental program.
- No performance measurement criteria for Case Managers.

Staffing

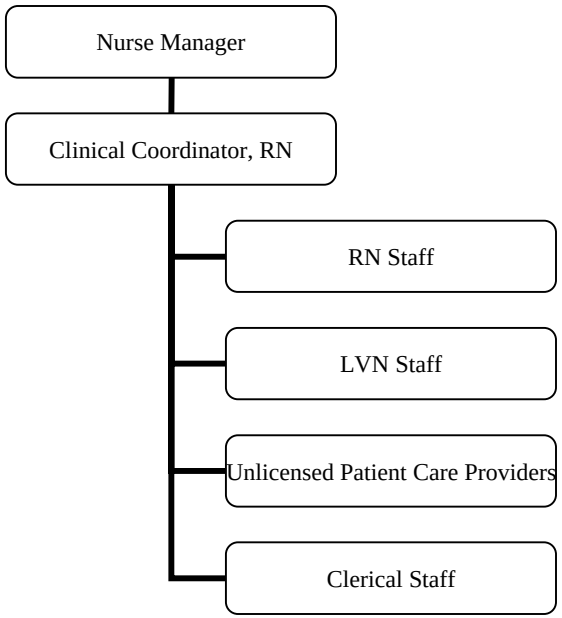
Recommendations

11.7.01 Complete a full staffing analysis when valid data is available.

11.7.02 Develop a care model and redesign staff roles and responsibilities.

11.7.03 Develop and implement Case Manager performance measures.

11.7.04 Implement new reporting structure in each clinic that reports to the designated Nurse Manager.



NAVIGANT CONSULTING

Information Technology

8. Information Technology

Information Technology

Assessment

- Requested updates and changes to the functionality of Affinity have been denied or delayed (one department has a template change pending for 3 years).
- Lack of understanding about what the capabilities of Affinity are.
- Physicians want the "building blocks" of an information system, not data warehousing when you have never seen the data.
- Physicians and nurses spend a lot of time transcribing data into the computer system.
- Only physicians have the security access to cross check who the treating physician is through Affinity when the clerical and nursing staff are the ones trying the accommodate the patient.
- Physicians must type a "buck" sheet in order to get a patient added to the OR schedule. The forms are not electronic, and there is no administrative support to type the forms, so the physicians have to search for a working typewriter to complete the form. The OR scheduler will not accept handwritten forms.
- Physician Assistants require additional training in order to access lab and radiology results.
- Limited number of workstations in the clinic.

Information Technology

Deficiencies

- Scheduling and registration system is underutilized, and staff are inefficient in using the system.
- Patient data is not available to all staff with a need to know.
- Limited workstations.

Recommendations

11.8.01 Improve electronic access to patient data for providers and staff.

11.8.02 Identify required Affinity functionality updates and implement.

11.8.03 Develop a IT plan for ambulatory care.

11.8.04 Streamline the OR scheduling process.

Facilities

9. Facilities

Facilities

Assessment

- Surgery clinic is very crowded.
- There is inadequate physician office space, patient waiting areas, patient rooms, equipment and supply storage in many of the clinics.
- Obstetrics and Gynecology space is currently inadequate to accommodate patient volume and efficient flow.
- Oral and Maxillofacial Surgery (OMFS) has inadequate recovery room space.
- Ophthalmology requires additional waiting room space.
- There is no door on exam room 3G, #B, just a curtain which does not allow auditory privacy . Two rooms are separated by only a partial partition.
- Ophthalmology requires additional waiting room space.
- There is no door on exam room 3G, #B, just a curtain which does not allow auditory privacy.
- Family Medicine at HHHCHC believes they need significantly more space, and Administration does not agree with the request. They are at an impasse.
- 4G Otolaryngology space does not currently have a room that is large enough to do operative procedures. Therefore, minor office procedures are done in the Ambulatory Surgery Center (i.e. flexible bronchoscopy, transnasal esophagoscopy, PEG, etc.).

Facilities

Assessment

- The ambulatory areas are dirty, and not routinely cleaned. Nursing staff frequently clean the clinics, but do not have access to mops. Only two clinics identified housekeeping was responsive and adequate.
- 4G Otolaryngology exam rooms are small and cannot accommodate more than 2 persons in the room at any one time.
- 3G Surgery Clinic has no physician workspace and only one computer terminal.
- 4M Internal Medicine had more patients than waiting room chairs.
- 4M no barrier from patient waiting room to clinical area. One patient was observed entering an exam room where a nurse was interviewing a patient because she wanted a question answered.
- Stairwell 1 when exiting from one of the floors does not indicate there is no reentry once you enter the stairwell. You must exit the building.
- Staff furniture was in gross disrepair. Torn fabric, lopsided, not ergonomically appropriate for desk height.
- There is no confidential space to register patients. Patients all line up at the same window, and protected health information is exchanged.

Facilities

Assessment

- Two or more patients are assessed during the check in process at the same time in the same room, violating patient right to confidentiality.
- Dollarhide Health Center checks in and checks out patients in the same room at the same time, frequently having three patients in the room at the same time where there is exchange of protected health information.
- Most clinics only have one emergency plug in their area. The code carts are plugged into the emergency plug, but the cart impedes the flow of traffic in 4G and 2H2.
- Exam room utilization is variable (benchmark is different depending on specialty). Accurate visit volume data is required in order to analyze.
- Due to the physical configuration of the Hematology/Oncology Clinic space, there is a lack of space to provide infusion therapy.

Facilities

Deficiencies

- There are lengthy wait times and patients line the hallways for hours without a place to sit.
- Patient flow is poor and space is inadequate due to overcrowding at peak periods.
- Patient flow and processing is ineffective due to lack of adequate space for daily operations.
- Disregard for patient confidentiality during the registration, check in and check out process.

Recommendations

11.9.01 Replace all broken and unsafe furniture.

11.9.02 Complete a full facility and space analysis.

11.9.03 Relocate red plugs in those areas where they are inappropriately placed.

11.9.04 Ensure minimum standards are met for housekeeping services in ambulatory care.

11.9.05 Move clinical interviewing of patients to the exam room to alleviate violations of patient confidentiality.

Equipment and Materials Management

10. Equipment and Materials Management

Equipment and Materials Management

Assessment

- Loop electrosurgical excision procedure (LEEP) equipment malfunctioning in OB/Gyn. The hose is taped to the filtering unit, the hose being used is from a nebulizer set up, the unit smokes abnormally when in use.
- 3G Surgery Clinic has no oto/ophthalmoscopes in the clinic, but they are completing histories and physicals on pre-operative patients.
- Capital equipment has been ordered, but not processed for several clinics. The process requires five signatures required to purchase supplies or equipment.
- Rhinoscopes and laryngoscopes are not replaced routinely in Otolaryngology (ENT). Physicians are using the scopes beyond the 3,000 treatment limit.
- Several lasers are broken beyond repair in Ophthalmology.
- There is no equipment replacement plan in the clinics. Purchases occur when something breaks, and after lengthy delay.
- Wait time for colonoscopy exceeds 6 months. The General Surgery faculty would complete flexible sigmoidoscopy if they had the equipment and space.
- Defibrillators are located in each clinic.

Equipment and Materials Management

Assessment

- There is no data available to support purchase decisions or costing analysis.
- Nursing staff have to requisition and pick up supplies from materials management, taking them away from the clinical site.
- The head support on the ENT chairs do not lock in place, causing the patient's head to lose support during procedures.
- Two out of five ENT chairs are torn and in disrepair.
- Ophthalmology chairs do not raise and lower as required for exams.
- 40% of clinics have at least one operational hi-lo exam table.
- 4G Clean and dirty supplies stored in the same room.
- 3G Paper towels and soap not available in some exam rooms. Housekeeping was notified at 7:30 am, and as of 9:30 am it had not been delivered.
- 3G exam tables in C and D have torn fabric.
- 2H2 Laser Smoke Evacuation Unit filter indicates it is to be changed after every 60 minutes of lasing. The staff change it "when the smoke does clear very well."
- Nitrous oxide machines in OMFS outdated.

Equipment and Materials Management

Assessment

- POP holding area only has three monitors for five beds.
- POP has no bassinets to use for newborns.

Deficiencies

- Patient safety concerns exist with use of current LEEP equipment.
- Existing equipment issues are a patient safety concern in several of the clinics.
- Lack of appropriate equipment to complete histories and physicals on patients.
- There is no plan for equipment replacement
- Non compliance with ADA standards for exam table accessibility.
- Cumbersome, inefficient process for obtaining basic supplies which delays patient treatment, and creates unsafe conditions when delivery is delayed.

Equipment and Materials Management

Recommendations

11.10.01 Replace malfunctioning equipment.

11.10.02 Purchase necessary equipment.

11.10.03 Develop a three year equipment purchase and replacement plan.

11.10.04 Streamline the materials management process.

Quality and Service

11. Quality and Service

Quality and Service

Assessment

- The CHP Clinic Nurse stated that patient satisfaction surveys are performed by the hospital, but they receive no receive feed-back.
- Customer service is lacking in most of the clinics.
- There is a feeling of helplessness in dealing with Human Resource and personnel issues. Staff have been "cascaded" through the system. One department has three out of five employees transferred to that department as a result of performance issues in another department.
- Customer Service standards are not clearly delineated and enforced.
- Clerical staff in the clinics have no consistent performance standards or duties. There is significant downtime among some clerical staff.
- Physicians and staff feel impotent in managing employees on IA s. One physician has been on "stress leave" for more than 5 years.
- Preponderance of HR issues exist in the departments. Unable to fire poor performing staff.

Quality and Service

Assessment

- Staff are tested for Spanish interpretation skills, and are certified to perform interpretation services. This is indicated on their paycheck stub, and in their personnel file.
- Employees get moved from one department to another without any negotiation or discussion with the manager. For example, Chief of Division was notified that two Physician Assistants were transferring to another department on a particular date with no regard to the patient coverage issues that would arise.
- Nursing staff and physicians do not work together as a team.
- HHHCHC Urgent Care PA had a number of patient complaints. No follow up on the resolution of this issue.
- No consistent documentation guidelines in the teaching clinics.
- Each clinical area independently decides what patients should be seen by an attending physician.
- Attending physician signatures are present on most charts, but there is lack of documentation of further assessment or medical decision making on the part of the attending physician.

Quality and Service

Assessment

- There is no formal mechanism to provide abnormal lab follow-up calls.
- Educational tools for patients are limited in some areas.
- Unresponsive to community requests for physician orders on patients because "medico legal in the county" told him to cease signing all physician order requests coming from outside agencies which were not on KDMC letterhead.
- KDMC has lost credibility with the community, especially by others providers who bypass referring patients to KDMC even when there is capacity.
- Dental programs unable to practice four handed dentistry because of staffing, requiring the attending to work as a Dental Assistant, or leave the resident to work without support.

Quality and Service

Assessment

- Speech/Language pathology services are minimal, permitting only evaluation and no treatment.
- Lines waiting for pharmacy services are long and extend along the hallways.
- Most frequent patient complaint is waiting time in the clinic, and second is disrespectful treatment.
- Breast Clinic patients have an identified Case Manager who tracks all results and treatment for patients. Physicians believe this is the ideal system for patient management.
- All patients receive a pre-operative anesthesia evaluation whether necessary or not based on the assessment of the surgeon.
- 4M Internal Medicine has the patient always see a physician regardless of the issue. Patient came for a BP check, and they made the patient wait to see the physician even though the BP was normal.

Quality and Service

Assessment

- 4M Internal Medicine does not refill patient medications unless they see the physician. If the physician does not have an available appointment within the time frame the patient needs, they tell the patient to report to the ED.
- Conscious sedation given in POP, GI Endoscopy, OMFS, Dental Clinic. Each area uses a different form, but all assess vital signs every 5 minutes. ASA is documented on each patient record. Each area does a pre-anesthesia assessment and only POP area discharges the patient based on criteria. OMFS have the provider evaluate the patient prior to discharge, and GI Endoscopy discharges the patient when they can walk from one end of the hall to the other.
- Pain assessment is completed on every visit, and regardless of the score, a further evaluation is completed.
- "The interaction between the doctor and the patient is the only thing that works well in ambulatory care.“
- Consulting physicians do not know who the referring provider is, therefore, no information is sent back to the physician.

Quality and Service

Assessment

- Documentation:
  - 2H2 unable to find documentation of preoperative teaching for patient undergoing TAH write out.
  - 2H2 physician progress notes all have "Vital Signs--see nursing assessment", but there were no nursing flow sheets with the same corresponding dates.
  - 2H2 Nutrition Consult ordered on patient July 24, 2004, but no consultant's report in the medical record.
  - 2H2 AI completing the "Nursing Assessment" sheet, but not cosigned by the RN. Only one out of nine AI assessments were co signed.
  - HHHCHC urgent care treatment record does not include assessment of pain or assessment of learning needs.
  - KDMC Nursing and Interventions form does not include review of medications list as part of the assessment, and over 80% of records do not contain a medication list.
  - KDMC Conscious Sedation flow sheet which is approved, requires documentation of the condition of the patient upon discharge, but does not include disposition of the patient.

Quality and Service

Assessment

- Neurology physicians reduced over the last 2 years leading to degradation of services, excessive on-call hours, suspension of medical student rotations in department, and low morale.
- 4M Internal Medicine had four patients on oxygen in the waiting room with 3 of those patients only Spanish speaking. The patient education material on oxygen safety was only available in English.
- Currently policy just requires the attending be "on site" in the facility, but CMS clearly states the attending physician must be present, complete key portions of the exam, and participate in medical decision making in order to bill for the service.

Deficiencies

- Patients are not provided with a minimally acceptable level of service related to wait times, space and accommodations, privacy and resolution to problems by clinic staff.
- Hispanic patients are often seen without appropriate interpreters.
- KDMC policy on Supervision of Residents is incongruent with CMS guidelines.
- Patients are not consistently notified of abnormal lab or diagnostic testing results.

Quality and Service

Deficiencies

- Lack of respect for patients, inattention to the dignity of patients, and lack of maintaining a confidential and private environment for patients.
- No prostodontic, orthodontic, periodontic or endodontic services available.
- Documentation fails to support the CMS requirement that attending physicians demonstrate involvement in patient assessment and medical decision making in order to bill for professional services.
- Educational materials are not readily available to patients in the clinics in both English and Spanish. Key materials missing are Advanced Directives, Pain Management and Organ/Tissue Donation.
- No continuity of care for KDMC patients receiving home health, outside therapy, assisted living, or skilled nursing care with their KDMC providers.
- Recovery room space is inadequate in OMFS for number of patients using it.
- Lengthy waiting times for pharmacy, with inadequate waiting room space.
- Waste of resources when evaluating all patients pre-operatively.
- Nursing triage is limited, causing physicians to see patients when unnecessary. This just further precipitates the access issue in some specialties.

Quality and Service

Recommendations

11.11.01 Develop a customer service program.

11.11.02 Develop policies and tools to ensure compliance with minimum standards of care.

11.11.03 Develop and implement a process for follow up of all patient lab and diagnostic test results.

11.11.04 Improve availability of pertinent patient educational information including Spanish versions.

11.11.05 Improve relationships with KDMC providers and outside agencies and providers.

Regulatory Compliance

12. Regulatory Compliance

Regulatory Compliance

Assessment

- Conscious sedation is performed in OMFS, Gastroenterology and Pediatric Urgent Care. In addition, OMFS also performs general anesthesia.
  - A different documentation tool was identified in each area.
- Medications are kept in a locked room in locked cabinets.
- Medication samples are not dispensed at clinic.
- The crash cart is secured in a central location.
- The crash cart and medications are checked monthly, and the logs are up to date.
- Clinic physicians and staff were unable to describe specific performance improvement activities/projects for the clinic or discuss examples of performance measurement and related documentation, in general. Only two clinics on the KDMC campus specifically identified PI activities.
- There are bio-hazardous bins and sharps containers in the exam rooms.
- Clinic physicians and staff were not aware of specific infection control surveillance activities that occur at the clinic or any tracking/trending of infections among the clinic population.

Regulatory Compliance

Assessment

- Hospital infection control personnel are responsible for infection control activities in the clinics, but clinic personnel cannot describe the specific activities that occur at the clinic; One physician stated that she believes air quality is monitored monthly, but was unable to describe the process or any related documentation.
- Inconsistent posting of “do not use” abbreviations in the clinics.
- Clinic staff in perinatal diagnostic services follow appropriate measures for maintaining patient privacy and protecting patient identifiable information.
  - The Clinic Nurse was able to describe privacy and confidentiality policy.
  - Medical records are secured in a locked file cabinet.
  - Electronic information is password protected.
  - Curtains are appropriately utilized in patient care area, where there are multiple patient beds in one room.
  - Staff was observed to speak quietly to each patient in order to maintain privacy.
- In perinatal diagnostic services, a supervising physician is typically nearby, but not always.
- Staff were unable to describe specific supervision requirements or the process for understanding what services residents can provide and what documentation is required.

Regulatory Compliance

Assessment

- POP did a performance improvement project on the identification of patients. They now put armbands on all their patients.
- 3G Patient with TB seen in clinic day before. Room needed to be decontaminated. Called it at 7:30 am, and was not cleaned as of 11:30 am.
- 3G Medication room is located inside a patient treatment room.
- All staff identify they clean exam tables between patients.
- Security and privacy issues are evident in most clinics.
- Using family members as interpreters and translators in the course of care when bilingual staff member is not available.
- The Denzel Washington Pediatric Pavilion is providing emergency care in an area not designated as emergency. They routinely intubate and hold patients for inpatient admission. The staff and physicians are PALS certified, and four faculty are ATLS certified. The Medical Director of this area is board certified in Pediatrics and Emergency Medicine.
- Patient registration and patient check out occurs in public where everyone can hear the patient information. In one area, the desk actually sits in the middle of the waiting room (4I).

Regulatory Compliance

Assessment

- Nursing staff in 4M using the dirty utility room as a workstation for processing paperwork and lab results.
- GI Endoscopy procedures are done in the same suite as Dermatology patients are seen. All dermatology patients must walk past the procedure rooms to get to the exam room. On both days of observation, the procedure room doors were open, exposing the Derm patients to the monitoring and patient treatment discussion.
- GI Endoscopy nurses area required to transport the narcotics unsecured for patients undergoing ERCP in Radiology (four floors away).
- 4I Dermatology was interviewing and taking vital signs on patients in the middle of the hall--breach of patient confidentiality and impeding the flow of traffic.
- 3G Room 3068 has three separate exam rooms in it with no auditory privacy.
- 2H2 found two different informed consent stamps on progress notes in the patient record; one for TAH and one for GA which did not list the risks and benefits, the physician performing the procedure and were not witnessed.
- KDMC Ambulatory Summary Lists are not completed consistently.

Regulatory Compliance

Assessment

- The clinics say it is the responsibility of the coder to print and file Ambulatory Summary Lists. They are difficult to locate in the record since they are filed as they are printed, and I found no records in which they were printed at each visit, indicating they were updated.
- No documentation of identifying learning needs, barriers to learning, preferred method of learning.
- Advanced directives not address in ambulatory care, but medical records do contain references for those patients who have had an admission. There were no copies of advanced directives in the record. The general consent form has a place to check advanced directives, but it was not completed on any chart reviewed.
- Ambulatory Summary list is located in a different place in every record. It is printed by the coder, and placed at various places throughout the record. In every record you had to search for the list.
- All medications were noted to be within the expiration time frame and were noted when opened for multiple dose vials.
- The Pediatric Outpatient Clinic uses Omnicell for all medications. It is the only outpatient area using a controlled unit dose system.

Regulatory Compliance

Assessment

- Narcotics were found to be double locked in all areas where they are stored.
- All medications were in locked locations.
- Each clinical area has a crash cart which is checked daily. Quality control checks were up to date, and carts were all locked.
- Pediatric code carts with pediatric dosages for emergency medications are present in the pediatric areas.
- Sample medications were not found in the ambulatory clinics.
- RN and provider assess every patient prior to initiation of conscious sedation or anesthesia.
- Cardiac monitoring, pulse oximetry, automated vital sign monitoring, IV therapy and resuscitation equipment is available in each site performing conscious sedation or anesthesia.
- The ASA of each patient is documented prior to initiation of sedation or anesthesia, and each area uses a "time out" and verification by the patient of the site of treatment.
- During sedation or anesthesia, vital signs are monitored every five minutes.

Regulatory Compliance

Assessment

- Documentation of patients being discharged after conscious sedation or anesthesia always list disposition, but do not consistently list the name of the responsible adult who the patient was released to.
- Each clinic location has a sign posted about what waived testing is performed in each location. The competency of staff is determined by a person from clinical laboratory, but there is not ongoing assessment. Assessment is done once, and ongoing assessment is not delineated. Waived testing performed in the clinics are urine dipstick, blood glucose, stool for occult blood and urine pregnancy testing.
- Patients are required to present a valid photo ID at each visit for patient registration. Patients are sent away if they present without ID.
- Patient rights are posted in each clinical area, both in English and Spanish.
- Performance improvement is evident at HHHCHC. The staff in the Dental Clinic are looking at the improvement rates of gingivitis in diabetic patients.
- Third floor chairs located in the hallway outside Ambulatory Surgery and Cystoscopy were used as a waiting room impeding the flow of traffic.
- Clinics consistently lack a list (binder) of the Professional Staff Association (PSA) members' clinical privileges.

Regulatory Compliance

Deficiencies

- Lack of infection control surveillance, tracking and trending of infections and/or exposure.
- The Infection Control department does not provide feed-back to the clinics (reports on air quality not shared with clinic staff).
- There is no defined performance improvement program in place.
- Satisfaction survey results are not shared with clinic staff.
- Medical records lack summary lists.
- Medical record documentation is not consistent.
- While the information is embedded within the patient chart, there is no specific section/methodology for making pertinent information (age, weight, diagnoses, allergies, sensitivities) for caregivers administering medication.
- Summary lists including at least significant diagnoses and conditions identified during ambulatory assessments; known surgical or invasive procedures; known ongoing medications including OTCs, prescriptions, or herbal remedies; and known adverse or allergic reactions to medications are not consistently completed.
- Many clinics list “problems”, suggesting that there may be some inconsistencies in usage across clinics.

Regulatory Compliance

Assessment

- Instruments are disinfected in a room that lacks adequate space for proper disinfection technique in the Orthopedic Clinic
  - Instruments are placed on a table top next to a desktop computer immediately following disinfection
  - Disinfection workspace is crowded with equipment and supplies
- Pediatric code kit on crash cart lacks a Broeslow tape in Orthopedic Clinic
- Current “No-Show” Rate for all Pediatric Subspecialty clinics is 41%. Strategies to reduce this rate and to improve patient appearances are being discussed in the Ambulatory Clinic committee meeting, with no agreement being reached on a planned strategy.
- Monthly system of inspecting crash carts is susceptible to the correct equipment and supplies not being present when needed in an emergency
  - A supply of breakaway locks is present in the clinic for staff to relock cart following their monthly inspection
  - The system should consist of Pharmacy conducting a final inspection immediately prior to locking the cart. The cart expiration date should be identified on outside of cart. No need for monthly inspection of cart contents as long as the current date is within the expiration period.

Regulatory Compliance

Assessment

- Due to patient volumes and limited space, there are two exam tables in each (patient) room on 2B. Despite the staff's attempts to minimize breaches of patient confidentiality by lowering their speaking voices, it is not possible to prevent conversations from being overheard. Given the sensitive nature of the care rendered to patients in this clinic, the lack of privacy and confidentiality presents a concern.
- In addition to hematology and oncology care being provided in this setting, by default, the Coumadin Clinic is located in this area and staffed by the Hematology/Oncology nursing staff (The Coumadin Clinic had been operated by a pharmacist, who left and was not replaced).
  - The Hematology/Oncology nurses have not been oriented or trained to provide Coumadin care.
  - Anticoag monitoring occurs in the Coumadin Clinic without any involvement by a pharmacist.
  - With up to 67 patients being cared for in the Coumadin Clinic within a 4-hour block of time, the Hematology/Oncology clinic is not staffed to handle this patient load.

Regulatory Compliance

Assessment

- Case conferences are not truly interdisciplinary. There is little, if any, involvement from social work or nutrition. Significant involvement from these and other disciplines would be expected in an oncology clinic.
- As evidenced by a significant number of questions they ask the hematologists/oncologists in this clinic, the hospital pharmacists are not current in their knowledge of chemotherapy regimens and protocols. This lack of knowledge presents a significant patient safety concern.
- The clinic oncology nurses are being pulled to the inpatient oncology unit and Chest Clinic to provide care, which taxes the staff's ability to provide care to their clinic patients.
- The Clinic staff and physicians are frustrated by delays in receiving Radiology reports and in getting oncology patient scheduled for exams.
- Services provided by the Nuclear Medicine service are reported as being timely.

Regulatory Compliance

Deficiencies

- Staff cannot consistently verbalize the National Patient Safety Goals.
- Hand washing signs were not visible in the clinic (2B).
- Lists of high-alert medications were not available in the clinics.
- Ambulatory services are not meeting the guidelines regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.
- Emergency treatment is being performed in a medical office setting.
- May be an EMTALA write out violation at KDMC when refusing treatment to patients without photo identification.

Recommendations

11.12.01 Complete analysis of structural needs to maintain patient confidentiality.

11.12.02 Ensure compliance with Title IV Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.

11.12.03 Develop Ambulatory Care Infection Control Plan.

11.12.04 Ensure compliance with Patient Safety standards.

11.12.05 Evaluate and redesign documentation tools.

Ambulatory Services

Performance Measures

- Appointments available within 14 days
  - Current not currently collected
  - Target 70%
- Visits per physician FTE
  - Current not currently collected
  - Target 3,664
- Support staff FTEs per 1,000 visits
  - Current not currently collected
  - Target 0.9
- Percentage of no shows
  - Current not currently collected
  - Target < 20%
- Visits per exam room per day
  - Current not currently collected
  - Target 6

Ambulatory Services

Performance Measures

- Physician cancellation rates
  - Current not currently collected
  - Target <3%
- Direct cost per visit (excluding provider costs)
  - Current not currently collected
  - Target $47

Responsibility

Vice President, Ambulatory and Community Programs

Section XII – Programs and Services

NAVIGANT CONSULTING

Interviews

• I. Dyer, Acting Director	Office of Planning, DHS
• M. Willock, MD	Dean, Drew University School of Medicine
• T. Yoshikawa, MD	Chairman, Department of Medicine
• T. Fukushima, MD	Chairman, Department of OB/GYN
• D. Ogunyemi, MD	Chief, Obstetrics/Dir. Perinatal Diagnostic Center
• S. Ashley, MD	Associate Dean, GME
• R. Peeks, MD	Chief Medical Officer, KDMC
• Y. Niihara, MD	Chief, Hematology/Oncology
• V. Kaushick, MD	Chief, Cardiology
• H. Douglas	President Drew University
• D. Sanders, MD	Chairman, Orthopedics
• G. Locke, MD	Chairman, Neuroscience
• L. Biggers, MD	Vice Chairman, Neuroscience
• N. Datta, MD	Interim Chairman, Surgery and Chief, Urology
• H. Ward, MD	Chief, Nephrology
• R. Casey, MD	Chairman, Ophthalmology
• C. Dang, MD	Vice Chairman, Emergency Medicine

Interviews

• S. Bhasin, MD	Chief, Endocrinology
• J. McQuirter, MD	Chairman, Oral/Maxillofacial Surgery, and Chairman, General Dentistry
• G. Gill, MD	Chairman, Chairman, Otolaryngology
• L. Robinson, MD	Chairman, Pediatrics
• G. Mallory, MD	Chairman, Psychiatry
• F. Pinder, MD	Director, Inpatient Services, Psychiatry
• C. Nalls	Administrator for Ambulatory Programs
• A. Singleton, MD	Pediatrics Ambulatory Care
• R. Baker, MD	Chair, Ambulatory Care Committee
• J. Keys	Interim CEO, Hubert H. HHHCHC
• L Makam, MD	Interim Medical Director, HHHCHC
• F. Taylor	Associate Administrator, HHHCHC
• P. Wauls	Associate Administrator, HHHCHC
• I. Carbins	Nursing Director, Southwest Area Health Centers
• D. Akerele	Nursing Director, Ambulatory Care KDMC
• L. Akhanjee, MD	Interim Chairman, Family Medicine
• W. Ford	Director, Office of Ambulatory Care, DHS

Programs and Services > Prioritized Summary of Recommendations

Medicine – Other		
N/A	12.5.13	Establish a time limited plan for the recruitment of additional GI, pulmonary, rheumatology and dermatology faculty.
	12.5.14	Establish and implement a plan to manage the availability of gastroenterology and pulmonary services to that which can be safely managed at desirable quality levels with the currently available resources.
N/A	12.5.15	Create a list of alternative County and other sub acute settings which can accommodate the domiciliary requirement in between IV therapy, including the potential for home health agency administration of the therapy.
Surgery		
N/A	12.5.16	Maintain the current Department of Surgery service profile while assessing demand as access to care in the hospital improves and wait times for clinic appointments are reasonably timely.
N/A	12.5.17	Evaluate a desired mix of full-time and part-time faculty under various scenarios of to what degree residency programs may return and/or rotate through KDMC for service provision and educational exposure.
N/A	12.5.18	Work with department and division leadership to assess desirable changes to data collection to enhance credibility of activity, effort and volume reporting.
Otolaryngology		
N/A	12.5.19	Grow the capacity for ENT services on an inpatient and outpatient basis to meet the current backlog of demonstrated need as well as the gaps in service, particularly in cooperation with Pediatrics.
N/A	12.5.20	Work with the ENT Chair and Dean of Drew School of Medicine to establish a succession and growth plan for leadership and faculty in the department.
N/A	12.5.21	Evaluate the potential for a more accessible, discrete and efficient ambulatory surgical capability which would serve this and many other disciplines now using the inpatient setting.
Ophthalmology		
N/A	12.5.22	Grow the services of ophthalmology, including optometry in conjunction with departmental efforts to address unmet needs in the community.
N/A	12.5.23	Assess the adequacy of current ambulatory surgery resources and address equipment and space issues to accommodate the current and potential growth in surgical services.
Orthopedics		
N/A	12.5.24	Grow services in sickle cell and oncology with grant funds, appropriate space, staffing, logistics for enhancement of care.

Programs and Services > Prioritized Summary of Recommendations

Obstetrics and Gynecology		
N/A	12.5.25	Strengthen the de-facto high risk obstetrics program status through formalized program development in key areas such as substance abuse, chronic disease management (i.e., diabetes), teen center, etc.
N/A	12.5.26	Grow the service through specialty contracts with public and private managed care plans for high risk and more routine obstetrics care.
N/A	12.5.27	Provide opportunities for community physicians to have faculty status to enable their referral to and participation in the OB/GYN services at KDMC.
N/A	12.5.28	Expedite faculty and staff position control changes to enhance productivity.
Neuroscience		
N/A	12.5.29	Develop a plan for the department that re-evaluates the relative roles of neurosurgery and neurology in KDMC clinical programs. Target growth and program development in areas which best match the clinical needs of the community.
N/A	12.5.30	Maintain services and begin planning for leadership succession, and focused new program development in the area of stroke care.
Pediatrics		
N/A	12.5.31	Collaborate with Surgery to recruit a pediatric surgeon to support higher levels of care in the NICU and PICU.
N/A	12.5.32	Grow subspecialty services in sickle cell disease, audiology and vision screening through collaboration with the Medicine, Otolaryngology, and Ophthalmology.
N/A	12.5.33	Provide an alternative licensed sites of care for the sickest POP cases or adjust the certification appropriately if volumes warrants.
N/A	12.5.34	Increase services in primary care pediatrics to better address community needs.
N/A	12.5.35	Enhance asthma programs.
Psychiatry		
N/A	12.5.36	Maintain the service at its current level addressing regulatory and clinical care programs.
N/A	12.5.37	Initiate discussions with DMH leadership on coordination of care for patients that are common to both organizations.
N/A	12.5.38	Find alternatives to having juveniles on the unit at any time.

Programs and Services > Prioritized Summary of Recommendations

Emergency Medicine		
N/A	12.5.39	Maintain level of emergency care capabilities until operational enhancements enable growth in service capabilities addressing issues regarding equipment and space.
Oral / Maxillofacial Surgery and General Dentistry		
N/A	12.5.40	Grow the Oral/Maxillofacial Surgery & General Dentistry services to include the capability for elective and primary care services, especially community outreach.
N/A	12.5.41	Restore the use of and staffing for the mobile dental van as a key component of community outreach to address unmet community dental needs.
Family Medicine		
N/A	12.5.42	Acquire the necessary medical and other staff to adequately cover the services offered in all locations and address all residency review program citations.
N/A	12.5.43	Grow Family Medicine services in response to community need for longitudinal primary care services.
Hubert H. Humphrey Comprehensive Health Center (HHHCHC)		
N/A	12.5.44	Elevate the priority for coordinated service delivery to the community through establishment of a KDMC vice president for ambulatory and community programs with responsibility and accountability for campus and community- based ambulatory care services, reporting directly to the KDMC CEO.
N/A	12.5.45	Clarify the responsibility of the KDMC Medical Director for physician services in the ambulatory care setting through the local medical director and/or appropriate faculty Chief of Service
N/A	12.5.46	Support the initiative for FQHC “look-a-like” status for HHHCHC with the Dollarhide affiliate.
N/A	12.5.47	Defer ambitions to seek network accreditation of KDMC and affiliated community-based health centers until sometime after 2006 when a practical assessment of services integration can be made and a work plan for successful network accreditation can be realistically developed.
N/A	12.5.48	Develop system-wide standards for timely specialty referral access and communication to referral sources for ambulatory care patients.
N/A	12.5.49	Grow the ambulatory care services available to serve the needs of the SPA 6 southwest cluster community in response to demonstrated unmet need.

Service Area

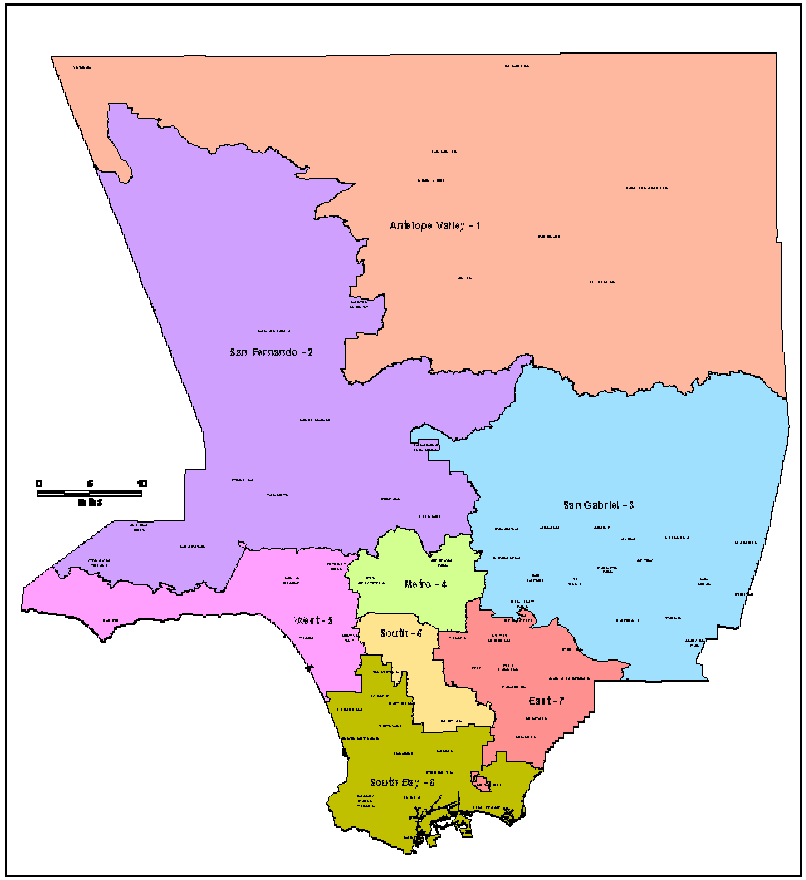
- Los Angeles County is approximately 4,000 square miles with a population of nearly 9 million, and governed by a five-member Board of Supervisors.
- DHS has responsibility for the County population public health requirements.
- DHS operates about a dozen “categorical” health centers for traditional public health services.
- DHS participates by contract in public/private partnerships with approximately one hundred ambulatory provider sites including numerous Federally Qualified Community Health Centers (FQHC’s), and ambulatory care centers.
- DHS operates hospitals and health centers to provide acute care and personal health services to low income and uninsured/indigent residents.
  - High Desert Hospital in Antelope Valley (recently converted to ambulatory care center)
  - Olive View Medical Center in San Fernando.
  - LAC+USC Medical Center in downtown Los Angeles.
  - KDMC in south Los Angeles.
  - Ranchos Los Amigos National Rehabilitation Center in south Los Angeles.
  - Harbor/UCLA Medical Center in the southern coastal part of the County.
- The Department of Mental Health is a separate County department which does not operate hospitals, but contracts for or operates outpatient mental health centers.

Service Area

- The conversion of High Desert Hospital is consistent with other DHS initiatives to approach a new level of rationalization and consolidation of health care services within its domain.
  - Conversion of Ranchos Los Amigos from acute care to rehabilitation.
  - Downgrading the Olive View Medical Center NICU to level I.
  - An intent to consolidate certain services, such as, ventilator dependent patients, and electroshock therapy at selected facilities.
  - There is a current notion to utilize the new soon to be completed 600-bed LAC-USC Medical Center as the key tertiary center for County services.
- LA County is segmented into different sections for various purposes.
  - There are five Supervisorial Districts for purposes of political representation.
  - There are five “Cluster Areas” for grouping DHS facilities.
  - There are eight Service Planning Areas (SPAs) for analysis and services planning with KDMC located in and serving SPA 6.
  - There is no consistent overlap of geography in these three approaches to County segmentation.

Service Area

- SPA 6 is located in the south central part of Los Angeles County as shown below.



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Service Area

- The table on the next page compares the eight SPAs by various demographic variables.
- The County acute care medical facilities are located as follows:
  - Olive View Medical Center is in SPA 2 (San Fernando)
  - LAC – USC Medical Center is in SPA 4 (Metro)
  - KDMC is in SPA 6 (South)
  - Harbor+UCLA Medical Center is in SPA 8 (South Bay)
- SPA 2 has the largest population and the largest number of residents below 200% of the federal poverty level (FPL)
  - SPA 6 has the largest number of residents below the FPL and the highest percentage of its total residents below 200% FPL (92%).
- Latinos are 45% of the County population and the largest ethnic group in five of the eight SPAs.
  - SPA 7 (East) has the highest number of Latino residents in the County.
  - SPA 6 has the highest number of Black residents in the County.
- SPA 6 also has the highest percentage of its population that is female, that is under 20 years old and under 5 years old.
- The demographics suggest that KDMC in SPA 6 is distinguished among the County hospitals with immediate service area healthcare needs of major proportion.

Service Area

Population Demographics: LAC Service Planning Areas

						LAC-USC					KDMC				HARBOR+UCLA					
	SPA 1		SPA 2		SPA 3		SPA 4		SPA 5		SPA 6		SPA 7		SPA 8		LAC	
	Number	(%)	Number	(%)	Number	(%)	Number	(%)	Number	(%)	Number	(%)	Number	(%)	Number	(%)	Number	(%)
Total Residents	305,527	(100%)	**1,981,844**	(100%)	1,734,244	(100%)	1,144,170	(100%)	613,191	(100%)	959,220	(100%)	1,285,345	(100%)	1,495,797	(100%)	9,519,338	(100%)
Sex																		
Male	152,184	(50%)	**981,274**	(50%)	846,510	(49%)	585,880	(51%)	297,669	(49%)	464,991	(48%)	633,569	(49%)	731,853	(49%)	4,693,930	(49%)
Female	153,343	(50%)	**1,000,570**	(50%)	887,734	(51%)	558,290	(49%)	315,522	(51%)	494,229	(52%)	651,776	(51%)	763,944	(51%)	4,825,408	(51%)
Race																		
Latino	89,286	(29%)	709,498	(36%)	755,084	(44%)	621,616	(54%)	97,934	(16%)	570,976	(60%)	**875,753**	**(68%)**	523,340	(35%)	4,243,487	(45%)
Black	38,143	(12%)	67,978	(3%)	80,644	(5%)	67,306	(6%)	37,901	(6%)	**332,904**	**(35%)**	34,050	(3%)	232,268	(16%)	891,194	(9%)
White	155,618	(51%)	**939,254**	(47%)	459,102	(26%)	249,449	(22%)	383,261	(63%)	24,586	(3%)	246,255	(19%)	488,620	(33%)	2,946,145	(31%)
Asian/PI	10,321	(3%)	182,994	(9%)	**393,733**	(23%)	174,912	(15%)	67,042	(11%)	16,587	(2%)	103,702	(8%)	199,049	(13%)	1,148,340	(12%)
Native Amer/AI	1,692	(1%)	4,468	(0%)	4,479	(0%)	3,232	(0%)	1,486	(0%)	2,332	(0%)	3,474	(0%)	**4,978**	(0%)	26,141	(0%)
Other/Mult/Unk	10,467	(3%)	**77,652**	(4%)	41,202	(2%)	27,655	(2%)	25,567	(4%)	11,835	(1%)	22,111	(2%)	47,542	(3%)	264,031	(3%)
Age (years)																		
0-4	24,565	(8%)	**143,159**	(7%)	125,821	(7%)	82,847	(7%)	28,558	(5%)	95,132	**(10%)**	112,017	(9%)	116,143	(8%)	728,242	(8%)
5-19	88,420	(29%)	**431,867**	(22%)	411,119	(24%)	225,145	(20%)	89,846	(15%)	282,648	**(29%)**	336,654	(26%)	342,772	(23%)	2,208,471	(23%)
20-44	111,173	(36%)	**795,879**	(40%)	660,213	(38%)	520,472	(45%)	274,672	(45%)	370,519	(39%)	496,288	(39%)	596,351	(40%)	3,825,567	(40%)
45-64	57,312	(19%)	**409,187**	(21%)	356,332	(21%)	206,094	(18%)	139,781	(23%)	141,524	(15%)	223,821	(17%)	296,037	(20%)	1,830,088	(19%)
65+	24,057	(8%)	**201,752**	(10%)	180,759	(10%)	109,612	(10%)	80,334	(13%)	69,397	(7%)	116,565	(9%)	144,494	(10%)	926,970	(10%)
Poverty Level																		
<100% FPL	46,405	(15%)	267,270	(13%)	237,515	(14%)	293,634	(26%)	71,800	(12%)	**301,897**	**(31%)**	203,783	(16%)	252,295	(17%)	1,674,599	(18%)
<200% FPL	103,457	(34%)	**637,026**	(32%)	581,696	(34%)	612,548	(54%)	141,881	(23%)	588,857	**(61%)**	521,313	(41%)	548,163	(37%)	3,734,941	(39%)

Source: U.S. Census Bureau, Census 2000, SF3

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Service Area

- The KDMC service area is considered to be a 94 square mile southern section of LA County with a multicultural population over 1.5 million.
  - It is located in Supervisorial District 2, the Southwest County Cluster Area, and SPA 6.
- Originally built at 392 beds in 1972, the hospital later achieved a licensed capacity of 537 beds, and currently operates at approximately 300 beds with an average daily census of approximately 200.
- Recent hospital literature identified Centers of Excellence in the following areas:
  - NICU, trauma, oral/maxillofacial surgery, ENT, ophthalmology, OB, pediatrics, psychiatry, neurosurgery and Sickle Cell treatment.

Community Health Issues

- DHS published “Key Indicators of Health” with over 60 health indicators for the population and each of the County’s eight SPAs for 2002/2003.
- KDMC is in SPA 6, which includes the communities of south Los Angeles, Lynwood and Compton.
- SPA 6 is statistically worse off than the LA County average in the following 28 health indicators:
  - Overweight children, obese adults, sedentary adults, and nutritional habits.
  - Perception of safe neighborhoods, safe places for children to play, high school dropout rate, reading to children daily, viewing three or more hours of TV daily, and ease of obtaining advice on raising children.
  - Self -reported adult health of fair to poor, children perceived by parents to be in fair to poor health, percent of uninsured below 65 years old, percent of children with no regular source of health care, percent of live births with late or no prenatal care, and adults 65 or older getting flu vaccine in the past year;
  - Adults diagnosed with diabetes or hypertension, percent of low weight births, rate of births to teens, infant mortality, cancer mortality, lung cancer mortality, cardiovascular disease mortality, diabetes mortality, stroke mortality, motor vehicle deaths, and homicide.

Community Health Issues

- While some number of the poor health indicators are social/environmental issues, there are clearly a number of conditions that not only create demand for health care services, but are possible to be improved with education and service outreach, ambulatory care and targeted clinical services.
- According to 2003 OSHPD data, which is the most recent data available, KDMC is one of six public hospitals in LA County, which provided 15% of public hospital discharges and 13% of the total discharge days.

OSHPD FY 2003				
	All County		KDMC	%
Number of Hospitals	6		1	
Number of Discharges	91,846		13,473	15%
Number of Discharge Days	624,777		83,015	13%

Community Health Issues

- The table below highlights selected clinical service areas where the community characteristics might require targeted interventions (highlighted in bold on the left column), contrasted with those services where KDMC is above the six hospital distribution for discharges by service (highlighted in bold on the right column).

	All County			KDMC	
PRINCIPAL DIAGNOSTIC GROUP	#	%		#	%
Infections	2,625	2.9%		352	2.6%
Neoplasms	6,552	7.1%		556	4.1%
Endocrine/Metabolism	3,798	4.1%		517	3.8%
Blood/Blood-forming Organs	1,360	1.5%		173	1.3%
Psychoses & Neurosis	4,788	5.2%		905	**6.7%**
Nervous & Sensory Systems	1,725	1.9%		199	1.5%
Circulatory	10,706	11.7%		1,627	**12.1%**
Respiratory	5,903	6.4%		1,445	**10.7%**
Digestive	10,533	11.5%		1,617	**12.0%**
Genitourinary	4,130	4.5%		589	4.4%
All Pregnancies	5,966	6.5%		1,103	**8.2%**
Skin Disorders	3,689	4.0%		567	**4.2%**
Musculoskeletal	2,804	3.1%		334	2.5%
Congenital Anomalies (Birth Defects	491	0.5%		23	0.2%
Perinatal Disorders	242	0.3%		46	0.3%
Symptoms	4,851	5.3%		252	1.9%
Injuries/Drugs/Complications	13,848	15.1%		2,313	**17.2%**
Other Reasons for Health Services	3,724	4.1%		107	0.8%
Births	4,111	4.5%		748	**5.6%**
Invalid	0	0.0%		0	0.0%
	91,846	100.0%		13,473	100.0%

Section XII – Programs and Services

1. Overview of Clinical Services
   - Medicine
   - Surgery
   - Otolaryngology
   - Ophthalmology
   - Orthopedics
   - OB/GYN
   - Neurosciences
   - Pediatrics
   - Psychiatry
   - Emergency Medicine
   - Oral/Maxillofacial Surgery and General Dentistry
   - Family Medicine
   - Hubert H. Humphrey Comprehensive Health Center (HHHCHC)

Overview of Clinical Services > Medicine

Assessment

- Scope of Services:
  - The Department of Medicine reflects the typical status of the largest volume service in a general hospital with FY03 discharges of 6,854, representing nearly 51% of all discharges and in the range of a quarter of all ambulatory visits.
  - A substantial service capability with eight specialty divisions within the department including Fellowships in the specialty areas of cardiology, infectious disease, endocrine and geriatrics.
  - General and specialty inpatient care as well as specialty consults are available, though timely and appropriate access to critical care is an institutional issue.
  - The department also operates a number of outpatient clinics in two locations in the hospital and some specialty support at the HHHCHC.
- Market/Community Need/Volume Issues:
  - There is substantial interface with the heath needs of the community as reflected in primary care/internal medicine services for hypertension, and specialty services for diabetes, cancer, heart disease, kidney failure and the at-risk elderly.
  - Appropriate access to care is absent in some of the specialty areas as the available first appointment times may be unreasonably long for services such as cardiology.

Overview of Clinical Services > Medicine

Assessment

- Market/Community Need/Volume Issues: (cont)
  - The chart below show the projected change in inpatient volume for the divisions and key services of the department.
    - Despite an overall decline in volume, cardiology, endocrinology, and medical oncology show growth.

KDMC MEDICINE INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
CARDIOLOGY	923	252	1,008	9.2%
CARDIOLOGY INTERVENTIONAL	1		-	-100.0%
DERMATOLOGY	497	92	368	-26.0%
ENDOCRINE	282	72	288	2.1%
GASTROENTEROLOGY	741	144	576	-22.3%
GENERAL MEDICINE	206	41	164	-20.4%
HEMATOLOGY	139	19	76	-45.3%
HIV	87	20	80	-8.0%
NEPHROLOGY	386	86	344	-10.9%
ONCOLOGY MEDICAL	215	63	252	17.2%
ONCOLOGY/HEMATOLOGY	4		-	-100.0%
PULMONARY	891	158	632	-29.1%
RHEUMATOLOGY	29	4	16	-44.8%
Grand Total	4,401	951	3,804	-13.6%

Overview of Clinical Services > Medicine

Assessment

- Market/Community Need/Volume Issues: (cont)
  - Ambulatory volume of patients seen by General Medicine at KDMC was 35,559 in FY03/04, and 18,234 in the first half of FY04/05 for an annualized total of 36,468.
    - An increase of 2.6% in patients seen.
    - Yet, of the total appointments for the period, 44% of the patients were not seen.
    - Whether the issues are broken appointments, leaving without being seen, no shows, emergency room use, or rescheduling; it appears that the clinic environment is actually seeing less than 60% of those captured in the system for continuity of care.
- Physician Issues:
  - There are no rheumatologists on the faculty.
  - There is only one full-time dermatologist on the faculty and he is the training program director for both KDMC and Harbor+UCLA.
  - There are other issues in the specialty areas ranging from the inability to recruit GI faculty to modest additional needs in infectious disease and cardiology, and an imminent major loss in endocrinology.

Overview of Clinical Services > Medicine

Assessment

- Service Gaps/Resource Issues:
  - Pulmonology and intensivist services represent gaps.
  - Rheumatology services for arthritis and other diseases is a complete service gap.
  - Dermatology, almost totally an outpatient service, has insufficient faculty to meet patient needs.
  - While Medicine does better than most departments, the normal resources available through Medical School funds in other settings are not present at KDMC, thus limiting support for faculty in key service areas.

Recommendations

12.5.01 Grow service capabilities in internal medicine; as it is essential for community access to general and specialty services required by the incidence of major adverse health conditions in the service area.

Overview of Clinical Services > Medicine

Performance Measures

- Inpatient discharges by clinical service grouping
- Inpatient consultations for other service patients
- Clinic visits per month by division
- Access by division

Responsibility

- Medical Director

Overview of Clinical Services > Medicine - Cardiology

Assessment

- Scope of Services:
  - Basic cardiology physician services with EKG, ECHO and stress test diagnostic capabilities.
  - Cardiac catheterization service is diagnostic only with largely theoretical potential to provide TPA intervention for active heart attacks.
    - Most patients get to care beyond the six- to twelve-hour window from onset of symptoms for effective administration.
    - Contributing to the missed window of opportunity can include the time taken to obtain the EKG and the subsequent consultations among cardiology residents, on-call cardiologist, and medicine attending physician before the emergency room physician will administer the drug.
- Market/Community Need/Volume Issues:
  - Cardiology services are fueled by high rates of hypertension, diabetes, drug abuse, and heart failure in the community.
  - Over a 25-year period, only the ethnicity of the population seen has shifted while the predisposition to seek care and practice compliant behavior has remained low, contributing to the incidence and severity of heart disease seen at KDMC.
  - Cardiology was 21% of all medicine discharges in FY04, and represented 26.5% of all medicine discharges in the first quarter of FY05 with 923 and 252 discharges respectively.

Overview of Clinical Services > Medicine - Cardiology

Assessment

- Market/Community Need/Volume Issues: (cont)
  - There are ambulatory cardiology programs in the hospital building for adults and children as well as stress testing and other diagnostic programs.
  - Pediatrics has a clinics for high risk and screening.
  - HHHCHC has a cardiology clinic with over 600 visits annually, although this year's volume is projected to decline to about 400.
    - This projected decline is inconsistent with the continuing community need for care.
  - There is a significant wait for outpatient testing which can be up to six months.
- Physician Issues:
  - There are four attending physicians for adult patients, only two of whom are invasive cardiologists capable of doing cardiac catheterizations.
    - This provides little relief from the on-call requirements of a large consult service.
    - There are eight residents and one Fellow.
  - There are two pediatricians, one Board certified in cardiology, who cover the pediatric cardiology high risk and screening clinics.

Overview of Clinical Services > Medicine - Cardiology

Assessment

- Service Gaps/Resource Issues:
  - Responsiveness for EKG, cardiac echo and stress testing are limited due to the small number of technicians.
    - There are two EKG techs with one being registry staff.
    - 10,000 to 12,000 EKGs are read and archived annually, but it is unclear how many emergency EKGs are read and returned to ER patient charts without archiving.
  - There is one echo technician to serve portable, outpatient, ER, OR and pediatric needs.
    - Machines are in department locations with no staff so some testing is done by the Fellow.
    - There is no evening or weekend echo or stress testing capability.
    - Tests ordered for inpatients or emergency room patients on Friday are not likely to get done until Monday, lengthening inpatient stays.
    - The first available appointment for an outpatient echocardiogram requested on January 13, 2005 would be scheduled for June29, 2005
    - The first available appointment for an outpatient stress test requested on January 13, 2005 would be scheduled for April 26, 2005.
  - The digital bilateral Cath Labs are the newest in LA County system. The department is clean and well organized. The staff speak with pride of new unit and state-of-the-art equipment.
  - All positive stress tests are referred for cardiac catheterizations.
    - There is no pediatric cardiac catheterization capability at KDMC.
  - The wait time between symptom-based referral, diagnosis and treatment is not consistent with contemporary medical practice.

Overview of Clinical Services > Medicine - Cardiology

Assessment

- Service Gaps/Resource Issues: (cont)
  - The process for equipment and supply acquisition is viewed as ineffective.
    - The patient vital signs monitoring system in the cath lab is working but is 12 years old and as of January 2005 and will no longer be serviced by the vendor.
    - This $120K system cannot be replaced until after it is no longer working.
    - A similar situation at two other County hospitals was avoided by seeking and obtaining approval to replace the entire cath lab at $1.2 million each.
    - Video tapes purchased through the system are claimed to cost $3.50 compared to $0.99 at local merchants.
  - The loss of open heart surgery and limited interventional staff reduces the demand for caths with little likelihood of increasing the current number of about 150 annually.
  - Access to intensive care beds is an issue, often requiring an extended ER stay for some patients.

Overview of Clinical Services > Medicine - Cardiology

Recommendations

12.5.02 Grow cardiology service, initially through appropriate resource allocation to meet existing demand for diagnostic testing.

12.5.03 Obtain required equipment and evaluate expansion of hours of operation and required resources to reduce the current backlog and manage volumes. (See Electrodiagnostic recommendations in Section X page 95).

Performance Measures

- Number of cardiology discharges
- Wait time for EKG, echo and stress testing for inpatients and outpatients upon order
- Wait time for cardiac catheterization after referral
- Number of EKGs read and archived
- Number of inpatient cardiology consults
- Number of visits at HHHCHC
- Clinic access

Responsibility

- COO

Overview of Clinical Services > Medicine - Endocrinology

Assessment

- Scope of Services:
  - Provides inpatient and outpatient, diagnostic and therapeutic services for metabolic system disorders; including, diabetes, obesity, thyroid problems, and reproductive functions.
    - There are diabetes management clinics at the hospital in English and Spanish, and at the HHHCHC.
- Market/Community Need/Volume Issues:
  - There is a substantial market in the service area given the higher County indicators of the numbers of diagnosed diabetics, diabetes mortality, overweight and obese adults and overweight children.
  - There is also potential for assisting with compliance behavior for hypertensive patients and contributing to high risk obstetrics care.
  - Inpatient discharges are trending at a 2% growth rate for FY05 over the last fiscal year with projected discharges of 288.
    - This does not include inpatient consultations to patients on other service groupings.
    - This growth rate, in a generally declining environment, shows a strong demand and a considerable requirement to address these needs

Overview of Clinical Services > Medicine - Endocrinology

Assessment

- Market/Community Need/Volume Issues: (cont)
  - The division chief joined KDMC in 1996, initiating the service and a single clinic session, which has now grown to eight.
  - The diabetes clinic at the hospital is at capacity; with the next new appointment said to be available in about three months, although data was inconclusive to substantiate this.
    - There is purportedly a clientele that travels from Mexico for this clinic.
  - At HHHCHC, volume in the diabetes management clinic went from 383 in FY02/03 to 1,210 in FY03/04 and ceased to operate in FY04/05 after three months and 173 visits.
- Physician Issues:
  - The medical staff are highly regarded by their peers.
  - The chief and a core of four physicians anchor a division that ranks in the top 20 nationally for NIH grant funding, having brought about $60 million in funding to the institution.
    - The chief is a reproductive endocrinologist who has authored textbook chapters and gets private patient referrals.
    - One physician is a former head of the American Diabetes Association and has written a highly successful protocol for diabetes management.

Overview of Clinical Services > Medicine - Endocrinology

Assessment

- Physician Issues: (cont)
  - Overall, the division medical staff has been enthusiastic about seeking to establish services that directly address the needs and quality of life issues of patients with potentially disabling conditions.
  - Regretfully, the division chair has committed to join the faculty at Boston University in about six months.
    - He cites a history of frustration with hospital management to provide operational and infrastructure support for the services and programs in the division.
  - There is a plan for succession of a chief and Fellowship program director.
  - It is uncertain how much of the division staff (which has grown from 3 in 1996 to about 50 today) and how many of the current research grants will also leave the organization.

Overview of Clinical Services > Medicine - Endocrinology

Assessment

- Service Gaps/Resource Issues:
  - There are several potentially significant service expansions, which have been attempted but could not be achieved or sustained.
  - Most of the resources for an obesity management clinic were established, but failed to be achieved.
    - A clinic protocol and involvement of a private bariatric surgeon were established.
      - Allegedly there was no staff or space to conduct the clinic and the pharmacy would not carry drugs for appetite suppression, metabolic and absorption rate management.
  - A minimally invasive thyroid procedure was introduced using a radioisotope to isolate the gland with a probe to target the laparoscopic procedure site, well before a local private hospital announced the same service.
    - This approach eliminated the long throat incision scar normally associated with the procedure
    - The physician who owned the probe left, and the hospital was unable to purchase the $20 K instrument to continue the service.
  - Erectile dysfunction for diabetic and hypertensive patients can be effectively managed with prescription medications (that the pharmacy does not carry), which in turn could enhance patient compliance with their chronic disease management and improve their quality of life.

Overview of Clinical Services > Medicine - Endocrinology

Recommendations

12.5.04 Work with the Department Chair and Division Chief to develop a service preservation and enhancement plan to enable a transition of medical staff to be achieved while maintaining and improving service and care to patients.

12.5.05 Work with the Dean of the Medical School and faculty to recruit the necessary faculty to fill the impending vacancies and clinical service gaps.

12.5.06 Determine what can be done by hospital management to address resource issues of space, staff, equipment and formulary additions that would enable expansion of evidence based service capabilities to the target patient population.

12.5.07 Grow the services in endocrinology to serve the large community need.

Performance Measures

- Number of inpatients and outpatients served by disease process
- Clinical access

Responsibility

- COO
- Medical Director

Overview of Clinical Services > Medicine - Geriatrics

Assessment

- Scope of Services:
  - Inpatient program, which had an elder abuse focus and distinct unit, has been dissipated into the general inpatient environment.
  - Outpatient services to the elderly are provided in clinic at HHHCHC.
    - HHHCHC geriatric clinic visits totaled 2,683 in FY02/03, dropping 12% to 2,355 in FY03/04.
    - FY04/05 visits for six months annualized are projected to be 1,836 or a decline of 22%.
    - It is possible that the inter-disciplinary approach to care and case management practiced on the former distinct geriatric inpatient unit impacted ambulatory volume.
- Market/Community Need/Volume Issues:
  - The service area has a 7% population of 65 and over, which is a smaller proportion than any of the other SPAs and accordingly the L A County average of 10%.
  - There is a documented elder abuse issue in the area, which in part helped sustain the former 30-bed geriatric unit in the hospital.
  - The service area has the lowest rate of seniors getting flu shots in the County.
  - Opportunities exist for establishing physician relationships with nursing home residents to better coordinate their well being.
  - By discharge volume, Medicare was only 6% of all patients in FY03/04, though persons older than 65 but not on Medicare could increase the actual service volume.

Overview of Clinical Services > Medicine - Geriatrics

Assessment

- Physician Issues:
  - There are distinguished faculty in geriatrics, including the Chair of Medicine who is editor in chief of the Journal of the American Geriatrics Society.
  - The program was nationally ranked at #number 28 in the 2002 issue of USN&WR issue of the top 100 hospitals and programs.
- Service Gaps/Resource Issues:
  - Closure of a distinct inpatient unit subverts the synergy required by specially-trained clinical staff to meet the unique needs of this population for care and community-based follow-up.
  - Access to Medicare does not necessarily mean the patient will have the benefit of specialty geriatrics care in the private sector and the past practice of transferring insured patients should be revisited.

Recommendations

12.5.08 Maintain the multi-disciplinary program and re-establish the geriatrics inpatient unit when availability of sufficient nursing and ancillary staffing is able to support it. Consider expanding the scope to include sub acute capability.

12.5.09 Develop a palliative care program.

Overview of Clinical Services > Medicine - Geriatrics

Performance Measures

- Inpatient referrals of 65+ year old patients met and unmet from faculty and community sources
- Geriatric clinic volume at KDMC and at HHHCHC
- Clinic appointment access
- Fall rate
- Flu and pneumovax rates

Responsibility

- Chief, Division of Geriatrics
- CNO
- Medical Director

Overview of Clinical Services > Medicine – Hematology/Oncology

Assessment

- Scope of Services:
  - Largely an inpatient consult service in addition to a small inpatient service for blood disease and the whole range of cancers, though with a special expertise in sickle cell disease.
    - There is an outpatient service as well as administration of chemotherapy.
- Market/Community Need/Volume Issues:
  - DHS data shows cancer mortality in the service area is the highest among all SPAs and significant per capita rates for cervical and lung cancer mortality.
  - Recent inpatient volume shows growth in the medical oncology area, but overall reductions because of drop in hematology discharges.

KDMC MEDICINE INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
HEMATOLOGY	139	19	76	-45.3%
ONCOLOGY MEDICAL	215	63	252	17.2%
ONCOLOGY/HEMATOLOGY	4		-	-100.0%
Grand Total	358	82	328	-8.4%

Overview of Clinical Services > Medicine – Hematology/Oncology

Assessment

- Market/Community Need/Volume Issues: (cont)
  - The inpatient consult service may see from 5 to 20 patients a day and attend 1 or 2 patients of their own.
  - There are an estimated 3,000 sickle cell disease patients in the greater Los Angeles area, with about 1,000 of them accounted for by the Children's Hospital at USC and KDMC.
  - Much of the sickle cell population resides in the KDMC service area.
- Physician Issues:
  - The Division Chief had an 11-year faculty tenure at Harbor/UCLA and was recruited in 2003 to strengthen the residency program.
  - There is one resident in hematology/oncology at a time, and a desire to start a fellowship program in order to strengthen the standard of care.
  - Current faculty include three FTEs, the minimum number of board certified faculty needed to initiate a fellowship program.
  - The addition of two new faculty and a Fellow would provide a foundation for a high quality cancer center, supported by a network of County and community oncologists.

Overview of Clinical Services > Medicine – Hematology/Oncology

Assessment

- Service Gaps/Resource Issues:
  - Hospital clinic space for hematology/oncology is inadequate and undignified
  - There is no radiation oncology capacity at KDMC.
  - There is a desire to participate in clinical trials, which would enable a greater availability of chemotherapy agents for the indigent patients.
  - Efforts in sickle cell have raised $2 million in grants and there is a new drug therapy now on a fast track at FDA for approval.
  - A grant effort with NIH is underway to support treatment and research in a sickle cell center.
    - These activities would facilitate cooperation with key people and lab resources at Harbor/UCLA and Children's at USC.
    - The vision for the sickle cell center includes a day hospital for alleviation of pain and reduction of hospitalizations.

Recommendations

12.5.10 Grow services in sickle cell and oncology with grant funds, appropriate space, staffing, and logistics for enhancement of care.

Overview of Clinical Services > Medicine – Hematology/Oncology

Performance Measures

- Number of patients in continuous care for sickle cell disease
- Clinical access
- Avoidable hospital days and admissions for chemotherapy
- Screening rates for breast, colon and cervical cancers

Responsibility

- Chief, Division of Hematology/Oncology KDMC
- Medical Director
- CEO

Overview of Clinical Services > Medicine – Nephrology

Assessment

- Scope of Services:
  - Inpatient nephrology consultations.
  - Inpatient and outpatient dialysis services including chronic peritoneal dialysis (CPD)
  - Clinics for hypertension, adult and pediatric renal disease.
- Market/Community Need/Volume Issues:
  - According to DHS figures, SPA 6 leads the County in the incidence of hypertension in adults, a leading cause of kidney disease and failure, along with diabetes and cocaine abuse.
  - Nephrology discharges, while robust, have declined in the current period as shown below.

KDMC MEDICINE INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
NEPHROLOGY	386	86	344	-10.9%

  - There are an estimated 20 - 25 new consults weekly, approximately 150 dialysis outpatients and 30 CPD patients.
  - About 1,300 inpatient dialysis treatments are done annually, most on the four-bed acute dialysis unit.
  - First appointment availability in the clinic is about two months for both adult and pediatric patients.

Overview of Clinical Services > Medicine – Nephrology

Assessment

- Physician Issues:
  - Three FTE faculty members.
  - Housestaff rotate through the community-based outpatient dialysis center.
- Service Gaps/Resource Issues:
  - New dialysis patients are not eligible for Medicare for 90 days, often during which a vascular fistula for access is done by surgeons at KDMC.
  - Inpatient nursing on floor units currently have a low capability to support the CPD patient catheter/bag exchange required during a hospital stay.
  - Physicians want to do a continuous slow dialysis for critically ill patients with multi-system illness but there are presently insufficient nursing staff trained to support the care for this technology.

Overview of Clinical Services > Medicine – Nephrology

Recommendations

12.5.11 Maintain current level of nephrology service while continuing to upgrade nursing care support for inpatient care capabilities.

12.5.12 Evaluate a contract service for some or all inpatient dialysis needs as a method of quickly acquiring the desired level of clinical support for patient care..

Performance Measures

- Number of inpatients not getting the desired level of dialysis support

Responsibility

- Medical Director
- Chief Nursing Officer
- Chief, Division of Nephrology

Overview of Clinical Services > Medicine – Other

Assessment

- Scope of Services:
  - Adult gastroenterology services are limited to what can be done by a single faculty gastroenterologist and three residents on staff.
    - A community gastroenterologist is contracted for ERCP procedures as the capability does not exist in-house
    - There are two colonoscopy procedure rooms and a GI clinic at the hospital.
  - Infectious disease services are largely inpatient, though three faculty attending physicians, a Fellow and two residents provide medical care in all settings.
    - The Medicine Department Chair provides clinical service and supervision three months a year and is one of three faculty attending physicians.
  - There is only a single full-time pulmonologist/medical intensivist on the staff, limiting the service available to patients
    - The physician is Boarded in pulmonology and critical care medicine, attends in the ICU, and oversees the pulmonary functions laboratory,
      - Consequently the lab is underutilized,
    - A community pulmonologist is contracted on an hourly basis to do bronchoscopies, but there is no dedicated space for performing procedures.
  - There are virtually no rheumatology services available.

Overview of Clinical Services > Medicine – Other

Assessment

- Market/Community Need/Volume Issues:
  - The inpatient volume associated with cellulitis (normally a dermatology issue) is related to infectious disease issues.
  - Gastroenterology is a high-demand service due to colon cancer, digestive ailments and any variety of causes for GI bleeding, including alcohol and cocaine abuse.
    - Colonoscopies are a recommended screening tool for middle age adults.
  - Three of the four SPAs with the County's highest incidence of HIV/AIDS are the Metro, South and South Bay areas.
  - Pulmonary disorders are typically among the highest number of medicine discharges in the hospital setting as also seen at KDMC.
  - Inpatient volumes in these and other related services are shown below.

KDMC MEDICINE INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
DERMATOLOGY	497	92	368	-26.0%
GASTROENTEROLOGY	741	144	576	-22.3%
HIV	87	20	80	-8.0%
PULMONARY	891	158	632	-29.1%
RHEUMATOLOGY	29	4	16	-44.8%
Grand Total	2,245	418	1,672	-25.5%

Overview of Clinical Services > Medicine – Other

Assessment

- Physician Issues:
  - There is a general shortage of gastroenterologists in the County, exacerbated by this now being one of the most highly paid specialists makes this a tough recruitment.
    - Harbor has integrated its training program with UCLA, thus eliminating or complicating the potential for KDMC to seek this alternative.
  - A single additional faculty member would address much of the immediate need in the infectious disease area.
  - Additional pulmonology faculty is required.
  - Absence of a rheumatologist means the likely significant need for arthritis care in the community is being managed by internal medicine physicians as best they can.
  - Succession planning for the dermatology faculty is needed.

Overview of Clinical Services > Medicine – Other

Assessment

- Service Gaps/Resource Issues:
  - There appear to be risks of unmet need and desired standards of care in GI and pulmonary/critical care services.
  - There appears to be unmet need for longitudinal primary care services and on-going continuous care for patients with chronic diseases.
  - The is inadequate availability of patient education services for health education and preventative services, i.e., smoking cessation, weight loss, exercise, etc.
  - There is an inadequate non-hospital resource for long-term IV therapy for infectious disease and other patients.

Recommendations

12.5.13 Establish a time limited plan for the recruitment of additional GI, pulmonary, rheumatology and dermatology faculty.

12.5.14 Establish and implement a plan to manage the availability of gastroenterology and pulmonary services to that which can be safely managed at desirable quality levels with the currently available resources.

12.5.15 Create a list of alternative County and other sub acute settings which can accommodate the domiciliary requirement in between IV therapy, including the potential for home health agency administration of the therapy.

Overview of Clinical Services > Medicine – Other

Performance Measures

- Access to clinic appointments for specialty and longitudinal primary care services

Responsibility

- Chairman, Department of Medicine
- Medical Director
- Chief, Infectious Disease
- COO

Overview of Clinical Services > Surgery

Assessment

Scope of Services:

- The Department of Surgery includes the divisions of general surgery, thoracic surgery, vascular surgery, urology and plastic surgery.
- Capabilities have been significantly diminished with loss of the surgical residency programs.
  - Formerly 38 residents with 20 on site at any given time, all working up to 80 hours per week.
  - That resource is now replaced with about 9 physician assistants working 40 hours per week.
  - All scheduled surgery clinics are being maintained at KDMC, though the urology clinic at HHHCHC has been terminated.
- The department has an interim chairman who is also Chief of Urology.
- General surgery does trauma and non-specialty care.
  - There are 16 faculty, evenly divided between trauma and general surgery.
- Thoracic surgery operates in the chest cavity on lungs, cancer and other masses, esophagus and fractures in the torso.
  - There are 1 full-time and 4 part-time faculty surgeons.
- Vascular surgery operates to improve blood flow, address ischemia, injuries, and access for dialysis patients.
  - Two part -time faculty staff this division.

Overview of Clinical Services > Surgery

Assessment

- Scope of Services: (cont)
  - Urology surgically treats the prostate, urinary tract, including bladder tumors, trauma and kidney stones.
    - There are three full-time faculty.
  - Plastic surgery is primarily cosmetic/reconstruction.
    - One part time faculty with a physician assistant serve this role.
- Market/Community Need/Volume Issues:
  - The market and community need for surgical services has not changed nearly as much as the capacity of KDMC has diminished to engage it.
  - The reduction of surgical production is likely due to the loss of the residency program and uncertainty around the status of the trauma center.

KDMC SURGERY INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
GENERAL SURGERY	919	187	748	-18.6%
THORACIC SURGERY	55	9	36	-34.5%
SURGICAL ONCOLOGY	17	4	16	-5.9%
THORACIC SURGERY	53	6	24	-54.7%
TRAUMA	303	53	212	-30.0%
UROLOGY	147	27	108	-26.5%
VASCULAR SURGERY	48	5	20	-58.3%
Grand Total	1,489	285	1,140	-23.4%

Overview of Clinical Services > Surgery

Assessment

- Market/Community Need/Volume Issues: (cont)
  - The data show significant reductions for inpatient volume in virtually all areas.
  - Data from all surgical areas for the first quarter of FY04/05 annualized shows a decrease of inpatient surgeries of 63, an increase of outpatient surgeries of 92, for a total net increase of 27 cases.
  - This trend of greater access to the operating rooms for outpatient surgery will likely accelerate over the course of the year producing an even larger net growth in total surgical volume.
    - In FY03/04 outpatient surgical volume was 53% of the total, whereas, in the first quarter of FY04/05 ambulatory surgery was 54.9% of a larger total volume trend.
  - Careful analysis of this data going forward is important in light of operating room throughput efficiencies proposed in other parts of this larger report and the reduction of inpatient and trauma cases depressing ambulatory surgical demand in the environment.
  - It is also thought that the current restricted inpatient capacity is depressing inpatient surgical volume because of bed availability, “boarding” in the recovery room and access to post surgical critical care beds.
  - As of mid January, access to surgical clinics at KDMC ranged from one week for general surgery, three weeks for urology, and four weeks for thoracic surgery.
  - The discontinued urology clinic at HHHCHC had FY02/03 patient volume of 757 visits and 475 when service ended in April 2004, nine months into the fiscal year.

Overview of Clinical Services > Surgery

Assessment

- Physician Issues:
  - While the changes in service volumes may suggest some opportunity to resize the medical staff, care should be taken.
  - The clinical work effort of the surgical (or medical for that matter) staff cannot be accurately gauged as many physicians do consults on more patients than those they attend.
    - The data gathering for service volume has been based on geographic patient placement rather than clinical service of the attending.
    - Similarly, in most environments, clinical activity is measured by some variation of a billing statistic but none of the physicians here find the revenue reports they see as barely credible.
  - Any significant resizing of physician staffing should be preceded with a well understood set of activity measures that effect the decisions.
    - These issues are germane to the entire medical staff, not just Surgery.

Overview of Clinical Services > Surgery

Assessment

- Service Gaps/Resource Issues:
  - Restoration of a trauma capability could be considered after significant enhancement of essential organizational and service issues are met and re-establishment support requirements for surgical resident resources.
    - To manage a trauma center, the standard of care would typically include a surgical residency program with on site coverage 24/7.
    - In addition, the level of trauma service is determined by the on site and on call availability and depth of surgical and surgical subspecialty capability as well as the depth and breadth of ancillary supports, e.g., immediately available angiography which is currently a challenge.
    - Given the current regulatory situation, re-establishment of a surgical residency could not realistically occur before July, 2006, perhaps later.
  - There is a two-month wait for a urology appointment and the other divisions wait times are at least comparable if not longer.
  - There is no post surgical radiation therapy for cancer care.
  - Referral to USC is required for kidney stone lithotripsy.

Overview of Clinical Services > Surgery

Recommendations

12.5.16 Maintain the current Department of Surgery service profile while assessing demand as access to care in the hospital improves and wait times for clinic appointments are reasonably timely.

12.5.17 Evaluate a desired mix of full-time and part-time faculty under various scenarios of to what degree residency programs may return and/or rotate through KDMC for service provision and educational exposure.

12.5.18 Work with department and division leadership to assess desirable changes to data collection to enhance credibility of activity, effort and volume reporting.

Performance Measures

- Next new appointment times in all clinics
- Mix of cases and level of effort to maintain access and quality.

Responsibility

- Medical Director
- Chair, Surgery
- Division Chiefs
- COO

Overview of Clinical Services > Otolaryngology

Assessment

- Scope of Services:
  - A free standing department outside of Surgery.
  - This small department handles most injuries and illnesses affecting the head and neck including facial fractures, neck wounds, cosmetic and congenital surgery, as well as communication disorders (i.e., speech, language, and hearing).
    - Most ENT patients get well, as even cancer patients have a high five-year survival rate.
  - Potentially 30% of children in the PCP office have an ENT issue such as an upper respiratory or allergy condition.
  - The department has 3.5 FTE faculty all Board certified, 3 audiologists, 5 residents, a speech/language pathologist, 1 PA and 3 PhD researchers.
  - The department provides services to the pediatric inpatient and outpatient population for ENT, audiology, speech pathology and newborn screening
- Market/Community Need/Volume Issues:
  - Otolaryngology is primarily an outpatient service, although the modest inpatient business is projected to grow 14.7% from 136 to 156 discharges.
    - Head and neck surgery services, about 50% inpatient, include major cancer and skull base cases.
  - At the KDMC ENT clinic 9,042 patients were seen in FY03/04, and the first six months of this year has the 4,198 patients trending to a 7% decline at 8,396.

Overview of Clinical Services > Otolaryngology

Assessment

- Market/Community Need/Volume Issues:
  - At HHHCHC, the ENT clinic saw from 505 to 560 visits annually until ending service there in October 2004 with 104 visits in four months.
  - The outpatient surgery is booming.
    - Surgery in FY03/04 was 66 inpatient and 300 outpatient cases for a 366 total volume.
    - First quarter FY04/05 statistics are 15 inpatient and 95 outpatient for a case load of 110.
    - This annualizes to 60 inpatients, 380 outpatients for a total of 440 surgical cases highlighted by a 27% increase in ambulatory surgery.
- Physician Issues:
  - Succession planning is an issue as the Chair is 65 years old and carrying a full-time clinical workload.
  - The residency program is highly regarded.
    - The program has had a 100% Board pass rate for the last 10 years.
- Service Gaps/Resource Issues:
  - Gaps include the absence of cochlear implant and cleft palate programs, conditions associated with prematurity and absence of prenatal care.
    - These cases are sent to Children's Hospital.

Overview of Clinical Services > Otolaryngology

Assessment

- Service Gaps/Resource Issues: (cont)
  - There is no bi-lingual speech pathology program.
  - Access to operating rooms for ambulatory surgery had been a bigger issue in the past, but the current growth suggests it could continue to be an issue.
  - As are most services, the department is plagued with physical plant deficiencies.

Recommendations

12.5.19 Grow the capacity for ENT services on an inpatient and outpatient basis to meet the current backlog of demonstrated need as well as the gaps in service, particularly in cooperation with Pediatrics.

12.5.20 Work with the ENT Chair and Dean of Drew School of Medicine to establish a succession and growth plan for leadership and faculty in the department.

12.5.21 Evaluate the potential for a more accessible, discrete and efficient ambulatory surgical capability which would serve this and many other disciplines now using the inpatient setting.

Overview of Clinical Services > Otolaryngology

Performance Measures

- First available timing for new appointments
- First available time in the OR for ambulatory cases

Responsibility

- Medical Director
- CNO
- CEO
- COO

Overview of Clinical Services > Ophthalmology

Assessment

- Scope of Services:
  - Provides a full range of ophthalmologic services, including general ophthalmology, cornea disease, neuro-ophth, glaucoma, pediatric, medical and surgical retina care, general ophthalmology surgery, and oculoplastics.
    - The department also has a full-time researcher with training in general ophthalmology and a PhD in epidemiology.
- Market/Community Need/Volume Issues:
  - The inpatient service is primarily consultative and much of the activity, such as bedside laser treatments, is not captured in current data gathering.
    - This suggests another potential for capturing revenue from existing activities.
    - In the past, trauma volume had impeded the potential for inpatient revenue.
  - Several faculty established a non-profit organization, The Los Angeles Eye Institute, to assess the unmet need in ophthalmologic care.
    - Unmet needs are calmly described as “tremendous.”
    - There is a huge dearth of eye care providers in the SPA 6 community.
    - Similarly there are large numbers of preventable conditions through early checks and intervention.

Overview of Clinical Services > Ophthalmology

Assessment

- Market/Community Need/Volume Issues:
  - OSHPD data show four ophthalmology discharges in FY03/04 and none the first quarter of the current year.
    - Ophthalmology is one of those services that may do procedures on a patient that has a discharge diagnosis and DRG in a different clinical grouping due to the primary reason for care.
  - KDMC OR case data show 30 inpatient and 258 outpatient surgical cases last year
    - First quarter data for the current fiscal year is 6 inpatient and 79 outpatient surgical cases for a total of 85 and an annualized volume of 340.
      - 93% of that volume is ambulatory.
  - The volume of ambulatory patients seen at both KDMC and HHHCHC was 19,700 in FY03/04, and projections of 16,034 based on six months of FY04/05.
    - The current year volume is projected to be nearly a19% decline from the prior year.
    - While volume at the HHHCHC grew nearly 5% in FY04, the projected decline this year is just under 40%.
      - In this same time period, the volume seen at HHHCHC has dropped from 30% of the department total to 22.4%.

Overview of Clinical Services > Ophthalmology

Assessment

- Physician Issues:
  - There are over 10 faculty, many with joint appointments at UCLA (Jules Stein Eye Institute) and some part-time faculty in private practice.
    - There is strong collaboration with UCLA on clinical, educational and research issues
  - The residency program has six slots with five filled and has full five year accreditation.
    - UCLA has been asked to reduce the size of its program and as a result is interested in greater collaboration with KDMC.
- Service Gaps/Resource Issues:
  - While the department offers a rather complete and high quality service offering, the issue of timely access to care remains as there is insufficient resources for meeting the current demonstrated needs in the community.
    - Department data as of late December 2004 showed appointment wait times for glaucoma clinic was 8 -10 weeks and retina clinic at 6 - 8 weeks.
    - The OP clinic lacks adequate equipment (both lasers are currently irrepairably broken) and space to provide standard ophthalmologic care.
    - Optometrists are few and they have not been adequately leveraged to their full potential scope of services.

Overview of Clinical Services > Ophthalmology

Recommendations

12.5.22 Grow the services of ophthalmology, including optometry in conjunction with departmental efforts to address unmet needs in the community.

12.5.23 Assess the adequacy of current ambulatory surgery resources and address equipment and space issues to accommodate the current and potential growth in surgical services.

Performance Measures

- Consults, surgical cases and clinic visits
- First available appointment times in clinics
- Scheduling access to OR use
- Diabetic eye screening rate

Drew Responsibility

- Medical Director
- CNO
- COO

Overview of Clinical Services > Orthopedics

Assessment

- Scope of Services:
  - A free standing department intent on building a full scope of orthopedic services, including elective procedures.
    - Operating basic orthopedic services with the exception of spine surgery.
- Market/Community Need/Volume Issues:
  - The uncertainty of the trauma center status will not affect the program development in that there are many community needs to be met.
    - Inpatient discharge volume projects a significant decline for the current fiscal year.

KDMC ORTHOPEDICS INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
ORTHOPEDICS	933	179	716	-23.3%

  - Surgical case volume for FY03/04 was 657 inpatient and 261 outpatient for a total surgical volume of 928.
    - Projections from first quarter FY04/05 numbers of 170 inpatients and 71 outpatients for a volume of 241 yields a annual figure of 964 cases, a 3.8% increase.
    - In that projection, the ambulatory surgery percentage of the total grows from 28% to 29.5%.

Overview of Clinical Services > Orthopedics

Assessment

- Market/Community Need/Volume Issues: (cont)
  - KDMC outpatient services are projected to decline from 9,963 patients seen last fiscal year to 7,696 this year, for a decline of nearly 23%.
  - Podiatry volume at HHHCHC declined nearly 13% last year from 847 visits to 737, before service was terminated three months into the current fiscal year with 177 visits.
- Physician Issues:
  - The incumbent Chair has a tenure in that position of about two months, but has been a part-time faculty member for 15 years.
    - The department lost three faculty and its only podiatrist.
  - Currently there are four attending physicians and several part-time faculty.
  - The plan is to stabilize the faculty at five to seven full-time physicians and about three FTE of part-time faculty.
  - There are currently ten residents, two in each year of the five-year residency.
    - The program is currently on proposed probation awaiting another review.

Overview of Clinical Services > Orthopedics

Assessment

- Service Gaps/Resource Issues:
  - Plans include replacement of a spine surgeon vacancy with a new recruit who will also do elective spine procedures.
  - There is intent to expand the sports medicine capability to address shoulder, knee and various other school/athletic injuries.
  - An expansion of joint replacement procedures will address issues with obesity and arthritis.
  - Two podiatrists are in the process of being credentialed and at 20 hours each will provide an FTE.
  - Limb care for diabetics and amputees will continue to be featured.
  - As of mid January 2005 the next available adult general orthopedic clinic visit was in three months.

Overview of Clinical Services > Orthopedics

Recommendations

12.5.24 Grow services in sickle cell and oncology with grant funds, appropriate space, staffing, and logistics for the enhancement of care.

Performance Measures

- Number of surgical procedures
- Orthopedic and podiatry clinic access through first available appointment

Responsibility

- Medical Director

Overview of Clinical Services > Obstetrics and Gynecology

Assessment

- Scope of Services:
  - Services are primarily high risk obstetrics, a perinatal diagnostic center, gynecology, including some GYN oncology, and very little endoscopic/laparoscopic surgery.
  - Market/Community Need/Volume Issues:
    - The market includes significant high risk factors, such as, lack of prenatal care, substance abuse, high teen pregnancy rates, mental illness, diabetes, and obesity.
    - There is great need for prenatal care services.
    - OSHPD discharge data show slight decreases in all OB/GYN categories except for high risk, as shown below.

KDMC OBSTETRICS & GYNECOLOGY INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
GYNECOLOGY	296	67	268	-9.5%
HIGH RISK OB	269	70	280	4.1%
OB/DELIVERY	661	158	632	-4.4%
OTHER OB	81	19	76	-6.2%
GRAND TOTAL	1,307	314	1,256	-3.9%

Overview of Clinical Services > Obstetrics and Gynecology

Assessment

- Market/Community Need/Volume Issues:
  - While overall surgical caseloads are also declining, the outpatient surgical cases are increasing, largely due to significant growth in gynecology cases.

KDMC OBSTETRICS & GYNECOLOGY SURGICAL VOLUME				
	TOTAL CASES	I/P CASES	O/P CASES	% CHANGE FY04 TO 05
FY03/04				
GYNECOLOGY	161	73	88	
OBSTETRICS	52	47	5	
OBSTETRICS/GYNECOLOGY	445	248	197	
TOTAL	658	368	290	
FY04/05 1QTR				
GYNECOLOGY	44	13	31	
OBSTETRICS	1	1	0	
OBSTETRICS/GYNECOLOGY	79	34	45	
TOTAL	124	48	76	
FY04/05 1QTR ANNUALIZED				
GYNECOLOGY	176	52	124	40.9%
OBSTETRICS	4	4	0	-100.0%
OBSTETRICS/GYNECOLOGY	316	136	180	-8.6%
TOTAL	496	192	304	4.8%
% CHANGE FY 04 TO 05	-24.6%	-47.8%	4.8%	

Overview of Clinical Services > Obstetrics and Gynecology

Assessment

- Market/Community Need/Volume Issues: (cont)
  - Outpatient visits at KDMC clinics are projected to be down from last fiscal year's total of 15,318 to 12,228 for a decline of nearly 20%.
  - Access to OB/GYN clinics is reasonably prompt with appointment availability within days, except for urology, which is four weeks.
  - OB/GYN clinics at HHHCHC are all projecting a decline from the last fiscal year based on patient visits though December:
    - GYN projected at 4,008 visits or (8%).
    - Prenatal projected at 878 or (11.4%).
    - Prenatal intake projected at 274 or (10.7%).
    - Family Planning (mid level providers) at 8,886 visits or (9.6).
  - Perhaps more than any other department, OB/GYN volumes have been negatively impacted by the closure of numerous community feeder clinics and a deliberate policy to direct patients with insurance (including Medi-Cal) to other providers.
  - This is partially demonstrated by a desire of some community physicians to redirect some portion of their insured business to KDMC for substance abuse and other high risk prenatal conditions.
  - While Medi-Cal is successful in providing low income women access to "mainstream" providers, some of their needs are better served in public settings such as KDMC.

Overview of Clinical Services > Obstetrics and Gynecology

Assessment

- Physician Issues:
  - For legitimate reasons, only nine of the eleven faculty are currently productive clinically.
    - Recently lost 3.5 faculty FTEs.
    - The GYN/oncology physician is shared half time with LAC Harbor/UCLA.
  - Two of the area's three board certified peri-natologists are on the faculty.
  - No community physicians participate as faculty.
  - The residency program has three slots per year and has 12 residents.
- Service Gaps/Resource Issues:
  - The physical condition of the labor and delivery suite is said to be below general community standards.
    - Fetal monitoring was just acquired last year.
    - There are no LDRs (labor/delivery/recovery room suites).
    - A unit-based procedure room was closed, now requiring use of the OR suite.
    - Ectopic pregnancies, when surgically managed, are managed by open surgery as opposed to laparoscopic techniques.
    - The available ultrasound machine does not provide prenatal assessments.
    - A new women's center, slated to open this spring, will create an opportunity to develop a clinic pilot with efficient operations.
  - There is no prenatal substance abuse program.
  - The low patient volume requires residents to rotate to other sites for some exposures.

Overview of Clinical Services > Obstetrics and Gynecology

Recommendations

12.5.25 Strengthen the de-facto high risk obstetrics program status through formalized program development in key areas such as substance abuse, chronic disease management (i.e., diabetes), teen center, etc.

12.5.26 Grow the service through specialty contracts with public and private managed care plans for high risk and more routine obstetrics care.

12.5.27 Provide opportunities for community physicians to have faculty status to enable their referral to and participation in the OB/GYN services at KDMC.

12.5.28 Expedite faculty and staff position control changes to enhance productivity.

Performance Measures

- Inter-disciplinary planning with infectious disease, endocrinology and pediatrics with formalized tracking of patient volume by high risk conditions.
- Productive hours against payroll.
- Access to services.

Overview of Clinical Services > Obstetrics and Gynecology

Responsibility

- Medical Director
- CEO
- Chairman, Department of OB/GYN

Overview of Clinical Services > Neuroscience

Assessment

- Scope of Services:
  - Among the pioneers in leveraging the combined potential of neurology and neurosurgery as a single department.
  - Consult and specialty services in neurosurgery and neurology, epilepsy, stroke care, Parkinson's Disease, movement disorders and trauma.
  - Historically effective in capturing research grants.
- Market/Community Need/Volume Issues:
  - In SPA 6, 20.4% of the adults have a disability, some portion of which are neurological in origin.
  - The service area has the highest stroke mortality rate in Los Angeles County, at 70.2 per 100,000.
    - This is 39% above the County average.
    - Adults with some form of stroke induced partial paralysis are a common sight in the community.

Overview of Clinical Services > Neuroscience

Assessment

- Market/Community Need/Volume Issues: (cont)
  - Inpatient service volume is projected to show a 37% decline this year.

KDMC NEUROSCIENCE INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
NEUROSURGERY	77	11	44	-42.9%
NEUROLOGY	475	76	304	-36.0%
Grand Total	552	87	348	-37.0%

  - The surgical case load is also projected to show a steep decline.

KDMC NEUROSCIENCE SURGICAL VOLUME			
FISCAL YEAR	TOTAL CASES	INPATIENT	OUTPATIENT
2003/04	118	94	24
2004/5 First Quarter	23	20	3
Projected 2004/05	92	80	12
% Change	-22.0%	-14.9%	-50.0%

  - Non-traumatic services will fuel the growth in neurosciences through emerging technologies in neuro-diagnostics and interventional services.
    - KDMC is not currently positioned to take advantage of that trend.

Overview of Clinical Services > Neuroscience

Assessment

- Market/Community Need/Volume Issues: (cont)
  - Outpatient visits are in decline at both KDMC and the HHHCHC.
  - KDMC volume in neuroscience, which includes neurosurgery and adult and pediatric neurology is trending at a 3.7% drop with 4,758 visits compared with last fiscal year at 4,943.
    - Access to neurology appointments is one month for pediatrics and two-and-a -half months for adults.
  - The decline at HHHCHC (neurology only) has accelerated in the current fiscal year projection of 558 visits, a drop of 28% from the prior year at 776.
    - The decline from FY03 to FY04 was a more modest 8% drop from 844 visits.
- Physician Issues:
  - There are three full-time neurologists and four of the five neurosurgeons are full-time.
    - There are no residents in this department.
  - Faculty has maintained a prominent role in both scientific and clinical research, garnering significant NIH grant support through the years.
  - Department leadership is nearing retirement and there is no overt succession planning.
    - There is concern that this department will have difficulty attracting faculty, as young, well-trained neurosurgeons are earning $500K and up; making senior leadership options from that discipline a low probability.

Overview of Clinical Services > Neuroscience

Assessment

- Service Gaps/Resource Issues:
  - There is distress over the lack of a critical care bed allocation to this department.
    - It is also acknowledged that there is inappropriate use of ICU beds by physicians because of concerns about various capabilities on some inpatient units.
    - Current resources may be organized into a stroke team to focus on the hundreds of stokes seen annually.
  - There is concern whether this department's reliance on emerging high quality imaging technologies can be met in the future. Proposals in this area are pending for high tech supports to broaden the scope of surgical capability
  - There are critical gaps in doppler echo capability.
  - There is concern that this department's reliance on emerging high quality imaging technologies can be met in the future.

Recommendations

12.5.29 Develop a plan for the department that re-evaluates the relative roles of neurosurgery and neurology in KDMC clinical programs. Target growth and program development in areas which best match the clinical needs of the community.

12.5.30 Maintain services and begin planning for leadership succession, and focused new program development in the area of stroke care.

Overview of Clinical Services > Neuroscience

Performance Measures

- First available appointment for people with targeted neurological conditions.
- Inpatient length of stay.

Responsibility

- Medical Director
- Dean, Drew School of Medicine

Overview of Clinical Services > Pediatrics

Assessment

- Scope of Services:
  - The department has general pediatrics and an extensive array of pediatric specialists with services in the areas of allergy, nephrology, child and adolescent development, neurology, dermatology, endocrinology, infectious disease, neonatology, cardiology and gastroenterology.
- Market/Community Need/Volume Issues:
  - While only 8.7% of children under 18 years old in the service area are reported to have no regular source of healthcare, it is the second highest level among the planning areas in the County.
  - With the size of the high risk obstetrics population, attention to child developmental issues is warranted.
  - Asthma is also a major health issue.

Overview of Clinical Services > Pediatrics

Assessment

- Market/Community Need/Volume Issues: (cont)
  - The table below shows the clinical distribution of the inpatient pediatrics volume with projections for the current year.

KDMC PEDIATRICS INPATIENT SERVICE DISTRIBUTION				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
DERMATOLOGY	59	29	116	96.6%
ENDOCRINE	46	6	24	-47.8%
GASTROENTEROLOGY	111	21	84	-24.3%
GENERAL MEDICINE	64	12	48	-25.0%
GENERAL SURGERY	1		-	-100.0%
HEMATOLOGY	9	1	4	-55.6%
NEONATOLOGY	550	143	572	4.0%
NEUROLOGY	98	12	48	-51.0%
NEUROSURGERY	7	2	8	14.3%
OPHTHALMOLOGY	4		-	-100.0%
OTOLARYNGOLOGY	48	10	40	-16.7%
PULMONARY	305	55	220	-27.9%
TRAUMA	20	6	24	20.0%
Grand Total	1,322	297	1,188	-10.1%

  - Pediatrics is primarily an ambulatory care discipline.
  - Inpatient pediatrics is in decline nationally with Children's Hospitals and some special pediatric units in general hospitals garnering most admissions.

Overview of Clinical Services > Pediatrics

Assessment

- Market/Community Need/Volume Issues: (cont)
  - At KDMC there were only 12 pediatric surgery cases last fiscal year (10 inpatient and 2 outpatient), and so far only one this year, as there is no longer a pediatric surgeon on staff.
  - The pursuit of a pediatric surgeon is key to maintaining a complete pediatric intensive care unit capability.
    - In the interim, medically critical patients can be well cared for in the PICU.
    - An assessment of the severity of illness should be completed to determine if the unit should be an intensive or intermediate care unit.
    - If the pediatric surgeon and other needed subspecialties are not able to be recruited, the operational requirements for a PICU may be too great.
  - During 2004, when there was no subspecialty pediatric surgery capability at KDMC, approximately one to two pediatric patients/week were transferred to other facilities from the KDMC ER.
  - The presence of a high risk obstetrics population makes maintenance of a neonatal ICU a requirement in this environment.
  - California Children Services designates three levels of NICU care; regional, community, and intermediate.
  - KDMC currently operates a regional NICU. The NICU should be designated a community NICU.
    - This level can be approved to provide surgery if and when pediatric surgical capabilities can be regained.

Overview of Clinical Services > Pediatrics

Assessment

- Market/Community Need/Volume Issues: (cont)
  - Pediatric outpatient activities take place in a variety of settings; including, the first floor of the hospital, the Denzel Washington Pediatric Pavilion on the same level, the Gammons modular building, the Oasis clinic, and HHHCHC.
  - Patient visit volumes are projected to decline on campus this fiscal year to 11,010 visits or 14.5% lower than last year's 12,881 visits.
  - At the HHHCHC where faculty also supervise a resident continuity of care clinic, visits increased in FY04 by 27.1% to 13,369 but are projected to drop this year by over 18% to 10,936.

Overview of Clinical Services > Pediatrics

Assessment

- Physician Issues:
  - There are 36 faculty in the department including 6 board certified neonatologists, 4 allergists and 2 child developmentalists.
  - There are about 40 residents.
  - A pediatric gastroenterologist serves one day a week, but there is no pediatric GI lab.
  - Service Gaps/Resource Issues:
    - Gaps include pediatric cardiac catheterization capability, though demand is uncertain.
    - There is a need for an intensivist, primary care continuity access and a surgeon
      - There is an opportunity to collaborate with the hematology/oncology division in Medicine with respect to sickle cell disease, as well as recruitment of a pediatric hematologist.
      - There have been preliminary discussions regarding the use of the Trauma center for out-patient surgery.
      - The pediatric outpatient service provides urgent care to a large number of patients, including some who might better meet emergency room level of care, through in a much more comfortable and hospitable environment than the current ER.
      - Hospitalization rates for asthma are increased.
      - Primary care continuity services are apparently not meeting community demand.

Overview of Clinical Services > Pediatrics

Recommendations

12.5.31 Collaborate with Surgery to recruit a pediatric surgeon to support higher levels of care in the NICU and PICU.

- Downgrade NICU from Regional to Community NICU.
- Assess the severity of illness in the PICU to determine if it should be an intensive or intermediate care unit.

12.5.32 Grow subspecialty services in sickle cell disease, audiology and vision screening through collaboration with the Medicine, Otolaryngology, and Ophthalmology.

12.5.33 Provide an alternative licensed sites of care for the sickest POP cases or adjust the certification appropriately if volumes warrants.

12.5.34 Increase services in primary care pediatrics to better address community needs.

12.5.35 Enhance asthma programs.

Overview of Clinical Services > Pediatrics

Performance Measures

- Cases appropriate for NICU and PICU admission
- Referrals for surgery
- Volume of outpatient visits and referrals out for these specialty and surgical services.
- Asthma inpatient admissions
- Access
- Immunization rates

Responsibility

- Medical Director
- CNO
- Chairman of Pediatrics
- Chairman, Surgery

Overview of Clinical Services > Psychiatry

Assessment

- Scope of Services:
  - Adult inpatient psychiatric services to a constant and cyclical population.
  - There is also a psychiatric emergency service (PES).
  - Outpatient services are provided by the County DMH.
- Market/Community Need/Volume Issues:
  - The market appears to be the adult chronic mentally ill that years ago were deinstitutionalized from the State hospitals and migrate among the streets, jail, DHS sponsored hospital units, and possibly DMH outpatient centers.
  - Some patients are from the community and/or brought in by family members.
  - Many patients have a dual diagnosis, with the cohort diagnosis being substance abuse.
  - The projection for decreased volume shown below is an artifact of the first quarter figure which may reflect a lower census level that began in Feb '04.

KDMC TOTAL INPATIENT PSYCHIATRY SERVICE				
Clinical Groupings / KDMC	FY03/04	1Q FY04/05	FY04/05 ANNUALIZED	% CHANGE
PSYCH/DRUG ABUSE	659	107	428	-35.1%

Overview of Clinical Services > Psychiatry

Assessment

- Physician Issues:
  - The interim department chair was asked to return from retirement to accept the position.
  - There are six full-time psychiatrists and one internal medicine physician.
    - The Office of GME shows a current listing of 26 residents in psychiatry.
- Service Gaps/Resource Issues:
  - Other than violence prevention and cessation, this review was not able to determine the nature of a therapeutic program.
  - Juveniles are held here until transportation to DMH is arranged for transfer to one of their facilities.
  - There is no effective coordination between the outpatient programs of DMH with this inpatient and emergency service.
  - There are significant facility issues and some staffing issues impacting delivery of safe, effective care.

Overview of Clinical Services > Psychiatry

Recommendations

12.5.36 Maintain the service at its current level addressing regulatory and clinical care programs.

12.5.37 Initiate discussions with DMH leadership on coordination of care for patients that are common to both organizations.

12.5.38 Find alternatives to having juveniles on the unit at any time.

Performance Measures

- Patient census and length of stay
- Number and attendance of groups
- Case management of common KDMC and DMH patients
- Presence and duration of any juvenile on the unit

Responsibility

- Medical Director
- Chairman, Psychiatry

Overview of Clinical Services > Emergency Medicine

Assessment

- Scope of Services:
  - Full range of medical care rendered in the emergency room.
  - Ultimate scope potential is at issue pending resolution of trauma center status.
- Market/Community Need/Volume Issues:
  - Market is the surrounding community and EMS providers.
  - Very sick patients are arriving from Mexico to be seen.
  - Violence and a large population with significant health and environmental issues create significant demand.
  - Delays in access to specialty clinics at the hospital contribute to the volume for work up and care.
  - Services include triage, wound checks, prescription refills, and other non-emergency services that patients show up for due to limited access to appropriate levels of care.
  - In FY03/04 a total of 184 surgical cases were performed in the ER.
  - The throughput issues that required ambulances to divert to other facilities are considered to be an impediment to meeting the community need for care.
    - Recommendations to improve throughput are in other sections of this report.
    - Improved decision making for cardiac catheterizations and TPA administration as well as access to key diagnostics like MRI are among issues to be addressed.

Overview of Clinical Services > Emergency Medicine

Assessment

- Physician Issues:
  - ER physicians cannot admit patients.
  - Attending physicians seek complete workups through the ER before accepting the admission, due to the concern of getting a timely work up on the floors.
  - There is variability in response to requests for specialty consults.
  - The GME office lists 39 residents in emergency medicine.
  - The residency training program, which shared a top ranking among the nation's emergency medicine programs is now seeing a decline of interest as the educational experiences associated with a trauma center (ex. Penetrating trauma) no longer distinguishes KDMC from many community hospital settings
- Service Gaps/Resource Issues:
  - Key diagnostic services are not readily available.
    - Cardiac catheterization
    - Cardiac stress testing
    - Cardiac monitoring equipment is suboptimal
    - The absence of transport support creates bottlenecks

Overview of Clinical Services > Emergency Medicine

Recommendations

12.5.39 Maintain level of emergency care capabilities until operational enhancements enable growth in service capabilities addressing issues regarding equipment and space.

Performance Measures

- Patient volume and service grouping
- Time to triage
- Length of stay

Responsibility

- Medical Director

Overview of Clinical Services > Oral/Maxillofacial Surgery and General Dentistry

Assessment

- Scope of Services:
  - Oral/Maxillofacial Surgery services include mouth care for tumors, fractures, infections, chronic pain, reconstruction.
    - Also provide clearance for surgical implant and transplant cases at LAC Harbor/UCLA.
  - The general dentistry practice section only sees referred patients that have active medical conditions or problems.
    - Includes a large HIV/AIDS practice on campus.
    - Operates a dental screening/pediatric high risk clinic (includes premature babies and/or children of substance abusing mothers).
      - These cases cannot usually be seen in normal settings because of behavioral issues or a need to go to the OR to provide dental care.
- Market/Community Need/Volume Issues:
  - This is the only LAC-DHS hospital for dental emergencies in the Southwest Cluster.
  - Approximately two patients per month present with such severe dental infections that it requires acute hospitalization and emergency surgery to prevent a blocked airway or prevent extension of the infection into sinuses, eyes or brain
  - Cases often require tertiary care for totally preventable disease processes.
  - Two community health centers and LAC-Harbor have closed their dental and oral surgery programs.
  - Elective surgeries have not had OR access due to capacity constraints.

Overview of Clinical Services > Oral/Maxillofacial Surgery and General Dentistry

Assessment

- Physician Issues:
  - There are five full-time faculty and two vacant faculty positions.
  - There are eight oral/maxillofacial surgery residents and four general practice residents (6 slots).
    - Residents rotate to Kaiser for elective surgeries and to Harbor for anesthesiology and general surgery.
      - The oral surgery program requires two months of internal medicine, one month of pulmonary medicine, one month of cardiology, six months of surgery and four months of anesthesiology in the course of a four year program.
    - The only residency review citation was need for a dental assistant and an office for the program director.
- Service Caps/Resource Issues:
  - There are no primary care or outreach programs functioning.
  - A mobile dental clinic equipped for teledentistry was obtain through a $750K donation.
    - It was forced to park near a campus drainage trench and flooding damaged the unit.
    - Clinical staff were laid off.

Overview of Clinical Services > Oral/Maxillofacial Surgery and General Dentistry

Recommendations

12.5.40 Grow the Oral/Maxillofacial Surgery & General Dentistry services to include the capability for elective and primary care services, especially community outreach.

12.5.41 Restore the use of and staffing for the mobile dental van as a key component of community outreach to address unmet community dental needs.

Performance Measures

- Monitor all service volumes.
- Monitor primary care interventions that directly impact preventable conditions.

Responsibility

- Chair, OMFS
- CEO
- Medical Director

Overview of Clinical Services > Family Medicine

Assessment

- Scope of Services:
  - Capable of providing a broad range of primary care services for adults, children and infants; including, screening procedures, minor surgical procedures, psychosocial and mental health services, nutritional counseling, prenatal care, and clinical services in outpatient, hospital, and nursing home settings.
  - Ambulatory care is currently provided five days a week at HHHCHC and Dollarhide.
    - Adult medicine is provided at HHHCHC.
    - Adult medicine, pediatrics, family planning, and prenatal care is provided at Dollarhide.
  - An inpatient service is maintained at KDMC.
  - Contract negotiations are in progress for provision of clinical services in a nursing home.
- Market/Community Need/Volume Issues:
  - The market served is SPA 6, the service area for KDMC.
  - The population has the worst health status in at least 28 indicators as measured by DHS.
  - Among the most frequent diagnoses of family medicine patients were hypertension, diabetes, urinary tract infection, immunizations, acute ear infections, skin infections, asthma, obesity, anemia, high cholesterol, congestive heart failure, vaginal bleeding, and depression.

Overview of Clinical Services > Family Medicine

Assessment

- Market/Community Need/Volume Issues:
  - These services are an essential component of addressing the unmet need for primary care services in the community.
  - The department does HIV screening and has a $2.4 million grant for the study of diabetes and depression in the minority community.
  - While a high-volume service provider, visits have decreased over the past couple of years as community-based clinic closures and relocations have occurred.
  - Family medicine is the highest volume clinic at HHHCHC, though the annualized volume projection is declining.
    - Seven months in FY03 showed 12,306 visits (annualized to 21,096).
    - Full FY04 visits were 18,812 (a decline of 10.8% from annualized FY03).
    - Six months of FY05 visits of 8,559 annualize to 17,118 or a decline of 9%.
  - Visits at Dollarhide were 12,566 in FY04 and six months of this year shows 5,414 visits, annualized at 10,828 for a decline of 13.8%.

Overview of Clinical Services > Family Medicine

Assessment

- Physician Issues:
  - There are seven faculty members.
    - The interim chair has served in that role for 18 months.
  - The GME office shows 8 slots in each year of the 3-year training program, filled with a total of 24 residents.
  - Recent activities have included family physician supervision of deliveries and residents' completion of newborn, and pediatric advanced life support training to perform selected neonatal care requirements,
  - The department is seeking to address residency program review citations for insufficient pediatric and OB/GYN patient volume in resident continuity clinics.
- Service Gaps/Resource Issues:
  - Faculty staffing is lean, such that, there is limited ability to cover for inevitable occasional faculty absences, especially at Dollarhide.
  - There are no nursing homes yet being medically covered by the department.
  - There has been difficulty in meeting the educational program space resource needs in the current ambulatory settings.

Overview of Clinical Services > Family Medicine

Recommendations

12.5.42 Acquire the necessary medical and other staff to adequately cover the services offered in all locations and address all residency review program citations.

12.5.43 Grow Family Medicine services in response to community need for longitudinal primary care services.

Performance Measures

- Volume and service categories of outpatient visits, hospital admissions and selected procedures

Responsibility

- Department Chair
- Medical Director
- CEO

Overview of Clinical Services > HHHCHC

Assessment

- Scope of Services:
  - The center provides urgent care, primary care, selected specialty care, physical therapy, and ancillary services.
    - Urgent care is provided by contract through the Medical Services Operating Agreement between DHS and Drew University.
    - Clinics include adult medicine, family medicine, OB/GYN, pediatrics, and dental in the primary care area.
      - Public health services, such as, immunizations are done in the primary care setting.
      - There is also a nurse-only clinic and a mid-level, provider-run, family planning clinic.
    - Specialty services include cardiology, geriatrics, neurology, ophthalmology (with optometry), and women's health.
      - There is also Main Street clinic for HIV early intervention that is state funded.
    - Other services include physical therapy, radiology and laboratory, and prenatal intake.
  - Services that have been discontinued in the current fiscal year include diabetes management, ENT, and podiatry.
  - As a comprehensive health center HHHCHC may operate health centers under its supervision, which is the relationship to Dollarhide.
  - Dollarhide has family medicine faculty physicians and residents operating adult, pediatric, prenatal and family planning services.

Overview of Clinical Services > HHHCHC

Assessment

- Scope of Services (cont)
  - HHHCHC is currently accredited by the Joint Commission on Accreditation of Healthcare Organizations through April 2006.
    - The center has been consistently accredited since at least 1994.
  - There has been consideration of having KDMC and HHHCHC pursue network accreditation.
    - Network accreditation would assess the degree of hospital and non-hospital entity service integration in meeting the needs of a common community of patients.
    - Given the difficulties that KDMC continues to have with JCAHO accreditation, it would be unwise to link the accreditation of each entity to the other at this point in time.
  - There is a current initiative in DHS to pursue FQHC “look-a-like” status for HHHCHC and other County comprehensive health centers.
    - The application for FQHC status proposes a joint governance structure of the County Board of Supervisors and a CHC local board with 51% community/patient membership.
      - The local board would have authority to accept, reject ,or terminate the health center CEO appointment.
    - One benefit would be cost-based payment under Medi-Cal for services rendered.
    - Such a governance arrangement could provide additional issues for KDMC to manage as the services integration to meet the needs of a common community increase.

Overview of Clinical Services > HHHCHC

Assessment

- Market/Community Need/Volume Issues:
  - The market is the SPA 6 service area with all the previously mentioned high indices of poor health status and challenges with access to care.
  - Recent closure of community clinics have disrupted patient/physician relationships that have led to decreased service volumes, such as, the relocation of Family Medicine from Imperial Heights to HHHCHC.
  - Other public payment and policy initiatives have created incentives for physicians in private practice to accept patients that were previously using public facilities as their only accessible source of care
    - The state funded Child Health & Disabilities program improved payment to pediatricians and shifted some clinic volume out.
    - Improved Medi-Cal payments to providers for deliveries has decreased public provider volume in obstetrics.
    - These volume declines were further encouraged through administrative policies discouraging care to patients with valid insurance coverage options.
  - Data is inconclusive if the recently improved access to private sector providers has improved overall access to care for the target population.
    - Budget and staffing reductions have reduced service capacities in some areas.
    - Current access to care is still marginal with waits for next available appointment scheduling for adult services being about three months.

Overview of Clinical Services > HHHCHC

Assessment

- Market/Community Need/Volume Issues: (cont)
  - The situation shows no significant improvement in access to care while visit volume continues to decline.
  - The table below shows visit volume trends and projection for selected categories of service for the two centers.

KING/DREW MEDICAL CENTER SELECTED HEALTH CENTER VISIT VOLUME FY 2003 - 2005 (Projected)*						
CENTER	FY 2002-03		FY 2003-04		FY2004-05 Proj.*	Proj. Change
Hubert H. Humphrey CHC						
Urgent Care	47,166		39,397		38,114	-3.3%
Ambulatory Care Clinics	100,117		99,668		77,500	-22.2%
Physical Therapy	1,792		1,442		694	-51.9%
Nurse Only Cllinics	9,813		6,576		8,434	28.3%
Sub-Total	158,888		147,083		124,742	-15.2%
Dollarhide Health Center	N/A		12,566		10,828	-13.8%
Grand Total	158,888		159,649		135,570	-15.1%
* Projections based on 6 monts data and include effect of clinic closures in the current year						

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Overview of Clinical Services > HHHCHC

Assessment

- Market/Community Need/Volume Issues: (cont)
  - The women's health clinic was intended to be a comprehensive program for adult women.
    - There is only a single internal medicine physician there now as an OB/GYN; a psychiatrist and a family medicine physician are no longer there.
  - Specialty clinic capabilities as issues at KDMC have limited participation of faculty and residents forcing elimination of neurology, urology and podiatry.
    - Cardiology, geriatrics, and ophthalmology continue to operate clinics.
  - The discontinued diabetes management clinic was a County run case management program that is likely to be replaced by services of the Division of Endocrinology from KDMC.
  - The emphasis to move obstetrics to private providers caused patients and providers to leave the center; resulting in the clinic now largely seeing gynecology patients with one physician and a nurse practitioner.
  - The Main Street clinic has a single infectious disease physician, a social worker and community worker.
  - The FIRM clinic was designed as a resident clinic follow-up for patients discharged from KDMC.
    - No residents have been assigned since November 2004.
    - Two of the three physician proctors will remain and be reassigned to adult medicine.

Overview of Clinical Services > HHHCHC

Assessment

- Physician Issues:
  - There are different models of physician practice involving employed physicians, faculty, and residents that create conflicts in health center operations, resource use and efficiency in providing care.
  - There is ambiguity and some conflict in the reporting relationships among the health center medical director, faculty, residents, Drew department chairs/chiefs and the KDMC medical director.
  - There is poor coordination and execution of health center referrals to campus specialty clinics and subsequent follow up notes to the PCP.
  - Chart availability for physician visits is below 70%.
- Service Gaps/Resource Issues:
  - Coordination for and access to specialty services is inadequate.
  - No routine follow up from KDMC hospitalizations or specialty visits.
  - While management has a formal reporting relationship to KDMC, the hospital management has historically not been responsive to health center needs for operational support.

Overview of Clinical Services > HHHCHC

Recommendations

12.5.44 Elevate the priority for coordinated service delivery to the community through establishment of a KDMC vice president for ambulatory and community programs with responsibility and accountability for campus and community-based ambulatory care services, reporting directly to the KDMC CEO.

12.5.45 Clarify the responsibility of the KDMC Medical Director for physician services in the ambulatory care setting through the local medical director and/or appropriate faculty Chief of Service

12.5.46 Support the initiative for FQHC “look-a-like” status for HHHCHC with the Dollarhide affiliate.

12.5.47 Defer ambitions to seek network accreditation of KDMC and affiliated community-based health centers until sometime after 2006 when a practical assessment of services integration can be made and a work plan for successful network accreditation can be realistically developed.

12.5.48 Develop system-wide standards for timely specialty referral access and communication to referral sources for ambulatory care patients.

12.5.49 Grow the ambulatory care services available to serve the needs of the SPA 6 southwest cluster community in response to demonstrated unmet need.

Overview of Clinical Services > HHHCHC

Performance Measures

- Patient visits by clinic
- Patient wait times

Responsibility

- CEO
- Medical Director
- Vice President for Ambulatory and Community Programs

Section XIII – Situational Analysis

NAVIGANT CONSULTING

Overview and Methodology

- The Baptist Health Care Leadership Institute (BLI) is pleased to present its Situational Analysis Report of Martin Luther King, Jr./Charles R. Drew Medical Center (MLK/Drew). The situational analysis was conducted in December 2004. BLI consultants reviewed articles and other information provided by Navigant Consulting, Inc. and conducted a Service Excellence Survey™ with the purpose to: 1) identify current strengths as they relate to service and operational excellence; 2) identify opportunities for improvement; and 3) recommend strategies for areas to focus on over the coming year to move MLK/Drew forward.
- The situational analysis conducted by BLI consultants included a review of the following documents while on site December 9 and 10, 2004:
  - Organizational Profile
  - Inpatient Satisfaction Template, Nursing Services, First Quarter 2003
  - Town Hall script, November 4, 2004. “Meet Navigant Consulting.”
  - Mission and Vision statements and the Standards
  - History of the organization and overview of Drew University
  - MLK/Drew Governance and Advisory Structure
  - Information sheets: units and services
  - Patient and employee ethnic mix
  - Organization Chart
  - L.A. Times five part series on MLK/Drew. Weber, Ornstein and Landsberg. December 2004
  - Employee Morale Pre-Test Survey, 1998

Overview and Methodology

- Additionally, MLK/Drew employees were asked to complete the Service Excellence Survey™ (see appendices for copy of survey instrument and the survey report.) More than 400 employees at various levels of the organization responded to the survey. The survey analysis lends its focus on five key dimensions of service and operational excellence. Other tools used to assess the current culture at MLK/Drew include qualitative research methods, such as:
  - Medical Staff interviews and focus groups
  - Employee and Directors focus groups
  - Interviews with community leaders, Drew University representatives, Department of Health Services leaders, and union representatives.
- Furthermore, BLI consultants conducted First Impression Audits by walking around the facility.

Executive Summary

- The results of the situational analysis indicate that MLK/Drew Medical Center has a rich history, a diverse work force and is positioned with a desire to move the organization toward greater achievements and fulfillment of its mission and vision. A large group of dedicated and passionate employees and physicians paired with a sense of commitment to serving the community are some of the strengths in place, which can be leveraged to take the organization to greater levels of achievement in the area of service and operational excellence. As MLK/Drew introduces proven strategies and practices focused on service excellence, the organization should be able to create the synergistic energy needed for substantial breakthrough advancements. However, organizations often find it difficult to transform their culture.

Overview of Identified Strengths

- Strengths identified include, but are not limited to:
  - Employee and physician pride in the hospital.
  - Long-term employees' commitment and loyalty.
  - An understanding and support of the mission of providing comprehensive medical care to the community.
- Other strengths revealed through the analysis were:
  - The affiliation with Drew University.
  - The diversity of the work force.
  - The support from the community.

Executive Summary

Overview of Identified Opportunities

- Involvement and participation, leader visibility and approachability, leaders leading by example, leadership development, planning and direction (the organization is reactive versus proactive), accountability, HR practices as they relate to service excellence, communication, cross-departmental teamwork and a consistent and well-deployed customer service focus in every department. Findings indicate that MLK/Drew has a culture of excuses and blaming. Alignment, deployment and consistency of service and operational excellence practices will be critical in moving the organization forward.

- The recommended Service and Operational Excellence Implementation Plan is focused on five key areas:
  - Create and Maintain a Great Culture, Select and Retain Great Employees, Commit to Service Excellence, Continuously Develop Great Leaders and Hardwire Success through Systems of Accountability.
    - Each of these areas includes leveraging current areas of strength as well as the introduction of new strategies and concepts. Working through the recommended Service Teams, MLK/Drew Medical Center will engage both leaders and employees in moving the organization forward following specific strategies outlined in the recommended Implementation Plan.

MLK/Drew Medical Center Service Excellence Survey™ Review

Introduction and Methodology

- The Service Excellence Survey ™ was completed by 428 Executives, Physicians, Directors, Managers, Supervisors, Clinical Staff and Support Staff at MLK/Drew Medical Center. Each question pertaining to each dimension is scored on a 5-point scale and is then calculated to a 100-percentile format using a weighted average by frequency of responses. Final scores for each dimension are reported for the organization at large and by the respondents' position. The score for each dimension is a benchmark measurement for the organization identifying areas of strength as well as areas that deserve the most attention. These dimension scores and the overall score for the organization are analyzed on a low-medium-high scale outlined below.

  Score of 10 - 50

  A foundation is not yet in place to support a culture of service excellence. Focus should be on educating the organization on the need for change. Intense communication and training with all employees should begin throughout the organization. Senior leaders need to be visible role models of expected behaviors.

  Score of 51 - 75

  A good foundation for service excellence exists and the organization is ready to take it to the next level. Focus should be on the alignment, deployment and consistent practice of service and operational excellence strategies.

  Score of 76 - 100

  There is a high level of commitment to service excellence with the foundational support of a culture of service excellence in place. Focus should be on maintaining the culture and continuously seeking ways to improve through advanced strategies for service and operational excellence.

MLK/Drew Medical Center Service Excellence Survey™ Review

Overview of Results

- The results from MLK/Drew's Service Excellence Survey™ reveal that a foundation for service excellence is not yet in place to support a culture of service excellence. Intense communication and training with all employees should begin throughout the organization. Senior leaders need to be visible role models of expected behaviors. The organization should focus on the five dimensions of service and operational excellence and their underlined goals and strategies as outlined in the Service Excellence Implementation Plan (page 33). The weighted averages per dimension by frequency of responses are outlined below.

	TOTAL (n=428)
Overall Service Excellence Survey™ Score	36.39
I: Building and Maintaining a Great Culture	32.89
II: Selecting and Retaining Great Employees	34.19
III: Focusing on Service Excellence	39.40
IV: Continuously Developing Leaders	33.82
V: Hardwiring Success Through Systems of Accountability	39.40
Other: Satisfaction, Loyalty and Commitment	*46.54*

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MLK/Drew Medical Center Service Excellence Survey™ Review

Demographics

- Four hundred twenty eight MLK/Drew Medical Center employees and contract workers responded to the Service Excellence Survey™. Close to 30% of the respondents described themselves as clinical staff, followed by 26% support staff. BLI consultants find it unusual that 15.4% of the respondents described themselves as "others" or did not respond to this question (10%.) This phenomenon could be due to the distribution mechanisms of the survey instrument itself, the inexperience of an employee survey process or caused by fear of retribution. 42.5% of the respondents answered that they have been employed with MLK/Drew for more than 15 years, indicating commitment and loyalty to the organization. Furthermore, close to 24% stated that they plan to stay at MLK/Drew for more than 15 years (see appendix for detailed information on survey demographics.)

MLK/Drew Medical Center Service Excellence Survey™ Review

Summary of Findings

- It is important to note that the current perceptions, as captured via the Service Excellence Survey™, are not in alignment among the various position levels of the organization. Executives, followed by Supervisors and Directors show the higher mean scores overall for the survey. The Physicians followed by Managers, Clinical Staff and Support Staff scored lower than the organization's mean score both overall and for most of the dimensions of service and operational excellence. This lack of alignment demonstrates a need to build a shared vision among all levels of the MLK/Drew team combined with consistent deployment of service excellence strategies out to front line staff. Furthermore, all survey dimensions scored low in the BLI database and they all deserve attention.
- The questions included in the outcome dimension Satisfaction, Loyalty and Commitment scored the highest on the Service Excellence Survey. MLK/Drew Medical Center has an apparent strength in its core group of dedicated and committed employees as identified in both the quantitative and qualitative data of the situational analysis.

MLK/Drew Medical Center Service Excellence Survey™ Review

Summary of Findings

- The Satisfaction, Loyalty and Commitment dimension consists of four survey questions. The single item scoring the highest is the Overall satisfaction with your job. However, Physicians, Support Staff and the "Other" category of employees scored below the organization's average for this item. Additionally, the score for this dimension is still low compared to the BLI database average and the health care industry best practice. Out of the five dimensions that the Baptist Health Care Leadership Institute has identified as keys to service and operational excellence, Focusing on Service Excellence scored the highest. The items contributing the most to this dimension's score are Our patients' well-being is a priority over our organization's financial or procedural concerns and All employees understand the customer service behaviors they are expected to demonstrate. Low-scoring items under the Focusing on Service Excellence dimension included areas such as education of employees, staffing, communication of patient satisfaction measures and bureaucratic barriers.

MLK/Drew Medical Center Service Excellence Survey™ Review

Summary of Findings

- Other strengths emerging when assessing MLK/Drew Medical Center's readiness for service and operational excellence are A positive customer service attitude is an important criterion when selecting new employees and I have a clear understanding of how I contribute to the success of the organization.
- The Building and Maintaining a Great Culture dimension received the lowest Service Excellence Survey score. The areas primarily driving this low dimension score are leadership items such as: leader visibility, leader credibility, and leaders' approachability in valuing everyone's opinions and suggestions. In addition to leadership items, teamwork across departments scored low. Securing a more permanent leadership at MLK/Drew along with a continuous leadership development program to build core leadership skills will be essential in moving the organization forward. The Leadership Index Score Card (see appendix) further reinforces the organization's need for a stronger focus on the development of the organization's leadership.

MLK/Drew Medical Center Service Excellence Survey™ Review

Summary of Findings

- In addition to Building and Maintaining a Great Culture, the dimensions measuring Continuous Leadership Development and Selecting and Retaining Great Employees both scored well below the organization's overall mean score. Items measuring the employees' opportunity to provide feedback on their supervisor, fair and equitable leaders and confidence in the leadership at MLK/Drew all scored low in the leadership development dimension. The item measuring whether employees receive personalized recognition for their positive behaviors and achievements scored the second lowest on the survey instrument after leader visibility. This item drives down the selecting and retaining great employees dimension together with senior leadership engagement in retention issues, communication of employee satisfaction measurement and soliciting employees input on how to improve performance.
- The survey results clearly demonstrate a need for leadership development, leader rounding, recognition of employees, improvement in hiring and promotion processes and employee engagement and empowerment. Again, it is important to emphasize that all surveyed areas scored low when compared to the BLI average database and the health care industry best practices. Therefore, all dimensions need attention.

MLK/Drew Medical Center Service Excellence Survey™ Review

Key Driver Analysis

- The Baptist Health Care Leadership Institute performed a key relationship analysis on four outcomes. The purpose is to aid in the understanding of how certain questions drive selected outcome measures. For the MLK/Drew assessment, the following outcomes were tested because they indicate commitment and dedication to the organization and have been identified as strengths of the organization. A focus on the key drivers will positively impact the chosen outcomes.
  1. Employee advocacy and willingness to recommend MLK/Drew Medical Center.
  2. Employee confidence in MLK/Drew Medical Center's leadership.
  3. Employee pride in MLK/Drew as a place to work.
  4. Overall employee satisfaction at MLK/Drew Medical Center.
- One should note that several low-scoring items are identified as key drivers of the outcome measures, such as leaders valuing everyone's opinions and suggestions, leaders leading by example, and the hospital's leadership's commitment to excellent customer service as demonstrated by their decisions and actions.

MLK/Drew Medical Staff Interviews and Focus Groups Report

Situation Overview and Method

- Qualitative research tools were used to uncover MLK/Drew Medical Staffs' perceptions of the current culture at the organization. Eight personal interviews were conducted on December 9 on the 4th floor of MLK/Drew Medical Center. Additionally, two focus groups were conducted on December 10 with a total of thirteen physicians in attendance. The personal interviews and the focus groups followed the same interview flow. The participants were recruited by Navigant Consulting, Inc.

Research Limitations

These findings are based on the opinions of a small number of respondents interviewed using qualitative techniques. The data are not statistically projectable and are best used to generate hypotheses and to develop an understanding of possible issues and concerns. Findings should be confirmed with quantitative research when necessary.

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MLK/Drew Medical Staff Interviews and Focus Groups Report

Key Findings

- Strengths of MLK/Drew that can be built upon to take the organization to a higher level:
  - Respondents were asked to identify three strengths that can be leveraged to move the organization forward. (It should be noted that some physicians hesitated, stating that it is hard to identify strengths of the organization at this point in time.)
- The following strengths were frequently mentioned both in personal interviews and in the two focus groups:
  - **Commitment and dedication to the mission** of MLK/Drew and Drew University. One group of physicians pointed out that there is a core group of committed people, about 75% of physicians and 60% of employees.
  - The **diversity** of the care providers is reflected in the patient care and there is an **understanding of the community needs**.
  - There are certain individuals that are true **champions** and bring new ideas to the table.
  - Commitment to medical residency and a good relationship with **Drew University**.
  - The **community** supports the institution. A few physicians pointed out that there is no graffiti or broken glass on the premises. The community recognizes the need for the hospital and respects the facility. It is a safe place.
  - The **next generation of medical leaders** has arrived and is committed and passionate about MLK/Drew.
  - **Location**: patients in the under-served community can walk or ride the bus to the facility.
  - **Clinical strengths** include strong surgical subspecialties, ED residency training and internal medicine.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Areas of organizational weaknesses or opportunities for improvement at MLK/Drew:
  - Themes identified when probing for opportunities for improvement at MLK/Drew included accountability, leadership, empowerment, organizational structure and planning/decision-making.
- The following issues were brought to the BLI consultants' attention:
  - Lack of permanent **leadership** that builds morale and supports employees.
  - Lack of **accountability**.
  - Lack of **empowerment**: staff is not motivated and has no say in decisions.
  - No **collaboration** among groups within the hospital.
  - Lack of **strategic planning** was cited by a few physicians as a weakness because the organization is too busy putting out fires. Additionally, the physicians believe that public opinion drives actions.
  - **Organizational structure** and **lack of local governance**. DHS was cited by many as an organizational weakness.
  - Job mentality versus career mentality - many employees are here for the paycheck. There is a **lack of service mentality**.
  - Frustrations with decisions being made without **consulting the Medical Staff**.
  - **Inbred culture**, especially physicians. This is all they know.
  - **Physician – nurse relationship**: perceptions that nurses at MLK/Drew don't care what the physician wants.
  - **Board of Supervisors – Medical Staff relationship**. Relationship colored by distrust.
  - The **public's perceptions** of the quality of care delivered at MLK/Drew / improve the image / negative publicity.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Barriers/challenges that can impact potential future success of change initiatives:
  - The selected members of MLK/Drew Medical Staff were asked to identify barriers or challenges that can impact future success of change initiatives. Common responses were accountability, re-establishing public trust, training and education of staff, politics, communication, and maintaining accreditation.
- The question produced the following feedback:
  - **Accountability**: Supervisors blame Civil Service for preventing discipline. Supervisors don't discipline staff – they never take action. According to the physicians, the organization allows poor performance and there is a lack of consequences for bad behavior.
  - Re-establishing **public trust** in the hospital. The image has been harmed through negative media reporting and it is taking a toll on employee morale. Lack of **training in service excellence behaviors**; staff doesn't know how to act.
  - Many physicians described the current culture at King Drew as a "**Culture of blamers**."
  - Lack of **positive reinforcement** and opportunity for **input** with DHS.
  - **Bureaucratic** red tape at the County level.
  - Lack of **communication** to physicians and throughout the facility.
  - **Focus on only negative issues**. The positive stories are not shared with employees.
  - Maintaining **JCAHO and CMS accreditation**.
  - **Process barriers** such as hiring practices. DHS controls staffing.
  - Loss of **pride** in working for MLK/Drew.
  - Employees are **fearful**.
  - Organization doesn't allow interchange. Very hierarchical, **top-down approach**.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Greatest challenges in providing quality customer service at MLK/Drew:
  - In order to gauge the readiness for building a culture of service excellence, the consultants wanted to identify current challenges in providing customer service at MLK/Drew.
- The question produced the following feedback:
  - Good nurses leave because they feel that no one recognizes their efforts. There is an apparent lack of staff and leader **recognition**. **Job role redesign** needed. Example was given of how physicians have to transport their own patients.
  - Lack of **training on customer service**. The physicians expressed a desire for service excellence training for both staff and physicians.
  - Staff has a **"civil service" attitude** with no feeling of permanency.
  - People not being held **accountable** was mentioned by several respondents as a major challenge in providing customer service.
  - Multiple patient **access barriers**.
  - Lack of **follow-through**. Example was given of scheduled surgery patients not called either before or after surgery.
  - Physicians and nurses must learn to show **care and concern**.
  - Some physicians noted that **communication with patients** is poor all over: front desk, clerks, etc.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Greatest challenges in providing quality customer service at MLK/Drew: (cont)
  - **Lack of County commitment** to make changes for improvement in **customer service focus**. Examples given include:
    - Outpatient pharmacy has lines that wrap around the building but the County won't expand.
    - Same-day surgical patients are placed in a crowded waiting room and made sit up until surgery. Hospital has plenty of closed units that could be made into a same-day surgery unit.
    - Respondents expressed a need for a **new CEO, COO and CNO**. The employees must have faith in these leaders and believe that they are invested in the organization's survival.
  - Lack of **organizational interest**, no one works together. It is all about "what I can do to make my day easier."

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Employee morale on a scale from 1-10 with 10 being the highest:
  - The question regarding employee morale spurred good conversation with the physicians. The message was clear and concise: employee morale is declining. Most respondents rated employee morale between zero and three on the 10-point scale.
- The following explanations were offered:
  - The employee morale is low mainly because of the **negative media coverage**. The media was accused of focusing on antidotal stories. People are not proud to say they work at King Drew. **Racial issues** were also mentioned as a reason for low morale.
  - The employee morale reflects the employee base - either very good or very bad. The morale of the good employees are brought down by the **bad employees**.
  - Some physicians stated that **lack of communication** is driving the low employee morale. Example offered was JCAHO report never being shared.
  - **Lack of a common goal** was also cited as drivers of low morale.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Physicians – nurse relationship on a scale from 1-10 with 10 being the highest:
  - Most physicians rated the nurse-physician relationship between a three and a five on the ten-point scale. Commonalities in the feedback include favoritism, issues with travel nurses, tension between medical residents and nurses, frustrations with mid-level nursing managers and a lack of alignment of Administration, Nursing and Medical Staff.
- The following specific feedback was produced:
  - Physician morale is a 3 - 4 due to **fear** of job and a fee schedule promotes a 9 to 5 mentality.
  - Nurse and PA **rounding** at the patient's bedside is lacking.
  - **Favoritism** between doctors and nurses.
  - Nurse **lack experience** from outside of King Drew. This is all they know. Expectations are not high.
  - Lack of **research involvement** is the reason many physicians leave.
  - Utilization of **travel nurses** was described as both an asset and a problem. One physician stated that travel nurses bring new experiences and have a greater work ethic. However, most of the respondents identified the travel nurses as a problem saying that they don't know where things are and do not know the system. One physician mentioned that the travel nurses do not have passwords to pull lab results and other reports and this prevents physicians in receiving the information they need to care for patients.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Physicians – nurse relationship on a scale from 1-10 with 10 being the highest: (cont)
  - **Tension** between various levels of staff. Nurses have delegated many traditional nursing functions to residents.
  - Nursing staff is hard to work with, especially for the medical interns. Physicians expressed frustrations with egos in play, especially in the **nurse – resident work relationship**.
  - One respondent stated that "**disrespect in the nurse-physician relationship goes both ways**. We have a lot of work to do in this area."
  - Physicians expressed frustration with **middle-level nursing managers**. This group was described as not being team players, turf issues, ego and a "don't tell me what to do" attitude. This group was also characterized as being less "trained" and "up to date" than younger, lower level nurses. The nurse leaders' attitudes were contributed to discouraging younger nurses.
  - There is a lack of connection and **alignment between Administration, Nursing, and Medical Staff**. Territorial situation.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Describe the desired state of MLK/Drew in year 2010:
- When probing for the desired state of MLK/Drew Medical Center, the following themes in the feedback were identified:
  - A highly-rated **comprehensive teaching and research facility** serving all with a mix of public and private patients (more insurance patients).
  - **Recruitment of top talent** and maximizes young talent.
  - An organization that gives **recognition** for doing a good job.
  - **Trauma center reopened** and 100% functional.
  - MLK/Drew affiliated with a **strong Drew University**.
  - **Community involvement**. One group of physicians pointed out that there is no graffiti or broken glass on the hospital's premises. The community respects the institution.
  - Solid **residency programs** and **JCAHO approved**.
  - A **noted leader** in providing medical care to an urban, multi-cultural population.
  - A **Center of Excellence for cultural-sensitivity training** of medical providers.
  - A facility staffed with **professional nurses, physicians and other health care providers** needed to provide safe and competent medical care to the community.
  - **"Standard of Care"** nationwide for under-served, minority populations.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- What it will take to turn MLK/Drew around and reach the desired state:
  - Physicians that were asked this questions offered a wide variety of opinions regarding what it would take to move MLK/Drew toward the desired state they had previously described. Common themes from both the personal interviews and the two focus groups include accountability, alignment, recognition, empowerment, a need for a common vision and a roadmap, and to rebuild public trust.
- The following specific feedback was produced:
  - **Accountability** and **alignment** of the organization must take place.
  - Move from interim positions to **permanent status**.
  - **Empowerment** of employees at all levels.
  - A **focus on the positive** and respond to the negative media coverage.
  - Improvement in **employee relations**.
  - **Rebuild public trust** in the institution. Many physicians recommended a marketing campaign for MLK/Drew. Others recommended that an Advisory Board be established.
  - At the County level: break County from Board of Supervisors to create objectivity. Take the **politics out of the decision-making.**
  - **Leadership** that operates independently from DHS.
  - Administration needs to send a **clear message** that they mean business and then follow through. **Need action** - no more talk.
  - The organization needs a new CEO, COO and CNO. Compliments were given to the CMO.
  - Continuous **training and education** of nurses and other clinical staff.
  - **A leadership development program** was identified as a necessity in making changes.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- In addition to the issues identified by the questions asked during interviews and focus groups, trust was repeatedly brought to the BLI consultants' attention. There appears to be a lack of trust between the Medical Staff and the Administration. According to several physicians, there has been a lot of turnover through the years and there is a strong presence of favoritism. Furthermore, respondents' comments indicate a degree of distrust within the county system and this was noted as a systematic problem. Some physicians also indicated that employees distrust the hospital administration.
- A few physicians noted that the medical issues at MLK/Drew are based on non-attentive patient care, not a lack of equipment, medications, etc. Other comments indicate that there is a perception that the current Board of Supervisors is not involved and that "everything is politically motivated." A few physicians stated that they think a lot of the negativity is racially motivated. One group of respondents pointed out that there are three cultures that need to change, namely the DHS, the Board of Supervisors and MLK/Drew Medical Center. Frustrations were expressed during interviews and focus groups that the Board of supervisors treats King Drew as a "step child." Furthermore, claims were made that DHS puts King Drew under scrutiny and holds the facility to a higher standard than other county hospital.

MLK/Drew Medical Staff Interviews and Focus Groups Report

- Many physicians stressed that Navigant has to create an infrastructure with good leadership and support. It was noted that there are many good employees at MLK/Drew and that their contributions should not be lost. The hospital was described as being demoralized and degraded. Several physicians expressed a deep frustration with the current situation and commented that there has never been a bottom this low.
- It was emphasized that the low employee morale might be Navigant's greatest challenge in moving the organization forward. Low morale is not a new concept at MLK/Drew. Low employee morale has been a problem at MLK/Drew for some time according to the Morale Pre-Test Survey that was conducted in the late 1990s. The pretest shows that 100% of the respondents stated that there were morale problems at King Drew Medical Center. The main reasons selected as drivers of low employee morale were "Promotions based on whom you know, not performance," "Favoritism" and "Lack of appreciation when a good job is done." The findings from BLI's qualitative research confirm the findings in the late 1990s Pre-Test Survey.

MLK/Drew Medical Center Focus Groups Report

Situation Overview and Method

- Qualitative research was utilized to identify current strengths and opportunities for improvement at work in the present culture at MLK/Drew. The objective was to assess the organization's culture and gauge its present status of readiness for making improvements. A total of six focus groups were held on December 9 and 10 at various MLK/Drew Medical Center locations. The respondents in all six groups were recruited by Navigant Consulting, Inc. based on random payroll selection. Respondents were qualified for three types of groups: Non-clinical staff, Clinical staff and Department Directors. The sessions were approximately one hour long and they were audio taped for reporting accuracy. Interview flow:
  - Welcome and Introductions
  - Descriptions of MLK/Drew work environment
  - Feedback on selected areas/competencies related to organizational culture
  - Perceptions of current organizational strengths
  - Perceptions of current organizational weaknesses
  - Closing comments

Research Limitations

These findings are based on the opinions of a small number of respondents interviewed using qualitative techniques. The data are not statistically projectable and are best used to generate hypotheses and to develop an understanding of possible issues and concerns. Findings should be confirmed with quantitative research when necessary. Focus Group research is best used as a problem detection tool.

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MLK/Drew Medical Center Focus Groups Report

Key Findings

- During the introductions, participants were asked to describe what it is like to work at MLK/Drew Medical Center. The following responses represent common themes in the feedback produced:
  - Overall, the groups reported that the environment at MLK/Drew is challenging. Most agreed that there are issues and concerns that must be addressed to move the organization forward.
  - Employees seem to believe that the services provided impact the patients, their family and the community at large. There is a strong sense of commitment to serving the needs of the diverse and under served community.
  - There is an apparent lack of communication between employees, departments and levels of the organization.
  - Many participants expressed frustrations with inconsistency in management and favoritism.
  - It was emphasized that a majority of the employees are dedicated to the hospital and the community it serves; however, poor and inconsistent management and frequently changing policies and procedures cause frustrations and have a negative impact on the morale.
  - The recent negative publicity is impacting employee morale.
- The next step on the focus group agenda was to solicit the respondents' impressions of the current culture at MLK/Drew through a voting process focused on organizational competencies. Respondents were asked to use the following voting cards: Green Card = Doing Great, Yellow Card = Doing Okay, Red Card = Needs Work. The votes were tabulated for all six groups and the colors were assigned scores from one to three. A lowest scoring area would be the one in need of immediate improvement. The scores are shown on the following page.

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MLK/Drew Medical Center Focus Groups Report

Area	Non-Clinical Staff Scores	Clinical Staff Scores	Director Scores	TOTAL
Teamwork	23	19	29	71
Communication	21	13	33	67
Leadership Effectiveness	23	19	31	73
Embracing Change	29	16	19	64
Prioritizing/Planning	21	16	14	51
Staff Recognition	14	11	13	38
Accountability	19	15	24	58
Customer Service	30	14	14	58

- When reviewing the scores it is important to note that qualitative research is not statistically valid. BLI uses this methodology to identify common themes of opportunities for improvement. Staff Recognition was agreed upon to be a deficit area for the organization followed by Prioritizing/Planning, Accountability and Customer Service.
- Each competency area was discussed after the vote was taken. The findings are reported per type of focus group. Each focus group type had two groups to allow for comparison of findings. The feedback reported is based on commonalities in the responses from the focus group and the comparison group.

MLK/Drew Medical Center Focus Groups Report

Clinical Staff

Teamwork

- Teamwork is affected by the low morale of the organization's employees.
- Employees only work together when there is a crisis. People are reactive versus proactive.
- Teamwork is lacking on a continuous day-to-day basis.
- Some employees are not team players.
- Trustworthiness between employees is an issue affecting teamwork.
- Teamwork is lacking in certain committees/groups and across departments.
- There are territorial problems within departments that affect teamwork.

MLK/Drew Medical Center Focus Groups Report

Communication

- Employees do not receive adequate information to perform job duties and create a sense of belonging to the organization.
- Revision of policies and procedures are not communicated in a timely manner.
- Communication only travels downward, if at all.
- Information in the organization is non-inclusive. It is not shared.
- Patients are getting repeat tests because of conflicts in doctors' order/communication.
- Lab tests/reports are not available when needed.
- Communication is lacking between departments.
- There is a lack of communication in the organization. Employees hear about problems in the organization from outside sources.
- Former CEO delegated time to speak with employees. Leaders must be more visible.
- Employees are not informed about newcomers. They simply show up in your department without any introduction.
- Regulatory agency reports are not shared.
- Access to information is limited.

MLK/Drew Medical Center Focus Groups Report

Leadership

- Secretive organization where leaders do not share information.
- Lack of role models. Nurses are not nurtured to grow or improve.
- Punitive, retaliation, and favoritism were used to describe the organization's dominant leadership style.
- Leaders lack professionalism.
- There is a need for leadership development.
- Employees have limited interaction with top leaders.
- Some leaders are good and others are not - inconsistency in practices.
- Most of the leaders are approachable but some do not follow through with employee concerns.
- Lacking stability in the leadership.

MLK/Drew Medical Center Focus Groups Report

Embracing Change

- Staff feels anxious when things change. There is a resistance to change among a majority of staff members.
- Employees that have been with the organization fear change, but new comers acknowledge the need for change.
- Some employees want change and recognize the need for change, but previous initiatives have not gone well.
- Employees believe they have no control over change.
- Fear of losing ones job contributes to the resistance to change.
- Changes are not being communicated to the employees.
- Leadership does not embrace change.
- Implementation of change takes too long. There are no “quick wins” to celebrate.

MLK/Drew Medical Center Focus Groups Report

Prioritizing and Planning

- Patients should be the priority, but because of other demands and lack of teamwork, patients come last.
- Everything is a crisis. There is no planning involved. Priorities are based on what is going on at the moment. The organization is reactive versus proactive.
- There is a shortage of staff and the organization needs a system to prioritize patients.
- Employees are not educated on the organization's goals. Hard to set individual priorities that align with the organization's priorities.
- Lack in consistency and alignment of goals in the organization.

Staff Recognition

- The organization does not have adequate recognition programs.
- Leaders are not concerned with retention and thus do not recognize the staff.
- Nurse recognition program was developed two years ago but employees are unsure if it's still in progress.
- Lack of recognition of employees that deserve it fuels low morale.

MLK/Drew Medical Center Focus Groups Report

Accountability

- The organization has a serious problem with the attendance of its employees.
- Employees see it as a waste of time to write up or discipline because there is no support from the supervisors or HR.
- Poor performance is accepted. Leaders make excuses for people not doing their job. Examples of excuses include "family problems" or "can't work on that unit because they do not get along."
- Employees are not held accountable for mistakes and no coaching takes place.
- Lack of respect in organization.
- The organization lacks a discipline system.

MLK/Drew Medical Center Focus Groups Report

Customer Service

- Customer service is lacking in certain departments. There is no consistency or organization-wide service program.
- The organization is too rigid. Focuses only on the patient and not on the family or visitors.
- The organization does conduct patient satisfaction measurement. Patients' comments are used to recognize employees; however, this practice is isolated to a few areas of the organization. Some departments measure patient satisfaction monthly; however, the results are not analyzed or shared.
- Customer service needs improvement throughout the medical center.
- We need a better system to measure patient satisfaction throughout the medical center.
- Employees lack friendliness to patients/visitors/families

MLK/Drew Medical Center Focus Groups Report

Non-Clinical Staff

Teamwork

- Everyone does not pull his or her own weight within the team.
- A culture of “one man's decision”; no teamwork in the organization.
- Teams are not effective because of weak team leaders.
- Too many people left out of the decision making process.
- Teams need to be formed randomly and not by friendship bond.
- No training/mentoring provided to educate employees on effective teamwork.

MLK/Drew Medical Center Focus Groups Report

Communication

- Lack of communication between departments and throughout the organization.
- Problems and decision making is not shared.
- Employees expressed frustrations around “freedom of speech.”
- Employees are punished for speaking their opinions.
- Lack of efficiency because the organization has too many secrets.
- Policies are shared in the organization; however not timely and consistently.
- Negative information is not shared in the organization.
- Communication only goes down the ladder and not up the ladder.
- Message bulletins are used to communicate changes of issues.
- Important information comes late to employees.

MLK/Drew Medical Center Focus Groups Report

Leadership

- Leaders are not held accountable for negative situations.
- Promotions are given to employees that do not have adequate training.
- Well-trained employees are deprived of promotions because of favoritism in top management.
- Leaders do not associate with lower level workers.
- Lack of strong leadership.
- Employees are unsure about what is going on with the top management.
- Employees are afraid to express concerns to top management.
- Punitive style leadership is dominant.

MLK/Drew Medical Center Focus Groups Report

Embracing Change

- The organization is generally receptive to ideas for change.
- Managers and supervisors are close-minded.
- Organization went four years without evaluations and there is a resistance to behavioral modification changes.
- Resistance to looking at organization's problems.
- Frustration escalates because changes are happening too fast.
- A system needs to be developed to plan and initiate change.
- Policy changes are not working.
- Problems are not being heard by top management. No communication from bottom-up.
- Changes that do take place need evaluation. How do we know it works?

MLK/Drew Medical Center Focus Groups Report

Prioritizing Planning

- Goals are not communicated between departments and administration.
- Administrative priorities are not aligned with other department priorities.
- A system to prioritize goals needs to be implemented.
- Priorities are not firm and are often set but not completed. Lack of accountability.

Staff Recognition

- Good employees are not being recognized for their hard work and efforts.
- Appraisal and profitability process is not efficient.
- Some employees are recognized by mail or email but not consistent and aligned.
- No formal committee to recognize and reward employees.
- Good employees are not promoted.
- No incentives for excellent work.
- Promotion submissions are always delayed.

MLK/Drew Medical Center Focus Groups Report

Accountability

- Overall a lack of accountability.
- No support from top management for disciplinary actions.
- Employees believe disciplinary actions take up too much time and paperwork.
- Employees that make mistakes are not held responsible.

Customer Service

- Patients are not getting adequate care because of a shortage of staff.
- Resources are limited.
- Lower level workers do not understand how actions impact patients.
- Need to focus on implementing patient satisfaction surveys.
- Need to emphasize customer service.
- Customer comments are put in employee evaluations.

MLK/Drew Medical Center Focus Groups Report

Department Directors

Teamwork

- Lack of teamwork between departments in the organization.
- Organization does not work as a team to achieve goals.
- Some employees lack teamwork skills. There is no training.
- Teamwork should be demonstrated daily not only in crisis situations. Very reactive versus proactive.
- Teamwork is effective in certain departments. Not aligned throughout the organization.
- No support system for the teams.
- Departments are territorial and are hesitant to work with other departments. System of “favors exchange.”

MLK/Drew Medical Center Focus Groups Report

Communication

- Information is not shared throughout the organization.
- Both positive and negative news is gained from outside sources.
- Concerns stop at manager and director level when they should go to top management.
- Information is not kept consistent and the communication changes constantly.
- Lack of communication technology. Most employees do not have internet/email access.
- Information is not delivered to employees in a timely manner.
- Goals of organization are not communicated effectively.
- The organization needs improvement in communication skills.

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MLK/Drew Medical Center Focus Groups Report

Leadership

- Direction of goals is not clear in the organization.
- Lack of stability in leaders.
- Top leaders focus on favoritism.
- Leaders do not interact with front-line employees.
- Leaders do not "walk the talk.“
- The organization does not have a formal leadership development program.

Embracing Change

- Change initiatives are not clear.
- The organization implements too many changes at once.
- Changes are too frequent and employees cannot keep up.
- Employees fear to speak up about changes because they are afraid of the top leader’s reaction.

MLK/Drew Medical Center Focus Groups Report

Prioritizing and Planning

- Lack of consistency in prioritizing goals/plans of the organization.
- Needs a system of prioritization.
- Conflicting priorities

Staff Recognition

- The organization does not have adequate recognition programs.
- The leaders do not have resources to use for recognition programs.
- Lack of recognition drives low employee morale.

Accountability

- Employees are not held responsible for mistakes.
- Employees' attendance and tardiness is a major issue.
- Disciplinary actions do not taken place when needed.
- A system of "favors."

MLK/Drew Medical Center Focus Groups Report

Focus Groups Conclusion of Findings

- Respondents across the six groups generally agreed that working at MLK/Drew is challenging. Most also agreed that there are many issues and concerns that must be addressed to move the organization forward. There is a strong sense of commitment to serving the needs of the diverse and medically poor community; however, the recent negative publicity is impacting employee morale. Lack of staff recognition is a major concern identified throughout the groups of respondents. According to several respondents, employees are not recognized for their hard work and good employees are not promoted. There is no formal recognition program in place at MLK/Drew.
- Another area of concern is prioritizing and planning. The organization's tendency to be reactive versus proactive was a common theme identified throughout the groups. One employee linked this phenomenon to teamwork when she stated, "employees only work together when there is a crisis - we are very reactive, always putting out fires and we have little time for planning ahead." Other areas of concern identified through the focus groups were the lack of accountability and the lack of a customer service focus. The organization has issues concerning employee attendance, accepting poor performance, and what many employees referred to as a "culture of finger pointing." Customer service needs improvement throughout the medical center and it will require strong leadership that "walks the talk" combined with empowered and engaged employees.

MLK/Drew Medical Center Personal and Phone Interviews Report

- In addition to Medical Staff, nine personal and phone interviews were conducted with DHS leaders, Drew University leaders, Union representatives and community leaders. The themes identified during the interviews are as follows:

1. Three areas of organizational strength that can be leveraged to improve MLK/Drew and take the organization to the next level:
   - Strong sense of mission, commitment and dedication to serving the community.
   - Medical education through Drew University.
   - History of community activism that creates a feeling among people that they are all in this together.
   - A patient population that needs the facility and has a desire to believe in MLK/Drew.

2. Three areas of organizational weaknesses or opportunities for improvement at MLK/Drew:
   - Lack of trust between the County, Drew University, MLK/Drew and within the hospital itself.
   - True leadership is absent. Lack of direction and avoidance of decision-making.
   - No leadership development program in place to support managers.
   - Lack of accountability and clear behavioral expectations resulting in low morale and poor customer service.
   - A reactive environment versus proactive.
   - A culture of excuses and corruption (employees exploiting the system.)
   - Lack of formal communication systems.
   - Lack of education to increase skill level of clinical staff

MLK/Drew Medical Center Personal and Phone Interviews Report

3. Barriers / challenges that can potentially impact the success of change initiatives:
   - Change leaders, culture leaders, intellectual leaders are not engaged to reinforce MLK/Drew's mission.
   - Employee incentive system
   - Politics and hidden agendas
   - There is a great deal of distrust
   - Centralized control
   - Promotions and hiring is based on whom you know, not merit.
   - Culture of excuses, finger-pointing, and lack of accountability.
   - Lack of bilingual nurses and doctors to meet the needs of the patients and their family members.
   - Rating of current employee morale on a scale from 1 - 10, with 10 being the highest:
   - The interviewees rated the employee's morale very low with most giving it a score of one.
   - One interviewee stated that the low morale will be Navigant's greatest challenge and that it will be crucial to identify nurses, physicians and others to serve as internal champions.
   - The low morale was attributed to lack of training and development of mid-level managers, the recent negative publicity, the CMS review, the JCAHO threat and the closing of the Trauma Center.

MLK/Drew Medical Center Personal and Phone Interviews Report

4. Rating of current employee morale on a scale from 1 - 10, with 10 being the highest:
   - The interviewees rated the employee's morale very low with most giving it a score of one.
   - One interviewee stated that the low morale will be Navigant's greatest challenge and that it will be crucial to identify nurses, physicians and others to serve as internal champions.
   - The low morale was attributed to lack of training and development of mid-level managers, the recent negative publicity, the CMS review, the JCAHO threat and the closing of the Trauma Center 5. Rating of the physician - nurse relationship on a scale from 1 - 10:
   - The interviewees rated this item highly variable with rating between one and seven.
   - One interviewee stated that each physician has identified certain nurses they trust.
   - Another interviewee said that those who are honest are frustrated about what they see and those who are "corrupt" are frustrated because they see change coming.
   - Nurses have a "whatever" attitude. There is a culture of "It's not my fault."

5. Rating of the physician - nurse relationship on a scale from 1 - 10:
   - The interviewees rated this item highly variable with rating between one and seven.
   - One interviewee stated that each physician has identified certain nurses they trust.
   - Another interviewee said that those who are honest are frustrated about what they see and those who are "corrupt" are frustrated because they see change coming.
   - Nurses have a "whatever" attitude. There is a culture of "It's not my fault."

MLK/Drew Medical Center Personal and Phone Interviews Report

6. Describe the desired state of MLK/Drew in year 2010:
   - Teaching and operational research facility with multi cultural (diversity) populations - a model of the future American hospital
   - A culture of ownership and excellence in clinical quality and customer service.
   - Training center focused on the advancement of employees.
   - High quality, full service teaching hospital geared toward meeting the needs of the community.

7. What it will take to turn MLK/Drew around and reach the desired state:
   - Provide basic nursing care
   - Assistance from Navigant to produce results
   - Decentralized control - more authority at the operational level
   - Strong, sustained leadership that is visible in the organization
   - Political change in leadership. The public and private sector will need to come together to turn the hospital around.
   - Restore public trust in the hospital
   - Restructure the recruitment processes to hire qualified and skillful staff.
   - Radical overhaul of the management system.
   - Comprehensive staff training programs

MLK/Drew Medical Center Personal and Phone Interviews Report

Conclusion

- There is a strong history of commitment and dedication to serving the community at MLK/Drew Medical Center. Furthermore, there is a strong sense of "togetherness" and desire to keep the hospital's doors open to the under served population. Throughout the interviews it became clear that one has to identify internal champions for change initiatives. Opportunities include leadership development, accountability, staff education, HR processes, restore public trust and organizational communication. Potential barriers to the success of change initiatives include distrust, centralized control, politics and perhaps the greatest challenge - improving employee morale. The desired state of the organization is a model of the future American hospital - a diverse teaching facility with a culture of service and operational excellence serving a multi-cultural, medically poor population.

MLK/Drew Medical Center First Impressions Audit

- As part of the situational analysis the Baptist Leadership consultants walked through the facility during the three-day site visit to ascertain 1) the overall ambiance of the organization, 2) the interactions between employees and with visitors, and 3) the general appearance of the facility.

Overall Ambiance

- The general atmosphere of the hospital was welcoming and friendly. There was a great deal of interactions between patients, visitors and employees. The facility was busy but did not seem chaotic.

Employee Interactions

- Throughout the facility employees were for the most part friendly. Employees were smiling and interactive with colleagues as well as visitors. There was almost always a hallway greeting of hello as the consultants toured the facility. Of note was an employee, Rhonda, who offered to assist the consultants in locating a taxi. She walked the consultants outside, waited for the taxi to arrive and offered advice on where to dine. She was warm, friendly and sincere in her efforts to assist. Rhonda, on duty at the Information Desk, welcomed the consultants each morning and asked about their stay in Los Angeles.

MLK/Drew Medical Center First Impressions Audit

- The consultants also experienced a patient who was in the administration office to share his experiences at King/Drew. As the consultants waited, they heard the gentleman tell the receptionist of the excellent care he had received as a patient. He mentioned the care he had experienced at another facility did not match the care at King Drew. He was concerned with the recent LA Times articles and wanted the hospital to know that he appreciated the services he had received. The receptionist thanked the gentleman and asked if he would be willing to write a letter describing his experiences.
- A visit to the nursing office left a less favorable first impression. The office personnel were found to be unfriendly and unwilling to assist the consultant in locating the nursing supervisor. There were visible signs of being inconvenienced, such as sighing, when the consultant asked for assistance. After being told to come back in 15 minutes, the consultant returned only to be told to come back in another 15 minutes. After three attempts to get assistance, the consultant left to begin touring the medical floors. The consultant experienced the same lack of assistance on the Telemetry Unit and the Medical Unit. Several inappropriate conversations were overheard including comments by staff about a patient's death that was conducted in a public area where the patient's family could overhear the comments. Also overheard was a family members request for Vaseline for her son's dry lips. The family member was told she had to wait until the nurse assessment later in the day.

MLK/Drew Medical Center First Impressions Audit

- While waiting for the elevator, the consultant noticed a gentleman carrying a large cart filled with trash who was also waiting. He became frustrated with the delay for the elevator and loudly used profanity before he walked away.
- Interactions with several of the nursing leaders were positive. The consultant received comments such as “Can I pick your brain?”, “I hope you can help us, we really do have a good facility” and “The community needs us.” The consultant also heard comments such as “It’s impossible to fire staff,” “I can’t work 24 hours a day” and “I don’t answer my phone after long days.”

General Appearance of the Facility

- The grounds and overall appearance of the facility was fairly good. There did not appear to be trash on the grounds or inside the facility and most of the public areas were clean and neat. Upon first arriving at the hospital the consultant noticed a trail of fresh blood in the main reception area. Further down the hall, near a bank of pay phones, there was a small pool of fresh blood. An hour later, the consultants revisited the area to find the floor had been cleaned. The appearance of the clinical areas was worn. Many of the corners had a build up of dust, there was dust in the vents and some areas were odoriferous. There was clutter in the hallways of several of the clinical units. Several units had bulletin boards that contained helpful patient information. It was also noted that there were many signs posted beginning with the phrase, “DO NOT . . . ”

Measurement and Tracking

- The establishment of a Results Management Office (RMO) provides the disciplined process and structured tracking and measurement critical to successful implementation of the Implementation Plan.

<u>The Implementation Plan</u>

- Each of the sections of the Implementation Plan have identified Recommendations and an executive who is responsible for ensuring the overall implementation.
- Each Recommendation has a Workplan that was developed in collaboration with key KDMC Leadership. Workplans were finalized including accountabilities and due dates.
- Each Recommendation was reviewed and identified as requiring the following:
  - Human resource support
  - New personnel needs (or filling of a vacant position)
  - Education or training needs
  - External resource needs
  - Information technology enablement
  - Equipment needs
  - Facility changes

Measurement and Tracking

- The Recommendations were also reviewed against recommendations or deficiencies for CMS, JCAHO, and ACGME to ensure comprehensiveness.
- The Workplan components include:
  - Time frame for each Recommendation
  - Action Steps
  - Accountable person for each Action Step
  - Due date for each Action Step
  - Required technology/equipment needs
  - Implementation risks identified
- The Workplan should be considered a “living” plan. Recommendations may be added or updated to reflect changes in course deemed appropriate. Timelines however, will not be changed without agreement of the CEO and COO.

Measurement and Tracking

- Number and timeframe of Recommendations summarized by Section:

Section	Section Description	Sub-Section	Sub-Section Description	Urgent	Short-term	Intermediate	Long-term	N/A	Total
1	Introduction								
2	General Ops/Org Structure	1	Governance	5	5	4			14
		2	Management/Structure	6	9				15
		3	Risk Management	2	13	5	1		21
		4	Regulatory	16	7				23
		5	Performance and Quality Improvement	9	43	2			54
		6	Infection Control	15	10				25
		7	Budget		2	6	3		11
		8	Productivity	2	5				7
		9	Space Planning	3	1	1			5
		10	Environment of Care	6	8				14
		11	Facilities Management	1	5	3	1		10
		12	Materials Management	1	12				13
		13	Contracted Services	6	8	1			15
	General Ops/Org Structure Total			72	128	22	5	-	227
3	Clinical Organization	1	Case Management and Utilization	4	25	13	4		46
		2	Capacity and Throughput	11	20	4	1	12	48
		3	Emergency Services	4	34	11	6		55
		4	Perioperative Services	13	23	8			44
	Clinical Organization Total			32	102	36	11	12	193
4	Medical Administration Total			14	17	54	35		120
5	Nursing Services Total			13	33	27	2		75
6	Psychiatric Services Total			18	19	6			43
7	Information Technology Total			4	10	4			18
8	Health Information Management Total			21	38	6	3		68
9	Human Resources Total			8	16	5			29
10	Ancillary Services	1	Radiology	7	13	3			23
		2	Laboratory/Pathology	21	26	4	4		55
		3	Pharmacy	19	5	1	6		31
		4	Electrodiagnostics					21	21
	Ancillary Services Total			47	44	8	10	21	130
11	Ambulatory Services Total							100	100
12	Programs and Services Total							49	49
Grand Total				**229**	**407**	**168**	**66**	**182**	**1,052**

NAVIGANT CONSULTING

Measurement and Tracking

- Sample Workplan

Section:	II - General Operations/Organizational Structure
Initiative:	II.9. Space Planning
Initiative Lead / NCI:	L. McAuley
Initiative Lead / KDMC Mgmt:	L. McAuley
Initiative Lead / KDMC:	M. Henderson
Status Update Through:	2/1/05
Overall Initiative Status:	Enter overall intiative status/comments here.

Workplan

Time Frame	Rec. #	Recommendation	Action Step #	Action Steps	Accountable Person	Due Date
Urgent	2.9.01	Develop a comprehensive summary of facilities needs and issues (by department) and prioritize them.	1	Complete listing of needs through surveying of each department	M. Henderson	3/1/05
Urgent	2.9.01	Develop a comprehensive summary of facilities needs and issues (by department) and prioritize them.	2	Develop initial prioritization based on Urgency and timing - Supportive of strategic goals - Life safety corrections - Return on investment potential - Improved functional/operational efficiency - Patient comfort/confidentiality - Quality improvements - System breakdown avoidance	M. Henderson	3/30/05
Urgent	2.9.01	Develop a comprehensive summary of facilities needs and issues (by department) and prioritize them.	3	Present to Committee for input and approval	M. Henderson	4/15/05
Urgent	2.9.01	Develop a comprehensive summary of facilities needs and issues (by department) and prioritize them.	4	Develop timelines, cost estimates and plans for each approved initiative	M. Henderson	5/15/05
Urgent	2.9.01	Develop a comprehensive summary of facilities needs and issues (by department) and prioritize them.	5	Inititiate projects, monitor progress, and report to Committee as appropriate	M. Henderson	6/15/05
Urgent	2.9.02	Identify critical space requirements and implement remediation plan for areas such as outpatient pharmacy.	1	Create short list based on patient/employee safety	M. Henderson	2/2/05
Urgent	2.9.02	Identify critical space requirements and implement remediation plan for areas such as outpatient pharmacy.	2	Identify solutions and approach for relocation/remediation	M. Henderson	2/7/05
Urgent	2.9.02	Identify critical space requirements and implement remediation plan for areas such as outpatient pharmacy.	3	Develop timeline and monitor progress toward solution of critical needs for relocation/remediation	M. Henderson	2/28/05

NAVIGANT CONSULTING

Measurement and Tracking

Measurement of Plan Execution

- Each of the Action Steps will be reviewed at their due date to ensure completion.
- Any Action Steps that are not achieved will be 'flagged' and a remediation plan will be identified and executed.

Measuring Outcomes

- Each of the sections identifies Performance Measures to objectively measure progress toward performance targets.
- A plan will be created to prioritize the rollout of these measures based on the timing of the Action Steps, importance and data availability.
- An organizational compass will be developed consisting of key indicators for the overall plan. In addition there will be compasses for specific areas, i.e. Perioperative.
- NCI will identify and train personnel in project management, measurement and monitoring and integrate RMO responsibilities to the organization.

Measurement and Tracking

Tracking Progress

- A “master” Workplan will be maintained within RMO.
- Progress on implementation of the Action Steps will be tracked and rolled up at multiple levels:
  - Roll up by Section;
  - Roll up by Time Frame;
  - Roll up by Accountable Person;
  - Roll up by Recommendation

- Sample status update roll up by Section:

KDMC Workplan Status Update Through 2-11-05

Section	Sub-Section	Status Update	Overall Status
III - Clinical Organization	III.1. Case Management and Utilization		Yellow
	III.2. Capacity & Throughput		Green
	III.3. Emergency Services		Yellow
	III.4. Perioperative Services		Yellow
	III.5. Transportation		Green

Sample Format:
The “overall status” do not reflect actual status.

NAVIGANT CONSULTING

Measurement and Tracking

- Sample status update roll up by Time Frame:

KDMC Workplan Status Update Through 2-11-05						
		% of Completion by Time Frame				
Section	Section Description	Urgent	Short-term	Intermediate	Long-term	Total
2	General Ops/Org Structure Total	64%	43%			45%
3	Clinical Organization Total	56%	55%			35%
4	Medical Administration Total	50%	44%			
5	Nursing Services Total	75%				
6	Psychiatric Services Total	65%				
7	Information Technology Total	58%				
8	Health Information Management Total	80%				
9	Human Resources Total	75%				
10	Ancillary Services Total	79%				
11	Ambulatory Services Total	55%				
12	Programs and Services Total	45%				
Grand Total		**50%**	**45%**	**30%**	**10%**	**27%**

Sample Format:
All numbers are random.

NAVIGANT CONSULTING

Measurement and Tracking

- Sample status update roll up by Accountable Person:

KDMC Workplan Status Update Through 2-11-05							
			% of Completion by Time Frame				
Accountable Executive	Accountable Director	Status	Urgent	Short-term	Intermediate	Long-term	Total
Cohen	Gray		75%	45%			
Cohen	McClure		75%	60%			
McAuley	Meade		70%				
McAuley	Henderson		78%				
Peeks MD	Kaiser MD		65%				
Price	O'Rourke		60%				
Price	Finley		54%				
Grand Total			**50%**	**45%**	**30%**	**10%**	**27%**

Sample Format:
All numbers are random.

NAVIGANT CONSULTING

Measurement and Tracking

- Sample status update roll up by Recommendation:

KDMC Workplan Status Update Through 2-11-05

Time Frame	Rec. #	Recommendation	Risk Identified? (Yes/No)	Status (Red/ Yellow/ Green)
Intermediate	2.1.01	BOS should continue to explore the feasibility of creating a Health Authority to govern the entire County health system.	Yes	Red
Urgent	2.1.02	BOS, DHS, KDMC and Drew University should publicly reaffirm their commitment to the joint goal of creating and sustaining a tr… common clinical and academic missions	No	Yellow
Urgent	2.1.03	BOS should immediately designate the … for oversight of KDMC, including the responsibility to oversee the clinical and educational programs of KDMC, reporting to the Supervisors on at least a quarterly basis.		reen
Urgent	2.1.04	BOS should delegate to the KDMC Advisory Board the authority to act as the governing body for all functions required in JCAHO, CMS & licensure regulations.	No	Green

Sample Format:
The "overall status" do not reflect actual status.

NAVIGANT CONSULTING

Measurement and Tracking

- Three sub groups composed of select KDMC, DHS, and LAC will meet regularly to support completion of the Action Steps.
  1. Human Resources
  2. Facilities and Equipment
  3. Technology
- The Human Resource Group will assist with the following:
  - Performance evaluation and management process
  - Management training and organizational development
  - Monitoring of regulatory compliance
  - Employee relations including grievance remediation
  - Recruitment and retention
  - Provision of operating report and data
  - Development of KDMC policies and procedures
  - Classification
- The Facilities/Equipment Group will assist with the identification, planning and implementation of facility changes. This group will also identify and expedite acquisition of specific equipment needs.
- The Technology Group will support and coordinate technology required to execute the plan. In addition, the group will assist in the tracking of the performance measures.

Measurement and Tracking

Oversight

- Status updates will be reviewed with KDMC senior staff every other week. This group will provide the oversight and management of the plan.
- This group will also serve as a discussion forum for interdependencies and synchronization of Action Steps in the Workplan.
- They will review all performance variance in Actions Steps due that week for completion and discus risks and issues with future Actions Steps.
- Monthly Performance Measures will be reviewed and discussed.
- Status updates will be reported to the newly created KDMC Governing Board and the Board of Supervisors monthly, and will include the following:
  1. Overall status of progress by Section.
  2. Measurement of Key Performance Measures.
  3. Areas of performance variance and corrective action plans.
  4. Identification of implementation risks.