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September 13, 2004

TO: Each Supervisor

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

SUBJECT: KING/DREW MEDICAL CENTER RESTRUCTURING

I am writing with regard to the restructuring of operations at King/Drew Medical Center (KDMC). As you know, in December 2003, the Department of Health Services (DHS) assigned a team of senior managers to take over day-to-day management of the hospital and develop and implement structural and operational reforms to its operations.

Progress has been made in many areas, such as instituting a clear management structure, implementing and monitoring new practices and protocols related to patient care, assessing and strengthening the skills competency of nursing staff, improving management of human resources activities, initiating improved billing and revenue management practices, and restructuring plant management operations. In their reviews of the hospital, both the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) have recognized and commented on the forward movement by the hospital.

These improvements notwithstanding, however, KDMC is far from "fixed". The hospital continues to experience clinical problems even as changes are implemented. Despite consistently noting the progress that has occurred, both CMS and JCAHO have made clear their concern about the sustainability of the Department's efforts and its capacity to continue moving forward to ensure a stable, safe clinical environment throughout the hospital at all times.

CMS has proposed entering into a Memorandum of Understanding (MOU) with the County that would include a number of additional elements to support DHS' efforts. I

am providing the following information to clarify the actions the Department is recommending to continue implementing and achieving this goal.

Background

KDMC was opened in 1972 to provide hospital inpatient and outpatient services to a community that long lacked access to health care services. The hospital has 513 licensed beds, 233 budgeted beds and close to 250 physicians in training. The 26-acre site includes an acute care hospital, pediatric pavilion, trauma center, mental health center, dormitory for resident physicians, and a services and supplies building. In addition to the main campus, KDMC administration is responsible for the operation of Hubert H. Humphrey Comprehensive Health Center and Dollarhide Health Center.

KDMC plays a vital role in the community both as a resource for health care and, with 2,900 employees, as a major employer in the area. KDMC is located in the South Service Planning Area (SPA 6), which has the highest rate of poverty in the County, with approximately 61 percent of the population living below 200 percent of the federal poverty level; compared to 39 percent County-wide. SPA 6 also has the highest rates of uninsurance, with 36 percent of non-elderly adults and 18 percent of children having no health insurance. Nearly one million people live within a five-mile radius of KDMC. Of these, 65 percent are living below 200 of the federal poverty level and 39 percent are uninsured.

Additionally, the community around KDMC has changed dramatically since its opening in 1972. At that time, African-Americans accounted for more than 80 percent of the population. Today, that percentage is less than 40 percent. During the same period, the Latino population grew from 12 percent to near 60 percent. Since KDMC is a vital part of South Central Los Angeles, the community's changing demographics have impacted the hospital both in the ethnic composition of its employees and patients.

Short-Term Changes

In the midst of this tremendous clinical need is a hospital in crisis. KDMC is facing significant clinical and operational problems that have led to threatened actions by the federal government and a national accrediting organization that could result in its closure. The Department must continue and build upon the efforts that already have been initiated to restructure operations. The proposed MOU with CMS provides the time and support to accomplish this.

The engagement of a contractor, as delineated in the CMS MOU, will provide the opportunity to establish a sustained effort over the next 12 months, as well as the infusion

of experts in a broad range of areas of particular importance, such as clinical resource allocation, physician organization and competency assessment, clinical productivity measurement, and organizational structure and effectiveness. This will relieve the staff from across DHS who have been increasingly drawn away from their regular responsibilities to support the KDMC restructuring effort.

Specifically, the consultant or outside management company would be responsible for:

- Assuming operational management of the Medical Center, under the supervision and direction of the Department.

- Continuously monitoring all major hospital systems on site, including reviewing, studying, monitoring, and reporting on all of the high priority concerns identified in the CMS Statement of Deficiencies.

- Making recommendations concerning all of the changes to KDMC's structure that it determines necessary to ensure consistent operations that produce dependable, safe, and high quality health care service throughout the hospital and advising and assisting in the implementation of recommendations adopted by the Department.

- Evaluating the governance, leadership, and competency of staff, including medical staff, nursing staff, and all health care professionals, proposing recommendations for improvement, and advising and assisting in the implementation of recommendations adopted by the Department.

- Evaluating labor-management issues, proposing recommendations to address such issues, and advising and assisting KDMC in hiring and retaining competent professional staff.

- Assessing operating procedures and operating systems, allocation of resources, recommending reforms, and advising and assisting in the implementation of recommendations adopted by the Department.

- Proposing recommendations to reduce emergency room diversion rates and generally improve capacity to provide appropriate access to care and delivery of quality care to the community and advising and assisting in the implementation of recommendations adopted by the Department.

The contractor also will be required to provide an initial written report that clearly describes the areas that require corrective action and provides a comprehensive plan to address each issue with anticipated timeframes for completing the remediation.

The short-term goal – within one year – is to restructure the clinical configuration of services at KDMC to allow for the safe management of patients and to set the stage for the long-term goal, as described by the Task Force on Graduate Medical Education (Satcher Task Force), of establishing a center of excellence for multicultural public health and medicine.

External accrediting bodies and internal DHS reviews have identified significant problems in physician management, which include allocation of physician resources, supervision of residents, integration of care among disciplines, and the credentialing and peer review processes. Too many physicians at KDMC have failed to exhibit the same recognition and commitment to the change in organizational culture as have other areas, such as nursing or pharmacy.

These issues have been identified not only by DHS and federal and state regulators, but confirmed by the Accreditation Council on Graduate Medical Education (ACGME) in its recent reviews of the resident training programs at KDMC. ACGME's criticism of many of the training programs, such as lack of resident supervision, poor performance by residents on specialty board examinations, and insufficient physician leadership and direction of clinical care are consistent with the lack of physician leadership at the hospital. These problems are clearly linked to the challenges faced by Drew University in attracting high quality academic physicians, in both leadership and line positions, as well as strong residents. The ability to attract and retain the highest quality physician faculty and residents, which drives the level of care and education, is directly related to the strength of the academic programs to which they are being recruited. The hospital's role as an academic institution is discussed later in this document.

In order to stabilize the hospital and ensure a safe patient environment at the hospital, immediate steps must be taken to limit the flow of patients into the hospital. KDMC presently treats approximately 47,000 emergency room and 2,100 trauma patients annually. The majority of the hospital's admissions come through either the emergency or trauma departments. This tremendous inflow of patients, many of which require high acuity care, results in stresses across the hospital, which range from the inability provide nursing staff for sufficient ICU and telemetry beds to overwhelmed pharmacy, laboratory, and other ancillary services.

The Department is recommending that KDMC relinquish its trauma designation and take further steps to limit its volume of emergency visits. Within 90 days, DHS will phase out the trauma program at KDMC and shift the transport of these patients to other trauma hospitals.

Trauma patients are the most critically ill and injured individuals cared for by the hospital. These patients also put significant demand on the supporting clinical services. Elimination of the trauma program would reduce the dependence on other clinical programs, such as surgery, orthopedics, and radiology – some of which are experiencing operational problems. Additionally, the regulatory requirements as to clinical coverage for an emergency room are substantially less stringent than those for trauma hospitals. Such a move also would allow the Department to substantially shrink other clinical services, such as neurosurgery, CT, and general and orthopedic surgery. These also are areas in which the resident training programs have either been terminated by the accrediting agency or are in serious trouble. Additionally, the hospital continues to experience difficulty ensuring sufficient physician coverage in many of the clinical areas that are mandated for hospitals with trauma designation.

While this would increase patient volume at surrounding trauma hospitals, it would retain emergency and inpatient and outpatient capacity at KDMC and would remove much of the strain presently experienced by the hospital. The Department's goal is to ensure that the trauma volume from KDMC is reallocated among the other hospitals in a manner that does not negatively impact availability or quality of care to trauma patients. The following steps will be taken to affect this:

- Adjust affected hospitals' trauma contracts to reflect increased volume
- Redraw trauma boundaries to reflect reallocated trauma caseload
- Submit revised trauma plan to the State
- Establish paramedic protocols to manage patient transports
- Educate local fire departments/ambulance companies to redrawn boundaries
- Evaluate other hospitals that may be interested in joining the trauma network

With regard to emergency services, a number of steps have been taken over the past nine months to divert patients from the hospital's emergency room in order to decompress its census. It is of great priority to the Department to increase the efficacy and efficiency of the emergency room at KDMC. Thus, one of the specific requirements for the consultant to be hired under the MOU with CMS will be to propose and assist in the implementation of recommendations to reduce KDMC's emergency room diversion rate and generally improve the hospital's capacity to provide appropriate access to quality emergency care.

This restructuring also will include the identification and consolidation or closure of clinical programs that are not fundamental to the hospital's mission. For example, a recent study by the University Healthcare Consortium of clinical practices across DHS facilities identified a number of clinical product lines with a low rate of utilization. Among these are spinal surgery, cardiothoracic surgery, surgical oncology, and vascular surgery. With the discontinuation of trauma services at the hospital, the need for on-call physician coverage for some of these services will be greatly reduced, if not eliminated. Within 90 days, the Department will provide a model for the clinical reconfiguration of the scope of services at KDMC. Additionally, prior to submission of this report, I will be forwarding to your Board my recommendations on the regionalization of neonatal intensive care services.

Long-Term Vision

As noted above, in the immediate term, the Department must continue to ensure a safe and competent clinical environment and bring the hospital's operations more in line with the community standard.

Over the long term, the focus and mission of the hospital, as well as its relationship with its affiliated medical school, must be reexamined and restructured in a manner that establishes a patient care environment that is both manageable and consistent with the community's needs.

This vision includes preserving the hospital and its important relationship to the community while continuing to upgrade the culture of accountability and integrity of the oversight and delivery of its clinical and academic programs. The capacity to identify the current and potential patient populations, target culturally and linguistically appropriate outreach and services to the population served, and hire or develop culturally competent managers and health care providers is vital to KDMC's survival and ultimate success.

The Department and KDMC leadership have been engaged in a process to proactively determine community health needs based on demographics, disease burden, and mortality rates in the service area. In order to further define KDMC as a center of excellence for urban multicultural health care, this information must become the basis of a redesigned delivery system at KDMC. The improved delivery system must reflect not only what is desirable, but what is achievable. It also must take into account other DHS facilities and the missions and resources of the Department.

This must be accomplished in a hospital, and in partnership with a medical school, in which patients and the community have confidence that the physicians, residents, nurses, and other clinical staff providing care meet a standard of high quality clinical and cultural competence.

While this is the long term goal, as noted above, there are immediate steps necessary to create a safe clinical environment, establish a clearly defined and manageable array of patient services, and strengthen the academic milieu of the hospital. Additionally, a setting must be created in which continuous improvements and changes can occur in a thoughtful and rational manner, rather than in a continual crisis mode, as is presently the case.

Academic Mission

Providing care in an academic environment and supporting the education of the physician residents has long been a part of DHS' mission. While the Department continues to believe the academic mission is an important one, it must be undertaken at KDMC in the context of the community health needs and the hospital's ability to recruit and retain sufficient and qualified physicians, nurses, and other clinical staff. Patient needs, not academic requirements, must drive the scope of services provided.

While Drew University has made an important contribution in increasing the number of minority medical students and physicians in the community, as noted by the Satcher Task Force, additional change must occur in its governance structure and program focus to sustain and enhance its continued relationship with Los Angeles County. The problems identified by the Satcher Task Force have weakened Drew University's stature as an academic institution and impacted its ability to attract high level physicians and residents. If the hospital is to continue serving as a site for the training of physicians, the fundamental premise of Drew University as a minority medical school must be carefully examined and modified to reflect the changes in society and medical training that have occurred over the past 30 years.

The process of ensuring the long-term viability of Drew University as an academic institution will necessitate substantial changes and will take an investment of time and outside support. As this process moves forward over the next several years, it is critical to ensure that appropriate steps are taken to ensure KDMC can obtain sufficient physician services to serve the patient population. The efforts to redefine the academic mission must span and be integrated into both the short- and long-term restructuring activities related to the clinical program at KDMC.

While one option would be to move away from an academic model and employ only physicians, DHS does not believe this is an optimal model of care. Given the Department's historic commitment to academic medicine, a more appropriate model during this transition period would be to closely evaluate those clinical services in which KDMC should continue to operate under a training model and those that should become non-academic (physician only) services.

The Department agrees with the Satcher Task Force recommendation that training programs that are not sustainable should be discontinued as independent programs before they receive unfavorable review by accrediting agencies. The Department believes a thorough review of the health of all training programs must occur prior to the resident match for the 2005-06 academic year and is working with the Graduate Medical Education Subcommittee of the Steering Committee on the Future of King/Drew Medical Center to accomplish this review and provide recommendations.

If KDMC is to remain as an academic training site in some clinical areas, the Department must actively pursue a relationship with another academic institution(s) to either initiate the rotation of residents from other training programs to the hospital (similar to the model at Olive View-UCLA Medical Center) or to partner in the sponsorship of newly constituted and smaller training programs.

The Department also is establishing an Academic and Clinical Oversight Panel to provide guidance and serve as a resource to the efforts to restructure KDMC's academic and clinical mission. This Panel will be comprised of a small group of academic and clinical leaders from outside organizations, such as USC and the University of California (including UCLA).

Broadening KDMC's academic partnerships will allow DHS to ensure the delivery of competent and safe care to the community and will provide an environment in which the County and Drew University can move forward to achieve the goals set forth in the Satcher Task Force report of establishing a center of excellence for urban multicultural health care delivery.

While the reforms being recommended will be difficult, they are critical to ensure the long-term stability and viability of KDMC and Drew University. The inability of the Department and the University to implement significant reforms will serve only to harm the patients and community they serve.

Recommendations

The Department requests that the Board of Supervisors approve the following recommendations.

1. Approve the Memorandum of Understanding between Los Angeles County and CMS codifying a partnership to strengthen KDMC and instruct the Department to immediately move forward to engage an outside consultant/management firm to

provide day-to-day operational oversight and strategic direction to the continued restructuring activities at KDMC.

2. Implement a plan to relinquish KDMC's trauma designation, including:

    a) Adjusting affected hospitals' trauma contracts to reflect increased volume;
    b) Allocating additional funding as necessary to Harbor-UCLA Medical Center to support increased trauma volume;
    c) Redrawing trauma boundaries to reflect reallocated trauma caseload;
    d) Establishing paramedic protocols to manage patient transports; and,
    e) Noticing of a requisite Beilenson hearing.

The Department will provide your Board with its initial recommendations within 90 days regarding the reconfiguration of both clinical services and resident training programs at KDMC.

Please let me know if you have any questions.

TLG:ak

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