



APRIL 2009

Achieving the Vision: Healthcare Options for Los Angeles County

A REPORT OF THE LOS ANGELES HEALTHCARE OPTIONS TASK FORCE



This report presents our analytical findings
and recommendations for
improving the quality and financial
sustainability of healthcare for medically
indigent individuals in the County.





Preface

The Los Angeles Healthcare Options Task Force was charged by The California Endowment to develop a vision and recommendations for achieving a high-quality, integrated healthcare delivery system in Los Angeles County. This report presents our analytical findings and recommendations for improving the quality and financial sustainability of healthcare for medically indigent individuals in the County.

We share with readers the inspiring and visionary experiences of other healthcare systems that have faced challenges comparable to Los Angeles County and yet have made remarkable advances. These healthcare systems have undergone significant, long-term transformations to successfully improve the quality of care they provide to their communities. Our recommendations are informed by the lessons learned from both their achievements and their challenges. In addition, our report builds on a substantial body of work by many others who have also considered ways to improve safety net healthcare in the County.

We include a focus on South Los Angeles and the proposed reopening of Martin Luther King Jr. Hospital, a critical component of the public healthcare system. Findings regarding changes in healthcare need after the closure of Martin Luther King Jr. Hospital helped to shape our vision and recommendations. For the hospital to succeed in the future, it is imperative that it be embedded in an integrated countywide system.

This work was prepared by the Los Angeles Healthcare Options Task Force, with assistance from the Health Industries Advisory Practice at PricewaterhouseCoopers and a team of health services researchers led by a Robert Wood Johnson Foundation Clinical Scholar.

An electronic version of this report, along with full appendices and referenced publications, is available at The California Endowment website: <http://www.calendow.org>.

Contents

Tables and Figures		iii
Acknowledgments and Definitions		iv
Abbreviations		v
Foreword		vi
Executive Summary		1
SECTION I	Introduction	9
SECTION II	Key Findings	15
	<i>Task Force Vision for Safety Net Healthcare Delivery in LA County</i>	15
	<i>Healthcare Needs and Utilization in LA County</i>	17
	<i>Leading Practices from Public Healthcare Delivery Systems in the U.S.</i>	25
	<i>Case Studies</i>	35
SECTION III	Recommendations: Transitioning to the Future	49
Appendix A	Reports, Memorandums and Other Documents on Governance and Operational Issues Relating to the LA County Department of Health Services (LACDHS) and/or Martin Luther King Jr. Hospital	59
Appendix B	Reports on Public Safety Net Healthcare Systems	62
Appendix C	Additional Details from the Needs Assessment of South LA	63
Appendix D	Health System Profiles	68
Appendix E	Report on Leading Practices of Public Safety Net Healthcare Delivery Systems in the United States (<i>prepared by PricewaterhouseCoopers</i>)	
<i>(electronic only)</i>		

Tables and Figures

Table 1.1	Los Angeles Healthcare Options Task Force Members	10
Table 2.1	Health Status, Insurance Status, and Emergency Room Utilization, by Service Planning Area	21
Table 2.2	Health Status, Healthcare, Insurance Coverage, and Delays in Care Among Children and Adolescents in Los Angeles County	22
Table 2.3	Perinatal Indicators, Los Angeles County	22
Table 2.4	South Los Angeles Healthcare Facilities	23
Table 2.5	Healthcare Infrastructure in South Los Angeles, West Los Angeles, and Los Angeles County	24
Table 2.6	Health Status, Emergency Room Use, and Delays in Care Among Older Persons in South Los Angeles Across Years and Geography	24
Table 3.1	Proposed Composition of the Los Angeles Healthcare Planning Commission	57
Table APP.1	Historical Milestones and Related Survey Data	64
Table APP.2	Demographics of Community Needs Assessment Survey of Older African Americans and Latinos, South Los Angeles, 2008	65
Table APP.3	Health Insurance, Educational Status, and Usual Source of Care, Older African Americans and Latinos, South Los Angeles, 2008	66
Table APP.4	Health Status, Preventive Health Services, Utilization, and Delays in Care by Selected Characteristics, Age 50 and Over, South Los Angeles, 2008	66
Table APP.5	Health Utilization, Delays in Care, and Access Measures, by Selected Characteristics, Age 50 and Over, South Los Angeles, 2008	67
Table APP.6	Geriatric Syndromes, by Selected Characteristics, Age 50 and Over, South Los Angeles, 2008	67
Figure ES.1	Representation of Safety Net Healthcare in LA County	2
Figure 1.1	LA Healthcare Options Task Force Approach to Developing a Vision and Recommendations	13
Figure 2.1	Representation of Safety Net Healthcare in LA County	17
Figure 2.2	Regular Source of Care by Insurance Status, Los Angeles County, CHIS 2007	20
Figure 2.3	Map of Service Planning Areas, Los Angeles County	20

Acknowledgments

This report was sponsored by The California Endowment. We are particularly grateful for the guidance and support provided throughout the project by The California Endowment staff, including Robert K. Ross, M.D., President and Chief Executive Officer; B. Kathlyn Mead, Executive Vice President, Organizational Effectiveness; and Beatriz Solis, Ph.D., Healthy Communities Strategies, South Region. We would also like to thank The California Endowment Communications staff for their assistance with this report.

We owe a huge debt of gratitude for the insights provided by the senior leadership of Jackson Health System of Miami-Dade County, Florida, and the New York City Health and Hospitals Corporation. Their willingness to candidly share their experiences and advice demonstrates their true commitment to the mission of public service. Thank you to these individuals and their staff.

We also thank the California HealthCare Foundation for their contributions to this report. The foundation's work in innovations for the underserved and better chronic disease care provided forward-looking ideas for improving healthcare.

We would also like to acknowledge the work of the Task Force Staff members: Dr. Ying-Ying Goh, M.D., M.S.H.S., Project Director; Dr. Kara Odom Walker, M.D., M.P.H., Robert Wood Johnson Clinical Scholar, Policy Research Director; Grace Ting, M.H.A., Health Services Director, Health Equities Programs, Anthem Blue Cross, Project Administrator; Betty Villagra, Executive Assistant; and Veronica Alexander, Intern. Anthem Blue Cross also contributed staff time for in-kind research and staff support.

Definitions

MEDICALLY INDIGENT

low-income, uninsured, or underinsured individuals with medical needs; includes the poor and near-poor, the employed and unemployed, and the uninsured and underinsured.

Sources: "County Programs for the Medically Indigent in California." Fact Sheet. The California HealthCare Foundation, August 2006. As of March 26, 2009: <http://www.chcf.org/documents/policy/CountyPrgrmsMedicallyIndigentFactSheet.pdf>.

The Future of Public Health, Institute of Medicine. 1988, p. 22.

HEALTHCARE SAFETY NET/SAFETY NET HEALTHCARE SYSTEM

a system that provides healthcare to low-income, uninsured, underinsured and other vulnerable populations; includes a wide array of providers, both private and public, across the spectrum of care.

Source: "Safety Net Monitoring Initiative." Fact Sheet. AHRQ Publication No. 03-P011, August 2003. Agency for Healthcare Research and Quality, Rockville, MD. As of March 26, 2009: <http://www.ahrq.gov/data/safetynet/netfact.htm>.

Abbreviations

CAO	Los Angeles Chief Administrative Officer
CCSF	City College of San Francisco
CDU	Charles Drew University of Medicine and Science
CEO	Chief Executive Officer
CHIS	California Health Interview Survey
COE	center of excellence
HASC	Hospital Association of Southern California
HCHD	Harris County Hospital District
HCICP	Kaiser Permanente's Health Care Interpreter Certificate Program
HCMC	Hennepin County Medical Center
HHC	New York City Health and Hospitals Corporation
HHS	Hennepin Healthcare System, Inc.
HMO	health maintenance organization
IHI	Institute for Healthcare Improvement
IT	information technology
JHS	Jackson Health System
KDMC	King/Drew Medical Center
LA	Los Angeles
LA COUNTY	Los Angeles County
LACDHS	Los Angeles County Department of Health Services
MLK HOSPITAL	Martin Luther King Jr. Hospital (also known as King-Harbor Hospital from 2006 to 2007)
MPI	Master Patient Index
NCQA	National Committee for Quality Assurance
PMO	Project Management Officer
RIE	rapid improvement initiative
SPA	Service Planning Area, LACDHS Designations
SPA 1	Antelope Valley
SPA 2	San Fernando Valley
SPA 3	San Gabriel Valley
SPA 4	Metro
SPA 5	West
SPA 6	South
SPA 7	East
SPA 8	South Bay



Foreword

The pages that follow lay out a vision of a reengineered safety net of health services for residents of Los Angeles County. This vision was not developed by some lofty academic think tank, or consultants from a faraway land. Rather, it was crafted primarily by regional civic leaders who are in the business of healthcare in our community, and who are as compassionate about high-quality healthcare as they are tough-minded about controlling costs and managing budgets.

This group of individuals is the Los Angeles Healthcare Options Task Force, and we asked them to focus on some key questions regarding our healthcare delivery system for medically indigent and publicly insured patients: Given the advances in healthcare delivery, what should LA County's currently fragmented and inefficient safety net healthcare system look like? What large, regional models nationally are doing better on this front, and what can we learn from them? Finally, in recognition of the significant challenges faced by community residents in South Los Angeles, what opportunities exist to build a model of integrated healthcare delivery around the future of a reopened Martin Luther King Jr. Hospital?

I readily confess that our foundation's Board, staff, and many regional health and civic leaders voiced one overriding concern about commissioning this report: Will it lead to anything? The pessimists amongst us predicted that this report would most likely end up in the graveyard of similar reports about LA County's safety net healthcare system authored by commissions and well-intended groups over the past two decades. Commissioning reports such as these costs time and money at a moment when both are in short supply.

We thoughtfully weighed these well-founded concerns, and decided to plow ahead. While the track record of LA County government in boldly addressing health challenges is mixed, there are several reasons to embrace a renewed sense of optimism that meaningful change can occur over the next few years:

- The idea of national health reform has traction, and President Barack Obama has made the issue a central focus of his administration. There has never been a better opportunity to engage federal leaders in addressing the plight of uninsured Americans and Angelenos.
- The unfortunate realities of the economic downturn will exacerbate the level of urgency about our national health crisis, and how this crisis affects the lives of millions of residents of LA County. Public funds for healthcare safety net services will become even more constrained, while at the same time the sheer numbers of uninsured and desperate patients will continue to grow. Business as usual in healthcare simply cannot be sustained in this environment. An integrated healthcare delivery model for our county is not just a nice thing to have – it is a fiscal imperative.
- Finally, recent news of the plans for County officials to reopen the shuttered Martin Luther King Jr. Hospital provides clear evidence that the Board of Supervisors is willing to rethink the notion of public-private partnership to deliver health services. The three-way partnership among the LA County

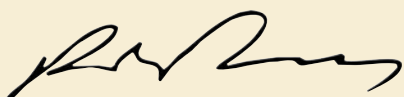
Board of Supervisors, the University of California, and the Governor's office is creative. The idea of a new, public-private board to oversee the reopened hospital is refreshing. The Board of Supervisors' invitation to the private, nonprofit sector to operate a reopened MLK Hospital under a completely different governance structure – and with the County's financial support – demonstrates courage and pragmatism in equal parts on the part of the Board of Supervisors.

The plan to reopen MLK Hospital is a great step. In releasing this report, at this moment, we are in effect saying to County officials: "Keep moving forward; we must achieve this vision of a countywide integrated delivery system." Moreover, the Task Force represents an important range of stakeholders: hospital executives, physicians, community clinics, health advocates, organized labor, and the business community. Thus this report's broader message to our County's elected officials is "If you choose to move even more boldly in this direction, you will have the support of our region's health, civic, community, and philanthropic leaders."

The Task Force's recommendation of a countywide, 18-month Planning Commission is an important interim step. County officials have historically viewed private and nonprofit health sector provider institutions merely as contractors for County-funded services. This is a limited and counterproductive view. Private and nonprofit health systems, hospitals, and health clinics are learning to deliver high-quality services with constrained and limited resources. A Planning Commission that allows County government to tap the expertise and experience of these providers provides a meaningful opportunity to solve problems in a thoughtful, partnership approach – and move towards a shared vision. As the report states, national health reform, the development of the next federal-state Medicaid waiver proposal, and the well-planned use of health information technology dollars in the federal stimulus package represent concrete opportunities to usher in a new era of public-private partnership to address our regional health challenges.

In closing, I would like to express our appreciation to the members of the LA Healthcare Options Task Force, as well as to the Health Industries Advisory Practice at PricewaterhouseCoopers, for their time and energy. The chair of the Task Force, Dr. Woodrow (Woody) Myers, deserves a special mention. He demonstrated an uncanny capacity to bring consensus to a group of stakeholders that often held divergent views on certain issues. Dr. Hector Flores, the vice chair, contributed his vast expertise on healthcare delivery for the medically indigent in LA and beyond. And of course, Dr. Myers's Project Staff provided tireless support and assistance (evidenced by updated report drafts that were often e-mailed at 2 a.m.). Mary Odell, my colleague and friend at the UniHealth Foundation, provided her guidance and support with the project, and we thank her as well.

Yes, we understand that this is "only" yet-another-report. But we are pleased to offer a vision – and recommendations on how to achieve that vision – of a new era of public, private, and civic partnership to meet the health needs of County residents who struggle to be healthy. The imperative and sense of urgency has never been more evident.



Robert K. Ross, M.D.
President and CEO, The California Endowment



Executive Summary

Introduction

Nationwide, discussion of U.S. healthcare reform has intensified as the recent economic downturn has further exposed the need for affordable, high-quality healthcare for all. In Los Angeles (LA) County, the fragmented healthcare system faces the challenge of serving a high volume of racially and ethnically diverse, medically indigent patients, and doing so within the bounds of significant financial and political constraints. Although certain considerations are unique to LA County, it is clear that other public healthcare systems across the country have successfully overcome similar challenges and offer important lessons for the LA County region.

The Los Angeles Healthcare Options Task Force (Task Force) was created in October 2008 by The California Endowment to develop a vision and recommendations for achieving a high-quality, integrated safety net healthcare delivery system in LA County. The Task Force was charged with providing recommendations, based in part on leading practices from other systems, for improving the quality and financial sustainability of healthcare for medically indigent individuals. This report includes a focus on South Los Angeles and the proposed reopening of Martin Luther King Jr. (MLK) Hospital, a critical component of the safety net healthcare system. In order for MLK Hospital to achieve its service mission in the future, it will need to be embedded in a high-performing, integrated healthcare delivery system. The Task Force's recommendations are intended to facilitate the success of MLK Hospital and other safety net providers in LA County.

We used several analytical components to inform our vision for safety net healthcare in LA County and to generate recommendations for realizing that vision. These components included:

- a review of the literature on the LA County healthcare system (including MLK Hospital) and on public healthcare systems in general.
- a community-based study to determine the nature and extent of delays in care and unmet healthcare needs of South LA elderly residents.
- a critical assessment of leading practices from other public healthcare systems in the United States.
- site visits to two leading systems with characteristics comparable to LA County.
- collaborative expert analysis sessions to evaluate the information and to consider it in the context of LA County.

It is important to recognize how this report differs from many others that preceded it, and what activities were outside the scope of the Task Force's mission. In contrast to prior efforts that have focused on specific alternative governance models for the LA County Department of Health Services (LACDHS), this report assesses healthcare systems comprehensively in order to make systemwide recommendations with a clear emphasis on improving quality of care. This report is not intended to catalogue the many examples of excellence in the current system, or to outline all the gaps and weaknesses. The Task Force did not repeat previous analyses and studies of LA County or of other public



healthcare systems in general; instead, we referenced and built upon this substantial body of work.

The County of Los Angeles is now at a critical juncture for improving the public healthcare system: Options for reopening MLK Hospital are being considered by LACDHS and the University of California, application for renewal of the California Medicaid waiver is approaching, federal funding streams have opened for healthcare effectiveness and information technology, and national healthcare reform is being considered. This report uniquely provides a rigorous and ambitious, yet achievable and realistic, set of recommendations to improve the service quality and financial viability of safety net healthcare in LA County. Equipped with this clear vision and recommendations, we feel that LA County is well positioned to take swift, bold,

and measured steps toward a high-quality, integrated healthcare delivery system accessible to all.

Key Findings

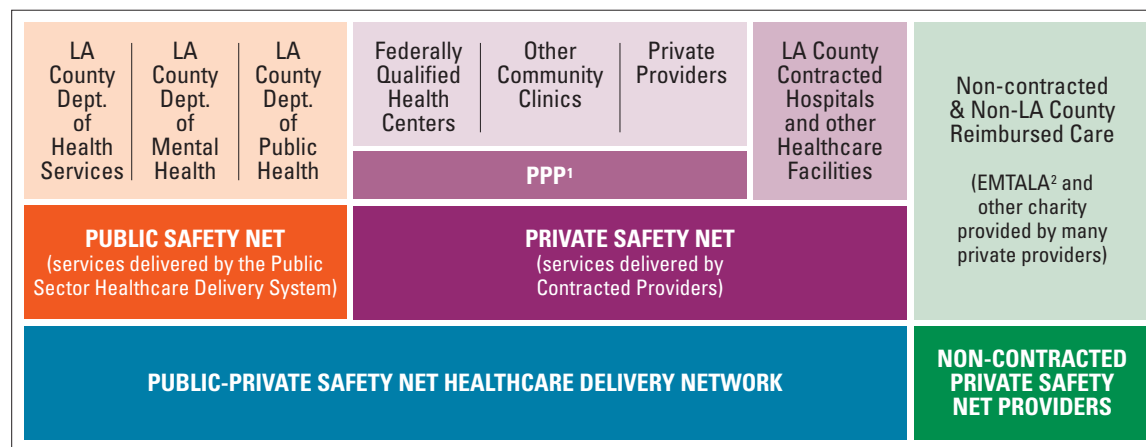
Task Force Vision for Safety Net Healthcare Delivery in Los Angeles County

To frame our analyses and recommendations, we first defined the make-up of the regional healthcare safety net and then developed a vision for improving the healthcare it delivers.

The “healthcare safety net” in LA County is the system that provides healthcare to the medically indigent (**See Figure ES.1**).

It is composed of the Public Sector Healthcare Delivery System, which provides Public Safety Net services, and contracted private providers

FIGURE ES.1 Representation of Safety Net Healthcare in LA County.



1 Providers who participate in the Public Private Partnership Program are private practice, free clinics, and Community Health Centers that receive funds from the LA County Board of Supervisors to provide care to uninsured residents in underserved areas of the county.

2 In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

that supply Private Safety Net services. We recognize that the functions of the Public Sector Healthcare Delivery System are not restricted to safety net services, and that the private sector provides critical services for the medically indigent. Because the healthcare safety net involves many providers in addition to LACDHS facilities, a coordinated and continuous effort is necessary on the part of both public and private entities. Below, we define a vision for the Public Sector Healthcare Delivery System, composed of the LA County Departments of Health Services, Mental Health, and Public Health, and directly controlled by the LA County Board of Supervisors.

A Vision for the Public Sector Healthcare Delivery System

We propose that the Public Sector Healthcare Delivery System be driven, first and foremost, by a mission to provide the highest quality healthcare to its patients. All operations should be quality-focused and patient-centered.

We propose that the Public Sector Healthcare Delivery System be driven, first and foremost, by a mission to provide the highest quality healthcare to its patients.

In addition, the Public Sector Healthcare Delivery System should:

- Function with transparency and accountability to the public and its leadership, through increased public availability of specific quality indicators and information.

- Engage its entire workforce in a mission-driven, collaborative process of continuous innovation and learning.
- Ensure its financial sustainability by improving its fiscal infrastructure, including diversification of its payer mix.
- Function as an integrated delivery system: a system that coordinates health from wellness and prevention to emergency and acute care services, and that emphasizes strategic planning and resource allocation, capitalizing upon economies of scale.
- Drive decisions and practices with accurate information (real-time process measures, clinical indicators, population outcomes, and cost measures).
- Work to eliminate inequality (a two-tiered healthcare system) by providing high-quality care – including prevention, primary care, specialty care, and tertiary and quaternary care – that is desirable to all residents of LA County.
- Recruit, develop, and retain transformational leaders who are expert in modern healthcare management.
- Expand long-term public-private partnerships and community engagement.
- Strengthen relationships with academic medical centers for education and research.
- Reintegrate MLK Hospital as part of a coordinated system that takes ownership of its mission and these underlying principles.

Although the recommendations that follow in this report (**See Section III, Recommendations**) pertain to the Public Sector Healthcare Delivery System, the quality of care for medically indigent patients in LA would be improved by synergies with both Private Safety Net Providers and Non-Contracted Private Providers who also serve these patients. Therefore, we describe a vision for strengthened public-private collaboration in the future.

A Vision for Public-Private Collaboration

The Los Angeles Public-Private Safety Net Healthcare Delivery Network (the Network) includes the Public Safety Net (services delivered by the Public Sector Healthcare Delivery System) and the Private Safety Net (services delivered by private entities with voluntary contractual and/or public-private partnership relationships with LACDHS, including Federally Qualified Health Centers (FQHCs), community clinics, and other private providers and hospitals) **(See Figure ES.1)**.

The Task Force proposes that, in the future, the Network should include private healthcare entities that voluntarily participate and are willing and able to take part in system improvement activities and provide services complementary to the Public Safety Net. The entire Network should be driven by a mission to provide the highest quality healthcare to its patients and should uphold the principles described above for the Public Sector Healthcare Delivery System, including transparency and accountability, continuous innovation, and coordinated, patient-centered care. The quality of care for patients served by the Network would be improved by future synergies with both Private Safety Net Providers (i.e., those with contractual relationships with LACDHS) and Non-Contracted Safety Net Providers.

In the next section, we outline the findings from the Task Force needs assessment and leading practices analysis. These findings reinforced the members' fundamental supposition that the achievement of these visions is necessary and possible, through defined contractual agreements that preserve the autonomy of private providers while facilitating the integration of services within the Public Sector Healthcare Delivery System.

Needs Assessment of LA County and South LA

Our review of healthcare needs across LA County highlighted variations in healthcare access and self-reported health status by Service Planning Areas (SPAs). We found variation among subgroups of the population in healthcare need and access. We also conducted a community-based study to determine the nature and extent of delays and unmet healthcare needs of South LA (SPA 6) elderly residents (we refer to this as "the MLK Study"). This telephone survey of African American and Latino middle-age and older residents found that certain segments of the population may have greater reported disease burden as well as mental and physical disability. The data also indicate significant delays in care and unmet preventive care needs that could be addressed through primary care and chronic disease management among older adults in South LA.

Leading Practices Analysis

From the leading practices analysis and healthcare system site visits, one overarching theme stands out from among all others:

Leading public healthcare systems have clarity of mission throughout the organizational culture: to achieve the highest-quality care through transparency, continuous innovation, and accountability at all levels.

The successes of leading public healthcare systems have been driven by dynamic leaders who (1) recognize that their greatest asset is their people and (2) have the authority necessary to drive organizational and cultural change. Leaders of these systems achieve this cultural transformation at all levels and within all component organizations; they cannot

successfully improve one part of the system without improving the whole system.

The Task Force utilized literature and expert discussions to identify four categories for improving the healthcare system in Los Angeles: quality care delivery, finance, information technology (IT), and governance and management. These categories are intended to be tools for organizing the leading practices analysis and are neither exclusive of each other nor exhaustive.

- Quality Care Delivery** – Leading public safety net healthcare systems sustain their commitment to high-quality clinical care through evidence-based medicine and continuous measurement and improvement. They focus on improving quality in order to be the “provider of choice” rather than the “provider of last resort,” and they demonstrate a patient-centered, safety-and-quality-first mindset in aspects of strategic planning, day-to-day care delivery, and other operational processes. They view every patient encounter as an opportunity to improve patient health, service, and satisfaction. Leading systems create a culture of innovation, utilize quality-improvement tools, and value cost-effectiveness. Measures and outcomes are made available to the public and to leaders, in order to achieve transparency and accountability. Other leading practices in quality care delivery include maintaining a strong focus on wellness, prevention, and primary care; reducing access barriers through innovative, community-based programs; and redesigning clinical and administrative processes to minimize wasted resources and patient inconvenience.
- Finance** – Leading financial practices include developing a community reputation for the highest-quality patient care to attract insured as well as medically indigent patients, minimizing

non-value-added costs, and achieving efficiencies of scale. These practices free resources that are then used to enhance the service mission. Leading systems engineer financial discipline into all activities, by carefully monitoring resource utilization and cost through rigorous metrics and integrated decision-support systems. These systems have the autonomy and authority to quickly implement allocations of resources across the system. They also work collaboratively with their affiliated governments to garner financial subsidies and contributions, even developing their own insurance products, critical to sustaining these services.

- Information Technology** – Leading IT practices include adoption of standard and interoperable clinical, financial, and administrative information systems, and alignment of IT strategy with organizational business strategy and goals. IT systems are used to create patient information continuity and to link hospitals with community-based providers. A single, centralized data warehouse across the entire healthcare system is crucial. These IT systems improve quality of care by supporting evidence-based medicine, reducing medical errors, and improving care coordination.
- Governance and Management** – Leading healthcare systems have autonomous governance bodies that have healthcare expertise and relative freedom from political pressures. These bodies remain accountable to, and subject to oversight by, an affiliated government that retains legally specified powers. These bodies create three-to-five-year strategic master plans and annual budgets with affiliated government input and approval. Leading systems are distinguished by having a dynamic, hands-on CEO and a talented, cohesive leadership team that is trusted by the dedicated and engaged governance body. Collectively, the leadership and governance

body promote a consistent vision and strategy for a mission-driven, value-based culture with accountability by all personnel. They establish policies that reinforce high performance behavior, innovation, and continuous improvement. Another practice of leading systems is transparency and open communication with all stakeholders.

Summary of Recommendations

The Task Force recommendations, organized in the same four categories, are based on our findings of leading practices in public healthcare systems and the analysis of these findings in the context of LA County. They also reflect the Task Force's vision for the Public Sector Healthcare Delivery System and Public-Private Collaboration in the future. All these recommendations support the mission of providing high-quality, financially sustainable healthcare in LA County for all.

Quality Care Delivery

The Public Sector Healthcare Delivery System should:

1. Embrace a culture of clinical excellence, innovation, continuous improvement, cost-effectiveness, and accountability. This includes engagement of its entire workforce – including physicians, managers, and front-line workers – in a mission-driven, collaborative process that operationalizes this cultural transformation.
2. Operate as an integrated delivery system, to provide seamless, coordinated care with accountability at all levels of the organization. This care coordination should be extended from the public system to other care providers in the safety net system, through public-private partnerships.
3. Continuously measure, evaluate, and improve performance, in order to deliver

the highest-quality healthcare. This requires transparency of performance measures and open communication with the public and its leaders.

4. Eliminate barriers to access in order to provide appropriate, patient-centered care in a timely fashion.
5. Focus on systemwide, long-term investments in population wellness, prevention, and the management of chronic diseases.

The Public Sector Healthcare Delivery System should embrace a culture of clinical excellence, innovation, continuous improvement, cost-effectiveness, and accountability.

Finance

The Public Sector Healthcare Delivery System should:

1. Accelerate efforts to achieve financial sustainability.
2. Appropriately improve revenue streams, including a diversified payer mix, in order to successfully achieve its service mission.
3. Minimize unnecessary, non-value-added costs.
4. Make capital and resource allocation decisions that best contribute to improved health outcomes through strategic, systemwide planning.

Information Technology

The Public Sector Healthcare Delivery System should:

1. Develop and advance an IT strategic plan for standardization and interoperability, enabling quality standards measurement, coordinated care, and financial rigor.

2. Establish an integrated countywide health information system for clinical, quality, and financial measures.
3. Create a best-in-class health IT leadership team to manage and coordinate the IT portfolio.
4. Develop a robust telemedicine and telehealth infrastructure to facilitate access and care coordination, by leveraging public-private partnerships.
5. Ensure that IT systems include decision-support-enabled population-care management tools that allow for tracking and optimization of key prevention and disease management outcomes for the population.

Governance and Management

The Public Sector Healthcare Delivery System would benefit from a body of expertise, accountable to the LA County Board of Supervisors, that is self-governed and has management autonomy and authority.

Mechanism for Transition: The LA Healthcare Planning Commission

These recommendations provide a proposed structure for achieving the vision of an integrated healthcare delivery system in Los Angeles, but we recognize that the County needs a mechanism for planning in order to move toward implementation. Thus, we recommend the formation of a Los Angeles Healthcare Planning Commission (hereafter referred to as the “Commission”).

This time-limited Commission, composed of members appointed by the Board of Supervisors, should be formed to conduct the planning necessary to advance the implementation of a high-performing, high-quality safety net healthcare system that serves all residents in LA County. The Commission’s work should be informed by the recommendations of the Los Angeles Healthcare Options Task Force. We propose

that funding be provided by the philanthropic community in the Los Angeles region and the LA County Board of Supervisors. We believe that an 18-month lifespan is sufficient for this Commission to complete its duties (July 1, 2009, to December 31, 2010).

This Commission would not be a governing body, and this report does not provide specific recommendations for a particular healthcare governance model. Other studies have analyzed alternative models and made recommendations (**See Appendix A**). However, the Commission could assist the Board of Supervisors with evaluation of potential future governance models.

In addition, this Commission could be directed by the Board of Supervisors to:

- Oversee the reintegration of inpatient and emergency services at MLK Hospital into the larger Network, as its initial task. This would include a more formal articulation of the ambulatory care system that will be needed to support MLK Hospital.
- Optimize the application for the California Medicaid waiver in 2010.
- Identify innovative strategies for the use of the federal economic stimulus funds.
- Create a coordinated and comprehensive countywide health IT plan.
- Identify a process to define and advance collaboration between public and private safety net providers.





Introduction

Background

Los Angeles (LA) County is home to world-class medical institutions, leading academic medical centers and training programs, and state-of-the-art medical facilities. An impressive array of high-quality services are also provided through a network of private specialty practices, community clinics, and primary care providers. Unfortunately, these services have not historically been available to all.

Following the 1965 Watts Riots, Martin Luther King Jr. (MLK) Hospital was opened in an attempt to address healthcare inequities in South Los Angeles. For many years, MLK Hospital provided high-quality services to the residents of South LA and fostered strong relationships with Charles R. Drew University of Medicine and Science (CDU) and other leading medical schools. However, institutional weaknesses emerged, persisted over time, and became evident in a series of quality and financial crises that ultimately led to the closure of MLK Hospital in 2007. As a result, the community in South LA is again lacking needed healthcare services. The proposed reopening of MLK Hospital is a key component of improving access to healthcare in LA County. However, the hospital cannot succeed by standing alone; it must be part of a fundamentally transformed high-quality healthcare delivery system.

The closure of MLK Hospital resonated at the national level as a stark example of the difficulty of achieving the mission of public healthcare systems: to provide high-quality care for the

medically indigent, amid constraining financial and political pressures. While the MLK Hospital closure was an extreme manifestation of failures at many levels, it is indicative of fundamental problems that may exist throughout the safety net healthcare system.

LA County is now at a critical juncture for addressing these fundamental problems: Options for reopening MLK Hospital are being considered by the LA County Department of Health Services (LACDHS) and the University of California at the same time that the nation and its new president are focused on reforming healthcare for the country. Federal funding streams have opened for innovation in healthcare effectiveness, disease prevention, and health information technology (IT). In addition, the application for renewal of the California Medicaid waiver is approaching. LA County is well positioned at this time to take swift, bold, and measured steps toward a high-quality, integrated healthcare delivery system accessible to all.

The Los Angeles Healthcare Options Task Force (the Task Force) was created in October 2008 by The California Endowment to support the creation of an integrated public-private partnership model of high-quality safety net healthcare in LA County (**See Table 1.1** for a list of Task Force members).

The Task Force was charged with identifying leading practices of public healthcare systems across the nation, with the goal of making recommendations to improve the quality of



healthcare for medically indigent individuals in LA County. The Task Force also focused on South LA and the proposed reopening of MLK Hospital, with the understanding that the best option for meeting the significant needs of the South LA community would be a high-performing hospital embedded in a strong, integrated system.

Previous Reports on the Public Sector Healthcare Delivery System in LA County

A history of other studies on safety net healthcare in LA County, conducted prior to the creation of this Task Force, provides necessary context for this report. Past analyses and recommendations for improvements to healthcare delivery for the medically indigent in LA County have been well documented. **Appendix A** lists selected reports, recommendations, and analyses that have been conducted over approximately the past decade. The documents referenced in **Appendix A** include studies of LACDHS and also those specific to MLK Hospital. In this section, we present some of the previous recommendations for governance of the Public Sector Healthcare Delivery System (LACDHS) and for MLK Hospital oversight.

In 1995, the Report of the Health Crisis Task Force recommended that a semiautonomous health authority, run by health policy experts, be established to operate LACDHS. In September 2000, the Los Angeles County Blue Ribbon Health Task Force recommended that the Board of Supervisors initiate an independent study to evaluate governance of the health system and explore other options. This led to a review of four governance structures that in August 2001

TABLE 1.1 Los Angeles Healthcare Options Task Force Members.

CHAIR:

WOODROW A. MYERS, JR., M.D., M.B.A.

Managing Director

Myers Ventures, LLC

VICE CHAIR:

HECTOR FLORES, M.D.

Medical Director

Family Care Specialists Medical Group

BENJAMIN CHU, M.D., M.P.H.

President

Kaiser Permanente Southern California

HELEN DUPLESSIS, M.D., M.P.H.

Adjunct Associate Professor of Pediatrics

UCLA School of Medicine and Public Health

LARK GALLOWAY-GILLIAM

Executive Director

Community Health Councils, Inc.

JIM LOTT

Executive Vice President

Hospital Association of Southern California

MARY ODELL

President

UniHealth Foundation

TOM PRISELAC, M.P.H.

President & CEO

Cedars-Sinai Medical Center

DEAN TIPPS

former Executive Director

Service Employees International Union,

California State Council

GARY TOEBBEN

President & CEO

Los Angeles Area Chamber of Commerce

resulted in a recommendation to provide LACDHS with more autonomy over contracting, financing, and personnel management.

In February 2002, the LA County Chief Administrative Officer (CAO) determined that a health commission model could be created by Board ordinance and become operative 30 days after the second reading of the ordinance. In May 2003, a report titled *An Analysis of Alternative Governance for the Los Angeles County Department of Health Services* recommended the creation of an independent health authority to operate LA County health services in cooperation with LACDHS. The report recommended that the authority should assume control of administrative, contracting, personnel management, and clinical service delivery responsibilities for LACDHS.

In April 2005, the CAO presented a *Health Authority Blueprint* to the Board of Supervisors that provided various options for delegating certain management functions of the public safety net. However, these were deemed unfeasible due to the prohibitive structural financial deficits facing the LACDHS. In 2006, CA Assembly Bill 2470 was enacted, calling for a master plan for healthcare in LA County including long-range planning and development of stronger public-private partnership, with LACDHS as a focal point.

On March 27, 2007, the Board of Supervisors approved Ordinance No. 2007-0048, dramatically changing the LA County governance structure, including delegation of significant day-to-day administrative authority from the Board of Supervisors to a new Chief Executive Officer (CEO). As a result, the CEO has formal line authority over and responsibility for the operations of the Departments of Health Services, Mental Health, and Public Health.

Previous Reports on MLK Hospital

Regarding MLK Hospital, the Steering Committee on the Future of King/Drew in 2004 found that the relationship between the hospital and Charles Drew University of Medicine and Science (CDU) led to policies and procedures that hindered the system's accountability for physician performance and compensation. The hospital and CDU also faced challenges with financial reporting, funding, and monitoring. In 2005, the Steering Committee recommended formation of a new MLK Hospital leadership structure to align management incentives and accountability. The Committee recommended that oversight be delegated to an external board of experts, independent and shielded from undue political influence. In addition, the report recommended that the hospital become "a healthcare institution recognized for consistent excellence in medical care delivery and services through publicly reported performance measures."

In January 2005, a separate King/Drew Medical Center Assessment Report recommended that the Board of Supervisors continue to explore implementation of a health authority to govern the entire LACDHS health system. This recommendation would have transferred oversight responsibility of MLK Hospital to an advisory board that would oversee clinical and educational programs, develop a strategic plan, assess financial performance, appoint executives, and make recommendations for improvements.

That same year, at the state legislative level, Assembly Bill 1230 would have authorized the Board of Supervisors to establish an Inspector General Office to exercise oversight of management and quality concerns, but was vetoed by the governor upon determination that the Board of Supervisors already had that reserved power.

After 40 years of operation, MLK Hospital's inpatient services and emergency department were closed in August 2007. Now, the reopening of MLK Hospital has been proposed, and important questions must be addressed on how to reintegrate this hospital into a stronger countywide healthcare delivery system in order to ensure its success.

Objectives and Scope

The objectives of this report are (1) to present a vision for a high-quality, financially sound public safety net healthcare delivery system supported by public-private partnerships and (2) to provide recommendations for turning this vision into reality. The vision for an integrated healthcare system in LA County is based on an understanding of not only the strengths and weaknesses of the current system, but also the history of healthcare delivery in the County.

What is an integrated healthcare delivery system? How can the stakeholders in LA County overcome significant political, financial, and operational challenges to better achieve the County's healthcare mission? From October 2008 to April 2009, the multidisciplinary Task Force of healthcare, business, and labor leaders researched and examined integrated public healthcare systems, including some inspiring examples of systems that overcame great obstacles to transform their quality of care and ensure financial stability. Although every region of the country faces unique circumstances and constraints, we are convinced that there are important lessons to learn and apply to LA County.

It is important to recognize how this report differs from many others that preceded it, and what activities were outside the scope of the Task Force's mission. In contrast to prior efforts that have focused on specific alternative governance models for LACDHS, this report

assesses healthcare systems comprehensively in order to make systemwide recommendations with a clear emphasis on improving quality of care. This report is not intended to catalogue the many examples of excellence in the current system, or to outline all the gaps and weaknesses. The Task Force did not repeat previous analyses and studies of LA County or of other public healthcare systems in general; instead, we referenced and built upon this substantial body of work.

...this report assesses
healthcare systems
comprehensively in order
to make systemwide
recommendations with
a clear emphasis on
improving quality of care.

We understand the complexity and challenge of serving LA County, the most populous county in the nation, and also understand the long history of how the current fragmented system evolved. As knowledgeable and experienced individuals who have served the Los Angeles community for many years in varied capacities, we brought our understanding of both the strengths and weaknesses of current healthcare in LA County to develop recommendations to improve it.

Approach

We used several analytical components to inform our vision for healthcare in LA County and to generate the recommendations in this report. **Figure 1.1** illustrates our approach for accomplishing the Task Force objectives. We reviewed the literature on the LA County

FIGURE 1.1 LA Healthcare Options Task Force Approach to Defining a Vision and Recommendations.



healthcare system (including MLK Hospital) and on public health systems in general; we critically assessed leading practices from public healthcare systems; we made site visits to two leading public healthcare systems with characteristics comparable to LA County; and, finally, we conducted collaborative expert analysis sessions to evaluate the information and to consider it in the context of LA County.

Literature Review

We reviewed the pertinent literature relating to previous efforts to improve healthcare delivery for the medically indigent in LA County and to strengthen LACDHS and/or MLK Hospital. We also used information from various studies on public healthcare delivery systems in general.

Needs Assessment

Because dramatic changes in the healthcare landscape in LA County may have differentially impacted certain communities more than others, we sought to describe and understand how healthcare need has changed in recent years. A team of health services researchers

worked with the Task Force to conduct a secondary data analysis of healthcare need in LA County and a primary data collection to describe health status and healthcare need for a targeted population in South LA.

Leading Practices Analysis

Our leading practices analysis consisted of a literature review and an analysis of public healthcare systems. The review of the literature included an assessment of the thoughtful and well-researched work that has been conducted on improving public healthcare systems, including that which focused specifically on LA County. We carefully assessed this literature, culling from it important concepts and recommendations on delivering high-quality healthcare, creating strong financial structures, implementing successful governance models, and using cost-effective IT.

In addition, we conducted, with assistance from specialists at PricewaterhouseCoopers, an in-depth analysis of six urban public healthcare systems in the United States to identify leading

practices in four categories: quality care delivery, finance, IT, and governance and management. These systems varied in their degree of integration and offered rich and relevant information from their diversity. In addition, we reviewed selected leading practices from private integrated systems in this analysis.

Site Visits

Task Force members met with senior leadership teams at two health systems, Jackson Health System (in Miami-Dade County, Florida) and the New York City Health and Hospitals Corporation. Site visit hosts included the Chief Executive Officers, health system board members, and other senior leaders from the systems. This allowed us to hear firsthand how the leadership of these health systems set and met systemwide quality and financial goals. Most important, we learned about the key drivers of the transformational process conducted at these health systems over a decade or more, and heard candid discussion of their successes, mistakes, and ongoing challenges.

Collaborative Expert Analysis Sessions

The Task Force members conducted collaborative group sessions to analyze the data and to contextualize the information from the needs assessment, leading practices analysis, and site visits. Task Force members also conducted individual stakeholder interviews across the County to further translate the findings into recommendations specific to LA.

Organization of this Document

The remainder of the document is organized as follows. In **Section II**, we describe our vision for safety net healthcare delivery in LA County and present the findings from our needs assessment, leading practices analysis,

and site visits. At the end of **Section II**, we provide profiles of the two health systems we visited and also several case studies that illustrate, in a vivid and meaningful way, the leading practices, initiatives, and programs that informed the Task Force recommendations. In **Section III**, we present our recommendations for achieving the vision we detail in **Section II**.

We learned about the key drivers of the transformational process conducted at these health systems over a decade or more, and heard candid discussion of their successes, mistakes, and ongoing challenges.

At the end of the report, we include a series of appendices. **Appendix A** provides a selected list of previous reports, memorandums, and other documents on governance and operational issues relating to LACDHS and MLK Hospital. **Appendix B** lists several studies on public safety net healthcare systems in general. **Appendix C** provides more details from the needs assessment of South LA. **Appendix D** profiles four of the six public safety net healthcare delivery systems included in our leading practices analysis (the remaining two public healthcare delivery systems are profiled in **Section II**). **Appendix E**, which is only available electronically, is the full *Report on Leading Practices of Public Safety Net Healthcare Delivery Systems in the United States*, prepared by PricewaterhouseCoopers.

Key Findings

In this section, we present our key findings in three parts. First, we describe the Task Force vision for safety net healthcare delivery in LA County. Then, we discuss the findings from our healthcare needs assessment in LA County and South LA. Finally, we describe the results of our leading practices analysis of public healthcare systems in the U.S. and our site visits to Jackson Health System (in Miami-Dade County, Florida) and the New York City Health and Hospitals Corporation.

Task Force Vision for Safety Net Healthcare Delivery in LA County

To frame our analyses and recommendations, we first defined the make-up of the regional healthcare safety net and then developed a vision for improved healthcare in LA County.

Components of the LA County Healthcare Safety Net

The healthcare safety net in LA County – the system that provides healthcare to the medically indigent – includes a wide array of providers, both public and private, across the spectrum of care. **Figure 2.1** represents the safety net healthcare providers in LA County. Nearly every provider of healthcare services in LA County fits into one or more of the categories.

Because the healthcare safety net involves many providers in addition to LACDHS facilities, a coordinated and continuous effort is necessary on the part of both public and private entities in order to achieve the Task Force vision of healthcare in LA County.

A Vision for the Public Sector Healthcare Delivery System

The Public Sector Healthcare Delivery System is the portion of the public-private network composed of the LA County Departments of Health Services, Mental Health, and Public Health and directly controlled by the LA County Board of Supervisors. Our vision for the future Public Sector Healthcare Delivery System is one that incorporates and operationalizes the following principles.



The Task Force proposes that the Public Sector Healthcare Delivery System should be driven, first and foremost, by a mission to provide the highest-quality healthcare to its patients. All operations should be quality-focused and patient-centered.

In addition, the Public Sector Healthcare Delivery System should:

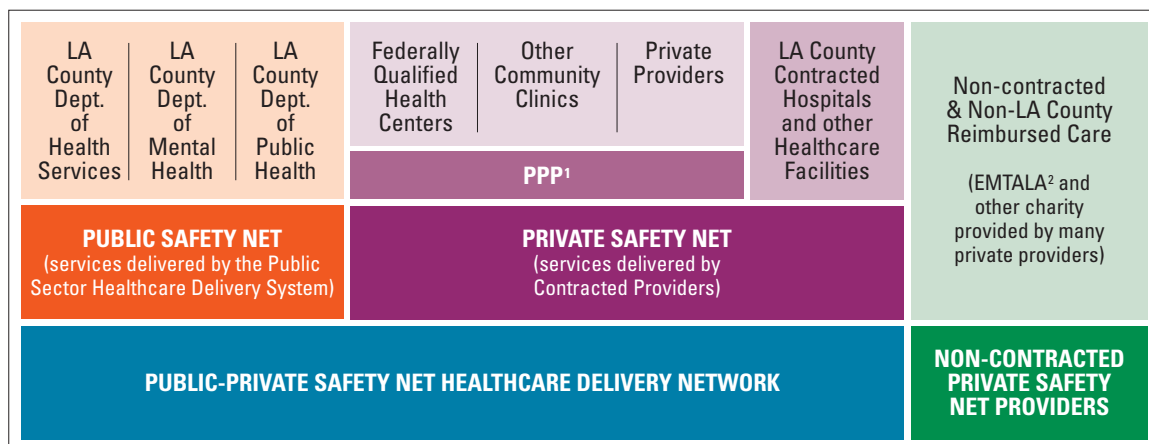
- Function with transparency and accountability to the public and its leadership, through increased public availability of specific quality indicators and information.
- Engage its entire workforce in a mission-driven collaborative process of continuous innovation and learning.
- Ensure its financial sustainability by improving its fiscal infrastructure, including diversification of its payer mix.
- Function as an integrated delivery system: a system that coordinates health from wellness and prevention to emergency and acute care services, and that emphasizes strategic planning and resource allocation, capitalizing upon economies of scale.
- Drive decisions and practices with accurate information (real-time process measures, clinical indicators, population outcomes, and cost measures).
- Work to eliminate inequality (a two-tiered healthcare system) by providing high-quality care – including prevention, primary care, specialty care, and tertiary and quaternary care – that is desirable to all residents of LA County.
- Recruit, develop, and retain transformational leaders who are expert in modern healthcare management.

- Expand long-term public-private partnerships and community engagement.
- Strengthen relationships with academic medical centers for education and research.
- Reintegrate MLK Hospital as a part of a coordinated system that takes ownership of its mission and these underlying principles.

The Task Force proposes that the Public Sector Healthcare Delivery System should be driven, first and foremost, by a mission to provide the highest-quality healthcare to its patients. All operations should be quality-focused and patient-centered.

Although the recommendations that follow in this report (**Section III, Recommendations**) pertain to the Public Sector Healthcare Delivery System, the quality of care for medically indigent patients in LA County would be improved by synergies with Private Safety Net Providers and Non-Contracted Private Providers who also serve these patients (**See Figure 2.1**). Therefore, we also present a vision for strengthened public-private collaboration in the future.

FIGURE 2.1 Representation of Safety Net Healthcare in LA County.



A Vision for Public-Private Collaboration

As shown in **Figure 2.1**, the LA County Public-Private Safety Net Healthcare Delivery Network (the Network) includes the *Public Safety Net* and the *Private Safety Net*. Providers of Private Safety Net services have voluntary contractual and/or Public-Private Partnership¹ relationships with LACDHS. These providers include Federally Qualified Health Centers (FQHCs), community clinics, and other private providers and hospitals. The Private Safety Net significantly augments the ability to serve an ever-expanding medically indigent population. Other non-contracted providers participate in the safety net through charity care and other types of reimbursed and unreimbursed services.²

The Task Force proposes that, in the future, the Network should include private healthcare entities that voluntarily participate and are willing and able to take part in systems improvement

activities and to provide services coordinated with and complementary to the Public Safety Net. The entire Network should be driven by a mission to provide the highest-quality healthcare to its patients and should uphold the principles described above for the Public Sector Healthcare Delivery System, including transparency and accountability, continuous innovation, and coordinated patient-centered care.

Healthcare Needs and Utilization in LA County

The vision and recommendations presented in this report were informed in part by data on healthcare utilization and need variations across LA County, a focused assessment of changes in healthcare access over time in South LA, and Task Force members' extensive knowledge of the current system. The Task Force work did not include extensive data analyses on LA County

¹ Providers who participate in the Public Private Partnership Program are private practice, free clinics, and Community Health Centers that receive funds from the LA County Board of Supervisors to provide care to uninsured residents in underserved areas of the county.

² In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

A VISION FOR THE PUBLIC SECTOR HEALTHCARE DELIVERY SYSTEM

Buena Vista Clinic – Monday, April 14, 2014, 9:21 a.m.

Consuelo Osili is running late once again. Today, her three-year-old son, Manny, is not the cause. As she pulls into the clinic driveway, she can blame another “new” electric SUV that has stalled on the southbound Harbor Freeway.

This is an important visit for Consuelo. She is expecting her second baby in another four months, and she has been feeling dizzy. Fortunately, for the past several years, the LA County Department of Health Services has contracted with several major chain supermarkets and pharmacies in her neighborhood to provide blood pressure, diabetes, and asthma monitoring at their stores. When Consuelo complained of a headache while grocery shopping with her best friend Alberta last Saturday, Alberta encouraged Consuelo to get her blood pressure checked right in the grocery store. The blood pressure reading was very high. When she returned home that afternoon, Consuelo sent a mobile phone text message to the prenatal nurse on-call at the LA County Department of Health Services clinics, who responded less than 30 minutes later.

When the nurse received Consuelo’s text message, Consuelo’s electronic medical record was automatically loaded to the nurse’s computer terminal for review. Consuelo had given permission for the LACDHS’s new computer system to recognize her telephone number and email address, which formed a part of the Master Patient Index needed to access the electronic medical records now available in every LA hospital and clinic that joined the new Los Angeles Integrated Delivery System, known as the Network.

The medical records indicated that Consuelo preferred to receive her medical care in Spanish. Before calling Consuelo back, the nurse accessed the LACDHS telephonic medical interpretation service and requested that a Spanish interpreter assist with the telephone consultation.

The medical records told the nurse that Consuelo was pregnant with her second child, had a family history of heart disease, and had mild blood pressure elevations when pregnant with Manny. The nurse also reviewed the report of the ultrasound image from Consuelo’s last prenatal visit and saw that Consuelo was gaining weight just a little faster than she should for this stage of her pregnancy. After a few more questions exchanged through the interpreter, the nurse suggested more rest over the weekend and set an appointment for early Monday morning. All of the clinics now use “Open Access” scheduling, which ensures that there will be slots available for patients like Consuelo who have an urgent need to see their physician.

Consuelo checks in at the front desk. The scheduling software had automatically adjusted the appointment times that morning after Consuelo did not check in by 9:10 a.m. for her 9 a.m. appointment. The front office staff quickly places a paper wristband on Consuelo showing her name, date of birth, and allergies, along with a bar code, and sends her to an examination room.

After a minimal wait, Consuelo is weighed on the electronic scale, and her blood pressure and temperature are taken. The aide scans the barcode and the results are automatically uploaded into the electronic clinic record. The aide also sends in a certified Spanish medical interpreter who is on staff at the clinic. Soon, the physician enters.

Dr. VanDyke is happy to see Consuelo and Manny. She took care of Consuelo during the last pregnancy with Manny. The medical student with Dr. VanDyke reads Consuelo’s medical record on the handheld electronic tablet and informs Dr. VanDyke about the text message and the telephone call a few days before. Dr. VanDyke asks Consuelo a few questions through the interpreter and orders both a urine test to look for protein and a blood test to check for possible anemia. Dr. VanDyke explains that the results will be ready shortly and that she will return to see Consuelo in a few minutes. The clinic now uses laboratory technology that generates real-time results for the most common tests used in the clinic: Patients do not need to make a return visit just to hear about lab results, and the medical decision can be made during the initial visit.

Twenty minutes later, Consuelo and Manny are invited into Dr. VanDyke’s office. She and the medical interpreter help Consuelo understand that this pregnancy is a little different from her previous one, and some changes are needed to minimize risk to her and to the baby. Dr. VanDyke prescribes a recently approved drug for hypertension

Continued on next page.

Continued from previous page.

in pre-eclampsia and places Consuelo in the Buena Vista Clinic Special Care Pregnancy program. Patients in the Special Care program are automatically scheduled for more frequent and longer visits, and between visits they receive Internet-based consultations on stress reduction, nutrition, and symptoms to watch for before the baby is born. In some cases, the mothers are prepared in advance for the possibility of a Caesarian delivery, which is done both through Internet-based seminars and through the Special Care support groups managed by the clinic. Years earlier, LA County learned that an intensive risk-reduction effort for Special Care patients reduces morbidity and mortality. As a result, the County now enjoys far lower infant mortality rates than in 2009.

After the consultation, Consuelo is relieved that there is something she can do to treat her dizziness and keep her unborn baby healthy. She stops at her corner chain pharmacy on the way home to pick up her prescription, as the clinic has sent the prescription electronically to the pharmacy of her choice. If the traffic isn't too bad, she'll be home before noon, but then you can never predict what happens on the Harbor freeway...

healthcare statistics (much is already publicly available); however, background information is provided here to build the context for the recommendations.

In addition to examining previous data on patient visits, healthcare resources, and changes in demand for inpatient and emergency services at private hospitals surrounding MLK Hospital, it was useful to review updated snapshots of healthcare utilization around the County and changes in access to care in South LA after the closure of MLK hospital. First, we conducted a literature search and analyzed previously collected survey data from the California Health Interview Survey (CHIS) to answer additional questions about the current picture in LA County. Second, a community-based study provided additional community-level information about potential delays in care after hospital closure in South LA (hereafter, we refer to this study as "the MLK study"). We describe both sets of findings in this section.

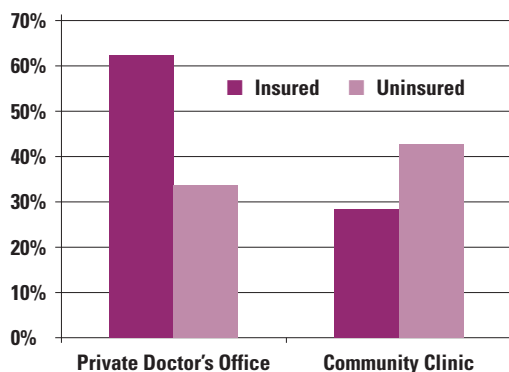
Los Angeles County

LACDHS serves a diverse population of more than 10 million residents; provides healthcare to over 700,000 patients and more than 300,000 emergency and trauma victims yearly; and currently operates four hospitals, two multi-service ambulatory care centers, six comprehensive health centers, and multiple health clinics throughout the County.

LA County has over 2.5 million people without health insurance – the highest rate among the nation's largest metropolitan areas. A large number of the uninsured receive their care from both the Public Sector Healthcare Delivery System and Private Safety Net providers. Almost one-third of the uninsured identify physicians from outside the public system as their usual source of care (**Figure 2.2**).

Data used in these analyses are shown by service planning area (SPA). These areas were first defined in 1993 and have since been used for planning by the Board of Supervisors and LA County health planning entities. **Figure 2.3** shows the geographic

FIGURE 2.2 Regular Source of Care by Insurance Status, Los Angeles County, CHIS 2007.



Source: California Health Interview Survey, 2007.

boundaries of the SPAs: SPA 1 is Antelope Valley, SPA 2 is the San Fernando Valley, SPA 3 is the San Gabriel Valley, SPA 4 is Metro Los Angeles, SPA 5 is West Los Angeles, SPA 6 is South Los Angeles, SPA 7 is East Los Angeles, and SPA 8 is the South Bay.

From an analysis of CHIS 2007 data, we see large differences in patient-reported health by SPA. In West LA (SPA 5), there are lower levels of fair/poor health compared with South LA (SPA 6), which has the highest levels of fair/poor health (**Table 2.1**).

FIGURE 2.3 Map of Service Planning Areas, Los Angeles County.



Source: LA County Department of Public Health website, <http://www.lapublichealth.org/SPA/spamap.htm>.

TABLE 2.1 Health Status, Insurance Status, and Emergency Room Utilization, by Service Planning Area.

	SPA 1 Antelope Valley	SPA 2 San Fernando	SPA 3 San Gabriel	SPA 4 Metro	SPA 5 West	SPA 6 South	SPA 7 East	SPA 8 South Bay
Self-reported fair/poor health (%)	24	19	23	25	11	33	25	18
Currently not insured (%)	17	17	18	31	8	27	20	20
Emergency room visits, past 12 months (%)	25	19	15	17	13	21	17	19

Source: California Health Interview Survey, adults age 18-85, 2007.

Populations in the SPAs of LA County vary in terms of sociodemographic factors that influence healthcare access, including racial/ethnic composition and economic status. In areas where residents report lower health status, we might expect that healthcare utilization and needs are also higher. In addition, communities with unmet needs face challenges in accessing care because of lack of insurance and low supply of healthcare resources.

Compared with West LA (SPA 5), South LA (SPA 6) has poorer reported health status and greater levels of uninsured residents. The Metro LA area (SPA 4) has the highest numbers of uninsured (31 percent). Comparing emergency room usage in the past 12 months reveals greater usage by residents in South LA (SPA 6) compared with those in Metro LA (SPA 4) (21 percent versus 17 percent, respectively).

Among the pediatric population, there are differences by age group in health status and healthcare utilization. Across LA County, those in younger age groups have more reported delays in needed medical care and are most

likely to visit an emergency room for care (**Table 2.2**). Adolescents are more likely to report fair/poor health and more likely to be uninsured than the younger age groups. They also have a higher rate of emergency room visits than children age 5 to 11. Data show that dental screening rates are better for adolescents than younger children, though still not in line with national recommendations.

Perinatal indicators suggest high levels of need in LA County (**Table 2.3**). First trimester prenatal care, teen pregnancies, and infant mortality rate and are shifting in the right direction, but still have room for improvement.

Healthcare Needs After the Closure of Martin Luther King Jr. Hospital: A Look at South Los Angeles (the MLK Study)

From the review of healthcare needs across LA County, it appears that variations in need and access to care among subgroups of the population do exist. The following study focused on South LA to take a closer look at the community surrounding MLK Hospital. The MLK Study was a community-based participatory study conducted to determine

TABLE 2.2 Health Status, Healthcare, Insurance Coverage, and Delays in Care Among Children and Adolescents in Los Angeles County.

	AGE GROUPS		
	0 - 4	5 - 11	12 - 17
Self-reported fair/poor health (%)	4.0	6.1	13.8
Type of health insurance coverage (%)			
Uninsured	4.9	7.3	7.5
Public	6.0	43.0	36.3
Private	49.1	50.7	56.2
Dentist visit, past 12 months* (%)	47.9	71.5	86.9
Visited an emergency room for care, past 12 months (%)	21.0	11.8	19.0
Delayed needed medical care, past 12 months (%)	7.0	5.0	5.1

Source: California Health Interview Survey, 2007; * Dentist visit for children age 2–5 and one-year-olds with teeth.

TABLE 2.3 Perinatal Indicators, Los Angeles County.

	YEAR	
	1997	2006
First-trimester prenatal care, % of all live births	82.5	90.3
Live births to mothers less than 18 years of age (% of all live births)	4.7	3.4
Infant mortality rate, per 1,000 live births	5.9	4.9

Source: Los Angeles Department of Public Health. Title V Perinatal Indicators. 2006.

the nature and extent of delays and unmet healthcare needs of South LA (SPA 6) elderly residents. South LA is a low-income, largely Latino and African American area of the city of Los Angeles and adjacent communities. South LA residents have high levels of healthcare need and have faced changes in healthcare supply, including the closure of MLK Hospital.

Approximately 26 percent of South LA residents are age 45 or older,³ and this age group is growing faster than any other age group. People over age 50 represent a disproportionately large percentage of hospital discharges (45 percent) and almost 50 percent of LACDHS adult outpatient visits.⁴ This group also uses the highest volume of services. Individuals with

³ Kurt Salmon Associates. Critical Condition: Examining the Scope of Medical Services in South Los Angeles. The California Endowment. October 2007.

⁴ Diamant, A. Patient Assessment Survey III: Final Report. 2005. As of March 26, 2009:

http://www.ladhs.org/wps/PA_1_QDN2DSD308H9E02DJM1JGM0000/Planning/pdf/PAS%20III%20Final%20Report%206-30-05.pdf

chronic disease and who are elderly have greater need for inpatient and chronic disease management services. Although this study focused only on older adults for these reasons, the limited scope is not intended to imply relative importance of their needs over those of children or other age groups.

The MLK Hospital closure in 2007 resulted in the loss of acute-care hospital beds, an extremely busy emergency room and trauma center, and an academic medical training center. This added increased stress on surrounding hospitals and emergency departments.⁵ Although numerous efforts failed to effectively reengineer hospital services and management to meet national standards, there continues to be strong need and commitment to reopening the facility, including a recent proposal supported by county and academic partners.

Unfortunately, as a result of the closure of MLK hospital, South LA's uninsured and underinsured may have even greater challenges with healthcare resources, physician supply, and emergency services. Currently, South LA facilities include private community hospitals, but no public hospital. The current healthcare facilities serving South LA are limited, as shown in **Table 2.4**.

South LA has fewer acute hospital beds, community clinics, and pharmacies when compared with the entire region of LA County and has significantly fewer healthcare resources than West LA, an area of LA County commonly considered to have the most abundant healthcare resources (**Table 2.5**).

Since 2004, more than ten hospitals have closed throughout LA County, and this created challenges, particularly for the uninsured and

TABLE 2.4 South Los Angeles Healthcare Facilities.

HOSPITALS

- Centinela Hospital Medical Center
- Kedren Community Mental Health Center
- Los Angeles Metropolitan Medical Center
- St. Francis Medical Center
- Promise Hospital of East Los Angeles Suburban Campus

DEPARTMENT OF HEALTH SERVICE CLINICS

- Dollarhide Health Center
- H. Claude Hudson Comprehensive Health Center
- Hubert H. Humphrey Comprehensive Health Center
- Martin Luther King Jr. Multi service Ambulatory Care Center

PUBLIC-PRIVATE PARTNERSHIP CLINICS

- BAART Community Healthcare
- California Family Medical Care Group
- Central City Community Health Center
- Central Neighborhood Medical Group, Inc.
- St. John's Well Child and Family Center, Inc.
- T.H.E. Clinic, Inc.
- University Muslim Medical Association, Inc.
- Watts Healthcare Corporation

Source: Office of Statewide Health Planning and Development; Los Angeles County Department of Health Services.

those with Medicaid.⁶ While such closures affect all county residents, the residents of South LA have been among the hardest hit after the closure of MLK Hospital. South LA faces the dual challenges of high healthcare need and low availability of healthcare resources.

The MLK study examined healthcare needs of older African American or Latino adults living in South LA after MLK Hospital closed, and compared these measures to previously collected data from CHIS (**Table 2.6**). Observing differences over time

⁵ Hospital Association of South Los Angeles. King-Harbor Closure Hospital Impact Analysis. Correspondence. March 28, 2008.

⁶ Buchmueller, TC, M Jacobson, Wold C. How far to the hospital? The effect of hospital closures on access to care. J Health Economics. 2005; 25:740–761.

TABLE 2.5 Healthcare Infrastructure in South Los Angeles, West Los Angeles, and Los Angeles County.

INDICATOR	SOUTH LA	LA COUNTY	WEST LA
General acute care hospitals per 100,000 population	0.45	0.90	1.23
Bed supply per 1,000 population (averaged)	0.68	1.23	1.83
Licensed available bed supply per 1,000 population	1.14	2.21	3.22
Community clinic supply per 1,000 uninsured population	0.09	0.10	0.12
Pharmacies per 100,000 population	7.72	15.14	21.81

Source: South Los Angeles Health Equity Scorecard, Community Health Councils, Inc.

TABLE 2.6 Health Status, Emergency Room Use, and Delays in Care Among Older Persons in South Los Angeles Across Years and Geography.

	CHIS COMPARISON				
	SPA 6 South LA 2008	SPA 6 South LA 2005	SPA 5 West LA	LA County	California
Self-reported fair/poor health (%)	39.6	49.6	36.3	42.4	40.2
Visited an emergency room for care, past 12 months (%)	32.3	32.7	25.5 [†]	26.8 [†]	24.6 [†]
Preventive health services and utilization (%)					
No flu shot in past 12 months	55.0	58.7	56.0	57.9	56.1
Never had a colonoscopy, within 10 years	41.0	55.0	14.4	36.6	36.4
Never had a pneumonia shot	67.2	70.8	66.5 [‡]	72.4 [‡]	70.9 [‡]
Mammogram, never/more than 2 years ago (women)	11.7	14.2	13.4	16.1	17.0
PSA, never/more than 1 year ago (men)	57.0	33.0	43.6 [†]	61.8 [†]	65.2 [†]
Delays in care (%)					
Problem to receive needed medical care	16.6	16.4	10.9	14.7	17.3
Problem to see a specialist	12.1	18.4	13.4	14.1	13.8

Source: CHIS data for geographic comparisons from most recent year available for SPA 6, African Americans and Latinos who are over age 50 similar to 2008 South Los Angeles study. Data shown is most recent CHIS survey (2007), unless otherwise noted: [†] CHIS 2005 [‡] CHIS 2003 [§] CHIS 2001. Italics indicate value is statistically unstable.

suggests greater demand for preventive care and primary care services after the closure of MLK hospital. **Appendix C** shows more details of the study results. Overall, among African Americans and Latinos who are over age 50 in South LA, there were differences in preventive care, delays in care, and unmet healthcare needs. There are significant differences among age and ethnic

groups. Routine screening guidelines for those over the age of 50 recommend a yearly flu shot, colon cancer screening every ten years, and a pneumonia shot once after the age of 65. In addition, most physicians continue to recommend prostate-specific antigen (PSA) screening, but may also discuss other options with their patients.

In the MLK study, significantly more adults age 50–64, relative to older adults, did not receive a flu shot, have a colonoscopy within 10 years, or have a pneumonia shot. Those who were Latino also had greater self-reported unmet preventive needs and delays in care compared with African Americans, including in rates of colonoscopy, pneumonia shot and prostate cancer screening.

Summary

Variation in the medical needs of vulnerable populations throughout LA County are reflected by variation in healthcare demands and utilization. Some of the most vulnerable populations within the County are in South LA, where there is considerable disease burden. With greater risk for morbidity and mortality, South LA may have seen an increase in primary care needs for preventive services and chronic disease management after the closure of MLK Hospital. In a community as diverse as South LA, the future system of care will need to address these challenges through integrated, high-quality, patient-centered care. These findings underscore the importance of the Task Force’s vision for an improved safety net healthcare system in LA County.

Leading Practices from Public Healthcare Delivery Systems in the U.S.

The Task Force engaged a senior team at the PricewaterhouseCoopers (PwC) Health Industries Advisory Practice to assist in identifying leading practices that have been found to be successful in other public safety net healthcare delivery systems. These leading practices, organized into four categories, informed the development of recommendations for achieving a sustainable, high-performing system in LA. Based on our review of the literature and collaborative analysis sessions, we determined these categories to be key areas of focus that could contribute to significant improvement in the Network.

The four categories are as follows:

- **Quality Care Delivery:** Leading practices that facilitate high-quality service delivery to patients and patient safety. This category includes practices that enable continuous quality improvement, a skilled workforce, and development of relationships with private sector physicians, hospitals, and academic medical centers.
- **Finance:** Leading practices that focus on securing the financial viability of public health systems in order to sustain and enhance the service mission.
- **Information Technology:** Leading practices that promote continuity of care and information, as well as cost-efficient IT systems that facilitate integrated healthcare delivery systems.
- **Governance and Management:** Leading practices that focus on the key components of successful management and oversight of healthcare systems. This category includes practices that support transformational change throughout the organization, including improvements in the other categories of service delivery, information technology, and finance.

The project methodology included a multidisciplinary approach to gather information on leading practices within the U.S. healthcare delivery system. Six urban public safety net healthcare delivery systems were identified by the Task Force and PwC. These systems have been recognized as high-performing and as having some characteristics comparable to LACDHS. The systems included in the analysis were Denver Health Medical Center (Denver, CO), Harris County Hospital District (Houston, TX), Hennepin Healthcare System (Minneapolis, MN), Jackson Health System (Miami-Dade County, FL), New York City Health and Hospitals Corporation (New York, NY), and Parkland Health and Hospital System (Dallas County, TX). We made site visits to Jackson Health System

and the New York City Health and Hospitals Corporation, and we provide a profile of these two systems later in this section. We describe the other four systems in **Appendix D**. The descriptions are based on publicly available information found on each system's respective website, annual reports to the community, and audited financial reports. Our methodology was specifically designed to bring together both internal points of view related to leading practices as well as external views of the healthcare industry, where these practices appear to be successfully implemented.

The full report by PwC on leading practices of public safety net healthcare delivery systems can be found electronically in **Appendix E**, at www.calendow.org.

Our methodology also included the following:

- **Review of the literature** on public healthcare systems in general, leading practices of certain systems, and previous reports and recommendations on the public healthcare system in LA County.
- **Analysis of public healthcare systems** through a PwC internal collaborative design session in December 2008 with subject-matter specialists to brainstorm ideas related to leading practices. With a focus on the four categories, the PwC team brought industry-level experience to the process and contributed to building a leading practices framework through knowledge of successful results.
- **Site visits** to two health systems, Jackson Health System and New York City Health and Hospitals Corporation. These two urban safety net hospital systems were chosen by the Task Force based on their relevance to LA County and their overall quality, financial, and operational performance. Task Force members conducted interactive focused discussions with senior leadership and board members

at both systems on a range of topics. Key topics included leading practice attributes of their systems, tools and methodologies for actualizing leading practices, and experience- and evidence-based guidance for transforming the healthcare delivery system in LA County.

- **Analysis of all the findings** in collaborative analysis sessions throughout February and March 2009.

Overarching Findings

From the leading practices analysis and healthcare system site visits, one overarching theme stands out from among all others:

Leading public healthcare systems have clarity of mission throughout the organizational culture: to achieve the highest-quality care through transparency, continuous innovation, and accountability at all levels.

The successes of leading public healthcare systems have been driven by dynamic leaders who (1) recognize that their greatest asset is their people and (2) have the authority necessary to drive organizational and cultural change. Leaders of these systems achieve this cultural transformation at all levels and within all component organizations; they cannot successfully improve one part of the system without improving the whole system.

Leading public healthcare systems have clarity of mission throughout the organizational culture: to achieve the highest-quality care through transparency, continuous innovation, and accountability at all levels.

In our site visits, one physician stated, “We are on a quest to be the best. If we see others with metrics higher than ours, we ask ‘why not us?’” Such statements illustrate the pervasive culture of change that seems to be fundamental to quality improvement in these healthcare systems.

Quality Care Delivery Findings

Leading public safety net healthcare systems sustain their commitment to high-quality clinical care through evidence-based medicine and continuous measurement and improvement. They take an integrated approach to delivering quality care and focus on improving quality in order to be the “provider of choice” rather than the “provider of last resort.” For example, their patient-centered, safety-and-quality-first mindset leads all aspects of strategic planning and day-to-day execution of care delivery and other operational processes. They view every patient encounter as an opportunity to improve patient health, service, and satisfaction.

Leading systems create a culture of innovation, utilize quality-improvement tools, and value cost-effectiveness. Measures and outcomes are made available to the public and to leaders in order to achieve transparency and accountability **(See Case Study 1, page 35).**

Other leading practices in quality care delivery include:

- Maintaining a strong focus on wellness, prevention, and primary care, including the establishment of a medical home for all patients.
- Reducing barriers to access through innovative, community-based programs such as implementation of open access scheduling models, comprehensive interpreter programs, and partnering with community providers

or nontraditional delivery sites **(See Case Studies 2-5, pages 37-43).**

- Developing centers of clinical excellence that provide state-of-the-art care aligned with community needs. These centers are often rooted in strong affiliations with top academic medical centers and research institutions.
- Streamlining services for efficiency, effectiveness, and service satisfaction from the point of the patient’s first contact with the system through to follow-up and health maintenance services **(See Case Study 6, page 43).**
- Encouraging patient enrollment in preventive and chronic disease management programs, including those for diabetes, asthma, and depression **(See Case Study 7, page 44).**
- Redesigning clinical and administrative processes utilizing performance-improvement initiatives led by front-line workforce. These initiatives minimize waste, unnecessary work steps, and patient inconveniences, which then frees resources to be redirected toward serving patients **(See Case Study 8, page 45).**
- Innovative labor-management partnerships to recruit, develop, and retain an experienced workforce that adapts easily to change and health system demands.

Finance Findings

Nearly all public safety net healthcare delivery systems, including the leaders, lose money every year from their patient care delivery operations. Public hospitals report that 17 percent of their costs are uncompensated, compared with 5.8 percent for all hospitals.⁷ In California, the Medi-Cal physician reimbursement rate ranks 42nd in the nation.⁸ Additional pressures include rising uninsurance due to unemployment and declining Medicaid reimbursement in response to lower tax revenues.

⁷ America’s Public Hospitals and Health Systems, 2007. Results of the Annual NAPH Hospital Characteristics Survey Interim Report – December 2008. *National Association of Public Hospitals and Health Systems.*

⁸ Kaiser Commission on Medicaid & the Uninsured Facts, The California Medicaid Program at a Glance. Kaiser Family Foundation, June 2005.

Leading public safety net healthcare delivery systems overcome the challenge of growing demand coupled with insufficient resources, by continuously working to improve the revenue they earn, to reduce unnecessary, non-value-added costs, and to leverage their capital as much as possible to increase community access and sustain high-quality healthcare service delivery.

Other leading practices include:

- Developing a community reputation and “brand recognition” for the highest-quality experience among all patients. Leading public systems successfully compete with private health systems, attracting not only indigent patients but increasing their market share of insured patients **(See Case Study 9, page 47)**.
- Developing unique insurance products and contracts that improve competitiveness and financial stability. Revenue earned from services to insured patients is used to cross-subsidize uncompensated costs of care to uninsured and underinsured patients, enhancing the service mission.
- Aligning quality and financial incentives to improve patient health status and deliver care more efficiently, for example, with pay-for-performance arrangements.
- Engineering financial discipline into all activities, including monitoring resource utilization and cost through integrated decision support systems aligned with quality objectives. Leading systems apply rigorous patient-centered performance improvement techniques, using ingenuity to reap available financial gains that can be reapplied to patient care.
- Using scale to exert volume purchasing power with vendors, to eliminate duplication and

inefficiencies, and to centralize and share resources across the delivery system.

- Having senior leaders deeply engaged in workforce-led initiatives that reduce risk and improve performance, with unions and management joining as stakeholder-partners to achieve a more efficient and effective care delivery system while ensuring recruitment and retention of workforce.
- Setting strategies that allocate resources for optimum systemwide return on investment – not only in a financial sense, but in terms of achieving mission goals of serving community safety net healthcare needs through the most efficient and effective operations and the highest-quality outcomes.

Leading public safety net healthcare delivery systems overcome the challenge of growing demand coupled with insufficient resources, by continuously working to improve the revenue they earn, to reduce unnecessary, non-value-added costs...

- Working collaboratively in a strong, constructive, interdependent partnership with their affiliated governments and the community at large, and meriting sufficient local government and taxpayer-supported subsidy levels that are critical for closing fiscal gaps and sustaining the public safety net healthcare delivery system.

Information Technology Findings

Leading public safety net healthcare delivery systems make use of technology and the information it provides to fundamentally transform the way they deliver care and run their operations. They develop systemwide IT strategies that are aligned with clinical, operational, and financial strategic plans.

Leading practices include:

- Utilizing standard, interoperable, broadly adopted IT systems to link patients and clinicians and improve care coordination between providers, including community providers, across the continuum of patient care. Health system investments in IT provide vital, readily accessible health information about patients, stored in a single, central data warehouse **(See Case Study 10, page 47)**.
- Providing clinicians with IT to reference medical knowledge and evidence-based protocols to inform clinical practice, and to support clinical decisions and processes, improving quality of care and reducing medical errors.
- Using IT to enable active promotion and management of patient wellness and prevention, thereby reducing unnecessary illnesses and costs.
- Developing and using robust, readily accessible decision support and data analysis IT capabilities for performance monitoring, risk management, and performance improvement initiatives. Unified systemwide metrics relate to clinical quality, resource use, and financial impact and can be aggregated or disaggregated at many levels, including the business or clinical unit.
- Using technology at all levels – from the Board of Directors and senior leaders, through front-line clinicians, managers, and staff – to share risk and performance information in a timely, transparent, and constructive manner. This drives accountability at all levels of responsibility,

as well as agile course corrections. Individuals and teams across the enterprise take ownership of solving performance problems at their root cause, continuously driving performance metrics to higher levels.

Governance and Management Findings

Leading public safety net healthcare delivery systems apply visionary leadership. They demonstrate how their ability to function as autonomous, self-governed, and self-managed organizations – separate from direct government operation – is critical in their progress toward greater efficiency, effectiveness, and high performance. This characteristic of autonomy does not usually mean complete independence: Under a variety of alternative structures, public systems remain accountable to, and subject to oversight by, an affiliated government that holds reserve powers.

Leading health systems leverage the mutual commitment, capabilities, resources, and benefits of an interdependent partnership between the care delivery system and affiliated government, with both entities focused on meeting community health needs.

Relating to governance and management, leading practices include:

- Benefiting from ongoing high levels of support for their autonomy – evidenced by financial support beyond mandated levels – from affiliated government officials and elected leaders who enable the system to do what is best for care delivery that meets community health needs.
- Having a formative charter and annual operating contract between a governance board and their affiliated governments to clarify mutual rights, authorities, funding obligations, service level obligations, and accountabilities. The charter and contracts

provide an effective framework to diffuse potential political pressures that may be inconsistent with a balanced healthcare delivery strategy.

- Preparing a three-to-five-year strategic master plan and annual budgets with affiliated government input and approval, enabling the autonomous care delivery system Board of Directors and management to effectively implement strategies and make operational decisions without unconstructive interventions.
- Having a dynamic, hands-on CEO and a talented, cohesive leadership team that is trusted by the dedicated, engaged health system board. Collectively, they promote a consistent vision and strategy of a sustainable safety net mission, a value-based culture, accountabilities for all personnel, and policies that reinforce high performance behavior,

innovation, and continuous improvement, embraced throughout the organization.

The following profiles of the two healthcare systems visited by the LA Healthcare Options Task Force include some background information, a financial profile, a summary of major recognitions, and selected leading practices. The selected leading practices cited for each system are examples and illustrations rather than an exhaustive list of every leading practice at each system. The information was obtained from our interviews with senior leadership, the healthcare system websites, annual community reports, financial reports, news releases, and other public sources as referenced. **Appendix D** contains profiles for four additional public safety net healthcare systems included in the leading practices analysis.

JACKSON HEALTH SYSTEM *(Miami-Dade County, FL)*

Established in 1918, Jackson Health System (JHS) is an integrated healthcare delivery system with more than 11,000 employees that provides a single, high standard of medical care services to residents of Miami-Dade County regardless of their ability to pay. JHS is governed by the Public Health Trust of Miami-Dade County, Florida (the Trust). The Trust was created on October 1, 1973, by county ordinance to provide for an independent governing body of volunteer citizens responsible for the operation, governance, and maintenance of designated facilities comprising the health system to assure that JHS is responsive to community needs. The Trust's Board of Trustees is appointed by the Miami-Dade County Commission. According to the September 30, 2007, audited financial statements of Miami-Dade County, the Trust is considered part of the primary government of Miami-Dade County, and is presented as an enterprise fund, rather than a component unit, in the County's financial statements. The Trust is not considered to hold sufficient corporate powers of its own to be considered legally separate from the County for financial reporting purposes.

JHS includes 12 primary care centers and two primary care mobile vans; multiple school-based clinics serving many elementary, middle, and high schools; two long-term care nursing facilities; six Corrections Health Services clinics; a network of mental health facilities; and Holtz Children's Hospital, Jackson Rehabilitation Hospital, Jackson North Medical Center, Jackson South Community Hospital, and its flagship hospital, Jackson Memorial Hospital. With more than 1,550 licensed beds, Jackson Memorial Hospital is a referral center, a magnet for medical research, and home to Ryder Trauma Center – the only adult and pediatric Level 1 trauma center in Miami-Dade County. In conjunction with the University of Miami Miller School of Medicine faculty, Jackson Memorial Hospital provides a wide range of patient services, educational programs, a clinical setting for research activities, and a number of

Continued on next page.

health-related community services. JHS also owns JMH Health Plan, an HMO serving over 105,000 commercial and Medicaid patients.

Financial Profile

In its audited September 30, 2008, financial statements, the Public Health Trust reported total operating revenue of \$1.4 billion, of which \$1.2 billion was net patient service revenue. The Trust reported an operating loss of \$426 million and negative cash flows from operating activities of \$344 million. Operating losses and negative cash flows were offset by \$452 million and \$440 million, respectively, of non-operating revenues and noncapital financing funds contributed by federal, state, and miscellaneous sources. The non-operating revenues and noncapital financing are principally composed of funding from Miami-Dade County generated by ad valorem taxes to defray costs of general operations, additional assistance from the County, and a half-cent sales tax approved by county voters in 1992 to support the operations of the Trust.

For fiscal year 2008, the Trust reported an overall increase in net assets of \$26 million and a net increase in cash and cash equivalents of \$53 million. The estimated cost incurred to provide charitable services for 2008 was reported at \$531 million.

Major Recognitions

Jackson Memorial Hospital has the distinction of being consistently listed among the top 50 of “America’s Best Hospitals” by *U.S. News & World Report*, with more specialties ranked among the best in America than any other hospital in South Florida for 2008.

Selected Leading Practices

- *Mission-Driven Culture and Transformational Leadership:* A clearly expressed sentiment among the senior leadership of JHS is the key role of a dynamic leader, in the position of CEO, with the autonomy and authority to assemble a strong leadership team and transform the culture of the organization to focus on quality of care and cost-effectiveness. This mission-driven culture is described as pervasive at all levels, with emphasis on continuous process improvement to eliminate costs that do not benefit patients.
- *Centers of Excellence (COEs):* JHS’s strategy is characterized by the provision of advanced treatments and excellent care, enabling it to attract patients regionally and internationally for its services. JHS is noted for its COEs in such areas as:
 - digestive disorders (more than half of the world’s reported multi-organ transplants have been performed there)
 - ear, nose, and throat (the Cochlear Implant Program is one of the most comprehensive and busiest programs in the nation)
 - hormonal disorders (a recognized world leader in cure-focused diabetes research and a pioneer in islet cell transplantation to treat diabetes)
 - kidney disease (home to a successful transplant program since 1977, where surgeons perform 150–200 transplants a year)
 - neurology and neurosurgery (a center of excellence in the neurosciences and a leader in the early treatment of stroke, spine surgery, non-invasive Gamma Knife radiosurgery for brain tumors, minimally invasive



interventional neuroradiology treatments for intracranial aneurysms, and cerebrovascular disorders such as aneurysm and stroke)

- ophthalmology (the University of Miami's Bascom Palmer Eye Institute has consistently been named the top institution in the nation where a person could receive care and treatment for diseases of the eye)
- urology (The Batchelor Urology Diagnostic and Treatment Center treats a wide range of urologic disorders in men, women and children. Areas of expertise include prostate, bladder and kidney cancer as well as male infertility and incontinence in females).
- *Affiliation with Academic Medical Schools:* Jackson Memorial Hospital provides the setting for the majority of clinical research projects conducted. Among the most notable activities of the medical school at Jackson Memorial Hospital are those of the Sylvester Comprehensive Cancer Center and studies on cystic fibrosis, neonatology, diabetes, children's kidney failure, transplantation, spinal cord regeneration, infant perception of temporal speech parameters, AIDS, hyperbaric therapy, microsurgery, clinical pharmacology, geriatrics, and Alzheimer's disease. In addition, the medical school runs the largest tissue bank in the world.
- *Adapting to Patient Needs:* Jackson's community outreach initiatives include two Jackson Care-A-Vans, staffed with bilingual and multicultural healthcare professionals and support staff. They bring high-quality, reliable, and comprehensive primary care services to adults and children in high-risk communities, including screenings, X-rays, pharmacy services, physicals, prescriptions, lab work, women's health services, and prenatal care. They also provide eligibility screenings and enrollment on-site for such programs as Medicaid and KidCare. The vans are equipped with wireless laptops, email, and Internet access, and they travel to seven different locations in Miami-Dade County.

Additionally, to address an overcrowded emergency room, the ER was remodeled, expanded, and underwent a process-improvement redesign. This enables non-urgent patients to be moved out of the ER and into Jackson's ambulatory clinics and primary care centers for same-day appointments. The use of dedicated "bed coordinators" and the addition of a discharge lounge have enhanced patient flow out of the ER and decreased overcrowding.

- *Innovative Primary Care:* To build a healthier community, JHS embarked on an innovative Primary Care Initiative to solve health problems by providing quality healthcare, education, and disease prevention. By linking primary care with disease management, school-based healthcare, and outreach, program staff members are improving the health of the community, with an added focus on recent immigrants and underserved areas.
- *Patient Safety Focus:* Patient safety rounds are scheduled weekly, allowing Jackson executive leaders and support staff to meet with those working on the hospital floors to better understand patient safety concerns. Once these safety issues are identified, a plan of action is quickly put into place to resolve them. A patient safety program also has been developed for all of Jackson's nursing units to study the causes of unsafe practices and put practical improvements in place to prevent medical errors. Through the use of Failure-Mode-Event-Analysis, a method of analysis adopted from the aviation industry, hospital staff now are better equipped to uncover potential quality and patient safety failure points, so they can prevent safety problems before they occur.

Sources:

Miami Dade County Financial Statements. 2007. Available at: <http://www.miamidade.gov/finance/finan07.asp>
 Miami-Dade County, Florida Comprehensive Annual Financial Report for the Fiscal Year Ended September 30, 2007.
 Jackson Health System. A Report to the Community 2005-2006. Available at: http://www.jhsmiami.org/workfiles/pdfs/JHS_Report_to_Community.pdf
 Jackson Health System website: <http://www.jhsmiami.org/>



NEW YORK CITY HEALTH AND HOSPITALS CORPORATION *(New York City, NY)*

New York City Health and Hospitals Corporation (HHC) is the largest municipal public safety net healthcare delivery system in the country, serving more than 1.3 million patients annually with a workforce of 39,000 physicians, nurses, and other healthcare professionals. HHC was established in 1970 as a public benefit organization by the New York State Legislature and is governed by a Board of Directors appointed by the Mayor of New York City (the City). According to the June 30, 2008, Comprehensive Annual Financial Report of the City, HHC is considered legally separate from the primary government of the City. The reason HHC is a discretely presented component unit in the City financial statements is because the City either appoints HHC's Board, is able to impose its will on HHC, or a financial benefit/burden situation exists.

HHC serves a diverse patient mix, including the uninsured and immigrant population, and provides care regardless of ability to pay. HHC is composed of 11 acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers, and more than 80 community-based clinics. HHC also owns MetroPlus HMO and operates a certified home healthcare agency. MetroPlus insures more than 340,000 people and is consistently ranked among the highest-scoring New York City Medicaid managed care plans for quality and customer service.

Financial Profile

Within its audited June 30, 2008, financial statements, HHC reported total operating revenue of \$5.9 billion, of which \$4.9 billion was net patient service revenue and \$0.8 billion was premium revenue generated from its health plan. HHC reported an operating loss of \$336 million and positive cash flows from operating activities of \$66 million. HHC's estimated expense incurred to provide charity care were reported at \$487 million.

During 2008, HHC's reported cash flow from operations included \$248 million in cash appropriations from the City of New York and \$338 million in HHC remittances to the City. The remittances to the City were principally for reimbursement of general liability settlements paid by the City on HHC's behalf and for debt service on debt the City incurred to fund HHC capital acquisitions. Also in 2008, HHC reported \$152 million in capital contributions by the City to fund major modernization and reconstruction projects.

Major Recognitions

HHC is consistently recognized by leading organizations for its quality and safety initiatives. In 2008, the Commonwealth Fund Commission on a High Performance Health System published a case study that recognized and described the innovations and high performance of the system. In 2006, HHC achieved five of the top ten Centers for Medicare and Medicaid Services (CMS) rankings in all of New York City in each of three key categories – treatment of pneumonia, heart attack, and heart failure. HHC has received numerous awards, including the 2008 John M. Eisenberg Award from the National Quality Forum and The Joint Commission for Patient Safety and Quality. HHC was also recognized for the North Bronx Health Network in 2008, receiving the HANYS (Hospital Association of New York State) Pinnacle Award for Quality Improvement and Patient Safety. HHC's Sea View Hospital Rehabilitation Center and Home earned the 2007 Ernest Amory Codman Award from The Joint Commission for excellence in its use of outcomes measures to achieve improvements in the quality and safety of healthcare. HHC's Generations Plus Northern Manhattan Health and Network Queens Health Network



both earned the Nicholas E. Davies Award from the Healthcare Information and Management Systems Society for excellence in their use of electronic health records to improve healthcare delivery. HHC's North Bronx Healthcare Network garnered the Most Wired Award in 2005 for the fourth consecutive year for the effective use of IT in the areas of safety, quality, customer service, business processes, and workforce training.

Political support and passion for its mission have been critical to the HHC's success. As noted in HHC's 2007 annual report to the community, Mayor Michael Bloomberg has provided unwavering support of the health system's core mission. HHC's President, Alan D. Aviles, noted: "HHC is transforming, changing to meet the complexity and breadth of our patients' needs and incorporating new technologies and treatment modalities that are dynamically altering the way healthcare is delivered. In many ways, HHC's hospitals and clinics are advancing at such a rapid pace that they are literally *redefining* public healthcare in New York City. Now, that is interesting."

Selected Leading Practices

- **Mission-Driven Culture:** Even under economic uncertainty, HHC holds steadfast in its core mission of affording broad access without regard to patients' ability to pay or immigrant status. Increasing access, making capital investments, improving IT, enhancing quality and patient safety, and reducing health disparities are all critical initiatives undertaken by HHC.
- **Centers of Excellence:** COEs at HHC offer city residents some of the best specialty care in New York City. For example, patients have access to 6 regional trauma centers, 11 designated AIDS centers, 2 burn centers, 2 regional perinatal centers, 11 Sexual Assault SAFE Centers, 9 stroke centers, 4 sickle cell anemia care centers, 2 Parkinson's disease care centers, and a World Trade Center Environmental Health Center with three locations.
- **Information Technology:** To drive clinical performance improvements while facing financial challenges, HHC identified several outdated information systems for replacement. HHC announced a rollout of a systemwide implementation over the next several years of new information systems. For example, the organization is implementing a new financial system that will ensure optimizing the collection of revenue due from third-party payers for all services provided to patients. Enhancements to the electronic medical record system will allow providers to more readily access a patient's clinical data from anywhere within the hospital system while offering much more robust functionality that will permit efficient documentation. Additionally, it will guide and support more comprehensive and consistent evidence-based care.
- **Centered on Patient Needs:** HHC focuses efforts on customer service to increase competitiveness through patient satisfaction. HHC's Options Program aims to make healthcare affordable for very low-income New Yorkers. HHC eliminated all outpatient fees for pregnant women and children of families with incomes below 250 percent of the federal poverty level. For patients at the lowest income levels, HHC reduced prescription drug fees to \$2 per prescription to further lower barriers to medication compliance. Additionally, marketing materials have been translated into 12 languages to increase access and to remain culturally competent.
- **Population Health Management/Disease Management:** HHC developed and implemented leading practices to help its patients manage their chronic disease more effectively, with an emphasis on asthma, diabetes, congestive heart failure, and depression. HHC has funded dedicated chronic disease coordinator positions in every network and has deployed clinical IT solutions, including electronic chronic disease registries, to help support this work.
- **Minimizing Costs:** HHC is leveraging the size and breadth of the health system to reduce cost. For example, it installed an e-commerce system that helps track procurement of goods and supplies. It has also centralized contracts to ensure that its vast purchasing volume is optimized to obtain the lowest possible price.

Sources:

Finance and Budget Reports. New York City. Available at: <http://www.nyc.gov/html/records/html/govpub/finan1.shtml>
 Comprehensive Annual Financial Report of the Comptroller of the City of New York for the Fiscal Year Ended June 30, 2008.
 New York City Health and Hospitals Corporation website: <http://www.nyc.gov/html/hhc/html/home/home.shtml>
 New York City Health and Hospitals Corporation. 2007 Year in Review.
 Available at: <http://www.nyc.gov/html/hhc/downloads/pdf/hhc-local-auth-ann-rpt-2008.pdf>
 Redefining HHC, 2007 Annual Report. New York City Health and Hospitals Corporation.
 Available at: <http://www.nyc.gov/html/hhc/downloads/pdf/hhc-community-report.pdf>
 New York City Health and Hospitals Corporation – SWOT Analysis. Global Markets Direct Company Profiles. January 2009.



Case Studies

1 What does it mean to “embrace transparency?”

In a healthcare system with transparency as a core value, processes are designed to improve clinical quality and patient safety at all levels of the organization. Hospitals and health systems (both public and private) incorporate multiple departments, committees, and specific positions dedicated to addressing these concerns. Chief medical officers, clinical quality officers, chief compliance officers, and utilization review boards are among those with oversight responsibilities regarding quality of care and patient safety.

Increased performance transparency enabled by the Internet (e.g., WebMD, The Leapfrog Group for Patient Safety, and HealthGrades), more educated consumers, and the influx of consumer-directed health plans has brought public attention to quality-control metrics that were previously unavailable. There is a large movement for healthcare systems to embrace transparency and to be held accountable for the quality of care provided. Well-publicized concerns on quality and safety include:

- Medical errors cost about \$38 billion annually and result in 100,000 deaths each year.
- If medical errors were combined into a single statistical cause of death, it would be the sixth

leading cause of death in the United States (based on 2006 data).

- Medicare will no longer reimburse hospitals for infections, complications, and incidents that the Centers for Medicare and Medicaid Services (CMS) has deemed preventable “never events.”
- The reputational damage due to poor quality and highly visible “never events” are potentially disastrous for healthcare providers.

According to the National Quality Forum, “never events” are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients and that indicate a real problem in the safety and credibility of a health care facility.

Many leading hospitals are able to demonstrate high-quality process and outcomes measures to promote their clinical excellence to consumers and payers. Health system commitment to high clinical quality and patient safety requires regular systematic and independent evaluations of their clinical, operational, and management processes and outcomes.

An Example of Embracing Transparency – New York City Health and Hospitals Corporation Quality Metrics

New York City Health and Hospitals Corporation (HHC) publishes its quality record, inviting public comparison with state and national performance averages. HHC has created a special section on their website for the public to see the quality measurements (i.e., indicators from both the Centers for Medicare and Medicaid Services and from the Agency for Healthcare Research

and Quality) that HHC is using to assess its progress, as well as to compare its quality measurements to established state and national standards.

Public dissemination of the information not only offers healthcare consumers comparative data in selecting their provider of choice, but also encourages HHC hospitals to strive for continuous improvement on the key quality measures in comparison with other HHC facilities and the best state and national benchmarks.

HEART FAILURE CARE

Appropriate and Timely Treatment and Prevention, Hospital-Specific Data, April 2006–March 2007. (%)

	NATIONAL AVERAGE	NYC VICINITY AVERAGE	HHC AVERAGE	BELLEVUE	CONY ISLAND	ELMHURST	HARLEM	JACOBI	KINGS COUNTY	LINCOLN	METROPOLITAN	NORTH CENTRAL BRONX	QUEENS	WOODHULL	
LVF Evaluation	85	93	99	100	98	100	96	99	98	100	100	100	97	100	TIMELY & EFFECTIVE CARE PREVENTION
Discharge Instructions Given	65	70	88	95	99	98	77	83	87	75	90	82	86	98	
Smoking Cessation Advice/Counseling	85	88	94	97	97	100	99	100	93	100	98	100	72	81	
ACEI/ARB for LVSD	83	86	95	92	97	98	99	93	95	100	98	94	90	92	

Source: New York City Health and Hospitals Corporation website. LVF – left ventricular function, ACEI – angiotensin converting enzyme inhibitor, ARB – angiotensin receptor blocker, LVSD – left ventricular systolic dysfunction.

Sources:

Levy, D. and C. Bleustein, "How Will Healthcare Systems Uphold High-Quality Care and Safety Standards Under an Increasingly Powerful Public Microscope?" PricewaterhouseCoopers Connected Thinking, Health Industries Advisory, 2008.
 The Leapfrog Group, Never Events Fact Sheet. As of March 27, 2009: http://www.leapfroggroup.org/media/file/Leapfrog-Never_Events_Fact_Sheet.pdf
 Centers for Medicare and Medicaid Services. "Eliminating Serious, Preventable and Costly Medical Errors – Never Events," press release, May 18, 2006. As of March 27, 2009: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=18639>
 New York City Health and Hospitals Corporation, "Understanding Our Quality and Safety Performance," web page. As of March 27, 2009: http://www.nyc.gov/html/hhc/infocus/html/home/performance_landing.shtml
 New York City Health and Hospitals Corporation, "Heart Failure Care," web page. As of March 27, 2009: http://www.nyc.gov/html/hhc/infocus/html/heart_failure/heartfailurecare_details.shtml

2 Open Access to Healthcare Appointments

Open access scheduling is a system that allows patients to schedule an appointment with their physician when they want or need to be seen. It redesigns patient access and the scheduling process to allow patients to schedule same-day appointments (or as close to same-day as possible), regardless of the nature of the patient's reason for seeking care.

The concept of same-day appointments has been a reality among medical group practices for almost a decade. For example, Healthcare Partners Medical Group, a Los Angeles-area practice with more than 500 primary care and specialty physicians in more than 40 medical offices, initiated open access as part of a complete overhaul of its practice protocols in early 2000. Healthcare Partners Medical Group provides care to over 550,000 members.

Open access scheduling is a system that allows patients to schedule an appointment with their physician when they want or need to be seen.

The medical group has pioneered such innovations as Premier Appointments, which ensures that patients can schedule same-day appointments with their doctors as needed during the clinic's regular business hours; automatic referral authorizations for most common specialty services; new patient orientations; and Care Teams for primary care patients.

Sources:

Butcher, Lola, "More Doctors Tell Patients, 'We'll See You Today,'" *ACP Observer* (American College of Physicians), November 2006.
 Lang, Lance, and Laura Jacobs. "Improving Patient Access: Health Plans and Physician Groups Unite!" *CAPG Update*. Vol. 5, No. 4, April 2003, p. 3.
 Witt, Mary J. "Advanced Access Works! Improved Patient Satisfaction, Access, P4P Scores." The Camden Group, 2006.

"We started by re-designing our clinical flow with the care team process and then we proceeded to open access," said Francis L. Yemofio, FACP.

Step one was assigning caregivers – two or three physicians, each with two medical assistants – to a "care team" and reconfiguring space so that team members worked closely together. That allows patients to become acquainted with other members of their physician's care team, and for the caregivers to share work as the need arises.

Healthcare Partners Medical Group is not unique in offering same-day access to primary care physicians. Many other California medical groups, including Kaiser Permanente Medical Group, Buenaventura Medical Group, Sharp Mission Park, Bristol Park Medical Group, and Palo Alto Medical Foundation, have also implemented this approach or other similar models.

In addition to patient satisfaction, the benefits they have achieved include the following:

- Improved clinical outcomes because continuity of care is increased as more patients see their regular physician of choice.
- Decline in urgent care or ER visits.
- Decline in office phone volume.
- Reduced patient no-show rates.
- Greater adherence to preventive care guidelines.
- Reduction in visits per patient, but increase in revenue per patient for fee-for-service patients.
- More manageable office practice, with greater physician and staff satisfaction.
- Increased capacity for new patients.

3 Public-Private Partnership Opportunity: A Health Care Interpreter Training Program

In order to meet the growing needs of the medically indigent, including those in South Los Angeles, more collaboration between the public and private sectors will be essential. One opportunity for public-private partnership exists in the area of health care interpreter services. Because of the diversity of languages spoken by LA County residents, a greater number of qualified professional health care interpreters is needed to provide linguistically and culturally appropriate health care assistance.

A program that could be adopted in South LA, and elsewhere in LA County, is Kaiser Permanente's Health Care Interpreter Certificate Program (HCICP). This program was a recipient of the 2006 Award for Innovative Practices in Multicultural Health Care from the National Committee for Quality Assurance (NCQA). As a training program, it could provide both employment opportunities and improved access and quality of care.

In 1995, Kaiser Permanente performed a national environmental scan of existing interpreter programs and found the following:

- No private or public accreditation program existed for professional healthcare interpretation.
- Interpreters provided by external agencies often lacked sufficient training and demonstrated an inconsistent quality in their interpretation.

Recognizing the lack of formally trained Health Care Interpreters and related training programs and certification standards, Kaiser Permanente designed a model Health Care Interpretation curriculum in 1996. Kaiser then collaborated with

the City College of San Francisco (CCSF) to offer the curriculum as a formal HCICP, making CCSF the first educational institution in the Western United States to offer Health Care Interpreter training at the college level.

Recognizing the lack of formally trained Health Care Interpreters and related training programs and certification standards, Kaiser Permanente designed a model Health Care Interpretation curriculum in 1996.

The model Health Care Interpreter curriculum has now been disseminated across the country through collaboration with *Hablamos Juntos*, a project of the Robert Wood Johnson Foundation. This innovative and cost-effective model has shown that partnerships between cross-sector health care organizations and accredited academic institutions are not only sustainable, but mutually beneficial. The collaborative efforts help promote a renewable balance of supply and demand. Kaiser Permanente continues to develop the core content materials and supports new and existing HCICP partnerships across the country. So far, over 100 faculties have received the training nationwide. Over 1,000 graduates can provide interpreter services in more than 10 different languages, including

Arabic, Cantonese, Farsi, Japanese, Khmer, Korean, Laotian, Mandarin, Portuguese, Russian, Spanish, Tagalog, and Vietnamese.

Key program resources necessary for success include:

- *Personnel:* Coordinators/instructors from each partnering academic and health care institution, language lab coaches, and volunteer lecturers, such as physicians and nurses.
- *Financial:* Kaiser Permanente pays for the initial instructor training and provides class materials and space. Grants or other sources of funding help support training and education programs.

- *Training:* The Health Care Interpreter Instructor Training Institute trains faculty at partnering academic institutions and improves skills of existing faculty.
- *Support:* Continuous technical support is provided to academic institutions and partner healthcare institutions.

“Kaiser Permanente has created a model for plans nationwide to follow on how to bridge language and cultural gaps that so easily get in the way of quality health care,” said NCQA President Margaret E. O’Kane, and provides “innovative solutions that tackle the very real issue of health care disparities among racial and ethnic minorities.”

Sources:
NCQA, Innovative Practices in Multicultural Health Care 2006. As of March 27, 2009: http://www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_InnovativePrac06.pdf
The Robert Wood Johnson Foundation, The National Health Plan Collaborative Toolkit. As of March 27, 2009: <http://www.rwjf.org/qualityequality/product.jsp?id=34036>

4 Innovative Care Delivery Models: Retail Clinics

When the California HealthCare Foundation (CHCF) issued its first report on the topic “Health Care in the Express Lane: The Emergence of Retail Clinics,” in the summer of 2006, there were just over 100 clinics across the country. In February of 2009, most estimates show about 1,200 active sites. This three-year period has seen not only a significant growth in sites, but the entrance of major players in the retail sector – CVS, WalMart, Walgreens – and significant experimentation with geographic locations, clinic design, and service models.

There is significant debate regarding the merits and detriments of the retail clinic model, and quantitative measures of the impact of the clinics are just beginning to emerge. Nevertheless, some interesting lessons have become evident in the past few years.

Background

Who Uses Retail Clinics?

The “typical” consumer (70 percent of visits) is a generation X woman (age 29–43) with children. Those without health coverage also comprise a large proportion (up to 20 percent) of patients.

What are Retail Clinics Used For?

The vast majority (75–90 percent) of visits are for seven common conditions – sinusitis, upper respiratory infection, pharyngitis, otitis media, bronchitis, urinary tract infection, and immunization. In the overall health care system, these conditions account for 17 percent of primary care provider visits and 15–30 percent of ER visits. Clinic operators consistently state that patients come to the clinic with appropriate conditions about 96–97 percent of the time (i.e. they’re not visiting clinics when they should be visiting ERs).

What is the typical layout and staffing model?

Layout and staffing vary significantly, but Minute Clinic, which has almost half of the sites in the United States, operates clinics with 100–200 square foot offices staffed with nurse practitioners overseen by offsite physicians. WalMart clinics are staffed by health care system partners. QuickHealth (Northern CA) uses a physician model and targets uninsured consumers.

Lessons Learned from Retail Clinics That May Be Applied in the Healthcare Safety Net

1. Retail clinics won't solve big health care systems' problems of quality and cost, but they demonstrate some value in "letting the simple things be simple."

Common conditions may be able to be diagnosed and treated in this setting, at a lower cost to patients and the system.

2. Health care consumers do exhibit some consistent preferences and behaviors.

Consumers/patients want to see a health care provider at a time and place that works for them, and they want to know what the cost (in time and money) of the visit will be. Polls on retail clinics have consistently shown satisfaction with the model, willingness to return to clinics, and willingness to refer friends and family. Patients' reasons for utilizing the clinics are that they either don't have a regular provider or can't get an appointment with him/her when they need one; that the locations are convenient (including parking); and that the cost of the retail clinic services is transparent.

3. Consumers have responded positively in surveys to nurse practitioners as providers in the retail clinic setting.

4. Efficiencies can be created by limiting the scope of service and applying evidence-based algorithms to minor, acute conditions.

The central tenet behind retail clinics is their limited scope of service. By limiting scope of service to simple routine acute care, these clinics are able to streamline operations, improve the customer experience, reduce costs, and maintain quality (through the use of technology and strict adherence to evidence-based care for minor conditions). Retail clinics are not trying to serve all patients in the same way with the same level of care.

5. While many were initially quite resistant to the concept, many health care systems are now testing the retail or "express" clinic model as a way to extend their customer offerings and to avoid unnecessary ER visits.

How Can Community Health Centers and Other Safety Net Providers Evaluate and/or Incorporate Elements of the Retail Clinic Model?

- Operate a retail clinic – in a retail location or within their facilities.
- Create a more involved partnership that includes an equity involvement.
- Create a simple partnership with a clinic to provide physician oversight and/or branding
- Watch, learn and adapt existing operations.

CHCF and Scott & Company have produced the Retail Clinic Toolkit for Safety Net Providers, which includes several tools for evaluating or adapting retail clinic concepts to the safety net setting. CHCF would like to work with one or more safety net systems to pilot the use of the toolkit.

Sources:

Margaret Laws, M.P.P., and Mary Kate Scott, "The Emergence of Retail-Based Clinics in the United States: Early Observations," *Health Affairs*, Vol. 27, No. 5, 2008, 1293–1298.
James C. Robinson, Ph.D., M.P.H., and Mark D. Smith, M.D., M.B.A., "Cost-Reducing Innovation in Health Care," *Health Affairs*, Vol. 27, No. 5, 2008, 1353–1356.
Contribution from Margaret Laws, Director of the Innovations for the Underserved Program of the California HealthCare Foundation.

5 Telemedicine and Telehealth

Telemedicine and telehealth programs have been active in California for more than a decade. According to Dr. Thomas Nesbitt of the University of California–Davis Medical Center, a nationally renowned expert on telehealth and steadfast California telehealth pioneer,

One might imagine such successes would have led to broad adoption of telehealth. Yet, in more than 15 years of working to eliminate disparities in care, I have often been frustrated that so few patients have been able to access care in this way. Telehealth works best, not as a “demonstration” project grafted onto a broken health care system, but when it is accepted as a way to leverage new technologies to create new models of care that were formerly impossible. At long last, the prospects in California are improving. Recent investments in telecommunications infrastructure by the Federal Communications Commission, the California Emerging Technology Fund, California Public Utilities Commission, and the State of California, through Proposition 1D bonds, are all potential “game changers.” I believe the time has finally come for telehealth to thrive.

Background – A Few Basic Facts What Is Telehealth?

Telehealth is the use of technology and processes to electronically connect patients in remote or underserved areas with health care providers and educators, overcoming barriers of time and distance and delivering health services and education in places that lack those resources. It can be as simple as a remote provider discussing a case over the phone with a specialist, or as sophisticated

as a patient having a virtual appointment with a distant provider via videoconferencing. Telehealth is an expansion of telemedicine. Whereas telemedicine is narrowly focused on diagnosis and direct treatment of illnesses, telehealth encompasses a broad definition of remote health care services enabled by telecommunication technology, including education, diagnosis, treatment, assessment, and monitoring.

What Are Some Prominent Uses?

Telehealth excels at services for which a remote provider can review an image and offer feedback – for example, radiology, dermatology, and diabetic retinopathy. A provider sends an image to a consultant or specialist in a structured format and the consultant can view the image at any time and provide feedback to the sending provider. This method, known as “store and forward,” removes some of the challenges associated with having both providers available at the same time. Specialties such as behavioral health and psychiatry – in which the intervention involves verbal communication and a visual examination of the patient – are also successful. A patient in a remote location can meet via video with a provider, and the provider can observe the patient visually and provide therapy.

These real-life examples illustrate the promise of telehealth:

- Live from the ER, a rural provider consults with a neurologist at an urban medical center as he treats a patient with acute head trauma. The neurologist can see what is happening via videoconferencing and advises the provider in real time.

- A remote provider keeps up on best practices and the latest advances in care through virtual attendance at grand rounds at a world-class medical center.
- A patient in an urban clinic has a persistent rash. Her primary care provider takes a picture and sends the image to a dermatologist via a “store and forward” system. The dermatologist reads the patient notes, views the image, and provides interpretation and treatment advice to the primary care provider. The patient is treated in a week instead of waiting months for an appointment with a dermatologist.
- A rural practitioner in Humboldt downloads diabetes educational materials in Spanish from the University of California Medical Center in Los Angeles to give to her Spanish-speaking patient.

What are the Benefits?

Patients: Telehealth technologies can help patients in underserved areas get access to medical resources around the state. People who need access to specialty care currently unavailable in their own communities can receive it without the cost and inconvenience of traveling.

Remote providers: Remote providers gain access to the consultative services of providers at other locations around the state, as well as educational opportunities and “knowledge networks” to improve their ability to manage patient care.

All Californians: All Californians benefit from the reduction in travel (fuel consumption and pollution) associated with the use of telehealth technologies. Telehealth technologies offer the opportunity to help make health care more environmentally friendly.

A patient in a remote location can meet via video with a provider, and the provider can observe the patient visually and provide therapy.

Lessons Learned About Telehealth Programs

It has been demonstrated that telehealth technology works and that patients and providers have high levels of satisfaction with telehealth. However, there has not been sufficient evaluation and business model development for programs to be sustained.

One of the major areas of promise for telehealth is connecting primary care providers with (scarce) specialist resources. The dearth of specialists willing to accept safety net patients, and our poor ability to match the limited supply with the demand, is one of the persistent challenges of launching and sustaining telehealth programs.

The use of traditional “paper” business processes and workflow with telehealth technologies does not leverage the technology, and changes in process and workflow are difficult for (and often not core competencies of) many primary care providers.

Reimbursement, billing, and coding for telehealth are not well understood by the provider community or payer organizations (public or private).

For examples of Telehealth Programs in California and links to resources, statistics and more in-depth information, see next page.

A FEW EXAMPLES OF ACTIVE TELEHEALTH PROGRAMS IN CALIFORNIA:

- *The Southside Coalition of Clinics in LA has recently launched a tele-dermatology program:*
<http://lahealthaction.org/index.php/directory/detail/1022>
- *The Open Door Health Network runs a "Telehealth and Visiting Specialists Center":*
<http://www.opendoorhealth.com/tvsc-opening.php>
- *Kings View Behavioral Health Telepsychiatry:* <http://www.kingsview.org/Default.aspx?tabid=38>
- *The Northern Sierra Health Network:*
http://www.nsrhn.org/index.php?option=com_content&task=view&id=33&Itemid=41
- *Children's Hospital LA Tele-Dentistry Program:*
<http://www.childrenshospitala.org/site/c.ipINKTOAJsG/b.3838323/>

LINKS TO RESOURCES, STATISTICS, AND MORE IN-DEPTH INFORMATION:

American Telemedicine Association: <http://www.americantelemed.org/i4a/pages/index.cfm?pageid=1>
 California Center for Connected Health: <http://www.chcf.org/topics/view.cfm?itemID=133805>
 California Telemedicine and eHealth Center: <http://www.cteonline.org/>
 California Telehealth Network: <http://www.caltelehealth.org/>
 Partners Center for Connected Health: <http://www.connected-health.org/>

Sources:

California HealthCare Foundation, *Delivering Care Anytime, Anywhere: Telehealth Alters the Medical Ecosystem*. November 2008. As of March 27, 2009:
<http://www.chcf.org/documents/policy/TelehealthAltersMedicalEcosystem.pdf>
 Contribution from Margaret Laws, Director of the Innovations for the Underserved Program of the California HealthCare Foundation.

6 Institute for Healthcare Improvement

The Institute for Healthcare Improvement (IHI) is an independent, not-for-profit organization with a mission to globally accelerate improvement of healthcare by fostering promising concepts for improving patient care and turning ideas into action. IHI's focus is on the Institute of Medicine's six improvement aims for the healthcare system: Safety, Effectiveness, Patient-Centered, Timeliness, Efficiency, and Equity.

IHI organizes various programs for health systems, hospitals, and professionals, which include but are not limited to:

- the *Improvement Map* to help hospitals understand numerous regulatory requirements and focus on high-leverage changes to transform care.
- campaigns such as the *5 Million Lives Campaign*, a national initiative to protect

patients from 5 million incidents of medical harm (e.g., hospital-acquired infections) in U.S. hospitals for a two-year period.

- conferences and seminars for professionals to learn and engage in conversations on improvement ideas.
- *IMPACT*, a membership network for healthcare organizations to come together in collaborative learning sessions to improve results in clinical outcomes, patient and provider satisfaction, and financial performance.
- professional development through training programs designed to help professionals develop and improve skills to lead improvement initiatives and to build their organization's overall capacity to change.

Leading healthcare systems committed to continuously improving patient care quality, like the New York Health and Hospitals Corporation,

take part in IHI activities. Senior HHC leaders regularly participate in IHI professional development programs.

IHI continuously seeks to identify organizations that are measuring their improvements and obtaining results. The Institute's aim is to close

the gap between the vision of ideal care and inadequate/unsatisfactory care. IHI disseminates this information through various programs and its website, so that healthcare organizations can learn and build upon successful practices.

Source: Institute for Healthcare Improvement website. As of March 27, 2009: <http://www.ihi.org>.

7 Integrated Medical Specialty Clinics

Successful long-term care of patients with chronic health conditions requires the skills of a multidisciplinary team of health professionals. In addition to primary healthcare providers, support from other professionals, such as specialist physicians, nurse practitioners, nurses, dietitians, social workers, pharmacists, psychologists, and other providers, is critical to ensuring that patients receive appropriate, high-quality services, including education for self-care. Such common conditions as diabetes, asthma, and cardiovascular disease could be better managed by integrated specialty clinics.

Patients in underserved communities such as South Los Angeles often lack necessary resources to seek, obtain, and coordinate complex care, such as time off from work, transportation, or insurance. The following case study describes a specialty diabetes management program within LACDHS that is achieving better health outcomes for medically indigent individuals.

LACDHS Specialty Diabetes Clinics

An existing program within LACDHS is already realizing the vision of patient-centered, effective, gold-standard diabetes management in low-income areas. Specialty diabetes clinics at the

Edward Roybal Comprehensive Health Center in East Los Angeles and the Hubert Humphrey Comprehensive Health Center in South Los Angeles, two communities with the highest rates of diabetes in the county, are run by interdisciplinary teams of nurse practitioners, doctors, pharmacists, social workers, and community educators to educate and support diabetic patients. Most of the patients are uninsured or on Medi-Cal.

The treatment team members make phone calls, hold classes, and help patients change their diets, prescriptions, or medication doses. They even visit patients' homes to keep treatment on track. Community members who speak the same language and share the same culture, and who have successfully controlled their diabetes, are recruited to teach classes and help coordinate care for newcomers to diabetes management. The model allows specialist physicians, such as endocrinologists, to become consultants to community-savvy teams led by nurse practitioners who have more opportunities to provide more consistent and frequent medical services and lifestyle education.

To participate, patients in the county program sign an agreement that they will keep appointments and follow medical instructions. If they fail to

comply, they are disenrolled from the program. Since funding is limited, patients can stay with the program only 6 to 9 months, but the expectation is that they can learn to control their disease in that time, then go back to a primary care physician.

Early studies suggest that the program works for controlling blood sugar, hypertension, and dyslipidemia. A report in the April 2006 *American Journal of Managed Care* looked at how a key blood sugar test, hemoglobin A1c, was controlled in 367 patients in the LA County program the year before and the year after they entered the program. The A1c guideline was met by only 28 percent of participants when they were under

traditional medical care. After a year in the program, 60 percent of patients met the blood sugar level goal.

A second study published in February 2007 in the journal *Diabetes Care* found that diabetic patients in the program reduced their ER use by half and cut down on hospitalizations. Total hospital charges dropped that year for the 331 patients studied to \$24,630, from \$129,176 the year before.

This type of program could potentially be replicated to achieve both better patient health outcomes and cost savings.

Sources:

Mayer B. Davidson, M.D.; Maria Castellanos, RN; Petra Duran, BS; and Vicki Karlan, MPH, "Effective Diabetes Care by a Registered Nurse Following Treatment Algorithms in a Minority Population," *American Journal of Managed Care*, Vol 12, 2006, 226–232.

Mayer B. Davidson, M.D., Adeela Ansari, M.D., and Vicki J. Karlan, MPH, "Effect of a Nurse-Directed Diabetes Disease Management Program on Urgent Care/Emergency Room Visits and Hospitalizations in a Minority Population," *Diabetes Care*, Vol. 30, 2007, 224–227.

Brink, Susan, "Their Best Shot," *Los Angeles Times*, May 07, 2007, p. F-1.

8 Tools for Continuous Process Improvement

Leading healthcare systems have tailored continuous process-improvement tools, proven effective for companies in other industries, for use in their quality improvement initiatives. These tools may become more effective when used in combination with complementary tools. Six Sigma and Lean are two of the oldest and most widely respected tools used for process improvement.

Six Sigma

Six Sigma,TM a registered trademark of Motorola, is a data-driven approach for reducing variation and developing consistently repeatable processes to meet customer requirements. Six Sigma evolved as a quality initiative aimed at improving manufacturing processes in the semiconductor industry and to eliminate defects. The components

of the Six Sigma methodology were created by Bill Smith at Motorola in the 1980s, inspired by decades of quality-improvement methodologies based on the work of Shewhart, Deming, Juran, Ishikawa, and others.

Lean

Lean has its roots as a method for optimizing automotive manufacturing mostly derived from the Toyota Production System. Lean manufacturing focuses on the elimination of waste and delays in an effort to create efficiencies and overall improvement of customer value.

Lean Six Sigma

Lean and Six Sigma have strongly complementary strengths that are particularly useful for systematically developing healthcare

service innovations. Synthesizing these approaches leads to an integrated program incorporating the organizational infrastructure and the thorough diagnosis and analysis tools of Six Sigma with Lean analysis tools and best-practice solutions for problems dealing with waste and unnecessary time consumption. A combined Lean/Six Sigma methodology for performance improvement assists organizations in managing the large-scale integration of fundamental changes in processes, culture, and stakeholder management to achieve and sustain breakaway results. Phases may include defining opportunities, measuring performance, analyzing opportunities, and improving performance. Benefits include the creation of operating efficiencies (e.g., through the elimination of re-work cycles or non-value-added activities), implementation of process controls, cost reductions, data-driven decision making, and standardized methodology.

A combined Lean/Six Sigma methodology for performance improvement assists organizations in managing the large-scale integration of fundamental changes in processes, culture, and stakeholder management to achieve and sustain breakaway results.

Process Improvement Methods at Work: The New York City Health and Hospitals Corporation

Queens Hospital Center held the Corporation's first *Breakthrough* event to improve the flow of patients through operating rooms. "The Queens team conducted a Rapid Improvement Event (RIE), a key *Breakthrough* tool used to identify waste, design new processes and effect immediate change. The team reviewed how patients were being processed for ambulatory and other surgeries performed in the operating room, identified waste and redundancy that could be removed to make the process more patient-centric, put the new processes in place, wrote up the new procedures and trained unit staff. As a result, the team was able to achieve a reduction in patient processing time of 1 hour and 20 minutes per patient."

HHC's corporate-wide *Breakthrough* initiative is "a system of principles and tools based in an improvement philosophy known widely as 'Lean,' that was first developed in the manufacturing industry and was more recently adapted for healthcare." Through *Breakthrough*, HHC will be creating "a culture that improves clinical outcomes, brings service closer to the patient, improves patient and staff satisfaction, and reduces waste and long-term costs."



Sources:

H deKoning, JP Verver, et al., "Lean Six Sigma in Healthcare," *Journal of Healthcare Quality*, March/April 2006.
 New York City Health and Hospitals Corporation, "Report to the Board of Directors: Queens Hospital Leads Corporate-Wide Breakthrough Initiative with Completion of First Rapid Improvement Event," March 27, 2008. As of March 27, 2009: <http://www.nyc.gov/html/hhc/html/board-report/hhc-presidents-report-2008-03.shtml>.

9 Diversifying Payer Mix to Achieve the Public Service Mission

By improving quality of care, many public safety net hospital systems are able to attract a more diversified payer mix that includes private payers. The health systems have found that this enhanced payer mix does not detract from their mission, but rather increases the resources available to provide high-quality care to the medically indigent.

The New York City Health and Hospitals Corporation (HHC), the largest municipal healthcare system in the United States, is one example. Over the past decade, HHC has transformed from an organization at risk of dissolution due to financial and quality problems, to a mission-driven, patient-centered system with higher performance and where many patients are choosing to obtain their care. In 2006, the total number of patients served by HHC's outpatient clinics increased again for the fifth time in the past six years. Inpatient discharges from all HHC acute care hospitals is up as well; overall, HHC's total inpatient occupancy rate is above 90 percent.

Source:

McCarthy, D and Mueller K. A., The New York City Health and Hospitals Corporation: Transforming a Public Safety Net Delivery System to Achieve Higher Performance. The Commonwealth Fund Commission on a High Performance Health System, October 2008. Available at <http://www.commonwealthfund.org>.

Multiple efforts have led to a stronger revenue streams, including financial counseling to enroll more uninsured patients eligible for public programs, and also consolidation of its Medicaid managed care to improve administrative efficiency and margins, and to align incentives to support prevention and care coordination. HHC contracts exclusively with its two affiliated plans (reduced from eighteen managed care plans): HealthFirst, in which HHC has an ownership stake, and MetroPlus Health Plan, a subsidiary that was started in 1985 and currently enrolls more than 320,000 members in Medicaid managed care, Medicare Advantage, the State Children's Health Insurance Program (SCHIP), and state coverage expansion programs. These tactics allow HHC to align its strategy and capture more revenue to fund improvements that sustain and expand the organization's ability to serve all patients.

10 Information Technology and Electronic Medical Records as the Backbone of an Integrated Medical System - Kaiser Permanente's HealthConnect™

In 2003, Kaiser Permanente took the bold step of launching a wide-scale, comprehensive electronic health record in more than 430 medical office buildings and 36 hospitals that would allow it to put patient safety first.

Today, Kaiser Permanente is nearing the completion of this transformative experience, and the system, HealthConnect,™ is the largest civilian electronic health record in the world. It securely connects 8.6 million people to

their health care teams, their personal health information, and the latest medical knowledge. All Kaiser Permanente members have an active HealthConnect record, providing them with new and evolving ways to partner with their doctors and other care providers.

HealthConnect is designed to help Kaiser Permanente standardize the practice of medicine across its eight regions, create better access to patient medical records, improve safety and efficacy of care, enhance patient experience and access to care, and become the largest single research source in the nation. HealthConnect's built-in treatment guidelines also help Kaiser Permanente improve the management of common/chronic conditions, such as diabetes and hypertension. Doctors and caregivers have data at their fingertips to identify what treatments and protocols work best. The system also offers scheduling, registration, and referral management.

Prior to HealthConnect, Kaiser Permanente faced a fractured IT infrastructure: There were nine separate communication silos formed by Kaiser Permanente's eight regions and its national infrastructure, no common platform, numerous disparate IT systems, limited standard data elements, expensive IT maintenance costs, and regional or physician office-owned paper medical records.

Industry studies show that paper medical records are unavailable up to 30 percent of the time for patient office visits and are almost never available for patient care in an emergency room. Kaiser Permanente's electronic health record is available when and where it is needed by any clinician serving the member.

For an integrated health care system like Kaiser Permanente, this capability helps the organization create a seamless experience for its members

as their health information moves quickly and securely between doctors' offices, hospitals, outpatient centers, and pharmacies, allowing scenarios in which ER staff can immediately access information about a patient's blood type, allergies, and medications.

In addition, because HealthConnect includes more comprehensive patient information, it is helping caregivers address multiple problems or the provision of multiple services in a single visit, reducing the need for additional follow-up appointments.

Besides patients' clinical medical records, the system also notes and uses up-to-date social and patient preference information to enhance personalized care with language interpretation or social services needs. There are patient access interfaces that provide patients information for shared decision making, which patients may access via telephone, Web, and email. The advances offered by HealthConnect reduce the cost of care and improve visit experiences. Costly in-person services are eliminated unless medically necessary or desired by the patient.

Kaiser is already seeing clear patient safety and improved clinical outcomes as a result of implementing HealthConnect. There has been dramatically lowered cardiac disease mortality, improved use of preferred drugs, better syndromic surveillance, improved vaccine rates, enhanced data about clinician performance for development of quality improvement initiatives and performance coaching, and improved Clinical Research Capabilities.

To learn more about the impact KP HealthConnect™ is having on care, videos profiling real members and caregivers are available for viewing at <http://www.kphctestimonials.org/>



Recommendations: Transitioning To The Future

After thorough analysis of the findings in Section II, the Task Force members generated a series of recommendations. All our recommendations support our vision of high-quality, financially sustainable healthcare in LA County. We present the recommendations in same order that we presented our four categories of findings in Section II – the areas of quality care delivery, finance, IT, and governance and management – and we conclude with an overarching recommendation to form a Los Angeles Healthcare Planning Commission. In each case, we present the recommendation, followed by some illustrative leading practices and discussion.

Quality Care Delivery Recommendations

1. **The Public Sector Healthcare Delivery System should embrace a culture of clinical excellence, innovation, continuous improvement, cost-effectiveness, and accountability.** This includes engagement of its entire workforce – including physicians, managers, and front-line workers – in a mission-driven, collaborative process that operationalizes this cultural transformation.

Quality is fundamental. Quality should be the driver for the strategic plan and should permeate throughout all levels of people

and departments in the system. This cultural transformation is crucial to improving patient care, and requires a workforce that embraces and supports transparent, timely measurement and reporting of process measures, clinical indicators, population outcomes, and cost.

2. **The Public Sector Healthcare Delivery System should operate as an integrated delivery system to provide seamless, coordinated care with accountability at all levels of the organization.** This care coordination should be extended from the



public system to other care providers in the safety net system, through expanded public-private partnerships.

Seamless care coordination and accountability. Continuity of care should be achieved by multispecialty teams focused on treating the whole person, beginning with prevention and wellness on a population level. Integration of the care delivery system can reduce delays in care, risk of medical errors, and duplicative services. Patients should be able to move efficiently and safely through the system and should have a medical home to help coordinate care.

Integrated care delivery planning. The Public Sector Healthcare Delivery System should have integrated care delivery planning across the system, so that it can shift resources as needed between different types of services, based on the measured needs of the population over time. It can then achieve the optimal balance between population health, prevention, primary care services, and specialty care services. Indicators must be available in real time for leadership to understand how patient needs are changing and make changes accordingly.

3. The Public Sector Healthcare Delivery System should continuously measure, evaluate, and improve performance, in order to deliver the highest-quality healthcare. This requires transparency of performance measures and open communication with the public.

Quality standards and measures. The Public Sector Healthcare Delivery System should define quality standards and safety measures, consistent with nationally recognized standards of professional, licensing, and accreditation bodies, to monitor

The Public Sector Healthcare Delivery System should define quality standards and safety measures, consistent with nationally recognized standards of professional, licensing, and accreditation bodies, to monitor and drive improvement.

and drive improvement. This includes the assessment of processes, individual and population outcomes, resource availability, patient satisfaction, technology adoption, and cost efficiency. This system of quality standards and measures must establish mechanisms for accountability at all levels of the organization and enhance transparency. Some examples include pay-for-performance programs and publication of measures through internal dashboards as well as more comprehensive, public reports.

Front-line quality-improvement strategies. Improvement strategies should be used at all levels of the system, including patient safety processes and clinical care, ancillary and administrative services, and management. Initiatives should be led by teams including both front-line workforce and management. The system should adopt and customize systematic improvement methodologies such as Six Sigma, or others used in leading practices in healthcare. Continued leadership training is essential to promote culture change for cost-effectiveness efforts and continuous quality improvement.

4. The Public Sector Healthcare Delivery System should eliminate barriers to access in order to provide appropriate, patient-centered care in a timely fashion.

Open access scheduling model. The Public Sector Healthcare Delivery System should adopt an open access scheduling model that allows patients to contact their provider and obtain an appointment on the same day or within one day, regardless of the type of appointment. An efficient referral system should be in place to allow appropriate referral and tracking to occur.

Appropriate level of care. The Public Sector Healthcare Delivery System should provide access to all levels of care, including a primary care medical home, specialty services, and hospital services. Geographic distribution of services should be equitable.

Community-oriented care. The Public Sector Healthcare Delivery System must adeptly serve an extremely diverse patient population through culturally competent care, including language services and community advisory boards that help the system identify and address the needs of the community.

New ways for patients to interface with the healthcare system. Innovative modes of care can improve access, quality, and cost-effectiveness. Technology can facilitate improved access to care providers, increased convenience, and reduced costs to patients seeking healthcare. New sites, such as retail or school-based clinics, may be beneficial to patients.

5. The Public Sector Healthcare Delivery System should focus on systemwide, long-term investments in population wellness, prevention, and the management of chronic diseases.

Population health and wellness. An integrated healthcare delivery system can leverage its size to focus on prevention and wellness. Prevention at both the individual and population level is beneficial to the health of communities and can create cost efficiencies as well. Disease prevention requires long-term planning across many disciplines beyond hospital-based medicine and will require partnership with other agencies.

Chronic disease prevention and management. The burden of chronic diseases, such as diabetes, obesity, asthma, and depression, is growing, and this burden is greater among the safety net patient population than the general population. The escalating human and financial costs must be stemmed by population-level interventions, as well as by coordinated case management. Models of specialty clinics that offer coordinated, cost-effective, evidence-based disease management to achieve better health outcomes exist both in LA County and elsewhere and should be supported and replicated.

Patient empowerment. Individual and group patient education should be conducted to help promote patient self-management and empowerment. High-quality, patient-centered discharge planning and post-hospitalization care and education are important to empower patients and reduce hospital readmission.

Finance Recommendations

1. The Public Sector Healthcare Delivery System should accelerate efforts to achieve financial sustainability.

LA County should provide sufficient start-up capital, such as liquid assets, facilities, equipment, and other infrastructure assets. The Public Sector Healthcare Delivery System should partner

with the County to carefully evaluate and define long-term operating and capital funding needs in the context of an agreed-upon strategic master plan, which should be reviewed annually.

2. The Public Sector Healthcare Delivery System should appropriately improve revenue streams, including a diversified payer mix, in order to successfully achieve its service mission.

Provider of choice. A major cultural shift needs to occur: The Public Sector Healthcare Delivery System should earn a community reputation for the highest-quality experience among all patients, as the “provider of choice” and not the “provider of last resort.” The Public Sector Healthcare Delivery System should increase their market share of insured patients and use the revenue to cross-subsidize uncompensated costs of care to uninsured and underinsured patients, enhancing the service mission.

Optimizing reimbursement. The Public Sector Healthcare Delivery System should work with the County government, other safety net healthcare providers, and industry groups to advocate for more rational reimbursement from the Medi-Cal program. It should also ensure completeness and accuracy of cost report data that drive supplemental, disproportionate share, and medical education funding from Medicaid and Medicare.

Financial counseling. The Public Sector Healthcare Delivery System should continue to work with patients for financial counseling to enroll patients in appropriate governmental programs, including development of a systemwide tool to monitor changes in enrollment status.

Collaborative, interdependent partnership with affiliated government and community. The Public Sector Healthcare Delivery System

should partner with the affiliated governments to merit sufficient local government and taxpayer-supported subsidy levels that are critical for financial sustainability. Private sources may be able to fund investments in care innovations and infrastructure.

County HMO. The healthcare system should “grow” its own health maintenance organization plan.

3. The Public Sector Healthcare Delivery System should minimize unnecessary, non-value-added costs.

Tools for minimizing unnecessary costs. The Public Sector Healthcare Delivery System should develop robust, readily accessible capabilities for decision support, cost accounting, and data analysis. Accurate data are important for both retrospective and forward-looking cost monitoring and for root-cause performance improvements that enhance the bottom line. The integrated system should use a comprehensive, unified decision support system with metrics for quality outcomes, resource use, and cost.

Quality-improvement strategies. The Public Sector Healthcare Delivery System should adopt patient-centered quality-improvement tools to develop cost efficiencies throughout the system. Performance improvement techniques such as Lean and Six Sigma can drive rapid, sustained improvements in quality of care and cost reduction.

Leveraging size to achieve economies of scale. The Public Sector Healthcare Delivery System should eliminate redundancies or inefficiencies to reduce unnecessary, non-value-added costs. It should utilize volume purchasing and bargaining power and use centralized, shared services where prudent.

Maximizing staff productivity. The Public Sector Healthcare Delivery System should invest in recruitment, retention, and skills development of employees at all levels. Senior leaders should engage in workforce-led initiatives to improve performance, and join with union partners to achieve a more efficient and effective care delivery system.

Efficient approaches to centralized management functions. The Public Sector Healthcare Delivery System should have the autonomy to develop its own efficient approaches to overhead and human resources management and procurement or purchasing functions.

Cost-effective care means higher-quality care for the same amount of (or fewer) resources. The Public Sector Healthcare Delivery System should utilize multidisciplinary teams, including physician extenders, strong partnerships with community health centers and physicians, and such resources as 24-hour call lines for remote screening and monitoring of patients.

4. The Public Sector Healthcare Delivery System should make capital and resource allocation decisions that best contribute to improved health outcomes through strategic, systemwide planning.

Autonomy in capital allocation. The Public Sector Healthcare Delivery System should have the autonomy and authority, with due oversight by the County, to make strategic allocations of capital across the care delivery system to optimize returns on investment – not only in a financial sense, but also in terms of achieving service mission goals.

Workforce as the greatest asset. The Public Sector Healthcare Delivery System, when integrated, will be able to promote leadership and professional development within its workforce, at all levels of the organization.

When necessary, staff retraining can be done across the system in a cost-effective way that supports the healthcare mission.

Information Technology Recommendations

1. The Public Sector Healthcare Delivery System should develop and advance an IT strategic plan for standardization and interoperability, enabling quality standards measurement, coordinated care, and financial rigor.

Strategic, centralized information technology planning. The Public Sector Healthcare Delivery System's central IT office, led by the chief information officer, should manage a state-of-the-art central data warehouse of clinical and financial information. The central office should ensure that IT projects are coordinated systemwide and are aligned with the healthcare system's strategic plan. The IT infrastructure must be able to link with all public facilities and affiliated private sector partners.

2. The Public Sector Healthcare Delivery System should develop an integrated countywide health information system for clinical, quality and financial measures.

Centralized database. The Public Sector Healthcare Delivery System should maintain a single, centralized database in order to conduct standardized monitoring of key quality and performance indicators.

Master Patient Index (MPI). A single, central MPI will allow the Public Sector Healthcare Delivery System to eliminate duplicate records and improve patient search capabilities to improve patient registration processes through the integrated healthcare system.

Health information system implementation.

The clinical health information system should include and integrate electronic medical records, inpatient computerized provider order entry, clinical decision support software, medication management and reconciliation, a picture archiving and communication system, and laboratory information systems. This interoperable infrastructure can inform clinical practice, interconnect providers, improve population health and health disparities monitoring, and promote adoption of future technologies across the healthcare delivery system.

3. The Public Sector Healthcare Delivery System should create a best-in-class health information technology leadership team to manage and coordinate the IT portfolio.

Project Management Office (PMO). Using a project management office to develop and manage the internal infrastructure for the organization's IT portfolio would promote a holistic view of IT initiatives. The PMO can evaluate the current available systems, design system and vendor interfaces, and test, implement, maintain, and upgrade the system. In order to promote technology adoption, technical support and hiring IT staff is critical for successful culture change. The PMO can also identify key organization health information technology "champions" for each initiative and change. The PMO is key to promoting adoption of technology by employees and patients.

4. The Public Sector Healthcare Delivery System should develop a robust telemedicine and telehealth infrastructure to facilitate access and care coordination, by leveraging public-private partnerships.

Telemedicine and telehealth technologies.

Telemedicine is an infrastructure that allows for multiple modalities of delivering care, including telephone, email, video, digital imaging, and healthcare monitoring devices. Telemedicine can increase access to specialties as well as assist monitoring homebound patients with chronic disease and disability. Automated health risk screenings can be used to assist clinicians in evaluating and managing health risks in persons in high-risk groups. Telehealth is an expansion of telemedicine, encompassing more types of health services enabled by telecommunication technology, including education, diagnosis, treatment, assessment, and monitoring.

5. The Public Sector Healthcare Delivery System should ensure that IT systems include robust, decision support tools for both the individual patient encounter as well as population care management.

Improving quality of patient care. The IT system should allow clinicians to reference medical literature and evidence-based protocols, in real time, and to support decisions and improve clinical care.

Population care management. The IT system should enable tracking and optimization of key prevention and disease management outcomes for the population.

Governance and Management Recommendations

1. The Public Sector Healthcare Delivery System would benefit from a body of expertise, accountable to the Los Angeles County Board of Supervisors, that is self-governed and has management autonomy and authority.

Formative charter. A formative charter establishes a framework for constructive working relations between the body of expertise and the affiliated government. It clarifies mutual rights, authorities, funding obligations, service level obligations, and accountabilities. It helps to diffuse political pressures that create barriers to a mission-focused healthcare strategy.

Self-governing and self-managing. The Public Sector Healthcare Delivery System would benefit from an autonomous, self-governed, and self-managed body of expertise that has both the time and the knowledge base to oversee the operations and management of the integration effort. This type of change in governance structure is essential to the successful recruitment of a transformational leader and key staff for the healthcare system envisioned by the Task Force.

Membership. The LA County Board of Supervisors should select members for this body of expertise who will be accountable to the Supervisors and, ultimately, the public. Mechanisms such as public meetings and annual accountability reports should be used, and members should also be able to act independently of individualized political interests. Other necessary attributes of the members include expertise in healthcare, a track record of good judgment and integrity, and a fiduciary mindset. The healthcare system body of expertise should provide continuous and dedicated service on a voluntary basis.

Transformational leadership. The Public Sector Healthcare Delivery System must recruit a CEO with a proven track record and the trust of the health system body of expertise. A senior leadership team should be assembled to carry out the improvements that will enable the healthcare system to better achieve its service mission.

2. The Public Sector Healthcare Delivery System should create a single strategic master plan with integrated clinical, quality, financial, and IT strategies, and should keep the organization focused on meeting quality and performance standards.

Strategic planning. The body of expertise should prepare a three-to-five-year strategic master plan with input and approval from affiliated government and stakeholders, and have authority for implementation of strategies without unconstructive interventions.

Relationships with academic partners. Relationships with hospital operating partners, particularly academic medical centers, should be reviewed with a rational set of criteria and measured performance outcomes. Agreements should be coordinated through the body of expertise to clearly define relationships with other service providers, including medical schools, and to evaluate the ability of partners to meet quality standards in exchange for the public's investment.

3. The Public Sector Healthcare Delivery System should be led by a dynamic, hands-on CEO and a talented, cohesive leadership team.

Leadership sets the tone. The CEO and leadership team should promote a mission-driven culture of innovation and continuous improvement. They should adopt and implement policies that reinforce high performance behavior, accountability, and transparency.

Overarching Recommendation: Form a Los Angeles Healthcare Planning Commission

These recommendations provide a proposed structure for achieving the vision of an integrated healthcare delivery system in LA County, but we recognize that the County needs a mechanism for planning, in order to move toward implementation. Thus, we recommend the formation of a Los Angeles Healthcare Planning Commission (hereafter referred to as “the Commission”).

This time-limited Commission, composed of members appointed by the Board of Supervisors, should be formed to conduct the planning necessary to advance the implementation of a high-performing, high-quality safety net healthcare system accessible to all residents in LA County. This Commission’s work should be informed by the recommendations of the Los Angeles Healthcare Options Task Force. We propose that funding be provided by the philanthropic community in Los Angeles and the LA County Board of Supervisors. We believe that an 18-month lifespan is sufficient for this Commission to complete its duties (July 1, 2009, to December 31, 2010).

The Commission’s primary tasks should be to develop a strategic plan for the Public Sector Healthcare Delivery System and to assist the LA County Board of Supervisors with consideration of potential future governance models. As evidenced by the proposed reopening of MLK Hospital with a novel form of governance, the LA County Board of Supervisors is taking creative, pragmatic steps to work with partners in order to improve County healthcare. The Planning Commission would not be a governing body, and this report

does not provide specific recommendations for a particular healthcare governance model. Other studies have analyzed alternative models and made recommendations (**See Appendix A**).

In addition, this Commission could be directed by the Board of Supervisors to accomplish other tasks:

- Oversee the reintegration of inpatient and emergency services at MLK Hospital into the larger Network, as its initial task. This would include a more formal articulation of the ambulatory care system that will be needed to support MLK Hospital.
- Optimize the application for the California Medicaid waiver in 2010.
- Create a coordinated and comprehensive countywide health information technology plan.

As evidenced by the
proposed reopening of
MLK Hospital with a novel
form of governance, the
LA County Board of
Supervisors is taking creative,
pragmatic steps to work
with partners in order to
improve County healthcare.

These suggested additional tasks for the Commission are complex, timely, and important for supporting the public safety net mission. Other planning commissions, including the Children’s Council, have served the Board of Supervisors as respected bodies on planning issues. We believe this planning model will also be successful for these specific tasks.

We propose the following composition for the Commission, with all members appointed by the Board of Supervisors **(See Table 3.1)**.

The Commission would be a public-private partnership composed of cross-sector experts in healthcare. The recommended members represent the Board of Supervisors, the Department of Health Services, the Department of Public Health, and the Department of Mental Health, as well as leading members from the community – business, community health organizations, consumers, hospitals, clinics, health plans, labor, philanthropy, and healthcare providers. The Chairman of the Board of Supervisors should appoint the Chair of

the Commission. The Commission will require qualified staff to support its work. This resource should be supplied by both public and private sector partners.

The Commission will lay the foundation for transformation of the Los Angeles Public-Private Safety Net Healthcare Delivery Network into a nationally recognized leading system. The recommendation for the establishment of this Commission, as well as the other recommendations proposed in this report, are intended to support the mission of providing the highest-quality healthcare for all in Los Angeles County.

TABLE 3.1 Proposed Composition of the Los Angeles Healthcare Planning Commission.

MEMBERSHIP SHOULD INCLUDE REPRESENTATION OF THE FOLLOWING STAKEHOLDERS:

- C.E.O. of Los Angeles County
- Los Angeles County Department of Health and Mental Health Services (Directors of Health Services, Mental Health, and Public Health)
- Local medical schools
- Los Angeles business community
- Los Angeles community advocacy organizations
- Los Angeles community clinics
- Los Angeles-based health plans involved in the care of Medi-Cal patients
- Los Angeles County healthcare consumers
- Los Angeles hospital community
- Los Angeles labor community
- Los Angeles medical community
- Los Angeles philanthropic community



Appendix A:

Reports, Memorandums and Other Documents on Governance and Operational Issues Relating to the LA County Department of Health Services (LACDHS) and/or Martin Luther King Jr. Hospital^{9,10}

Note: Many of these documents are available at www.lahealthaction.org.

TITLE	DATE	AUTHOR	TYPE	DESCRIPTION
DHS response to the Hospital Association of Southern California (HASC) Report: "King-Harbor Closure Hospital Inpatient Impact Analysis"	Apr. 2008	LACDHS	Report	DHS response to the March 28, 2008, report published by the HASC and authored by National Health Foundation (NHF).
HMA Report – MLK MACC Provider Productivity Benchmarks	Mar. 2008	HMA	Report	Commissioned by LACDHS, this document prepares a preliminary manual for implementing HMA's recommendations from the October 31, 2007, report, "MLK Ambulatory Network Staffing Plan." That report was generated based on patient volumes goals for outpatient visits provided by DHS, data, interviews, and observations taken shortly after the closure of MLK inpatient services and the establishment of a Multiservice Ambulatory Care Center.
King-Harbor Closure Hospital Inpatient Impact Analysis	Mar. 2008	National Health Foundation	Report	The report explores the impact that the closure of MLK Hospital and other County policy decisions are having upon surrounding private hospitals.
Report on the Impact of the Closure of Emergency Depts. on the EMS Provider Agencies in South LA	Nov. 2007	Bruce Chernoff, Director and Chief Medical Officer	Report	Report to the LA County Board of Supervisors about the impact that the closure of MLK Hospital has had on Emergency Medical Services (EMS) provider agencies in LA County, including fire departments and private ambulance companies.
Critical Condition: Examining the Scope of Medical Services in South Los Angeles	Oct. 2007	Kurt Salmon Associates	Report	This report found that, based on virtually every health indicator, the South LA area is among the most disadvantaged and underserved communities in the state. The findings paint an alarming picture of a broken health system that has failed to meet the needs of South LA residents, even prior to the closure of the MLK Hospital inpatient facility.
Martin Luther King-Harbor Community Hospital Closure Analysis	Jun. 2007	Hospital Association of Southern California	Report	Report providing information on the capacity of surrounding hospitals to absorb patients should MLK Hospital close.

⁹ From LA Health Action, www.lahealthaction.org. Accessed March 2, 2009.

¹⁰ Updated from the summary provided in Janssen, D. Memorandum to the Board of Supervisors, *Health Authority Blueprint – Preliminary Report* (April 18, 2005). From LA Health Action website: www.lahealthaction.org.

TITLE	DATE	AUTHOR	TYPE	DESCRIPTION
LAC DHS Recommendation for the Future of KDMC	Sept. 2005	King/Drew Center Hospital Advisory Board	Memorandum	Hospital Advisory Board memorandum to the Board of Supervisors providing comments to the LACDHS August 5, 2005, memorandum.
King/Drew Medical Center (KDMC) Timeline	Sept. 2005	Steering Committee on the Future of King/Drew Medical Center	Document	Document providing timeline of key events taking place with respect to governance, accrediting agencies, the community and other entities for KDMC and CDU.
Recommendations for the Future of the King/Drew Medical Center	Aug. 2005	Dr. Thomas Garthwaite	Memorandum	LACDHS memorandum to the Board of Supervisors regarding recommendations for the future of KDMC.
Recommendations for the Future of the King/Drew Medical Center	Aug. 2005	Dr. Thomas Garthwaite	Presentation	Presentation by Dr. Garthwaite regarding recommendations for the future configuration of KDMC.
2004-2005 Los Angeles County Civil Grand Jury Final Report	July 2005	LA County Civil Grand Jury	Report	Recommends creating a separate LA County health authority (after review of LACDHS and the LA County Department of Mental Health and various alternatives available) with a governing board comprising individuals with training and expertise in hospital and healthcare operations to realize improvements, operational efficiency, quality of care, and fiscal stability.
Health Authority Blue Print Report – Additional Information	Jun. 2005	David Janssen, LA County Chief Administrative Office (CAO)	Report	Provided an update to the April 2005 CAO memorandum. It provided an update on health authority legislation: updated the 2001 estimate of transition costs, which are potentially significant for all models with the exception of the commission model.
Community Briefing on King/Drew Medical Center	May 2005	Yolanda Vera	Presentation	Presentation about health disparities in SPA 6 (South LA) and KDMC.
Health Authority Blue Print – Preliminary Report	Apr. 2005	David Janssen, LA County Chief Administrative Office (CAO)	Report	Developed a draft Health Authority Blue Print as a plan for the possible implementation of a health authority to run the County's entire hospital.
Fulfilling the Promise: A Roadmap for Meeting the Health Care Needs of the South L.A. Community	Mar. 2005	Steering Committee on the Future of King/Drew Medical Center	Report	Report providing roadmap for the King/Drew complex to realize its full potential for becoming an academic medical center of excellence.
King/Drew Medical Center Assessment Report	Jan. 2005	Navigant Consulting	Report	Recommended that the Board of Supervisors continue to explore implementation of a health authority to govern the entire County health system. Recommended that the Board of Supervisors immediately transfer oversight responsibility of KDMC to the existing KDMC Hospital Advisory Board.
Steering Committee on the Future of King/Drew Medical Center Final Report	Nov. 2004	The Camden Group	Report	Report commissioned by the Steering Committee to provide a comprehensive financial overview of King/Drew Medical Center and Drew University.
Brief History of King/Drew Medical Center	July 2004	LACDHS	Document	Document providing a brief history of KDMC.

TITLE	DATE	AUTHOR	TYPE	DESCRIPTION
Should the Governance of the Los Angeles County Health Services Agency be Changed?	June 2003	Hospital Association of Southern California	Report	The brief concludes that the Health Authority model shows the most promise, providing the greatest flexibility in areas of personnel, procurement, and contracting; some of the financial issues can be addressed in enabling legislation; and it appears to have the most widespread support.
An Analysis of Alternative Governance for the Los Angeles County Department of Health Services	May 2003	Michael Cousineau, Elizabeth Graddy and Robert Tranquada, USC Keck School of Medicine, Division of Community Health	Report	Recommends the creation of an independent authority by the Legislature in cooperation with the County to operate LACDHS, with the exception of certain public health functions.
Redesign of the Department of Health Services	June 2002	Dr. Thomas Garthwaite, LACDHS Director	Memorandum	Recommended creation of a public authority that would allow Rancho Los Amigos National Rehabilitation Center to continue to operate under the governance of a public entity, but not under the auspices of LA County.
Action Plan and Estimated Timetable for Conversion to Alternative Health Governance Models	Feb. 2002	David Janssen, LA County Chief Administrative Office (CAO)	Memorandum	Illustrated major steps and timeframes associated with creating three possible governance structures – health commission, health authority, health district, and private nonprofit public benefit corporation.
Final Report Ad Hoc Hearing Body on Governance	Feb. 2002	County of Los Angeles	Report	Recommended that the Board of Supervisors should explore the desirability and feasibility of establishing a health authority to govern LACDHS.
Administrative Flexibility Proposals for the Department of Health Services	Dec. 2001	David Janssen, LA County Chief Administrative Office (CAO)	Memorandum	Outlined four areas that would provide LACDHS with more administrative flexibility – delegated authority to solicit and execute certain types of contracts; CAO, rather than the Board of Supervisors.
Governance of the Department of Health Services	Aug. 2001	David Janssen, LA County Chief Administrative Office (CAO)	Memorandum	Extensive review of four possible governance structures – health commission, health authority, private nonprofit public benefit corporation, and healthcare district – and case study examples of health systems that operate under each of the four models.
Los Angeles County Blue Ribbon Health Task Force Report	Sept. 2000	County of Los Angeles	Report	Recommended that the Board of Supervisors initiate an independent study to evaluate current governance of LACDHS and explore other options for its oversight.
Governance of the Department of Health Services	Dec. 1995	Burt Margolin, Health Crisis Manager for LA County	Memorandum	A report that evaluates the feasibility of creating a health authority to oversee the management of LACDHS; recommended the creation of a seven-member semi-autonomous health authority that would have responsibility for developing and presenting major policy and implementation recommendations to the Board, which could ratify recommendations by a yes or a no vote.
Report of the Health Crisis Task Force	July 1995	County of Los Angeles	Report	Recommended the Board of Supervisors constitute a semi-autonomous health authority.

Appendix B:

Reports on Public Safety Net Healthcare Systems

TITLE	DATE	AUTHOR	SUMMARY
Strategies to Align the Performance of Medical Staff and Public Hospitals and Health Systems	Nov. 2006	Browne R, Keroack M, et al. National Association of Public Hospitals and Health Systems (NAPH)	A report based on surveys/interviews in 2004 of NAPH membership.
The New York City Health and Hospitals Corporation: Transforming a Public Safety Net Delivery System to Achieve Higher Performance NYCHHC	Oct. 2008	Issues Research, Inc. The Commonwealth Fund	A case study of NYCHHC, describing its achievements of higher levels of performance.
Organizing the U.S. Health Care Delivery System for High Performance	Aug. 2008	Shih A, Davis K, et al. The Commonwealth Fund	A report that examines fragmentation in our healthcare delivery system and offers policy recommendations to stimulate greater organization.
Denver Health: A High-Performance Public Health Care System	July 2008	Nunzum R, McCarthy D, et al. The Commonwealth Fund	A case study of Denver Health, a comprehensive and integrated system serving 25 percent of Denver residents.
Public Hospital Governance and Legal Structure: Analysis of Cook County Bureau of Health Services Restructuring Efforts in Light of Industry Best Practices	2008	National Public Health and Hospital Institute	A review of proposals submitted to restructure the Cook County Bureau of Health Services' public hospital systems.
Best Practices in Public Hospital Governance	May 2008	National Public Health and Hospital Institute Gage L and Gross D	Based on successful experience of restructured public hospital systems, this report outlines the most important best practices that should be taken into account in restructuring any public hospital or health system, including factors likely to be essential to success in such areas as legal structure, board composition, governance, clinical services, strategic planning, and the relative degree of autonomy vs. retained county accountability in areas such as operations, budget and finance, purchasing, human resources, and other areas.
Assessing Health and Health Care in the District of Columbia, Phase I and II	Jan. 2008	Lurie N, Gresenz RG, et al. RAND Health	A report on alternative ways to invest tobacco settlement funds in the District of Columbia to improve health and the healthcare delivery system in the District.
Aiming Higher – Results from a State Scorecard on Health System Performance	June 2007	Cantor J, Schoen C, et al. The Commonwealth Fund	A report summarizing results of the <i>State Scorecard</i> and presenting overall state rankings and rankings on each of five dimensions of health system performance: access, quality, potentially avoidable use of hospitals and cost of care, and healthy lives.
Legal Structure and Governance of Public Hospitals and Health Systems	2006	Gage L, Camper A, et al. National Association of Public Hospitals and Health Systems	A report providing an overview of effective hospital governance and management in light of the public safety net funding crisis and the regulatory requirements set forth by the Sarbanes-Oxley Act.
The California Hospital Financing Medicaid Waiver: Year One Implementation and Results for Public Hospitals	Nov. 2006	California Association of Public Hospitals and Health Systems	A report on the California Hospital Financing Medicaid Waiver in September 2005, which gave the state a five-year waiver from Federal Medicaid rules.

TITLE	DATE	AUTHOR	SUMMARY
Ambulatory Care for the Urban Poor: Structure, Financing and System Stability	June 2001	Ormond B, Lutzky A The Urban Institute	A report, based on case studies conducted in the three study communities between October 1999 and February 2000, examining the organization and financing of ambulatory care for the poor in three urban communities – Houston, Denver, and Los Angeles – and the challenges posed to these systems by ongoing changes in the healthcare sector.
Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion	Sept. 2000	Bovbjerg R, Marsteller J, et al. The Urban Institute	In-depth case studies of five localities (Milwaukee, Boston, Hillsborough County, FL, San Diego, and Philadelphia) that stopped operating their public hospitals.

Appendix C:

Additional Details from the Needs Assessment of South LA

Introduction

Changes in the healthcare infrastructure, persistent health needs, and unique sociodemographic factors make South Los Angeles an important setting within which to examine the impact of safety net hospital closure on access to care, health status, and unmet need for care among middle aged adults and older adults. The closure of several healthcare facilities in LA County, including the closure of MLK Hospital and its emergency department, has altered the safety net infrastructure, particularly for areas with limited resources, such as South LA. South LA is a low-income, largely Latino and African American area of Los Angeles with high levels of healthcare need. In addition, persistently low physician supply may contribute to the challenges of this at-risk population. South LA (or SPA 6, as designated by LA Angeles County) faces the dual challenges of high healthcare need and low availability of healthcare resources. Relative to other areas in Los Angeles, SPA 6 has higher rates of diabetes, hypertension, and HIV/AIDS and higher mortality from preventable or treatable conditions, such as heart disease, stroke, and lung cancer.¹¹

The impact of these closures on those residents who need healthcare services most, among them community-dwelling minority elderly, remains poorly understood. To inform policy decisions for the Task Force about restructuring safety net services and reopening MLK Hospital, we conducted a community-based participatory study that assessed delays and unmet healthcare needs of South LA elderly residents. In order to focus in on this at-risk population, we examined trends among older Latino and African American populations. The elderly residents of South LA are only one part of the South LA population, of whom may have been impacted by changes in healthcare infrastructure.

Methods

Using a telephone survey, we interviewed African American and Latino middle-age and older residents of South Los Angeles about their healthcare needs, access to care (including specialty care and primary care), and use of services after the MLK Hospital and emergency department closure. We refer to this telephone survey as “the MLK Survey.” Using previous data from the California Health Interview Survey (CHIS), we compared findings to the similarly conducted population-based survey of LA County residents fielded prior to the closure of MLK. These cross-sectional comparisons allow us to leverage knowledge derived from existing data and explore current levels of unmet need for care and use of services in order to assess change over time for middle-aged and older community-dwelling residents. A brief timeline of the hospital’s closure is shown in **Table APP.1**.

Data

Community-Based Survey (MLK Survey)

Using a telephone survey, we interviewed middle-age and older residents of South Los Angeles about their healthcare needs, access to care (including specialty care and primary care), and use of services after the MLK Hospital and emergency department closure. The survey used a random, listed household sample from zip codes in SPA 6 among residents over age 50 and was conducted in English and Spanish. The community-partnered study was approved by the RAND Institutional Review Board and led by University of California, Los Angeles UCLA health services researchers. The survey response rate was 25.4 percent using American Association for Public

11 Los Angeles County Department of Public Health. Key Indicators of Health. 2007. As of March 26, 2009: http://www.publichealth.lacounty.gov/docs/Key05Report_FINAL.pdf

TABLE APP.1 Historical Milestones and Related Survey Data.

HISTORICAL MILESTONES		SURVEY DATA SOURCE
1965:	Watts Riots & McCone Commission Recommendations	CHIS
1972:	MLK Hospital built	
2003:		
2004:	Hospital was unable to meet licensing standards	CHIS
2005:		
2007:	Inpatient Beds and Emergency Department closed	MLK Survey
2008:		

CHIS = California Health Interview Survey; MLK Survey=Survey conducted by UCLA and Task Force.

Opinion Research (AAPOR) RR4 method. In addition, missing data among specific survey items ranged from 0 percent to 17 percent.

California Health Interview Survey

CHIS is a collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. The survey examines public health and healthcare access issues in California. The CHIS telephone survey is the largest state health survey ever undertaken in the United States and was fielded in 2001, 2003, 2005, and 2007. The survey monitors the health of Californians and examines changes over time by conducting periodic surveys. Sampling is performed within LA County by geographic areas (SPAs) where residential telephone numbers were selected through random-digit dial (RDD) sampling, and within each household, one adult (age 18 or over) respondent was randomly selected. Sampling weights and imputed values (substitution of estimated values for missing data) are included in the survey data set. In addition, CHIS data is available for public use at www.askchis.com.

Description of Variables

Demographic Variables

The MLK Survey used self-reported race/ethnicity for all survey respondents including those either Latino (of any race) and non-Latino African American. For the CHIS data, a similar definition was used for data collection.

Health Variables

Fair/Poor Health. This variable is the combination of two answers to the question, “In general would you say your health is excellent, very good, good, fair, or poor?” This variable represents the sum of respondents who reported their health as either fair or poor.

Self-Reported Disease. Disease specific variables were for questions on whether respondents ever had been told they had the condition.

Health Utilization and Access Variables

Every participant was asked questions about whether they “had a problem receiving care you or your doctor believed necessary” or “problem seeing a specialist,” and the variable is a combination of two answers: big problem or small problem.

Trend Calculations

Although it is possible to compare trends between two surveys that have similar design, we did not apply statistical test on data across the two surveys because the survey response rates and methods were slightly different. Our data analysis included statistical tests only between groups for the MLK Survey.

Weighting

The survey data was weighted for the SPA 6 population according to U.S. Census data for this area as defined by study zip codes. The data are adjusted to reflect the actual distribution of characteristics of the larger population from which the sample was drawn for population race/ethnicity, age distribution, and poverty levels. The CHIS data are also weighted, and more detail on their weighting methodology is available at <http://www.chis.ucla.edu/methodology.html>.

Suppressed Data

When a cell has fewer than five respondents in it, no information is presented for the CHIS data.

Results

Table APP.2 shows the demographic characteristics of the study participants. More women than men and more individuals from higher- rather than lower-income brackets participated in the study. Among the study participants, we analyzed the overall results and present the data weighted to be more representative of South LA (SPA 6) by certain factors (age, race, and poverty). In addition, we compare results by:

- race/ethnicity
- age groups (50–64 years old vs. over 65)
- previous survey data
- geographic comparisons.

TABLE APP.2 Demographics of Community Needs Assessment Survey of Older African Americans and Latinos, South Los Angeles, 2008.

	% OF PARTICIPANTS
AGE GROUPS	
50 to 54	18
55 to 59	18
60 to 64	14
65 to 69	17.7
70 and Older	32.3
GENDER	
Male	32
Female	68
RACE/ETHNICITY	
African American	50
Latino	50
LANGUAGE	
English	57
Spanish	43
INCOME AS PERCENT OF FEDERAL POVERTY LEVEL	
0–99% FPL	28.4
100–199% FPL	3.7
200%+ FPL	51.2
Declined to State	16.7

Previously collected CHIS data are shown as a benchmark to the current survey. In our data analysis, we performed several analyses of the 2008 MLK Survey and provide benchmark data for reference alongside in the results tables (**Tables APP.3–APP.6**).

First, we examined type of health coverage, educational status, and usual source of care and compared across race and age groups (**Table APP.3**). Latinos are more likely to be uninsured and less likely to have employer-based coverage compared with African Americans. In addition, older adults (over age 65) compared with those age 50–64 are also more likely to be covered by governmental programs. Comparing educational status between groups, African Americans and the younger age group are more likely to have higher levels of education. Comparing those who have a regular source of medical care, overall percentages are somewhat similar, however, by location of care, African Americans are more likely to go to a doctor's office compared than Latinos. In addition, the older age group is more likely to go to a doctor's office for their regular care.

Self-reported health has been shown to predict health outcomes. In response to "how would you rate your health?" Latinos report poorer health compared with African Americans (**Table APP.4**). Similar rates of fair/poor health exist among age groups. For specific chronic conditions, there are similar distributions of disease prevalence across racial/ethnic and age groups. In addition, there are similar levels of chronic disease comparing across time and geographic areas.

There are significant differences in utilization of recommended preventative health services and in receiving other needed care between age and race/ethnic groups (**Table APP.4**). Routine screening guidelines suggest that everyone over the age of 50 should have a yearly flu shot, colon cancer screening every ten years, and a pneumonia shot once after the age of 65. In addition, most physicians continue to recommend PSA screening, but discuss options with their patients. In the MLK study, significantly more adults age 50–64 have not received a flu shot, had a colonoscopy within 10 years, or had a pneumonia vaccine. Those who are Latino report lower utilization of preventive services compared with African Americans, including colonoscopy, pneumonia vaccine, and prostate cancer screening. We additionally compared reported delays and problems receiving care (**Table APP.5**). Latinos reported greater difficulty receiving needed medical and specialty care.

Geriatric syndromes are an important indicator of quality of life and independent living. **Table APP.6** shows similar difficulty with memory, tasks of daily living, and getting outside the home across racial/ethnic and age group. There is a trend of more African Americans and more from the 50–64 year old age group having difficulty with falls. In South LA, there may be increased need for supportive care services for older persons.

Conclusions

As LA County continues to grow older, the needs of older persons will continue to drive healthcare demand and costs. Our survey showed that segments of the South LA population are at greater risk for morbidity and mortality. As such, primary care needs for preventive services and chronic disease management, as well as acute care needs, should continue to be in focus for an integrated health system of the future. In a community as diverse as South LA, the future system of care in this community must remain committed to the elimination of health disparities through provision of high quality culturally and linguistically appropriate care.

Author Information

Kara Odom Walker is the Principal Investigator of the community survey, a Robert Wood Johnson Clinical scholar at UCLA, and Policy Research Director of the Los Angeles Healthcare Options Task Force.

Acknowledgements

Special thanks to The California Endowment and Task Force for supporting this project, as well as to the UCLA research advisory team for their ongoing support, including Arleen Brown, M.D., Ph.D., Associate Professor at UCLA and primary research mentor; Li-Jung Liang, Ph.D. Assistant Professor, UCLA, and primary statistician; Leo S. Morales, M.D., Ph.D., Associate Professor, UCLA; and Carol Mangione, M.D., M.S.H.S., Professor, UCLA and RWJ Clinical Scholars Program Director. In addition, special thanks to community mentors who assisted with survey preparation and study design, including: Loretta Jones, MS, Health African American Families II; Tony Kuo, M.D., M.S.H.S., Director, Office of Senior Health; Nell Forge,

TABLE APP.3 Health Insurance, Educational Status, and Usual Source of Care, Older African Americans and Latinos, South Los Angeles, 2008.

	MLK SURVEY					CHIS	
	Overall 2008 (%)	RACE/ETHNICITY		AGE GROUP		2005 (%)	2003 (%)
		African American (%)	Latino (%)	50–64 (%)	>65 (%)		
Type of Health Coverage							
Through Employer	44.6	51.1	31.7	54.6	30.8	36.6	31.5
Medicare	19.8	21.7	15.9	8.4	36.6	13.2	12.7
Medi-Cal	13.6	9.6	21.5	13.2	14.2	6.2	12.2
Other/missing	15.2	14.9	25.8	13.3	16.6	29.4	25.7
Uninsured	6.8	2.7	15.1	10.5	1.8	14.6	17.9
Educational Status							
Less than high school	25.0	6.5	62.0	28.4	20.2	38.4	41.1
High School	17.1	18.9	13.5	16.2	18.4	26.7	26.3
Some college or technical school	30.6	40.6	10.7	32.4	28.1	21.5	19.2
College degree	14.0	16.9	8.0	9.0	20.9	7.1	8.3
Graduate degree	13.3	17.2	5.7	14.0	12.4	6.3	5.1
Have a Usual Source of Care	92.9	95.6	86.4	91.7	93.6	93.1	94.5
Location of Usual Source of Care							
Doctor's Office	43.6	51.1	28.5	38.7	50.4	57.5	71.3
Clinic	43.3	37.5	55.1	47.4	37.7	35.6	20.4
Other	13.1	11.4	16.4	13.9	11.9	6.9	8.3

Note: CHIS data for geographic comparisons from most recent year available for Service Planning Area 6, African Americans and Latinos who are over age 50 similar to MLK Survey.

TABLE APP.4 Health Status, Preventive Health Services, Utilization, and Delays in Care by Selected Characteristics, Age 50 and Over, South Los Angeles, 2008.

	MLK SURVEY					CHIS				
	Overall 2008 (%)	RACE/ETHNICITY		AGE GROUP		OVERALL SO. LA		GEOGRAPHIC COMPARISONS		
		African American (%)	Latino (%)	50–64 (%)	>65 (%)	2005 (%)	2003 (%)	SPA 5 West LA (%)	LA County (%)	California (%)
Health Status										
Self-reported fair/poor health	39.6	30.5	57.6	37.4	42.5	49.6	50.4	36.3	42.4	40.2
Arthritis	39.0	43.0	30.9	34.0	45.9	37.3	37.3	31.4 [^]	40.1 [^]	38.4 [^]
Asthma	10.6	11.3	9.2	12.1	8.5	14.4	10.3	20.8	9.8	11.0
Diabetes	24.5	23.4	26.6	23.9	25.2	25.6	22.8	18.5	22.3	23.0
Heart disease	10.4	10.0	11.2	7.6	14.3	11.3	17.8	10.3	12.6	12.1
High blood pressure	65.1	69.3	56.8	54.5	80.0	53.1	60.3	55.7	49.5	49.3
Condition that limits basic activities (disability)	36.5	35.6	38.2	35.1	38.4	37.5	37.5	27.9 [†]	46.8 [†]	47.6 [†]
Preventive Health Services and Utilization										
No flu shot in past 12 months	54.8	57.8	48.8	61.3	45.9	62.9	58.7	56.0	57.9	56.1
Never had a colonoscopy, within 10 years	41.2	30.3	63.0	48.8	30.5	48.8	55.0	14.4	36.6	36.4
Never had a pneumovax	67.2	62.0	77.6	81.4	47.4	N/A	70.8	66.5 [†]	72.4 [†]	70.9 [†]
Mammogram, never/more than 2 years ago (women)	11.7	12.0	11.1	8.6	16.2	6.7	14.2	13.4	16.1	17.0
PSA, never/more than 1 year ago (men)	57.0	47.2	74.4	57.6	56.2	20.1	33.0	43.6 [†]	61.8 [†]	65.2 [†]
Delays in Care										
Problem to receive needed medical care	16.6	13.0	23.7	19.4	12.6	N/A	16.4	10.9	14.7	17.3
Problem to see a specialist	12.1	8.2	19.8	14.3	9.0	N/A	18.4	13.4	14.1	13.8

Note: CHIS data for geographic comparisons from most recent year available for SPA 6, African Americans and Latinos who are over age 50 similar to MLK sample. Data shown are from 2007 CHIS, unless otherwise noted: [†] CHIS 2005 [‡] CHIS 2003 [^] CHIS 2001. Italics indicate value is statistically unstable. Bold values show statistical differences between the groups, where $p < 0.05$. Never had a colonoscopy = CHIS 2007 asked respondents if they had a colonoscopy, sigmoidoscopy, or fecal occult blood test (FOBT); n/a=data not available for this year.

TABLE APP.5 Health Utilization, Delays in Care, and Access Measures, by Selected Characteristics, Age 50 and Over, South Los Angeles, 2008.

	MLK SURVEY					CHIS			
	Overall 2008 (%)	RACE/ETHNICITY		AGE GROUP		GEOGRAPHIC COMPARISONS			
		African American (%)	Latino (%)	50–64 (%)	>65 (%)	South LA (%)	SPA 5 West LA (%)	LA County (%)	California (%)
Visited an emergency room for care, past 12 months	32.3	28.6	34.1	31.8	33.0	32.7 [†]	25.5 [†]	26.8 [†]	24.6 [†]
Delays Delayed medical care needed, last 12 months Delayed a medication prescribed	12.9 11.0	14.6 8.7	12.0 8.7	16.6 9.8	7.7 1.9	15.8 [†] 12.7 [†]	14.5 11.2	11.2 10.5	11.1 11.6
Dental Visit, more than 12 months	47.7	55.1	42.5	45.2	48.6	40.6 [‡]	34.3 [‡]	37.4 [‡]	35.9 [‡]

Note: CHIS data for geographic comparisons from most recent year available for SPA 6, African Americans and Latinos who are over age 50 similar to MLK sample. Data shown are from 2007 CHIS, unless otherwise noted: [†] CHIS 2005 [‡]CHIS 2003 [^]CHIS 2001. Italics indicate value is statistically unstable.

TABLE APP.6 Geriatric Syndromes, by Selected Characteristics, Age 50 and Over, South Los Angeles, 2008.

	MLK SURVEY					CHIS	
	Overall 2008 (%)	RACE/ETHNICITY		AGE GROUP		2005 (%)	2003 (%)
		African American (%)	Latino (%)	50–64 (%)	>65 (%)		
Difficulty with: Learning, remembering, concentrating Dressing, bathing, or getting around home Going outside the home alone	18.5 8.7 12.5	27.2 12.4 15.4	14.1 6.9 11.0	17.2 8.7 9.8	20.3 8.8 16.2	17.9 11.4 17.3	N/A N/A N/A
Geriatric Health Indicators Fell to the ground more than once in past 12 months Incontinence within past 30 days	14.1 18.3	21.1 21.2	10.5 16.9	17.0 17.5	10.0 19.4	N/A N/A	10.6 24.9

Ph.D., M.P.H., Assistant Professor, Charles Drew University; Keith Norris, Professor and Vice President for Research, Charles Drew University; and Sandy Berry, Ph.D., RAND Health. We also thank many community advisory board members from the Resources for the Center of Health Improvement for Minority Elderly, including: Ms. Cheryl Branch, Chair and Co-Founder, African American Alcohol and Other Drug Services Advisory Council of LA County (AAAOD); Dr. David Martins, Medical Director, T.H.E. Clinic, Inc.; Mr. Franco Reyna, Associate Director, American Diabetes Association; Ms. Janine Souffront-Palomino, Project Director, Promotores de Salud para Nuestra Tercera

Edad, Behavioral Health Services Inc. Medicine Education Program; Ms. Laura Trejo, General Manager, Los Angeles Dept of Aging; Ms. Fannie Upshaw, Community Resource Specialist, His Sheltering Arms, Inc.; Ms. Turusew Gedebu-Wilson, Independent Health Educator.

Dr. Walker received support from received support from the Los Angeles Healthcare Options Task Force, Robert Wood Johnson Foundation Clinical Scholars Program, and the UCLA Resource Center for Minority Aging Research/Center for Health Improvement of Minority Elderly (RCMAR/CHIME) under NIH/NIA Grant P30AG021684.

Appendix D:

Health System Profiles

This appendix profiles four public safety net healthcare delivery systems in the United States, and includes background information, a financial profile, a summary of some major recognitions, and selected leading practices. The selected leading practices cited for each system are examples and illustrations only, rather than an exhaustive list of every leading practice at each system. The information is cited from the websites, annual community reports, financial reports, news releases, and other public sources as referenced.

Denver Health and Hospital Authority (Denver, CO)

Denver Health, formerly Denver General, was first established in 1860 as part of the city government. In 1997, it became the Denver Health and Hospital Authority (the Authority, or Denver Health), separating its governance from the city government. However, Denver Health has remained as the city's healthcare system. Denver Health provides access to care for individuals regardless of their ability to pay; its "mantra" is to provide high-quality care without disparity. It provides life-saving emergent and trauma services, fulfills public health functions, participates in medical education, and engages in research.

Denver Health is an integrated organization that includes a hospital housing a trauma center, a 911 response system for Denver County, the Denver Public Health Department, 8 family health centers, 12 school-based health centers, the Rocky Mountain Poison and Drug Center, a telephone advice line for patients, a community detoxification facility, correctional facility care, and a health plan. Denver Health also has research and education operations that include the Denver Health Paramedic School; the Rocky Mountain Center for Medical Response to Terrorism, Mass Casualties and Epidemics; the Rita Bass Trauma & EMS Education Institute; and the Colorado Biological, Nuclear, Incendiary, Chemical and Explosive (BNICE) Training Center. Denver Health estimates that 25 percent of all Denver residents, or 160,000 individuals, receive their healthcare through Denver Health.

The Denver Public Health Department's physicians not only treat patients, but also manage issues related to epidemics, tuberculosis, HIV/AIDS, and sexually transmitted diseases. Denver's Public Health Department also offers immunizations and provides inoculations to people planning travel abroad. In the area of infectious disease, the Public Health Department has three board-certified specialists and seven physicians and incurs 50,000 patient visits each year.

Denver Health is governed by a nine-member Board of Directors that is appointed by the Mayor of Denver. The State of Colorado statute that created the Authority indicates that "except for the power of the City and the Mayor to appoint and remove members of the Authority's Board of Directors, the City shall have no further control over the operation of the health system." Since the City of

Denver's accountability for the Authority does not extend beyond making Board appointments and there is no fiscal dependency by the Authority on the City, the City considers the Authority a related organization and does not present the financial position and results for the Authority in the City's financial statements.

Financial Profile

Since 1996, the City and the Authority have adopted an Operating Agreement to describe the relationship in the provision of services to the City. According to the City of Denver's audited December 31, 2007, Comprehensive Annual Financial Report, the City reimbursed the Authority \$51.2 million for providing various health related services to the City and its residents during 2007, and the Authority made payments in the amount of \$1.9 million to the City for police, fire, legal, and human resources services.

According to its 2007 Annual Report to the Community, Denver Health reported total operating revenue of \$551 million, principally composed of \$219 million in net patient service revenue, \$124 million in premiums earned from its managed care plan, Denver Health Medical Plan, Inc., \$70 million in Medicaid disproportionate share and other safety net reimbursement, \$44 million in hospital and other purchased services by the City of Denver, \$31 million in Federal and State grants, \$22 million in poison and drug center contracts, and \$17 million in other grants. Denver Health reported operating income of \$5 million and an increase in net assets of \$6 million. The Annual Report indicates that \$276 million of care was provided to the uninsured in 2007, but does not identify whether that amount represents the cost of care provided or the amount of charges foregone for such care.

Major Recognitions

Denver Health was named a top performing public safety net hospital by the University Healthcare Consortium (UHC) for areas related to patient safety and quality. Denver Health has also received the following recognitions: The Denver Health Immunization Program (DHIP) received the Award of Excellence from the Colorado Department of Public Health and Environment for its Immunization Outreach Project; Denver Health was named to Hospitals & Health Network's 2007 "Most Wired" list; and Denver Health ranked on the Hospitals & Health Network's Top 25 Most Improved list in 2005 and 2003.

Selected Leading Practices

- *Quality Measures:* Denver Health focuses on reducing mortality rates within service lines and has been praised by the Commonwealth Fund for being a “learning laboratory” for the nation in patient safety and quality. Mortality information is displayed as expected-to-observed, with the standard being one to one – one expected death, one observed death. At Denver Health, the ratio dropped to as low as 0.47, meaning that less than half the expected deaths occurred. The ratio was consistently below 1.0 during the entire previous three-year period.
- *Trauma Care:* The Rocky Mountain Regional Level One Trauma Center at Denver Health cares for severely injured patients from around the region. The trauma team consists of emergency medicine physicians, surgeons, neurosurgeons, orthopedic surgeons, plastic surgeons, anesthesiologists, radiologists, and numerous physician specialists, along with trauma nurses and other critical care professionals. The survival rate for patients entering the facility is 95 percent. A highly trained cadre of paramedics serves as the pre-hospital team.
- *Continuous Improvement/Improved Cost Effectiveness:* Denver Health was once faced with serious challenges to its financial viability. Rather than cutting the number of uninsured patients it served, Denver Health embraced the need for transformation and launched a comprehensive redesign initiative.

In 2003, Denver Health streamlined its operations using Toyota’s “Lean Manufacturing” approach, focusing on access, inpatient flow, outpatient flow, operating room flow, and billing. The Lean model was used to identify and eliminate waste to reduce overhead. Lean process improvements have generated the most widespread activity and the broadest organization-wide change. The Lean tools for seeing and eliminating waste are employed in a structured way in the Rapid Improvement Event (RIE), which pulls together a team of employees with the goal of fixing a process problem in one week. Ultimately, Denver Health trained 100 employees, including doctors and nurses, as “Black Belts” in Lean. In this manner, Denver Health eliminates wasteful steps and processes, improving efficiency and quality by engaging hundreds of employees. As a result, Denver Health employees have become very savvy about eliminating waste.

As noted by Denver Health’s CEO and Medical Director, Patricia A. Grabow, M.D., in the 2007 Annual Report, Denver Health views the elimination of waste through the Lean as a matter of respect for people – fundamental

to the organization’s commitment. “It may seem strange to say that elimination of waste is about respect, but the president of Toyota has said just that: ‘waste is disrespectful of humanity because it squanders scarce resources, and waste is disrespectful of the individual because it asks them to work with no value.’ At Denver Health, we have added that waste is disrespectful of our patients because it makes them endure processes with no value.”

In 2007, Denver Health reported saving \$11 million with 100 Black Belt employees, including 130 RIEs held and 704 employees involved. Over 19 different departments successfully used RIEs. Employees consistently came up with ideas for RIEs that have the potential to enhance the patient experience, solve problems, reduce waste, and save money in just one week.

Other reported noticeable benefits included:

- Hospital length of stay decreased by one day.
 - Clinic visits per provider increased, adding revenue without adding cost and increasing patient access.
 - The time from initial bed request to room assignment was reduced by more than 33 percent.
 - Patients receiving antibiotics within one hour of surgical cut reached nearly 100 percent, thereby reducing the number of hospital acquired infections.
 - Patient appointment reminder calls initiated with a 75 percent patient contact rate.
 - Collection of unused pagers resulted in a savings of more than \$4,000 per year.
 - Infusion Center redesigned to add patient care space thereby increasing revenue by nearly \$200,000 in just one year.
- *Telemedicine:* Denver Health offers telemedicine to treat and teach. Telemedicine is used to treat minor injuries and illnesses as an alternate option to an in-person consult with prisoners. Denver Health’s educational programs in trauma/EMS, medicine, pediatrics, and nursing are available via videoconferencing.
 - *Population Health/Disease Management:* Denver Health offers a “Health Coach” program that assists its members in managing chronic disease and promotes healthy lifestyle changes. The program places an emphasis on the members that have more than one chronic disease, such as asthma and diabetes. Members who have complicated healthcare issues have been hospitalized or had an ER visit can also obtain coaching from a Health Coach. Most coaching is conducted over the telephone and through e-mail.

Sources:

Denver Health Facts. Available at: www.denverhealth.org/portal/LinkClick.aspx?fileticket=qo6FWIIcPho%3d&tabid=1966&mid=3083
Denver Health 2007 Annual Report. Available at: <http://www.denverhealth.org/portal/LinkClick.aspx?fileticket=rxqVFwSXkY%3d&tabid=1976&mid=3084>
Denver Health website. Available at: <http://www.denverhealth.org/portal/AboutDH/DenverHealthOverview/tabid/267/Default.aspx>
Denver Health Brochure. Available at: <http://www.denverhealth.org/portal/LinkClick.aspx?fileticket=d1Wry7whCSU%3d&tabid=1966&mid=3083>
R. Nuzum, D. McCarthy, A. Gauthier, and C. Beck, Denver Health: A High-Performance Public Health Care System, The Commonwealth Fund, July 2007.
Denver Audits, 2008. Available at: <http://www.denvergov.org/Audits2008/tabid/428946/Default.aspx>

Harris County Hospital District (Houston, TX)

The Harris County Hospital District (HCHD, or “the District”) was established in 1966 as a political subdivision with taxing authority by the State of Texas legislature and approved by the voters of Harris County. According to the February 29, 2008, HCHD-audited financial statements and the Harris County, Texas, audited Comprehensive Annual Financial Report, the District is legally separate from the County and is presented as a discrete component unit in the Harris County financial statements, since the members of the District’s governing Board of Managers are appointed by the Harris County Commissioners’ Court, composed of four Commissioners and the County Judge. The Harris County Commissioners’ Court also approves the District’s tax rate, as well as the annual operating and capital budget. Harris County does not provide any funding to the District, hold title to any of the District’s assets, or have any rights to any surpluses of the District. The Hospital District cannot issue bonded debt without Commissioners’ Court approval, and the County has no obligation to assume any liability for the bonds issued by the District.

HCHD provides medical care to all residents of Harris County, regardless of their ability to pay. The Hospital District includes three hospitals (Ben Taub General Hospital, Lyndon B. Johnson General Hospital, and Quentin Mease Community Hospital), 12 community health centers, a dialysis center, a dental center, 8 school-based clinics, 13 homeless shelter clinics, and 5 mobile health units throughout Harris County. In 2004, HCHD accommodated more than 1.26 million emergency and outpatient visits.

Best known for its hospitals and trauma care, HCHD offers a broad range of services for Houston’s uninsured and underinsured. As the public healthcare system for the nation’s third most populous county, HCHD delivers fully integrated healthcare services to a broad cross-section of area residents. Patients are insured by Medicare, Medicaid, or private insurance, but many are among the 1.2 million Harris County residents who are uninsured or underinsured. Harris County has unique employment characteristics, with small businesses employing a majority of the residents. Such small businesses are not able to afford adequate employee health insurance, and, as a result, there is a major need for healthcare services greater than what is currently provided at HCHD facilities.

Financial Profile

In its audited February 29, 2008, financial statements, the District reported total operating revenue of \$793 million, principally composed of \$258 million in net patient service revenue, \$165 million of Disproportionate Share Hospital and Upper Payment Limit Funding through the State of Texas Medicaid program, and \$345 million in premium revenue from the District’s health maintenance organization, Community Health Choice, Inc. The District reported an operating loss of \$389 million and negative cash flows from operating activities of \$250 million. Operating losses

and negative cash flows were offset by \$521 million and \$505 million, respectively, of non-operating revenues and noncapital financing funds principally composed of ad valorem taxes levied by the Harris County Commissioner’s Court for the District, as provided under state law.

Overall, for fiscal year 2008, the District reported an increase in net assets of \$133 million and a net increase in cash and cash equivalents of \$45 million. The estimated cost incurred to provide charitable services for 2008 was reported at \$846 million.

Major Recognitions

HCHD received the 2007 Gold Award for community-based programs from the American Psychiatric Association for the Community Behavioral Health Program.

Selected Leading Practices

- *Taxing Authority:* Harris receives tax-based support – over \$478 million received in 2008. HCHD is tax-supported and almost 60 percent of funding comes from other sources. During fiscal year 2008, HCHD leveraged that \$478 million in tax-base support into \$846 million of charity care.
- *Capital Investment:* During fiscal year 2008, HCHD launched a major, multiphase capital program. Over the next four years, an investment of over \$350 million is planned to expand and balance their healthcare delivery platform. Investments are intended to improve access to healthcare services, reduce wait times, and increase the number of patients. As a basis for their capital investments, HCHD developed a strategic plan designed to ensure that patients are seen by the appropriate clinicians at the appropriate locations. HCHD’s plan emphasizes community-based preventive and primary care, augments the traditional doctor/nurse model with a wide variety of medical practitioners, and provides for outpatient and diagnostic services outside of the hospital setting.
- *Centers of Excellence:* Patients benefit from a Level 1 Trauma Center, a regional center for neonatal intensive care, a mental health program, and an HIV/AIDS treatment facility.
- *Community Health and Disease Management:* HCHD provides several community programs that promote preventive care and disease management. Such programs include *TroubleShooting for Health* – a mobile health program providing preventive care and health screenings to patients in their neighborhoods.
- *Patient Access and Counseling:* HCHD helps patients choose a facility to meet their needs through a free telephone service. This service is staffed by a registered nurse and is available 24 hours a day, seven days a week. The nurse advises patients regarding whether an ER visit is required, as well as information on treatment of routine medical conditions.

Sources:

Harris County Financial Statements. Available at: http://www.co.harris.tx.us/Auditor/statements_reports.aspx

A Healthier Harris County. 2008 Annual Report. Available at: <http://www.hchdonline.com/about/financials/2008AnnualReport.pdf>

Hennepin Healthcare System, Inc. (Minneapolis, MN)

Hennepin County Medical Center (HCMC) was founded in 1964 after Hennepin County (the County) assumed ownership. Predecessor organizations provided care for the health of County residents for almost 120 years. HCMC includes one hospital and four primary care clinics in the Twin Cities. HCMC is the Level 1 Trauma center for the state and is the leading safety net system in the region for low income, uninsured, and vulnerable patients. HCMC serves patients, regardless of their ability to pay.

In 2005, the Minnesota Legislature passed legislation enabling the Hennepin County Board of Commissioners to create Hennepin Healthcare System, Inc. (HHS), a public corporation to be operated as a subsidiary of the County. The purpose of HHS is to deliver healthcare and related services to the general public, including the indigent, to engage in related programs of education and research, continuing to operate HCMC, and to possibly develop other healthcare services in the future. This change in governance was designed to give HCMC the autonomy and flexibility it needs to compete in a rapidly and ever-changing healthcare industry.

HHS's volunteer Board of Directors consists of between 11 and 15 members (13 during the first three years) and includes two County Commissioners and the CEO of the Corporation in an ex officio capacity. Remaining Board members are selected based in part on the objective of ensuring diverse and beneficial perspectives including, but not limited to medical and other health professionals, urban, cultural, and ethnic professionals served, business management, law, finance, health sector employees, public health, serving the uninsured, health professional training, and the patient or consumer perspective. The initial Board of Directors was appointed by the County Board; thereafter, except for the ex officio directors, the HHS Board selects its own directors through a nomination process facilitated by an HHS Governance Committee.

The County Board retains significant control over HHS's mission and operations, capital planning, issuance of debt, and authority over the operating budget via annual approval. State legislation provides that if the County Board is not satisfied with the performance of HHS, it may dissolve the corporation with a two-thirds vote of the County Board.

Financial Profile

According to the December 31, 2007, audited Comprehensive Annual Financial Report of Hennepin County, HCMC is a legally separate entity and is presented as a discrete component unit with the County's financial statements, rather than as a County enterprise fund, as was the case prior to the January 1, 2007, governance change. For the year ended December 31, 2006 – the year prior to the governance change – HCMC reported total operating revenue of \$464 million, principally composed of \$430 million in net patient service revenue. HCMC

reported an operating loss of \$12 million and negative cash flows from operating activities of \$5 million. Operating losses and negative cash flows were offset by \$20 million and \$44 million, respectively, of non-operating revenues and noncapital financing funds principally composed of property taxes.

According to the December 31, 2007, audited Comprehensive Annual Financial Report of Hennepin County, the County is committed to provide significant support to HCMC operations based upon the community benefits it provides. This includes use of certain County-owned lands and buildings at essentially no cost (the County owns the hospital assets), guaranteeing a specific level of cash liquidity for the Medical Center, providing funding for the provision of uncompensated care based on a specific formula, and providing funds (\$90 million) for certain large Medical Center capital improvement projects.

The County provided 100 percent of employer paid healthcare benefits for HCMC employees retired as of December 31, 2006, and agreed that it would pay 50 percent of such costs in excess of \$1 million for employees retiring after December 31, 2006.

The net assets contributed from the County to HCMC when it initially became a separately governed entity were in excess of \$173.5 million. During 2007, the County provided \$28 million to HCMC in support of uncompensated care provided to County citizens.

Major Recognitions

In 2008, HCMC was named one of America's Best Hospitals by *U.S. News & World Report* for the 12th year in a row. HCMC has a kidney transplant program that was ranked third in the nation in 2003 by the University Health System Consortium (UHC) study of "best performers" in the area of kidney transplants. HCMC was awarded the 2003 Medica Choice Quality Improvement award in the areas of diabetes, prenatal, and child and teen checkups. HCMC was the recipient of the Partners for Change Award from the Hospitals for a Healthy Environment (H2E) program, by the U.S. Environmental Protection Agency, the American Hospital Association, the American Nurses Association, and Health Care without Harm designed to improve the environmental performance of the field.

Selected Leading Practices

- *Operational Agility Through County-Initiated Governance Change:* In her 2007 annual budget message, Hennepin County Administrator, Sandra L. Vargas, provided these comments on Hennepin County Medical Center governance:

"The cost of healthcare services and technology has skyrocketed, and the number of residents without insurance and without access to health insurance has continued to climb. Uncompensated care costs at the hospital increased 27 percent, from about \$26 million in 2004 to more than \$33 million in 2005. Given this

and other industry pressures, [the County] Board recognized the need to provide the hospital with greater operational agility.”

- *Centers of Excellence:* HCMC offers COEs for patients in the following areas – Cardiology/CV Surgery, Critical Care Medicine/Pulmonary, Diabetes, Emergency Services, Gastroenterology/Digestive Disorders, Infectious Diseases, Maternal/Child Health, Neurosciences, Oncology, Orthopedics, Primary Care/Adult and Children, Psychiatry, Renal Diseases/Transplantation, Physical Rehabilitation, Sleep Disorders, and Trauma.
- *Disaster Preparedness:* HCMC is the backbone of the state’s disaster-preparedness system. HCMC provides trauma training to police, sheriff, and fire “first responders,” ambulance and air-link crews, and local emergency department health personnel across the state. HCMC provides Critical Care Teleconferences to hospitals outside the metro area and on-site trauma consultation and/or customized on-site training at the request of rural hospitals. Other efforts include:
 - Leading the coordination of hospital response to emergency events within the metro area and the state.
 - Treating the first cases of any unknown infectious disease that arrive in the Twin Cities.
 - Coordinating a cooperation response agreement with 28 area hospitals to coordinate a disaster response.
- Monitoring and reporting hospital bed availability and coordinating transportation of patients between the hospital and the disaster site.
- Providing funding to hospitals and law enforcement agencies to purchase equipment, build decontamination facilities, increase supplies of key pharmaceuticals, and otherwise prepare to respond to any incident where a large number of casualties must be treated.
- Providing training in hazardous materials to first responders for illnesses and injuries related to weapons of mass destruction.
- *Traumatic Brain Injury Focus:* Hennepin’s “Save This Brain” campaign was an effort to educate consumers about the impact, recognition, prevention, and treatment of traumatic brain injuries. As a result of much success, Hennepin was presented with the international Consumer Health World Award for its successful public awareness and prevention program.
- *Community Health:* HCMC is focusing on enhancing mental health, reducing health disparities, and improving the health of immigrant populations, expanding access to primary care, and training the healthcare workforce.
- *Cancer Care:* The Cancer Center at Hennepin County Medical Center was awarded a certificate of approval with commendation from the Commission on Cancer, approving the cancer program through the year 2010. The cancer program exceeded standards of excellence in the diagnosis and treatment of cancer patients.

Sources:

Hennepin County website. Available at: <http://www.co.hennepin.mn.us/portal> and <http://www.hcmc.org/pr/publicrelations.asp>

Hennepin County Medical Center Governance. Available at: <http://www.hcmc.org/governance.htm>

Hennepin County Medical Center. National Reputation for Quality and Centers of Emphasis and Excellence.

Available at: <http://www.hcmc.org/pr/documents/NationalReputationforQuality.doc>

Hennepin County Medical Center. Minnesota’s Safety Net. Available at: <http://www.hcmc.org/pr/documents/SafetyNet.doc>

News Releases:

a. Hennepin Receives International Award for Health Promotion. December 2008.

b. Public invited to review 2008/2009 Health Services Plan draft. September 2008.

c. One of America’s Best Hospitals – for the 12th year in a row. July 2008.

d. Comprehensive Cancer Center approved with commendation from Commission on Cancer. April 2008.

Hennepin County Medical Center. Proposed Bylaws of Hennepin Healthcare System, Inc. April, 2006. Available at: http://www.hcmc.org/governance_bylaws.htm.

Appendix D continued on next page.

Parkland Health and Hospital System, Dallas County Hospital District (Dallas, TX)

Parkland Health and Hospital System has served the community since the late 1800s. It was forever thrust into national memory on November 22, 1963, as Parkland Hospital's trauma doctors and nurses struggled to save the life of President John F. Kennedy.

From the poor and homeless to the wealthy, Parkland's care delivery system, with over 8,100 physicians, nurses, and employees, treats one of the largest and most diverse groups of patients in the area. Parkland reports a diverse payer mix, comprised of self-pay (22 percent), charity (26 percent), Medicare (13 percent), Medicaid (30 percent), and commercial patients (9 percent).

According to the audited September 30, 2008, financial statements of Dallas County Hospital District, doing business as Parkland Health and Hospital System (the District or Parkland) and the audited September 30, 2007, Dallas County, Texas (the County) Comprehensive Annual Financial Report, the District is a political subdivision of the State of Texas, legally separate from the primary government of the County. The District operates as a special taxing district created in 1954 by a vote of the taxpayers of the County.

The District is governed by a seven-member, volunteer Board of Managers appointed by, but not composed of, County Commissioners. Five members of the Board are selected by individual Court officials; the remaining two serve in an at-large capacity. The Commissioners Court of the County (composed of the four County Commissioners and the County Judge) approves the District's tax rate and annual budget; however, the District operates under different statutory and constitutional authority. The District has a separate constitutional tax limitation; independent power of eminent domain; and individual right of ownership of property. Dallas County does not provide any funding to the District, hold title to any of the District's assets, or have any rights to any surpluses of the District. The District is presented as a discrete component unit in the Dallas County financial statements to emphasize that it is legally separate from the primary Dallas County government.

Financial Profile

In its audited September 30, 2008 financial statements, Parkland reported total operating revenue of \$983 million, principally composed of \$385 million in net patient service revenue, \$181 million of Disproportionate Share Hospital and Upper Payment Limit Funding through the State of Texas Medicaid program, and \$386 million in premium revenue from Parkland's HMO. Parkland reported an operating loss of \$321 million and negative cash flows from operating activities of \$345 million. Operating losses and negative cash flows were offset by \$444 million and \$403 million, respectively, of non-operating revenues and noncapital financing funds principally composed of ad

valorem taxes levied by Parkland and collected on its behalf by the County.

For fiscal year 2008, the District reported an increase in net assets of \$128 million and a net increase in cash and cash equivalents of \$80 million. The estimated cost incurred to provide charitable services for 2008 was reported at \$259 million.

Major Recognitions

In 2008, Parkland was listed as one America's Best Hospitals for the 15th consecutive year by *U.S. News & World Report*. Additional recognitions include listing in the 2009 'Top 100 Hospitals to Work For' for nurses, the 2007 Thomson 100 Top Hospitals National Benchmarks for Success award, and the 2007 Quality Improvement Achievement Award from the TMF Health Quality Institute. Additionally, in 2008, four Parkland nurses were named in the "Great 100 Nurses" by the Texas Nurses Association and the Dallas-Fort Worth Hospital Council. Parkland was also included in Verispan's "Best of the Rest" listing of Integrated Healthcare Networks in 2007.

Selected Leading Practices

- *Engaged Board:* Parkland's dedicated governing Board of Managers meets monthly to oversee management's activities, approve major contracts and policies, and perform reviews of performance results and major improvement initiatives. The Board's agenda includes detailed briefings and analysis of historic and forward-looking metrics, including comparisons against targets, benchmarks, and peer groups, in such areas as clinical quality, finance, technology, and internal audits. The Board is supported by the work of its committees, including Strategic Planning, Quality and Risk Management, Budget and Finance, Audit and Compliance, Information Systems, and Human Resources. The Board transparently publishes its agendas, minutes and meeting materials on the Parkland website. The Board meets in executive session when warranted within the parameters established by State of Texas statute.
- *Philanthropic Activity and Taxpayer-Approved Funding Increase to Support Strategic Facility Upgrade:* During 2008, Parkland Foundation, the system's philanthropic arm, announced its \$150 million "I Stand for Parkland" campaign to replace Parkland's aging main facility and announced total gifts and commitments of approximately \$80 million. The effort supports the system's strategic plan, which includes a \$1.3 billion capital project for a 968-bed replacement hospital, outpatient center, and office space across from the present facility. Built in 1954, the hospital, which operates at full capacity, is more than 50 percent too small for the current volume of more than 1 million patient visits per year and to accommodate a doubling of Dallas County's population by 2025.

In November 2008, Dallas County voters overwhelmingly approved supporting ad valorem tax increase to support the issuance of up to \$747 million in a combination of tax and revenue bonds – the primary source for the capital project. Current and future hospital cash and investments are anticipated as another primary source of funding for the modernization project. Otherwise, Parkland's tax rate did not increase from 2000 to 2008.

- *Affiliation with Academic Medical Schools:* Parkland is a primary teaching hospital for the University of Texas Southwestern Medical Center. The hospital's affiliation with the University of Texas Southwestern Medical Center at Dallas helps educate physicians through residency and fellowship programs. More than 60 percent of the doctors in the Dallas area have undergone formal training at Parkland.
- *Centers of Excellence:* Parkland is comprised of one hospital organized around 10 COEs with the most skilled health professionals and state-of-the-art tools and equipment: Trauma, Burns, Spinal Cord Injuries, Cancer, Endocrinology, Women and Infants, Epilepsy, Gastroenterology, Cardiology, and Orthopedics.
- *Primary Care and Outreach:* In addition to Parkland's COEs at its hospital, the system focuses on community health through its eleven community-oriented primary care health centers, eleven youth and family centers, eight women's clinics, four mobile vans, and various outreach programs aimed at education and prevention. For example, Parkland offers a Homeless Outreach Medical Services program that provides medical care to homeless individuals through medical vans. Another program is the mobile mammography van that assists in early detection of breast cancer in the community.
- *Process Improvement:* Parkland adopted the Lean Six Sigma methodology to reduce variations and wasted costs from processes, operational inefficiencies, and organizational performance. "As a public hospital system it behooves us to find better ways to manage our dollars and to become more efficient in the ways

we use those funds. Part of our responsibility is to be good stewards of our taxpayers' dollars as well as contributions from philanthropists, community organizations and government entities that help fund many of our programs," said Ron Anderson, M.D., president and CEO of Parkland. "Six Sigma helps bring those principles to the forefront of our operations."

- *Managed Care Plan and Programs to Promote Access and Integrated Care:* To focus on its mission, the Parkland Community Health Plan, Inc. (PCHP) serves as a bridge, connecting Medicaid and Children's Health Insurance Program (CHIP) members to programs and services designed specifically for them. PCHP members have a "medical home" to address their medical and related social needs in a comprehensive, coordinated fashion. The PCHP Medicaid Managed Care Program is called Parkland HEALTHfirst and the PCHP Children's Health Insurance Program is Parkland KIDSfirst. Unique to PCHP, members of Parkland HEALTHfirst and Parkland KIDSfirst who choose Parkland providers can access their "medical home" with their provider after Medicaid or CHIP eligibility ends through the Parkland HEALTHplus program. Members' primary care provider serves as a partner who helps them manage their medical care and well-being.

Parkland HEALTHplus is not a part of Parkland Community Health Plan, and is not health insurance. Parkland HEALTHplus is for Dallas County residents who qualify based on information such as income, family size, and residency. Parkland HEALTHplus is a payment program for services received at Parkland Memorial Hospital or at one of the Parkland Community Oriented Primary Care health centers only. There is no enrollment cost. Eligible enrollees are asked for a co-payment due at the time of service for clinic visits, pharmacy prescriptions, supply items, or specific procedures. Parkland HEALTHplus patients receive services that are medically necessary and are normally provided at any Parkland facility.

Sources:

Parkland Hospital website. Available at: <http://www.parklandhospital.com/index.html>
 Parkland Hospital Careers. Available at: <http://www.parklandcareers.com/content.asp?c=abopar>
 Parkland Hospital 2006-2007 Annual Report. Available at <http://www.parklandhospital.com/whoweare/pdf/AnnualReport.pdf>
 Parkland Hospital Fact Sheet. Available at: http://www.parklandhospital.com/whoweare/pdf/Parkland_FactSheet_FY07.pdf
 Corporate Approaches in Public Hospital Management. The Magazine of the National Association of Public Hospitals and Health Systems. The Safety Net, 21 (1). Winter 2007.
 National Association of Public Hospitals and Health Systems website. Available at: www.naph.org

Appendix E:

Report on Leading Practices of Public Safety Net Healthcare Delivery Systems in the United States, prepared by PricewaterhouseCoopers Available at www.calendow.org.

PHOTO CREDITS:

Inside Cover, 33, 35 : New York City Health and Hospitals Corporation; Pages 2, 10, 15 : Anthem Blue Cross; Page 9 : UniHealth Foundation; Pages 31-32 : Jackson Health System; Pages 35, 49, 50 : Los Angeles County Department of Health Services.



Los Angeles
Healthcare Options 2009
A Task Force of The California Endowment