

KING/DREW MEDICAL CENTER TRANSITION REPORT

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LA Health Action



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KING/DREW MEDICAL CENTER TRANSITION REPORT: EXECUTIVE SUMMARY

The Los Angeles County Board of Supervisors faces a difficult decision: How to ensure that Martin Luther King Jr./Drew Medical Center (KDMC) patients receive high quality medical care and that this medical center is prudently administered, both fiscally and managerially? Various health care administrators, policy makers and community advocates have suggested different solutions, one of which is to convert KDMC from a teaching hospital to a non-teaching community hospital.

This report seeks to answer the question, "If KDMC becomes a non-teaching facility, what are the implications for the delivery of health services to Service Planning Area (SPA) 6 residents?" In doing so, it presents summaries of qualitative data from reports, interviews, etc., and uses quantitative data to compare KDMC with the three other general acute care hospitals in SPA 6--LA Metropolitan Medical Center, St. Francis Medical Center and Suburban Medical Center. This study does not address the quality of care issues raised by the series of articles by the Los Angeles Times¹, nor the administrative problems of concern to the Los Angeles County Board of Supervisors.

Key Findings

This information is provided under two headings. The first focuses on KDMC's current contributions to health services in SPA 6 and the other on what could be expected if it ceased to be a teaching hospital.

KDMC's current contributions:

- Between 2000 and 2004, KDMC provided 40% of most licensed bed types, although the number of staffed beds declined in all SPA 6 hospitals over this time.
- While Medical is the predominant payor for all patients in SPA 6, KDMC has the highest proportion of self-pay patients and provides the highest amount of uncompensated care.
- Over the last four years, 80% of KDMC's inpatient admits came through its ED and in 2003, it discharged almost half of patients in SPA 6 admitted for ambulatory sensitive diagnoses.
- In 2004 KDMC provided slightly more than one-third (37%) of all ED patient visits in SPA 6, provided inpatient services for nearly half (47%) of all patients admitted from EDs, and almost three-quarters (71%) of its discharged patients resided in SPA 6.

Potential consequences if KDMC loses its teaching status:

- Over \$98 million/year² revenues in terms of Medi-Cal reimbursements will be lost. These dollars provide funding for physician intern salaries enabling the hospital to serve a large number of uninsured patients.
- Over \$20 million/year in research funding will also be lost. These dollars support unique programs at KDMC, e.g. sickle cell, endocrinology and neuroscience research and services, and they give low-income patients access to cutting-edge treatments as participants in clinical trials and research protocols.
- Many specialty training programs will be eliminated including emergency medicine, OB-GYN, family and internal medicine, pediatrics, psychiatry and several others, further compounding difficulties in accessing specialty services which are more expensive to provide.
- The number of trained physicians willing to practice in low-income inner city communities (including South LA) will be reduced. Over 80% of KDMC graduates practice in low-income urban centers compared to 20% of physician graduates from UCLA.
- Uninsured SPA 6 patients will find it more difficult to access services. As a teaching hospital, KDMC has been able to treat more uninsured and county indigent patients than other SPA 6 hospitals; however this number has been decreasing since 2000. In 2004, KDMC served almost twice the number of uninsured patients (2,826 patients, 28% of total patients served) than St. Francis (1,514, 6% of total patients served).

As a teaching hospital, KDMC will be better equipped to meet the medical needs of SPA 6 residents. If the access it provides to specialty services is removed, SPA 6 patients will seek them elsewhere. Wherever the uninsured patients among them seek care, they will confront providers reluctant to serve them. This will further stress a health delivery system for low income and indigent patients that is already over-burdened.

¹On December 5, 2004 the Los Angeles Times began a five part series focusing on systemic problems at KDMC. While the last article in the series was published on December 23, 2004, periodic other accounts in the Times suggested that many of the problems identified in its series had not been fixed. However, a somewhat positive article was published in the Times on July 27, 2005.

² This figure is based on NHF's estimation using 2000-2003 OSHPD Hospital Annual Financial Data.

I. INTRODUCTION

In late 2004, the Los Angeles Times (Times) ran a series of articles on medical care at Martin Luther King Jr./Drew Medical Center (KDMC) which raised questions about the quality of the care this facility has been providing.¹ This same concern was raised about hospitals throughout the country by the Institute of Medicine in its 1999 report entitled *To Err is Human: Building A Safe Healthy System*. As the Los Angeles Board of Supervisors (Board) sought to understand and respond to the Times claims, it began to look in a new way at the administrative and managerial issues that had long plagued KDMC. The Board also brought in a consultant (Navigant) to correct the many problems at KDMC that had been identified. In devising solutions to these problems, health care administrators, policy makers and the public have suggested many different strategies, one of which is to convert KDMC from a teaching to a non-teaching hospital.

KDMC has long had the support of various community advocates and at the possibility of losing its teaching status, they became extremely concerned about the potential loss of services to an already poorly serviced area (SPA 6)² with a population that is generally in poorer health than those in other SPAs. Historically SPA 6 residents have experienced a shortage of hospitals and medical providers, and within SPA 6, South LA has the fewest hospitals, fewest physicians, and highest number of patients in the entire county. KDMC is one of only four hospitals serving over 1 million men, women, and children compared to West Los Angeles (in SPA 5) which has seven hospitals serving a population of 620,000.³

Data from the County of Los Angeles, Department of Health Services, show that SPA 6 residents also tend to be poorer and sicker. Poverty indicators showing SPA 6 is statistically worse off than the LA County average include 28% of households having incomes of less than 100% of the Federal Poverty Level, 27% of high school students dropping out, and 36% of adults (18-64) and 18% of children (0-17) being uninsured. The sickness in this SPA is demonstrated by 9% of the adults having been diagnosed with diabetes and 25% with hypertension, an infant mortality rate of 6.5/1,000 live births, 26% of all children in grades 5, 7 and 9 being overweight, and above average age adjusted mortality rates for lung cancer (51/100,000 population), cardiovascular disease (268.3/100,000), diabetes (38.3/100,000) and stroke (70.2/100,000).⁴

Given these brief profiles of the health services capacity and residents in SPA 6, it is hardly surprising that community advocates strongly believe that the proposed conversion of KDMC would adversely affect the residents of SPA 6. They and supporters of Drew University have been vocal that KDMC should remain a teaching hospital.

¹ On December 5, 2004 the Los Angeles Times began a five part series focusing on systemic problems at KDMC. While the last article in the series was published on December 23, 2004, periodic other accounts in the Times suggested that many of the problems identified in its series had not been fixed. However, a somewhat positive article was published in the Times on July 27, 2005.

² Los Angeles County is divided into eight service planning areas (SPAs). KDMC is located in SPA 6.

³ Campaign to Transform King/Drew extracted on 7/28/2005 from

http://www.charityfinders.com/cf/servlet/SIGenerateSite?action=otherInfo.jsp&oiCode=2&charity_id=061405CHA002

⁴ County of Los Angeles Department of Health Services, Public Health, *Key Indicators of Health by Service Planning Area 2002/2003*, retrieved from www.lapublichealth.org, July 29, 2005

This study does not address the quality of care issues raised by the Times, nor the administrative problems of concern to the Board. It does seek to answer two broad questions: What are the differences between teaching and non-teaching community hospitals? And, using existing data, how can we begin to think about the implications for health services delivery to SPA 6 residents if KDMC ceases to be a teaching facility?

This report is organized into six sections. This section (I) includes the Introduction and a brief discussion of study methods and data analyses. Section II describes various types of hospitals, while Section III presents some unique characteristics of KDMC. Section IV identifies services that have been eliminated and added from KDMC since 2000, and Section V compares the four hospitals' contributions to services delivery in SPA 6 (data tables to support these findings are provided in the Appendix). Section VI discusses some of the effects of converting KDMC to a non-teaching hospital and, finally, some concluding thoughts are presented in Section VII.

Methods

To answer these questions, historical data at the patient and facility levels from a variety of sources were used. Data sources include: four databases from the Office of Statewide Health Planning and Development (2000-2003 Hospital Annual Financial Data, 2004 Hospital Quarterly Financial Data, 2000-2003 Inpatient Hospital Discharge Data, 2000-2004 Hospital Annual Utilization Data)⁵, the County of Los Angeles King/Drew Medical Center Navigant Consulting Assessment Report (2005)⁶, the American Hospital Association (AHA) Guide to the Health Care Field 2002 and 2005 editions⁷, the Hospital Self Pay Study Findings Report prepared by the National Health Foundation (2005)⁸, and interviews with health care professionals at KDMC as well as other leaders and professionals in the Los Angeles health care arena.

Four hospitals in SPA 6--Suburban Medical Center (Suburban), St. Francis Medical Center (St. Francis), Los Angeles Metropolitan Medical Center (LA Metro) and LAC-DHS King/Drew Medical Center (KDMC)--comprised the study population. Of them, only three, Suburban, St. Francis and KDMC had at least basic level emergency departments between 2000 and 2004.⁹ Rather than taking a County-wide perspective, the data analyses for this study focused on SPA # 6. This was because 70% of patients discharged from KDMC live in SPA 6 and because this SPA is known to be an under-resourced area.

Data analyses

Quantitative patient and facility level data from OSHPD were used to compare current and historical trends among the four SPA 6 hospitals. Generally, these data are presented in two ways; those describing individual hospitals, and those describing each hospital's contribution to SPA 6 services. Qualitative data were used both to provide information and background for the quantitative trend and comparative analyses.

II. TYPES OF HOSPITALS

Hospital typologies vary depending on who creates them. For this study, it is most appropriate to begin with the dichotomy between community hospitals and academic medical centers. The latter are typically university owned, but they share many characteristics of community teaching

⁵ Information retrieved July 1, 2005, from <http://www.oshpd.ca.gov>

⁶ Information retrieved July 6, 2005, from <http://www.ladhs.org/planning/navigant.htm>

⁷ Information retrieved July 6, 2005, from <http://www.ahaonlinestore.com/>

⁸ Information retrieved July 6, 2005, from http://www.nhfca.org/reports/Self_Pay_Study.pdf

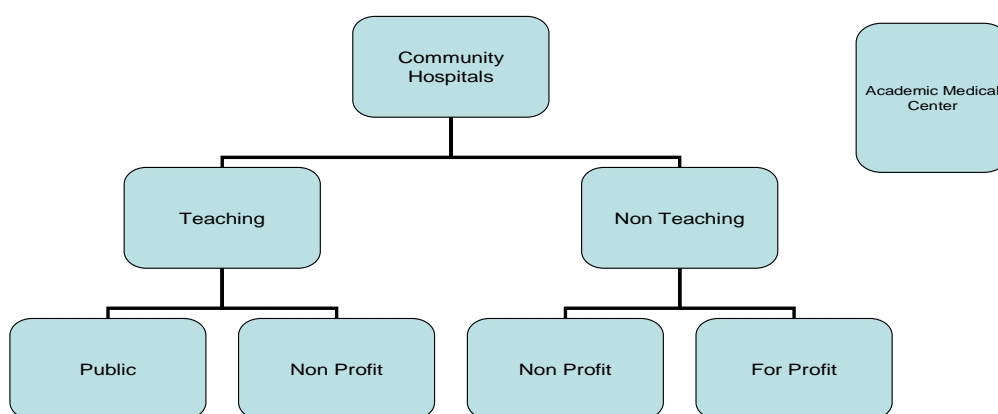
⁹ Suburban Hospital closed its Emergency Department in December 2004.

hospitals. However, there are no academic medical centers in SPA 6 (see Figure 1). The remainder of this section briefly presents the similarities among community hospitals and some distinct features of community teaching hospitals.

Community Hospitals

Community hospitals are all non-federal, short-term general and special institutions whose facilities and services are available to the public.¹⁰ They can be grouped into three ownership categories: not-for-profit (owned and operated by community or religious organizations), for-profit (investor-owned), and public (owned by state or local government). The public ownership category of community hospitals can also include teaching hospitals. KDMC falls into this category (see Figure 1).

Figure 1: Hospital Types



Source: NHF adapted from Williams, Stephen J. and Torrens, Paul R. Introduction to Health Services. 6th Edition. 2002. Delmar Publishing. Page 217.

Community hospitals can be teaching or non-teaching hospitals. Teaching community hospitals typically have residency programs, research grants and have access to funding sources that allow them to be compensated for some indigent care. Whether teaching or non-teaching, community hospitals have traditionally provided care for acute illnesses and injuries, but over the last several years their outpatient role has become increasingly important. Not-for profit and for profit community hospitals tend to be smaller than public community teaching hospitals.

To summarize, community teaching hospitals can be publicly owned (like KDMC) or not-for-profit (none in SPA 6); non-teaching community hospitals can be not-for-profit, e.g., St. Francis in SPA 6, or for-profit as are Suburban and LA Metro.

Community Teaching Hospitals

Teaching and non-teaching community hospitals differ in that while teaching hospitals generally offer all the services non-teaching hospitals do, they also offer many more. Teaching hospitals also differ in the following ways:

- they educate future physicians through residency training programs,
- they are staffed with many faculty physicians engaged in clinical research,

¹⁰ The Los Angeles County Department of Health Services. Hospital Advisory Board Orientation May 9, 2005. Martin Luther King, Jr./Drew Medical Center. Glossary. Page 114.

- they are sites for much of the nation's research,
- they tend to provide a broader range of services with more state-of-the-art technology,
- they tend to treat more complex medical cases,
- they treat indigent patients who have medical conditions with teaching value, and
- they receive additional funds related to teaching status from government-reimbursement and other sources.

Public community teaching hospitals provide care for all patients regardless of their ability to pay, and offer services that many for-profit and not-for-profit hospitals cannot or will not provide, e.g., alcohol and drug abuse treatment, psychiatric services, care for persons with communicable diseases, and treatment of persons with AIDS. They are located in inner-city areas where private physicians are often in short supply, and their outpatient departments become the chief source of ambulatory care for the poor. More than half of all practicing physicians receive at least some of their training in public hospitals.¹¹

III. UNIQUE CHARACTERISTICS OF KDMC

KDMC as a public community teaching hospital has provided many services to patients and medical students, several of which have not been available at other SPA 6 hospitals and which have been made possible through teaching and research support grants. Historically, KDMC has provided a wide range of clinical services in each of the following areas¹²:

- Medicine
- Surgery
- Otolaryngology
- Ophthalmology
- Orthopedics
- OB/GYN
- Neurosciences
- Pediatrics
- Psychiatry
- Emergency Medicine
- Oral/Maxillofacial Surgery and General Dentistry
- Family Medicine

Furthermore, there are several services unique to KDMC that, if lost, would not be available anywhere else in SPA 6. It is informative to compare KDMC's services with those of St. Francis which has the most services of the three comparison hospitals. Before doing so however, it must be noted that there may be more unique services that should be added to this list, which is based on information from the AHA Guide 2005. In comparing this data source with others, it became clear that the AHA Guide did not include an exhaustive list of services falling under departments such as Dermatology, Endocrinology, Gastroenterology, Rheumatology, etc. With these caveats, the following identifies 20 specific services only provided by KDMC in SPA 6¹³:

¹¹ Williams, Stephen J. and Torrens, Paul R. Introduction to Health Services. 6th Edition. 2002. Delmar Publishing. Page 217.

¹² County of Los Angeles King/Drew Medical Center Navigant Consulting Assessment Report (January 31, 2005). Overview of Clinical Services. Page 16. Retrieved on July 12, 2005, from http://www.ladhs.org/planning/pdf/navigant/12_Programs_1_30.pdf

¹³ Information extracted from AHA Guide to the Health Care Field 2005 Edition. Information reflected is based on data collected as of June 30, 2004. According to the AHA Guide, this information is reported directly by the hospital.

1. Ambulance Services
2. Adult Day Care program
3. Alcoholism-drug abuse or dependency outpatient unit
4. Alzheimer Center
5. Auxiliary organization
6. Bariatric/weight control services
7. Cardiac intensive care services
8. Crisis Prevention
9. Dental services
10. Enabling services
11. Fertility Clinic
12. Freestanding outpatient care center
13. Genetic Testing/Counseling
14. Geriatric services
15. Psychiatric education services
16. Psychiatric geriatric services
17. Sports medicine
18. Support groups
19. Teen outreach services
20. Tobacco Treatment/Cessation Program

IV. SERVICES ELIMINATED AND ADDED AT KDMC SINCE 2000

Since 2000, KDMC has undergone many changes and many services have been lost or reduced.¹⁴ Services that have been curtailed or eliminated include:

1. Angioplasty
2. Pediatric Intensive Care
3. Positron Emission Tomography Scanner (PET)
4. Psychiatric Child Adolescent Services
5. Radiation Therapy
6. Single-photon Emission Computerized Tomography (SPECT)
7. Trauma Unit
8. Loss of accreditation of surgery residency training program
9. Loss of accreditation of radiology residency training program
10. Loss of accreditation of neonatal-perinatal medicine residency training program
11. Loss of open heart surgery
12. Inpatient Geriatric program, which had an elder abuse focus and distinct unit, has been dissipated into the general inpatient environment

The AHA Guide notes that it does not include a complete list of all the services a hospital may provide. List of unique services provided by KDMC is based on a comparison of services between KDMC and St. Francis. Information for LA Metro and Suburban were not available. For definitions of these services, see Table 2, Appendix B.

¹⁴ Information extracted from multiple sources. Information about lost services 1-6 extracted from AHA Guide to the Health Care Field 2002 Edition which is composed of data collected in 2000. Information about lost services 7-9 extracted from Final Report of the Steering Committee on the Future of King/Drew Medical Center (March 30, 2005). Fulfilling the Promise: A Roadmap for Meeting the Health Care Needs of the South Los Angeles Community. Retrieved on July 12, 2005, from http://www.ladhs.org/khab/doc/kingdrew_fina_report.pdf. Information about lost services 10-19 extracted from County of Los Angeles King/Drew Medical Center Navigant Consulting Assessment Report (January 31, 2005). Retrieved on July 12, 2005, from http://www.ladhs.org/planning/pdf/navigant/12_Programs_1_30.pdf

13. Urology Clinic at Hubert H. Humphrey Comprehensive Health Center (HHHCHC) has been eliminated
14. Podiatry Clinic at HHHCHC has been eliminated
15. Neurology Clinic at HHHCHC has been eliminated
16. ENT Services at HHHCHC have been eliminated
17. Diabetes Management Clinic at HHHCHC has been eliminated
18. Pediatric Surgical capabilities
19. Mobile Dental Clinic for community outreach

Despite these service losses, between 2000 and 2005 KDMC made considerable effort to improve patient care and respond to community health needs by adding new and expanding existing services.¹⁵ Many of these services were, and still are, unavailable at other SPA 6 general acute care hospitals. KDMC's actions not only show its effort to improve services but also to fill service gaps and to respond to SPA 6 patients' needs. While the following is probably not a comprehensive list, since 2000, KDMC has expanded the following service capabilities.¹⁶ Those that are unique to King/Drew and not provided by the other general acute care hospitals in SPA 6, are asterisked (*):

- Ambulance Service*
- Alcoholism-drug abuse or dependency outpatient unit*
- Community health status assessment
- Enabling Services*
- Enrollment Assistance services
- Freestanding Outpatient Care Center*
- Nutrition Programs
- Skilled nursing or other long-term care services
- Sports medicine*
- Teen outreach services*
- Tobacco/Treatment Cessation Program*

These new services are clearly related to many of the needs of SPA 6 residents. Those who have no transportation are assisted to appointments through KDMC's ambulance service. The alcoholism-drug abuse or dependency outpatient unit, teen outreach services and the tobacco/treatment cessation program address the behavioral aspects of disease or focus on difficult to reach populations. The many research dollars flowing to KDMC have helped provide these services.

V. KDMC'S CONTRIBUTION TO SPA 6

This section describes in detail KDMC's contribution to SPA 6 based on hospital, patient, and financial data from multiple sources. These data are presented under nine headings and include information that ranges from comparing KDMC with the three other hospitals on the acuity levels of patients using their Emergency Departments to their performances on different fiscal measures.

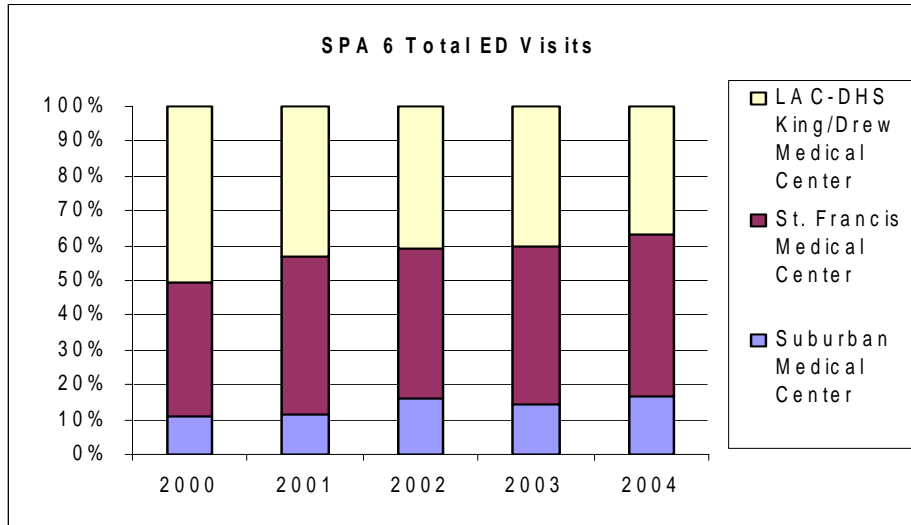
¹⁵ For definitions of these services, see Table 3, Appendix B.

¹⁶ This list of services compiled based on data from the AHA Guide to the Health Care Field 2002 and 2005 editions.

a. Emergency Department Visits

Of all the ED visits to SPA 6 hospitals over the last four years, the proportion provided by KDMC has decreased while that provided by St. Francis has increased. In 2000, over half of these visits were provided by KDMC, but by 2004, St. Francis was providing almost half, while KDMC provided only slightly more than one third (see Figure 2). Note: Suburban’s Emergency Department was closed in December of 2004.

Figure 2



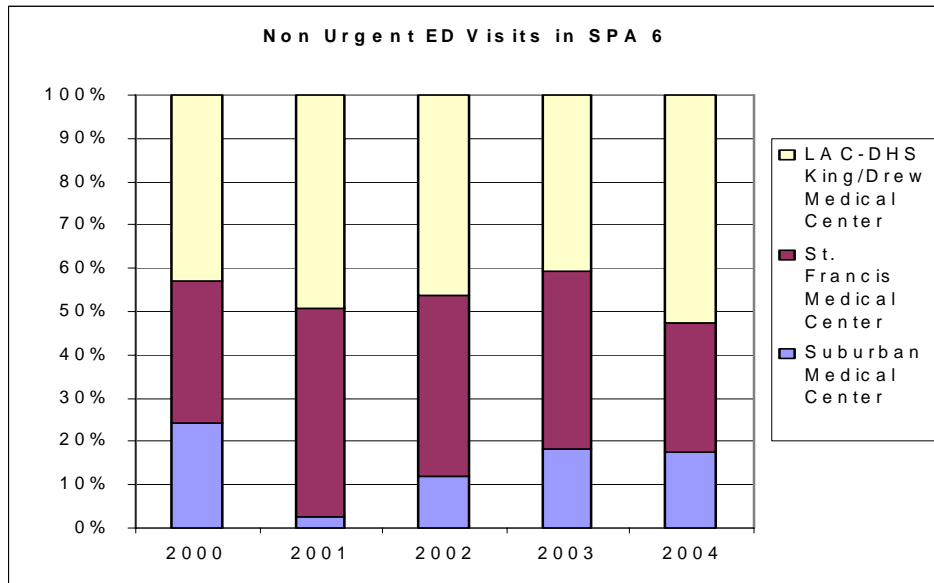
Source: National Health Foundation Compiled from 2000-2004 Hospital Annual Utilization Data

ED visits are categorized as non-urgent, urgent, and critical,¹⁷ and between 2000 and 2003, KDMC’s ED provided between 40% and 50% of all non-urgent visits in SPA 6 and, in 2004, it provided a four year high of 53% of the total urgent visits in SPA 6 (see Figure 3). Also during these four years, St. Francis’ proportion of all non-urgent visits in SPA 6 ranged from a high of 48% in 2001, to a low of 30% in 2004. Suburban’s proportion was highest in 2000 (24%) and in 2004 was 17%. The next graphs look at critical and non-urgent visits; urgent visit data are not included because OSHPD expanded this category’s definition; these data are provided in Table 1, Appendix C.

¹⁷ OSHPD, in its 2002 Hospital Annual Utilization Reports, redefined this typology by expanding the “urgent” category to “urgent, moderate, and severe.” Because this study looked at trends from 2000 it does not report out on the urgent category. The definitions retrieved from the OSHPD website on August 10, 2005, are as follows:

- a. **Non-Urgent** - a patient with a non-emergent injury, illness, or condition; sometimes chronic; that can be treated in a non-emergency setting and not necessarily on the same day they are seen in the EMS department (e.g., pregnancy tests, toothache, minor cold, ingrown toenail).
- b. **Urgent** - a patient with an acute injury or illness where loss of life or limb is not an immediate threat to their well-being, or a patient who needs a timely evaluation (fracture or laceration).
- c. **Critical** - a patient presents an acute injury or illness that could result in permanent damage, injury or death (head injury, vehicular accident, a shooting).

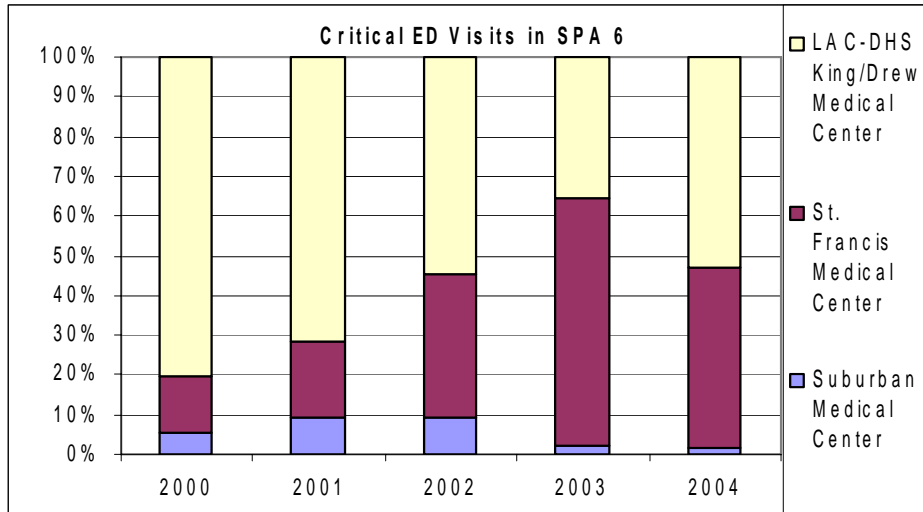
Figure 3



Source: National Health Foundation Compiled From 2000-2004 Hospital Annual Utilization Data

The pattern of critical visits provided by KDMC shows more variability than that of non-urgent visits over the same 4 years. In 2000, more than 80% of all SPA 6 critical patients visiting the ED came through King/Drew. From 2000 to 2003 this number declined to 35% as St. Francis increasingly saw more of these patients. In 2004, however, KDMC showed an increase accounting for over half (53%) of all SPA 6 critical ED patients (see Figure 4).

Figure 4

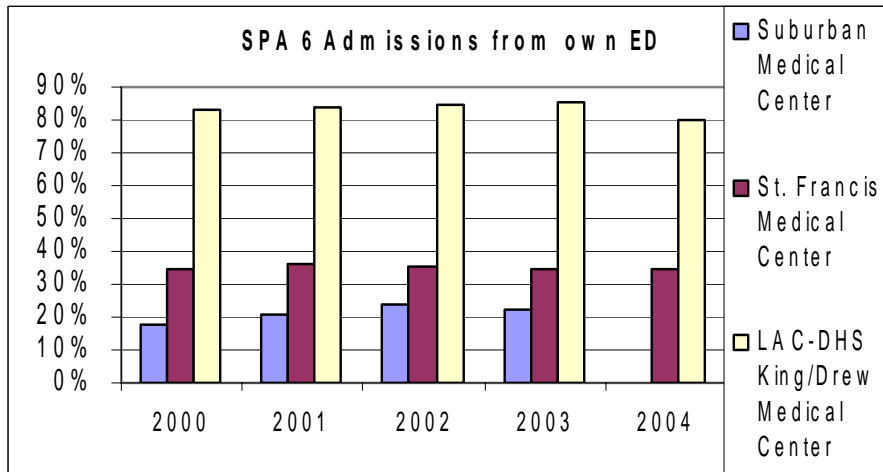


Source: National Health Foundation Compiled From 2000-2004 Hospital Annual Utilization Data

b. Admissions via Emergency Departments

Consistently between 2000 and 2004, more than 80% of the patients admitted to KDMC were admitted as a result of going to its ED (see Table 2, Appendix C). This means that only 20% of KDMC’s admissions were scheduled by physicians. KDMC’s 80% admissions via ED is more than double the proportion seen at St. Francis and nearly quadruple that of Suburban (see Figure 5). Note: 2004 data are not available for Suburban Medical Center because this hospital did not respond to the NHF Self Pay Survey.

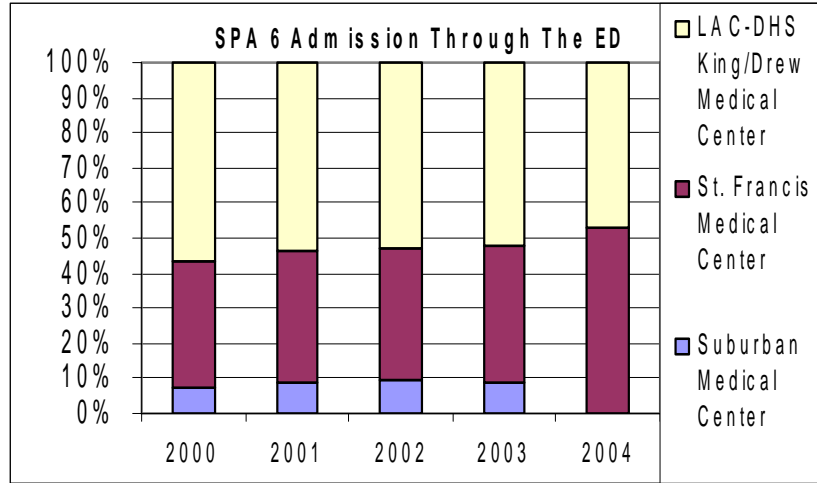
Figure 5



Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data, 2004 Data NHF Self Pay Survey

Between 2000 and 2003, while KDMC was consistently providing over half of all the admissions via ED in SPA 6, this proportion decreased from 57% to 52% (see Table 3, Appendix C). In 2004, Suburban closed its ED, KDMC admitted approximately 3,600 fewer patients via its ED than the year before and St. Francis began admitting the majority (53%) of the patients coming through SPA 6 EDs (see Figure 6). Note: There are no 2004 data for Suburban Medical Center because this hospital did not respond to the NHF Self Pay Survey.

Figure 6

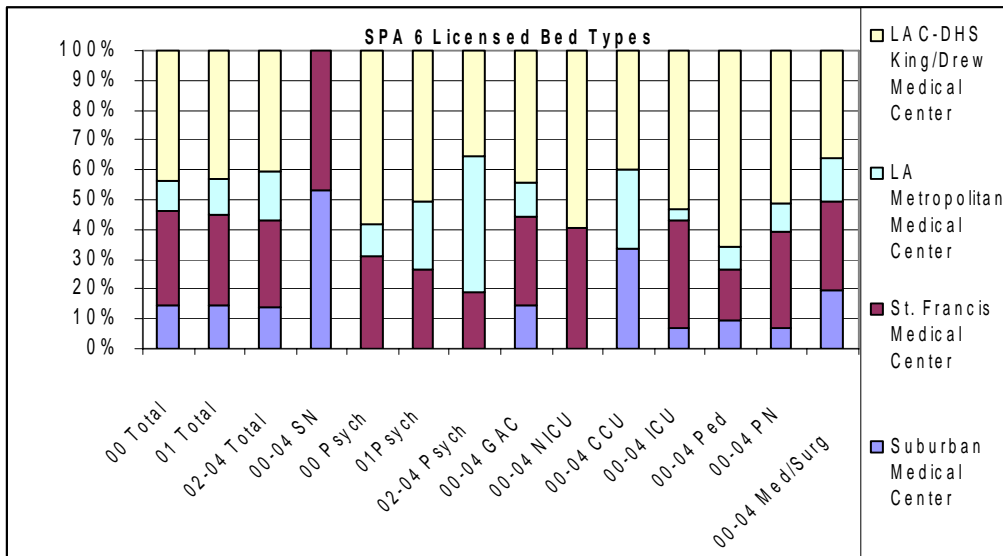


Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data, 2004 Data NHF Self Pay Survey

c. Bed Types

In general, KDMC has the most licensed beds and bed types in SPA 6 providing 40% of all beds in 2004 (see Table 4, Appendix C).¹⁸ However, it does not have any licensed skilled nursing beds and in 2004 did not have the most licensed psychiatric beds. Between 2000 and 2004 the only change to the number of licensed beds in SPA 6 came from LA Metro adding 20 psychiatric beds in 2001 and another 64 in 2002 (see Figure 7).

Figure 7

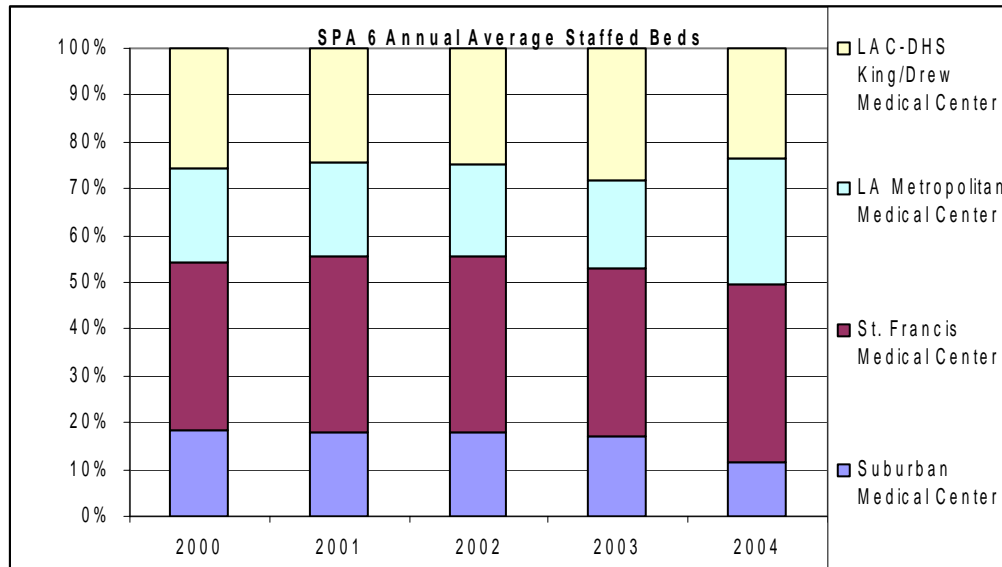


Source: National Health Foundation Compiled From 2000-2004 OSHPD Hospital Annual Utilization Data

¹⁸ There are no licensed Intermediate Care, Chemical Dependency, Intermediate Care/Developmentally Disabled, Rehabilitation Care, Burn, or Acute Respiratory beds in SPA 6 hospitals and therefore they are not included in the analysis.

While KDMC represents 41% of SPA 6 total licensed beds, on average it represents one quarter (24%) of total SPA 6 staffed beds. Except for LA Metro, which added more psychiatric beds, the remaining three general acute care hospitals have seen a decline in staffed beds from 2000 and 2004 (see Figure 8). During this period Suburban's average annual staffed beds declined by 50%, St. Francis by 15% and KDMC by 25% (see Table 5, Appendix C).

Figure 8

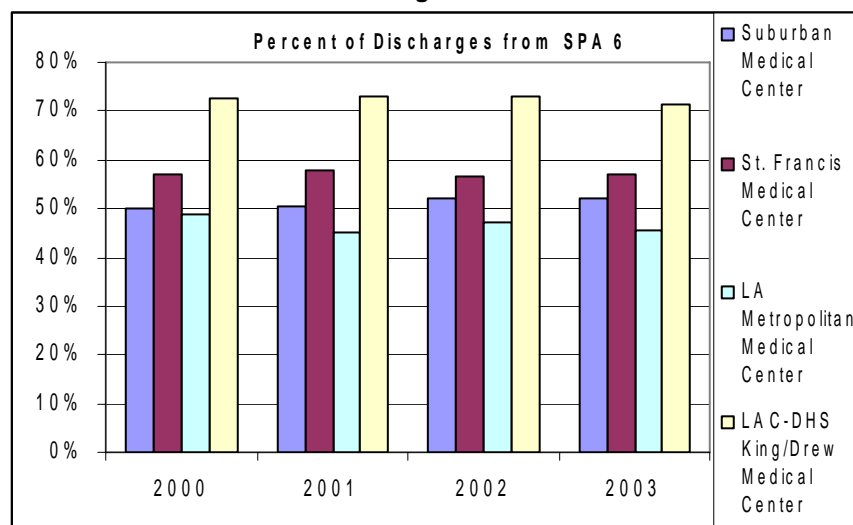


Source: National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data, 2004 OSHPD Hospital Quarterly Financial Data

d. Discharged patients

Between 2000 and 2004, more than 70% of KDMC's discharged patients resided in a SPA 6 zip code (see SPA 6 Zip Code List, Appendix A and Table 6, Appendix C). This is more than 15% higher than for the other three hospitals (see Figure 9).

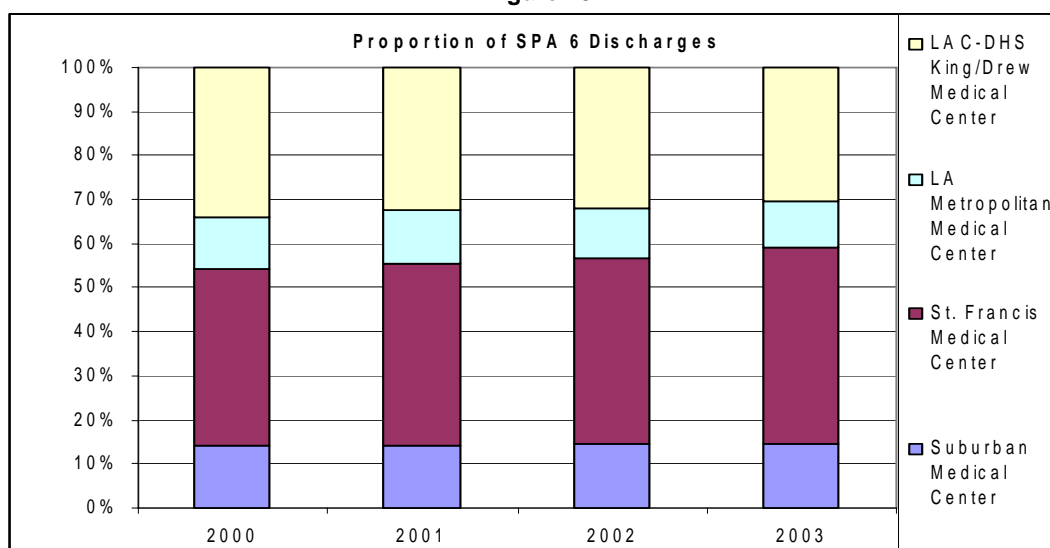
Figure 9



Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data

Between 2000 and 2004, while the total number of discharged patients that lived in SPA 6 zip codes declined, not all hospitals experienced a similar decline. The proportions discharged from St. Francis and Suburban increased, for St Francis the increase was 5% bringing the proportion to 45% and for Suburban it was 1% bringing it to 15%. The proportions discharged from KDMC and LA Metro decreased. For KDMC the decrease was 4% reducing the proportion to 30% and for LA Metro it was 2% reducing it to 10% (see Figure 10). St. Francis' increase involved 458 patients while KDMC's decrease involved 1,806 patients (see Table 7, Appendix C).

Figure 10



Source: 2000-2003 OSHPD Inpatient Hospital Discharge Data

e. Payer sources for discharged patients

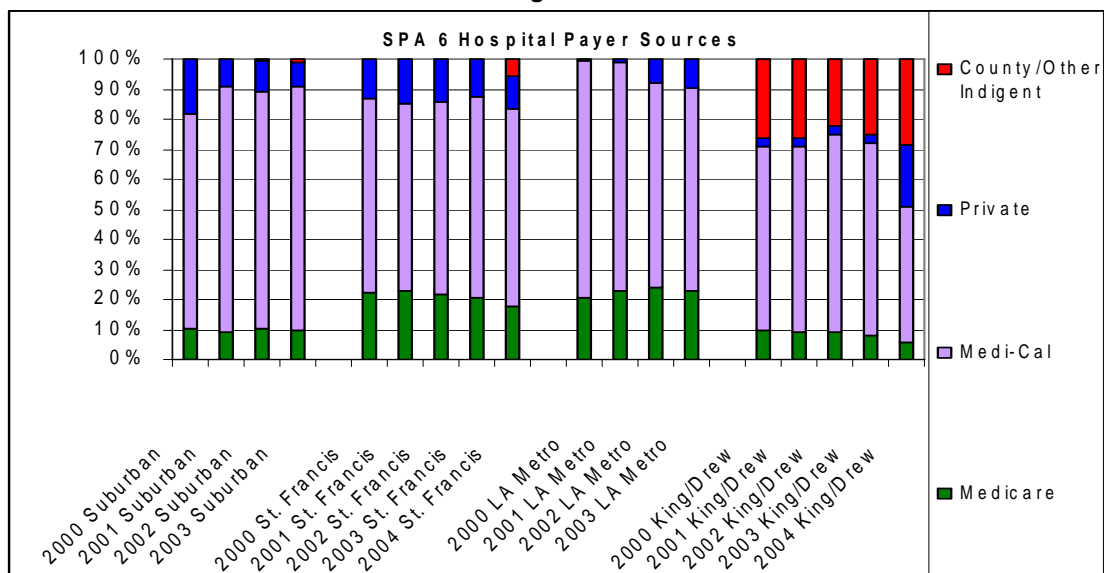
From 2000-2003, Medi-Cal patients comprised at least 60% of the patients discharged from SPA 6 hospitals. These included 58% of all KDMC discharged patients, 70% of LA Metro's, 59% of St. Francis', and 76% of Suburban's, while Medicare accounted for 20% of St. Francis' and LA Metro's discharges compared to 10% of Suburban's and less than that 9% of KDMC's. In addition, one quarter of KDMC's discharged patients' care costs are paid by County and Other Indigent payers.¹⁹ Also from 2000-2003, the population whose payer sources included County and Other Indigent, Self Pay, Other and Unknown represented nearly 30% of KDMC's discharges versus less than 10% of St. Francis and less than 5% of LA Metro's and Suburban's discharges (see Figure 11 and Table 8, Appendix C). Note: There are no 2004 data for

¹⁹ Payer categories as defined by OSHPD Inpatient Hospital Discharge Data:

- a) **County Indigent Programs (CIP)**- Patients covered under Welfare and Institutions Code Section 1700. includes programs funded in whole or in part by County Medical services Program (CMSP), California Healthcare for Indigents Program (CHIP), and/or other Realignment Funds whether or not a bill is rendered.
- b) **Other**- Any third party payment not including Medicare, Medi-Cal, private coverage, worker's compensation, county indigent programs, other government, other indigent. Included are cases where no payment will be required by the facility, such as special research or courtesy patients.
- c) **Unknown**- payor sources that were not reported or reported in error.

Suburban as they did not respond to the NHF Self Pay Survey and for LA Metro because they were not surveyed (only LA County hospitals with emergency departments were surveyed).

Figure 11



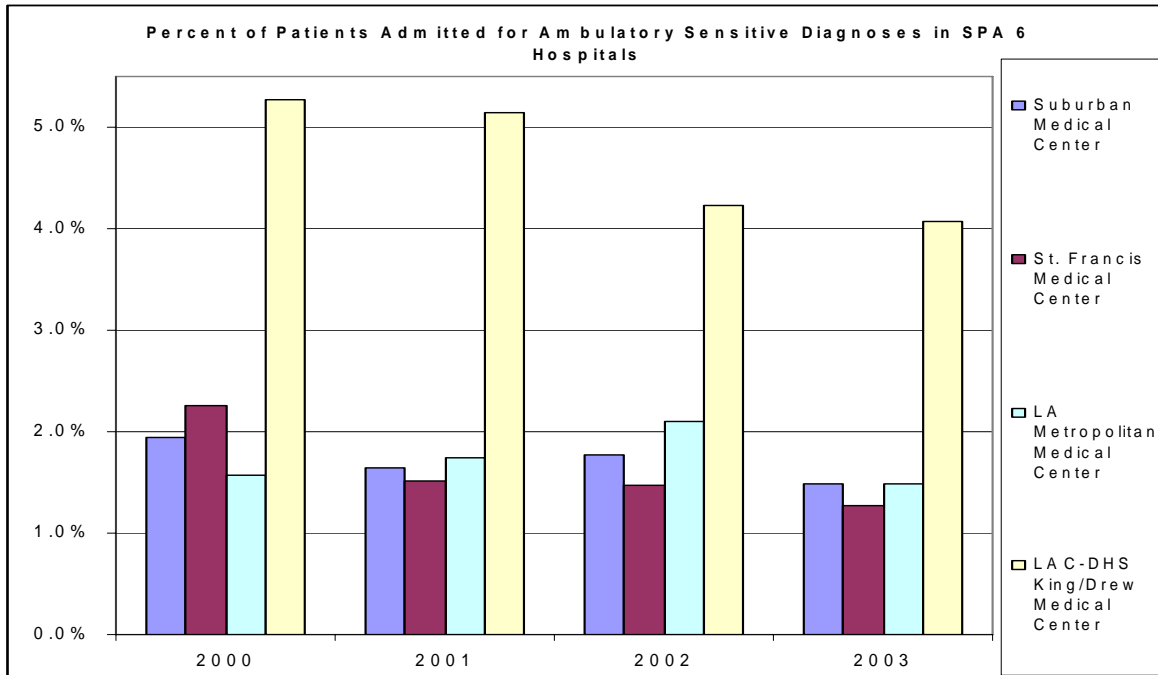
Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data, 2004 Data NHF Self Pay Survey

f. Ambulatory Sensitive Diagnoses

Ambulatory sensitive diagnoses are diagnoses provided in the OSHPD discharge database that indicate admissions for conditions which should be managed by outpatient or primary care, e.g. diabetes and asthma. Such diagnoses are often used as indicators of economic, geographic and racial disparities. For example, low income urban African-Americans experience much higher rates of ambulatory sensitive diagnoses.²⁰ The proportions of patients that were discharged for ambulatory sensitive diagnoses between the years 2000 and 2004 at KDMC ranged between 4.1% and 5.3% and were more than double those of any of the other three hospitals (see Figure 12). Furthermore, KDMC discharged approximately half of all SPA 6 patients (49.8%) with ambulatory sensitive diagnoses, compared to 28.6% from St. Francis, 12.0% from Suburban, and 9.6% from LA Metro in 2003 (see Table 9, Appendix C).

²⁰ Institute of Medicine, Guidance for the National Healthcare Disparities Report (2002). Pg 76-77. Culler et al, 1998 Reference. Retrieved from <http://www.nap.edu/books/0309085195/html/76.html>

Figure 12

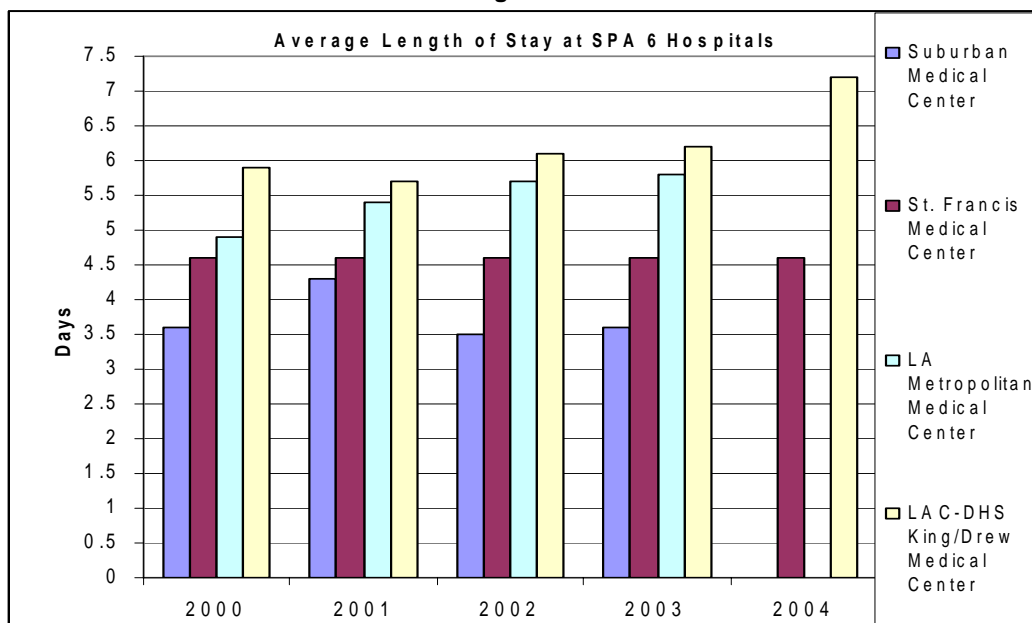


Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data

g. Average Length of Stay

For each year between 2000 and 2003, patients stayed longer at KDMC than at any other general acute care hospitals in SPA 6. Overall, length of stay increased at KDMC (from 5.8 to 6.3 days) and LA Metropolitan (from 4.9 to 5.8 days) during these years, while at St. Francis it remained steady (around 4.6 days) and at Suburban it fluctuated between 3.6 and 4.6 days. Based on responses to the NHF Self Pay survey in 2004, St. Francis' average length of stay also held steady while for KDMC it increased even more to 7.2 days (see Figure 13 and Table 10, Appendix C). This measure can be interpreted in different ways, for example, it may be seen as indicating management inefficiency or of the hospital treating sicker patients. NHF was not asked to look at the administrative and fiscal efficiencies of SPA 6 hospitals, however a cluster of several measures (longer average lengths of stay, high rates of uninsured, more patients being admitted through its ED and more patients admitted for ambulatory sensitive diagnoses) suggests that KDMC may be treating sicker patients.

Figure 13



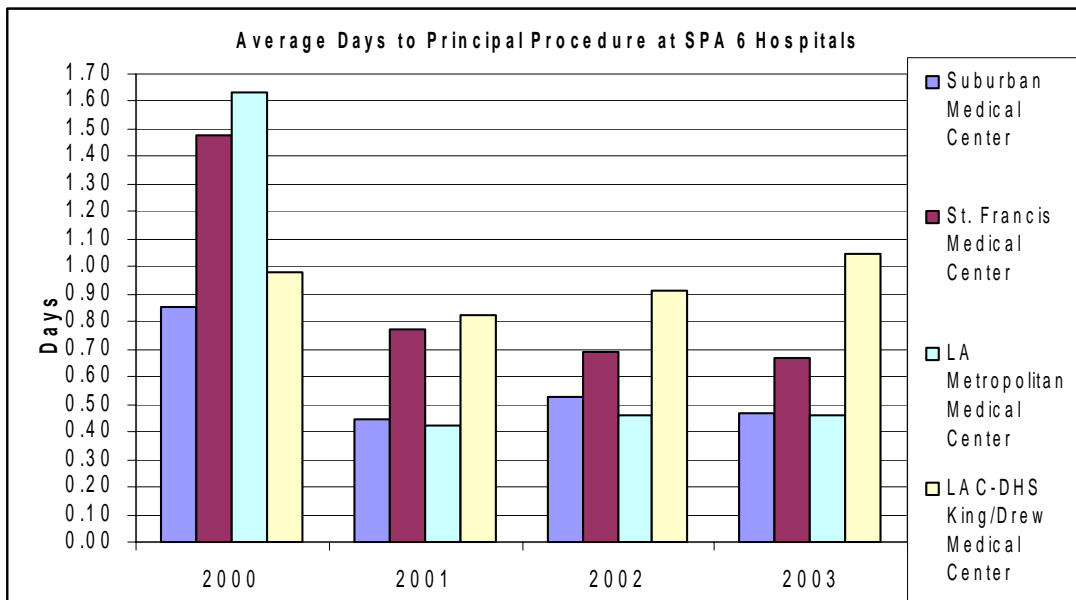
Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data, 2004 Data NHF Self Pay Survey

h. Wait Time for Principal Procedures²¹

From 2000 to 2003 every general acute care hospital in SPA 6 except KDMC saw a decrease of approximately half in the number of days patients waited to receive the principal procedures for which they had been admitted. Compared to 2000, KDMC's patients had to wait approximately 3 ½ hours longer in 2003. During this time also, KDMC was losing staffed beds. As staffed beds decrease, it means that patients will have to wait longer for care if discharges do not also decrease (see Figure 14 and Table 11, Appendix C).

²¹ According to the OSHPD dataset, a principal procedure is defined as one which was performed for definitive treatment rather than one performed for diagnostic or explorative purposes, or which was necessary to take care of a complication.

Figure 14



Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data

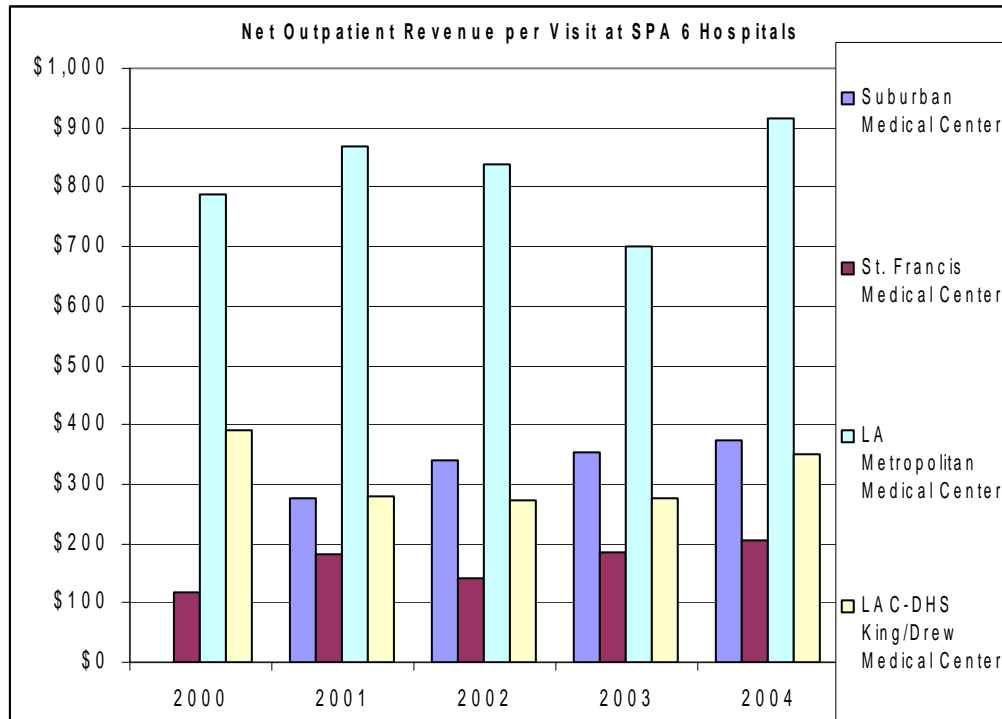
i. Fiscal Measures Across Hospitals

Four fiscal measures are reviewed: 1) net outpatient revenue/visit, 2) net inpatient revenue/day, 3) net inpatient revenue/discharge and 4) operating margin. The data for each of these measures came from OSHPD’s hospital financial data.

1) Net Outpatient Revenue/Visit

Between 2000 and 2004, LA Metro consistently had the highest net outpatient revenue/visit (\$790/visit in 2000 and \$920/visit in 2004). KDMC’s net outpatient revenue/visit declined between 2000 and 2003 by \$115 (from \$390/visit to \$275/visit) but returned to \$350/visit in 2004. Data on Suburban are only available for 2001 to 2004 and show a steady increase from \$275/visit in 2001 to \$375 in 2004. St. Francis has the lowest net outpatient revenue/visit throughout this period (\$115/visit in 2000 and \$200/visit in 2004 (see Figure 15 and Table 12, Appendix C).

Figure 15

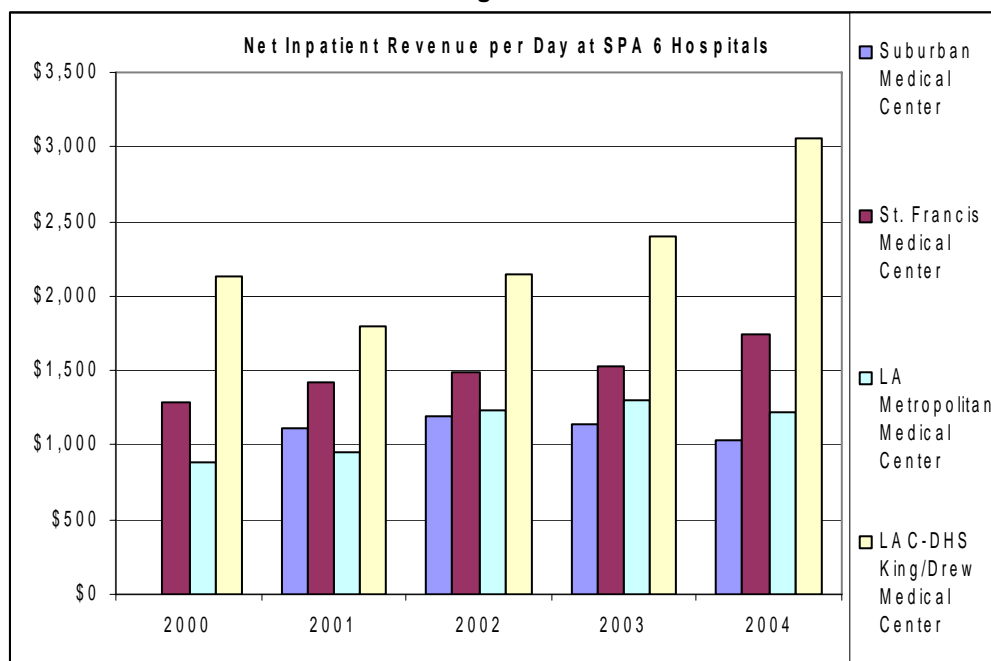


Source: National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data, 2004 OSHPD Hospital Quarterly Financial Data

2) Net Inpatient Revenue/Day

Each year from 2000-2004 KDMC had the highest net inpatient revenue/day of any hospital in SPA 6, and between 2002 and 2004 it increased from \$2,150/day to \$3,050/day. Although St. Francis' net inpatient revenue/day had also steadily increased since 2000, in 2004 it was still only \$1,750/day, slightly more than half that of KDMC (see Figure 16 and Table 13, Appendix C).

Figure 16

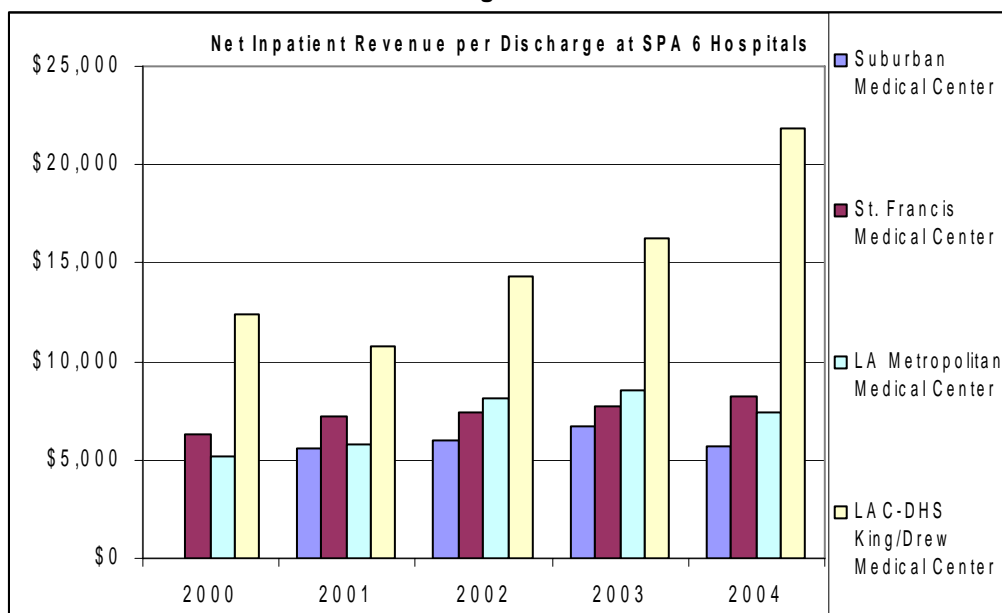


Source: National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data, 2004 OSHPD Hospital Quarterly Financial Data

3) *Net Inpatient Revenue/Discharge*

KDMC has the longest average length of stay and the highest net inpatient revenue/day. Consequently, it has the highest net inpatient revenue/discharge. Over the five years from 2000 to 2004 KDMC averaged more than double the net revenue/discharge of the remaining hospitals in SPA 6 (see Figure 17 and Table 14, Appendix C). In 2003, KDMC discharged 13,473 patients. Assuming that the difference in net revenue/discharge between St. Francis (in 2003, \$7,741) and KDMC (in 2003, \$16,285) is due to KDMC's teaching status, then this status brought KDMC at least \$98,777,184 in additional monies.

Figure 17



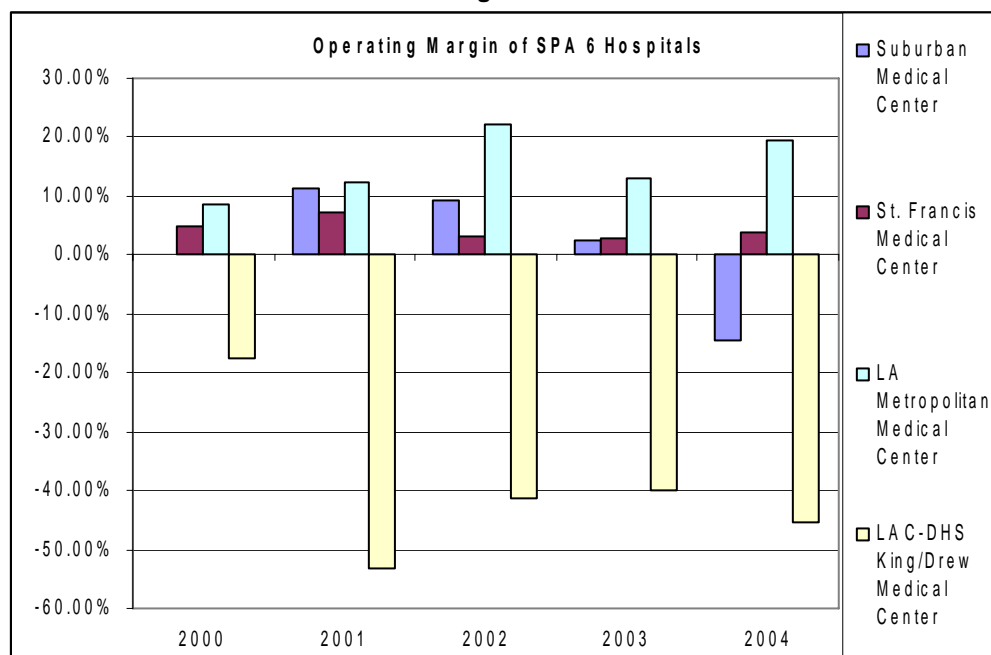
Source: National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data, 2004 OSHPD Hospital Quarterly Financial Data

4) Operating Margin

Between 2001 and 2004, KDMC spent almost one and a half times the amount it generated in revenue accounting for an average operating margin of -45%.²² All LAC-DHS hospitals had significant operating losses during the same period. Harbor/UCLA Medical Center had a 2001-2004 average operating margin of -27%, LAC+USC Medical Center's equaled -30% and Olive View Medical Center's was -49%. The only other general acute care hospital in SPA 6 to have a negative operating margin during this time was Suburban. Its 2004 operating margin was -14%. Suburban closed its ED at the end of 2004 (see Figure 18 and Table 15, Appendix C).

²² In OSHPD Financial Data, "operating margin" is defined as net revenue from operations (total operating revenue minus total operating expenses) divided by total revenue from operations.

Figure 18



Source: National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data, 2004 OSHPD Hospital Quarterly Financial Data

j. Uncompensated Care Costs as a Percentage of Operating Costs

In 2000 and 2001 with a bad debt (BD) and charity care (charity) to operating expenses proportion of 10%, LA Metro lead SPA 6 hospitals on this measure.²³ In 2001, LA Metro more than doubled its staffed psychiatric beds from 14 to 34 beds; in 2002 it almost tripled this number by increasing these beds to 98. After 2001, LA Metro’s charity and bad debt to operating expense proportion fell to 4%. From 2002 on, St. Francis had the highest bad debt and charity care to operating expense proportion of the three non-teaching SPA 6 hospitals. When county indigent programs (CIP) are included for KDMC, its total CIP, bad debt and charity care accounted, on average, for over one third of its operating expenses between 2000 and 2004 (see Figure 19 and Table 16, Appendix C). In fact, during this period the average proportion of operating expenses attributable to county indigent programs+bad debt+charity care at the three other LAC-DHS teaching hospitals (Olive View, LAC+USC and Harbor/UCLA) mirrored KDMC at just over one third.

²³ In OSHPD Financial Data, the following definitions are offered:

Bad Debts:

Accounts receivable which, although the patients have the ability to pay, are regarded as uncollectible and are charged as a credit loss against gross patient revenue. Bad debts are not included in Total Operating Expenses.

Charity Care:

The difference between full established charges for services rendered to patients who are not able to pay for all or part of the services provided and the amount paid by or on behalf of the patient, if any. Previously included care provided to medically indigent for which counties are responsible.

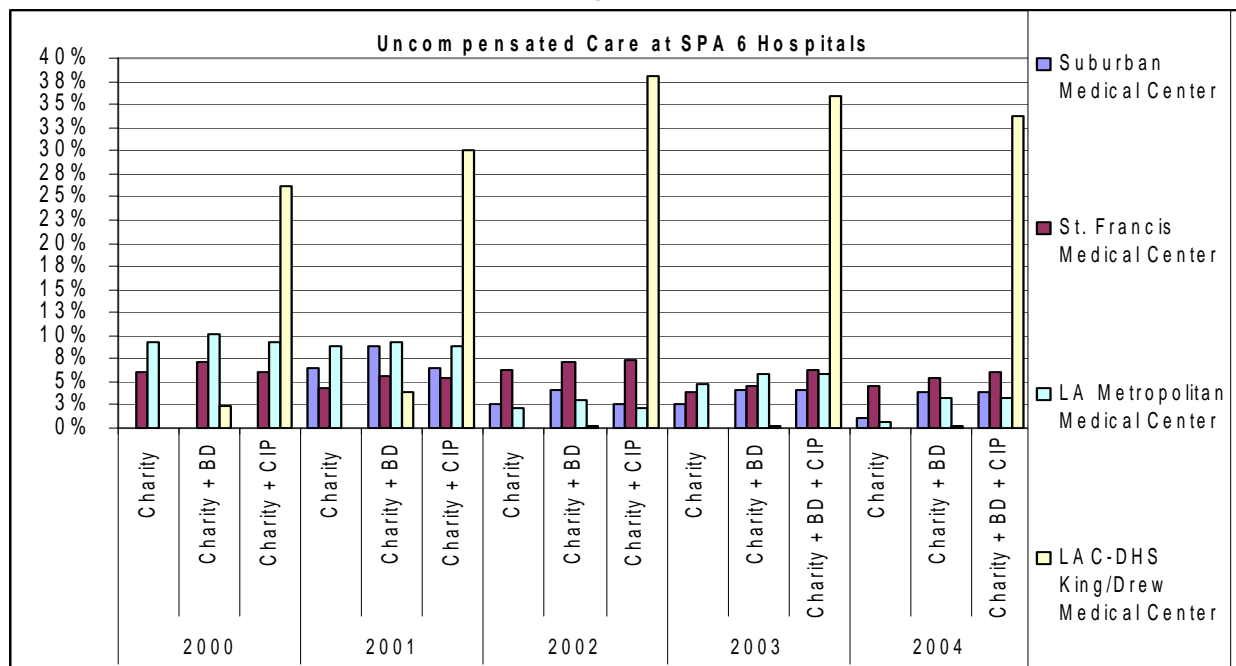
Charity - Hill-Burton:

The amount of charity care rendered by the hospital to satisfy, or partially satisfy, its obligations to uncompensated services as required under the federal Hill-Burton Program.

Charity - Other:

The amount of charity care rendered exclusive of charity care related to the Hill-Burton obligation. Previously included care provided to medically indigent patients for which counties are responsible.

Figure 19



Source: 2000-2003 OSHPD Hospital Annual Financial Data, 2004 OSHPD Hospital Quarterly Financial Data

VI. WHAT WOULD HAPPEN IF KDMC IS CONVERTED?

Short of being able to predict the future, this question can be answered from different levels of specificity. The most general level relates to the obvious impact on faculty and staff of losing teaching-related funds.²⁴ A more specific level assesses what other services are at risk of being lost should the conversion take place. The most specific level would focus on the patients and where they would go for the “lost” services. Properly addressing this most specific level would require considerably more analysis of OSHPD procedures and services data than the timeline for this study allowed. The following discussion focuses on the first two levels: general problems and threatened services.

General problems

Clearly if KDMC was converted to a non-teaching community hospital, it would lose the teaching-related funding streams currently available to it. Therefore, programs that used these research and special funds (e.g., Medicare and Medi-Cal) would be lost. Specialty services would be particularly affected by such a loss because they tend to be more expensive to provide.²⁵ According to a presentation on research at KDMC, in 2002 almost twenty-million dollars in NIH research grants were awarded to KDMC. With its conversion, none of these funds would be available to support the hospital’s medical research and care.²⁶

²⁴ NHF was not asked to assess the fiscal impact of losing these funds.

²⁵ The Los Angeles County Department of Health Services. Hospital Advisory Board Orientation May 9, 2005. Martin Luther King, Jr./Drew Medical Center. AHA Trendwatch June 2002, Vol. 4, No. 3. Page 3.

²⁶ Charles R. Drew University of Medicine and Science. Health Care Disparity: The Drew Response. May 18, 2005. PowerPoint presentation. RCMI Impact on Research at Drew. Retrieved July 21, 2005.

It must be pointed out that even now, before KDMC's fate has been decided, faculty physicians are leaving to pursue their teaching and research interests at other institutions. Obviously, the medical care and programs staffed by these faculty and their staffs are also being lost. The extent of this loss is exemplified by KDMC's surgical residency programs. When these programs were accredited, KDMC had 38 surgical residents all working up to 80 hours/week and with 20 of them on site at all times. These residents have now been replaced with approximately 9 physician assistants working 40 hours/week²⁷. Not only has this loss of surgical residents resulted in a sharp decrease in surgical production, it will also be a major factor in preventing the reopening of KDMC's trauma unit which requires on site surgical coverage 24/7.²⁸

It is not simply that programs and services will be lost. Without KDMC's research faculty developing and testing cutting-edge treatments, the low-income residents of SPA 6 would lose access to state-of-the-art medical care by participating in clinical trials and other research protocols. Patients would also lose the benefits that come from the extra medical attention that derives from being involved in the teaching and research process.

Furthermore, conversion of KDMC from a teaching to a non-teaching community hospital will undoubtedly have long-term impacts on the provision of healthcare and the supply of providers in underserved areas such as SPA 6. Eighty-six percent of the KDMC medical graduates go on to practice in underserved communities. This is substantially higher than graduates from most other medical schools; for example, only 20% of medical graduates from UCLA go on to practice in underserved communities.²⁹ Currently, KDMC trains approximately 20% of California's minority physicians each year.³⁰

Threatened services

A more detailed review of services that appear threatened by a conversion can be inferred from the Navigant report. It seems safe to assume that with conversion and the consequent loss of funding and services, small departments or programs with two or three faculty could be severely affected if just one of them left. Using this criteria and other information in the Navigant report, services at high risk for being lost include:

1. Cardiac catheterization
2. Rheumatology services
3. Dermatology services
4. GI services
5. Pulmonology and intensivist services
6. Endocrinology division ranks in the top 20 nationally for NIH grant funding, having brought about \$60 million in funding to the institution. A conversion to a non-teaching community hospital would substantially impact the research and grant

²⁷ County of Los Angeles King/Drew Medical Center Navigant Consulting Assessment Report (January 31, 2005). Overview of Clinical Services: Surgery. Page 47. Retrieved on July 12, 2005, from http://www.ladhs.org/planning/pdf/navigant/12_Programs_1_30.pdf

²⁸ County of Los Angeles King/Drew Medical Center Navigant Consulting Assessment Report (January 31, 2005). Overview of Clinical Services: Surgery. Pages 48, 51. Retrieved on July 12, 2005, from http://www.ladhs.org/planning/pdf/navigant/12_Programs_1_30.pdf

²⁹ Charles R. Drew University of Medicine and Science. Health Care Disparity: The Drew Response. May 18, 2005. PowerPoint presentation. Figure 2. Graduation Questionnaire: Do you plan to work in an underserved area? Retrieved July 21, 2005.

³⁰ Campaign to Transform King Drew. Retrieved July 26, 2005, from http://www.charityfinders.com/cf/servlet/SIGenerateSite?action=otherInfo.jsp&oiCode=4&charity_id=061405CHA002

money coming into this department and it is probably that faculty would leave, resulting in the loss of services. For example, an NIH funded Sickle Cell Center is currently underway to support treatment and research, this would probably be severely threatened if KDMC were to lose its teaching/research capabilities

7. Adult Gastroenterology services
8. Otolaryngology services would almost certainly be threatened-- of the 16.5 FTE working in this department, 5 are filled by residents and 3 by PhD researchers
9. Neuroscience services, a department historically effective in capturing NIH research grant support, may be threatened because of concerns about whether it's reliance on emerging high quality imaging technologies can be met in the future
10. Family Medicine services would probably be threatened; current faculty staffing has limited ability to cover even occasional faculty absences and this department includes 24 residents
11. Residency Program in Anesthesiology
12. Residency Program in Dentistry
13. Residency Program in Dermatology
14. Residency Program in Emergency Medicine
15. Residency Program in Family Medicine
16. Residency Program in Internal Medicine
17. Residency Program in Obstetrics and Gynecology
18. Residency Program in Ophthalmology
19. Residency Program in Oral Surgery
20. Residency Program in Orthopedic Surgery
21. Residency Program in Otolaryngology
22. Residency Program in Pediatrics
23. Residency Program in Psychiatry

Thus, not only has KDMC already lost many services, its conversion to a non-teaching hospital would likely threaten the loss of many more. The impact of losing these services will ripple throughout Los Angeles and its health care industry because almost one-third of patients discharged from KDMC, more than 3,500/year, have no means of paying for their hospital care. Given providers' reluctance to treat uninsured patients, these, as well as many others, will lose access to cutting edge treatment protocols through research programs as well as to more routine services. But, most important, all these patients currently being treated at King/Drew, particularly those using the services that only KDMC provides in SPA 6, will either go without services or will seek them outside SPA 6 further burdening an already strained health care system.

VII. CONCLUSIONS

Findings from this study make it clear that if the King/Drew Medical Center ceases being a teaching hospital three things will occur. First a significant amount of revenue in terms of Medi-Cal reimbursements will be lost (over \$98 million/year). These dollars provide funding for physician intern salaries enabling the hospital to serve a large number of uninsured patients. Second, significant revenues from research funding will also be lost (over \$20 million/year). These dollars support unique programs at KDMC, e.g. sickle cell, endocrinology and neuroscience research and services. Finally, many specialty training programs will be eliminated including emergency medicine, OB-GYN, family and internal medicine, pediatrics, psychiatry and several others. Not only are these programs essential for serving the health care needs of SPA 6 residents, they have also been very important in increasing the supply of physicians willing to practice in low-income inner city communities.

Equally clear is the unique role that this facility plays in serving the residents of SPA 6. More than 80% of patients admitted to KDMC come through its ED which is more than double the percentage of St. Francis and nearly quadruple the percentage of Suburban. For nearly all of the past five years KDMC has provided inpatient services for half of all patients in SPA 6 admitted through EDs. Between 2000 and 2004 more than 70% of KDMC's discharged patients resided in SPA 6, which is more than 15 % higher than any other general acute care hospital in the area. KDMC also sees more uninsured patients. Thirty percent of its discharged patients either had no insurance or were county indigent patients compared to 10% at St. Francis.

Uninsured patients have been shown to be sicker than insured patients because they delay health care and this factor combined with three others suggests that KDMC's patients are sicker.³¹ The three other factors are: patients' longer average length of stay in KDMC, the high proportion of patients being admitted via its ED, and the fact that more patients were admitted for ambulatory sensitive diagnoses than at the other general acute care hospitals in SPA 6. Whether longer average lengths of stay are because KDMC's patients are sicker or because it is inefficiently managed can be discussed, but the fact that this is combined with the other three factors, all of which indicate inadequate health services infrastructure in a community, indicates that illness severity may be a factor in the longer average lengths of stay.

There is no question that a non-teaching community hospital will be capable of providing health services to some SPA 6 residents. However, a teaching hospital is better equipped to meet the overall service needs given the large population and its demand for medical services, the high proportion of uninsured and the higher morbidity of this population. However, whether KDMC remains a teaching hospital or not, the most important issue, which was not addressed in this study, centers on the quality of care provided at KDMC. The LA Times articles clearly indicated that quality of care problems exist at KDMC, just as the Institute of Medicine study showed they exist in hospitals throughout the nation. Everyone needs high quality hospital care and the residents of SPA 6 need the services being provided by KDMC. Thus, the task at hand should focus on how to maintain KDMC's services at the highest possible quality.

³¹ Uninsured patients tend to be sicker due to delays in receiving care. Kaiser Commission on Medicaid and the Uninsured. Sicker and Poorer: The Consequences of Being Uninsured. Updated February 2003. Retrieved August 10, 2005, from <http://www.kff.org/uninsured/20020510-index.cfm>.

APPENDIX A: SPA 6 Zip Codes

SPA 6 Zip Codes		
Zip Code	City	Health District
90001	Florence	South
90002	Watts	South
90059	Willowbrook	South
90061	West Compton	South
90011	South Central LA	Southeast
90003	Humphrey	Southeast
90016	Adams	Southwest
90018	Jefferson Park	Southwest
90007	Exposition Park	Southwest
90037	Exposition Park	Southwest
90008	Crenshaw District	Southwest
90062	Leimert Park	Southwest
90043	Hyde Park	Southwest
90047	Hyde Park	Southwest
90044	South Vermont	Southwest
90220	Compton	Compton
90221	Compton	Compton
90222	Compton	Compton
90262	Lynwood	Compton
90723	Paramount	Compton

Source: https://admin.lapublichealth.org/spa6/stats/spa6_stats_introduction.htm

APPENDIX B: Ambulatory Sensitive ICD9-CM Codes and Conditions and Service Definitions

ICD-9-CM	Ambulatory Sensitive Condition
493.01	Asthma with Status Asthmaticus
493.11	Asthma with Status Asthmaticus
493.21	Asthma with Status Asthmaticus
493.91	Asthma with Status Asthmaticus
493	Asthma without Status Asthmaticus
493.1	Asthma without Status Asthmaticus
493.2	Asthma without Status Asthmaticus
493.9	Asthma without Status Asthmaticus
428	Congestive Heart Failure (CHF)
428.1	Congestive Heart Failure (CHF)
428.9	Congestive Heart Failure (CHF)
402.01	Congestive Heart Failure (CHF)
402.11	Congestive Heart Failure (CHF)
402.91	Congestive Heart Failure (CHF)
404.01	Congestive Heart Failure (CHF)
404.11	Congestive Heart Failure (CHF)
404.91	Congestive Heart Failure (CHF)
404.03	Congestive Heart Failure (CHF)
404.13	Congestive Heart Failure (CHF)
404.93	Congestive Heart Failure (CHF)
491	Chronic Obstructive Pulmonary Disease (COPD)
492	Chronic Obstructive Pulmonary Disease (COPD)
494	Chronic Obstructive Pulmonary Disease (COPD)
495	Chronic Obstructive Pulmonary Disease (COPD)
496	Chronic Obstructive Pulmonary Disease (COPD)
401	Hypertension
401.1	Hypertension
401.9	Hypertension
402	Hypertension
402.1	Hypertension
402.9	Hypertension
403	Hypertension
403.1	Hypertension
403.9	Hypertension
404	Hypertension
404.1	Hypertension
404.9	Hypertension
250	Diabetes without Complication
250.01	Diabetes without Complication
250.02	Diabetes without Complication
250.03	Diabetes without Complication
250.1	Diabetes with Complication
250.11	Diabetes with Complication
250.12	Diabetes with Complication

ICD-9-CM	Ambulatory Sensitive Condition
250.13	Diabetes with Complication
250.2	Diabetes with Complication
250.21	Diabetes with Complication
250.22	Diabetes with Complication
250.23	Diabetes with Complication
250.3	Diabetes with Complication
250.31	Diabetes with Complication
250.32	Diabetes with Complication
250.33	Diabetes with Complication
250.4	Diabetes with Complication
250.41	Diabetes with Complication
250.42	Diabetes with Complication
250.43	Diabetes with Complication
250.5	Diabetes with Complication
250.51	Diabetes with Complication
250.52	Diabetes with Complication
250.53	Diabetes with Complication
250.6	Diabetes with Complication
250.61	Diabetes with Complication
250.62	Diabetes with Complication
250.63	Diabetes with Complication
250.7	Diabetes with Complication
250.71	Diabetes with Complication
250.72	Diabetes with Complication
250.73	Diabetes with Complication
250.8	Diabetes with Complication
250.81	Diabetes with Complication
250.82	Diabetes with Complication
250.83	Diabetes with Complication
250.9	Diabetes with Complication
250.91	Diabetes with Complication
250.92	Diabetes with Complication
250.93	Diabetes with Complication

Source: OSHPD Inpatient Discharge Data 1999

TABLE 2: Unique Services Provided by KDMC and their Definitions

<i>Name of Service</i>	<i>AHA Definition</i>
<i>Ambulance service</i>	Provision of ambulance services to the ill and injured who require medical attention on a scheduled or unscheduled basis.
<i>Adult Day Care program</i>	Program providing supervision, medical and psychological care, and social activities for older adults who live at home or in another family setting, but cannot be alone or prefer to be with others during the day. May include intake assessment, health monitoring, occupational therapy, personal care, noon meal, and transportation services.
<i>Alcoholism-drug abuse or dependency outpatient unit</i>	Organized hospital services that provide medical care and/or rehabilitative treatment services to outpatients for whom the primary diagnosis is alcoholism or other chemical dependency.
<i>Alzheimer Center</i>	Facility that offers care to persons with Alzheimer's disease and their families through an integrated program of clinical services, research, and education.
<i>Auxiliary Organization</i>	A volunteer community organization formed to assist the hospital in carrying out its purpose and to serve as a link between the institution and the community.
<i>Bariatric/weight control services</i>	Bariatrics is the medical practice of weight reduction.
<i>Cardiac Intensive Care services</i>	Provides patient care of a more specialized nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open-heart surgery, or other life-threatening conditions, require intensified, comprehensive observation and care. May include myocardial infarction, pulmonary care, and heart transplant units.
<i>Crisis Prevention</i>	Services provided in order to promote physical and mental well being and the early identification of disease and ill health prior to the onset and recognition of symptoms so as to permit early treatment.
<i>Dental Services</i>	An organized dental service, not necessarily involving special facilities, that provides dental or oral services to inpatients or outpatients.
<i>Enabling Services</i>	A program that is designed to help the patient access health care services by offering any of the following linguistic services, transportation services, and/or referrals to local social services agencies.
<i>Fertility clinic</i>	A specialized program set in an infertility center that provides counseling and education as well as advanced reproductive techniques such as: injectable therapy, reproductive surgeries, treatment for endometriosis, male factor infertility, tubal reversals, in vitro fertilization (IVF), donor eggs, and other such services to help patients achieve successful pregnancies.
<i>Freestanding outpatient care center</i>	A facility owned and operated by the hospital, but physically separate from the hospital, that provides various medical treatments on an outpatient basis only. In addition to treating minor illnesses or injuries, the center will stabilize seriously ill or injured patients before transporting them to a hospital. Laboratory and radiology services are usually available.
<i>Genetic Testing/Counseling</i>	A service equipped with adequate laboratory facilities and directed by a qualified physician to advise parents and prospective parents on potential problems in cases of genetic defects. A genetic test is the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites in order to detect heritable-disease related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Genetic tests can have diverse purposes, including the diagnosis of genetic diseases in newborns, children, and adults; the identification of future health risks; the prediction of drug responses; and the assessment of risks to future children.
<i>Geriatric services</i>	The branch of medicine dealing with the physiology of aging and the diagnosis and treatment of disease affecting the aged. Services could include: Adult day care program; Alzheimer's diagnostic-assessment services; Comprehensive geriatric assessment; Emergency response system; Geriatric acute care unit; and/or Geriatric clinics.
<i>Psychiatric education services</i>	Provides psychiatric educational services to community agencies and workers such as schools, police courts, public health nurses, welfare agencies, clergy and so forth.

<i>Name of Service</i>	<i>AHA Definition</i>
	The purpose is to expand the mental health knowledge and competence of personnel not working in the mental health field and to promote good mental health through improved understanding, attitudes, and behavioral patterns.
<i>Psychiatric geriatric services</i>	Provides care to emotionally disturbed elderly patients, including those admitted for diagnosis and those admitted for treatment.
<i>Sports medicine</i>	Provision of diagnostic screening and assessment and clinical and rehabilitation services for the prevention and treatment of sports-related injuries.
<i>Support groups</i>	A hospital sponsored program which allows a group of individuals with the same or similar problems who meet periodically to share experiences, problems, and solutions, in order to support each other.
<i>Teen outreach services</i>	A program focusing on the teenager which encourages an improved health status and a healthful lifestyle including physical, emotional, mental, social, spiritual and economic health through education, exercise, nutrition and health promotion.
<i>Tobacco Treatment/Cessation Program</i>	Organized hospital services with the purpose of ending tobacco-use habits of patients addicted to tobacco/nicotine.

Source: National Health Foundation Compiled from American Hospitals Association AHA Guide 2005

TABLE 3: Services Added at KDMC since 2000 and their Definitions

Name of Service	AHA definition
Ambulance Service	Provision of ambulance services to the ill and injured who require medical attention on a scheduled or unscheduled basis.
Alcoholism-drug abuse or dependency outpatient unit	Organized hospital services that provide medical care and/or rehabilitative treatment services to outpatients for whom the primary diagnosis is alcoholism or other chemical dependency.
Community health status assessment	Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community?
Enabling services	A program that is designed to help the patient access health care services by offering any of the following linguistic services, transportation services, and/or referrals to local social services agencies.
Enrollment Assistance services	A program that provides enrollment assistance for patients who are potentially eligible for public health insurance programs such as Medicaid, State Children’s Health Insurance, or local/state indigent care programs. The specific services offered could include explanation of benefits, assist applicants in completing the application and locating all relevant documents, conduct eligibility interviews, and/or forward applications and documentation to state/local social service or health agency.
Freestanding Outpatient care center	A facility owned and operated by the hospital, but physically separate from the hospital, that provides various medical treatments on an outpatient basis only. In addition to treating minor illnesses or injuries, the center will stabilize seriously ill or injured patients before transporting them to a hospital. Laboratory and radiology services are usually available.
Nutrition Programs	Those services within a health care facility which are designed to provide inexpensive, nutritionally sound meals to patients.
Skilled nursing or other long-term care services	Provides non-acute medical and skilled nursing care services, therapy, and social services under the supervision of a licensed registered nurse on a 24-hour basis.
Sports medicine	Provision of diagnostic screening and assessment and clinical and rehabilitation services for the prevention and treatment of sports-related injuries.
Teen outreach services	A program focusing on the teenager which encourages an improved health status and a healthful lifestyle including physical, emotional, mental, social, spiritual and economic health through education, exercise, nutrition and health promotion.
Tobacco/Treatment Cessation Program	Organized hospital services with the purpose of ending tobacco-use habits of patients addicted to tobacco/nicotine.

Source: National Health Foundation Compiled from American Hospitals Association AHA Guide 2005

APPENDIX C: Data Tables

Table 1: SPA 6 ED Visits by Acuity

Year	Acuity Level	Suburban Medical Center		St. Francis Medical Center		LAC-DHS King/Drew Medical Center		Total SPA 6 ED Visits
		N	%	N	%	N	%	
2000	Non Urgent	13,259	24%	17,713	33%	23,325	43%	54,297
	Urgent	3,400	4%	40,127	45%	46,546	52%	90,073
	Critical	625	5%	1,651	14%	9,156	80%	11,432
	Total	17,284	11%	59,491	38%	79,027	51%	155,802
2001	Non Urgent	900	3%	16,135	48%	16,567	49%	33,602
	Urgent	13,511	15%	41,944	47%	33,303	38%	88,758
	Critical	963	9%	1,934	19%	7,252	71%	10,149
	Total	15,374	12%	60,013	45%	57,122	43%	132,509
2002	Non Urgent	3,484	12%	12,066	42%	13,370	46%	28,920
	Urgent	8,263	16%	15,485	31%	26,878	53%	50,626
	Moderate	3,809	19%	16,615	81%	0	0%	20,424
	Severe	1,510	91%	153	9%	0	0%	1,663
	Critical	1,023	10%	3,831	36%	5,855	55%	10,709
	Total	18,089	16%	48,150	43%	46,103	41%	112,342
2003	Non Urgent	4,019	18%	8,968	41%	8,884	41%	21,871
	Urgent	8,688	33%	9,064	34%	8,529	32%	26,281
	Moderate	3,712	7%	25,929	48%	24,311	45%	53,952
	Severe	1,525	51%	102	3%	1,348	45%	2,975
	Critical	570	2%	14,968	62%	8,546	35%	24,084
	Total	18,514	14%	59,031	46%	51,618	40%	129,163
2004	Non Urgent	3,663	17%	6,287	30%	11,110	53%	21,060
	Urgent	8,555	51%	3,654	22%	4,614	27%	16,823
	Moderate	4,187	10%	22,579	53%	15,609	37%	42,375
	Severe	2,163	12%	13,418	76%	2,171	12%	17,752
	Critical	243	2%	6,437	45%	7,589	53%	14,269
	Total	18,811	17%	52,375	47%	41,093	37%	112,279

Source: National Health Foundation Compiled From 2000-2004 OSHPD Hospital Annual Utilization Data

Table 2: Numbers & Percentages of ED admits by Hospital

Year	Suburban Medical Center			St. Francis Medical Center			LAC-DHS King/Drew Medical Center		
	Total Admits	Admits via ED	% Admit Via ED	Total Admits	Admits via ED	% Admit Via ED	Total Admits	Admits via ED	% Admit Via ED
2000	9,363	1,645	18%	23,481	8,170	35%	15,569	12,918	83%
2001	9,403	1,945	21%	23,509	8,587	37%	14,835	12,383	83%
2002	8,763	2,068	24%	23,586	8,327	35%	13,891	11,786	85%
2003	8,860	2,004	23%	24,636	8,626	35%	13,473	11,543	86%
2004	No Data		No Data	26,136	8,971	34%	9,919	7,935	80%

Source: National Health Foundation Compiled From 2000-2003 OSPD Inpatient Hospital Discharge Data and 2004 Data NHF Self Pay Survey

Table 3: SPA 6 Hospitals' Proportion of Total ED Admits

Year	Suburban Medical Center		St. Francis Medical Center		LAC-DHS King/Drew Medical Center		Total SPA 6 Admits from ED
	N	%	N	%	N	%	N
2000	1,645	7.2%	8,170	35.9%	12,918	56.8%	22,733
2001	1,945	8.5%	8,587	37.5%	12,383	54.0%	22,915
2002	2,068	9.3%	8,327	37.5%	11,786	53.1%	22,181
2003	2,004	9.0%	8,626	38.9%	11,543	52.1%	22,173
2004	No Data	No Data	8,971	53.1%	7,935	46.9%	16,906
Source:	National Health Foundation Compiled From 2000-2003 OSPD Inpatient Hospital Discharge Data and 2004 Data NHF Self Pay Survey						

Table 4: Licensed Beds at SPA 6 Hospitals

		<i>Suburban Medical Center</i>		<i>St. Francis Medical Center</i>		<i>LA Metropolitan Medical Center</i>		<i>LAC-DHS King/Drew Medical Center</i>		<i>Total</i>
	Bed Type	N	%	N	%	N	%	N	%	N
2000	00 Total	182	15%	384	31%	129	10%	537	44%	1,232
2001	01 Total	182	15%	384	31%	149	12%	537	43%	1,252
2002-2004	02-04 Total	182	14%	384	29%	213	16%	537	41%	1,316
2000-2004	00-04 SN	34	53%	30	47%	0	0%	0	0%	64
2000	00 Psych	0	0%	40	31%	14	11%	76	58%	130
2001	01Psych	0	0%	40	27%	34	23%	76	51%	150
2002-2004	02-04 Psych	0	0%	40	19%	98	46%	76	36%	214
2000-2004	00-04 GAC	148	14%	314	30%	115	11%	461	44%	1,038
2000-2004	00-04 NICU	0	0%	29	40%	0	0%	43	60%	72
2000-2004	00-04 CCU	5	33%	0	0%	4	27%	6	40%	15
2000-2004	00-04 ICU	7	7%	36	36%	4	4%	53	53%	100
2000-2004	00-04 Ped	8	10%	14	17%	6	7%	54	66%	82
2000-2004	00-04 PN	12	7%	57	33%	16	9%	90	51%	175
2000-2004	00-04 Med/Surg	116	20%	178	30%	85	14%	215	36%	594

Source: National Health Foundation Compiled From 2000-2004 OSHPD Hospital Annual Utilization Data

Table 5: SPA 6 Staffed Beds

		<i>Suburban Medical Center</i>		<i>St. Francis Medical Center</i>		<i>LA Metropolitan Medical Center</i>		<i>LAC-DHS King/Drew Medical Center</i>		<i>Total</i>
Year	N	%	N	%	N	%	N	%	N	
2000	182	18%	353	36%	201	20%	253	26%	989	
2001	182	18%	384	38%	201	20%	249	25%	1,016	
2002	182	18%	377	37%	201	20%	249	25%	1,009	
2003	182	17%	383	36%	201	19%	298	28%	1,064	
2004	92	12%	299	38%	213	27%	188	24%	791	

Source: National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data and 2004 OSHPD Hospital Quarterly Financial Data

Table 6: Discharged Patients with SPA 6 Zip Codes

		Suburban Medical Center		St. Francis Medical Center		LA Metropolitan Medical Center		LAC-DHS King/Drew Medical Center		Total Discharges with SPA 6 Zip Code
Year	N	%	N	%	N	%	N	%	N	
2000	0	50%	0	57%	0	49%	0	73%	33,734	
2001	0	51%	0	58%	0	45%	0	73%	33,795	
2002	0	52%	0	57%	0	47%	0	73%	32,146	
2003	0	52%	0	57%	0	45%	0	71%	31,657	
Source	National Health Foundation Compiled From 2000-2003 OSHPD Patient Level Discharge Data									

Table 7: Proportion of Patients with SPA 6 Zip Codes Discharged

		Suburban Medical Center		St. Francis Medical Center		LA Metropolitan Medical Center		LAC-DHS King/Drew Medical Center		Total
Year	N	%	N	%	N	%	N	%	N	
2000	4,669	14%	13,406	40%	3,995	12%	11,274	34%	33,344	
2001	4,748	14%	13,649	41%	4,014	12%	10,829	33%	33,240	
2002	4,585	14%	13,314	42%	3,587	11%	10,136	32%	31,622	
2003	4,556	15%	13,864	45%	3,174	10%	9,468	30%	31,062	
Source	National Health Foundation Compiled From 2000-2003 OSHPD Patient Level Discharge Data									

Table 8: Payer Source of Discharges at SPA 6 Hospitals

		Suburban Medical Center		St. Francis Medical Center		LA Metropolitan Medical Center		LAC-DHS King/Drew Medical Center	
Payer Source		N	%	N	%	N	%	N	%
2000	Medicare	906	10%	4,839	21%	1,613	20%	1,513	9%
	Medi-Cal	6,496	69%	13,989	60%	6,191	76%	9,267	58%
	Private	1,654	18%	2,883	12%	27	0%	390	2%
	Worker's Comp/Other Gov	16	0%	113	0%	7	0%	711	4%
	County/Other Indigent	0	0%	2	0%	0	0%	4,034	25%
	Self Pay/Other/Unknown	291	3%	1,652	7%	354	4%	14	0%
	Total	9,363	100%	23,478	100%	8,192	100%	15,929	100%
2001	Medicare	828	9%	4,788	20%	1,878	21%	1,229	8%
	Medi-Cal	7,460	79%	13,101	56%	6,280	70%	8,547	58%
	Private	846	9%	3,101	13%	112	1%	342	2%
	Worker's Comp/Other Gov	23	0%	85	0%	6	0%	553	4%
	County/Other Indigent	0	0%	2	0%	0	0%	3,624	24%
	Self Pay	246	3%	2,432	10%	642	7%	540	4%
	Total	9,403	100%	23,509	100%	8,918	100%	14,835	100%
2002	Medicare	885	10%	4,557	19%	1,761	23%	1,129	8%
	Medi-Cal	6,727	77%	13,575	58%	5,059	66%	8,296	60%
	Private	870	10%	2,981	13%	584	8%	310	2%
	Worker's Comp/Other Gov	30	0%	82	0%	6	0%	435	3%
	County/Other Indigent	67	1%	0	0%	0	0%	2,813	20%
	Self Pay/Other/Unknown	184	2%	2,391	10%	202	3%	908	7%
	Total	8,763	100%	23,586	100%	7,612	100%	13,891	100%
2003	Medicare	834	9%	4,612	19%	1,557	22%	991	7%
	Medi-Cal	7,083	80%	14,820	60%	4,659	66%	7,658	57%
	Private	701	8%	2,850	12%	667	9%	335	2%
	Worker's Comp/Other Gov	34	0%	103	0%	6	0%	639	5%
	County/Other Indigent	94	1%	0	0%	0	0%	3,005	22%
	Self Pay/Other/Unknown	114	1%	2,251	9%	169	2%	845	6%
	Total	8,860	100%	24,636	100%	7,058	100%	13,473	100%
2004	Medicare	No Data	No Data	4,676	18%	No Data	No Data	575	6%
	Medi-Cal	No Data	No Data	17,167	66%	No Data	No Data	4,455	45%
	Private	No Data	No Data	2,779	11%	No Data	No Data	2,063	21%
	Self Pay/Other/Unknown	No Data	No Data	1,514	6%	No Data	No Data	2,826	28%
	Total	No Data	No Data	26,136	100%	No Data	No Data	9,919	100%

Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data and 2004 Data NHF Self Pay Survey

Table 9: Proportion of Patients Admitted for Ambulatory Sensitive Diagnoses at SPA 6 Hospitals

Year	Suburban Medical Center		St. Francis Medical Center		LA Metropolitan Medical Center		LAC-DHS King/Drew Medical Center		Total SPA 6 Discharges with Ambulatory Sensitive Diagnosis
	N	%	N	%	N	%	N	%	
2000	182	1.9%	529	2.3%	129	1.6%	819	5.3%	1,659
2001	154	1.6%	357	1.5%	155	1.7%	762	5.1%	1,428
2002	155	1.8%	347	1.5%	159	2.1%	588	4.2%	1,249
2003	130	1.5%	310	1.3%	104	1.5%	540	4.1%	1,084
Source	National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data								

Table 10: Average Length of Stay at SPA 6 Hospitals

	Suburban Medical Center	St. Francis Medical Center	LA Metropolitan Medical Center	LAC-DHS King/Drew Medical Center
2000	3.6	4.6	4.9	5.9
2001	4.3	4.6	5.4	5.7
2002	3.5	4.6	5.7	6.1
2003	3.6	4.6	5.8	6.2
2004	No Data	4.6	No Data	7.2
Source:	National Health Foundation Compiled From 2000-2003 Inpatient Hospital Discharge Data and 2004 Data NHF Self Pay Survey			

Table 11: Days to Principal Procedure at SPA 6 Hospitals

Year	Suburban Medical Center	St. Francis Medical Center	LA Metropolitan Medical Center	LAC-DHS King/Drew Medical Center
2000	0.86	1.48	1.63	0.98
2001	0.44	0.77	0.42	0.82
2002	0.52	0.69	0.46	0.91
2003	0.47	0.67	0.46	1.05

Source: National Health Foundation Compiled From 2000-2003 OSHPD Inpatient Hospital Discharge Data

Table 12: Net Outpatient Revenue per Visit at SPA 6 Hospitals

Year	Financial Indicator	Suburban Medical Center	St. Francis Medical Center	LA Metropolitan Medical Center	LAC-DHS King/Drew Medical Center
2000	Net Outpatient Revenue per Visit	No Data	\$118	\$788	\$389
2001	Net Outpatient Revenue per Visit	\$276	\$182	\$868	\$280
2002	Net Outpatient Revenue per Visit	\$339	\$141	\$838	\$274
2003	Net Outpatient Revenue per Visit	\$354	\$185	\$699	\$277
2004	Net Outpatient Revenue per Visit	\$373	\$206	\$915	\$352

Source National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data and 2004 OSHPD Hospital Quarterly Financial Data

Table 13: Net Inpatient Revenue per Day at SPA 6 Hospitals

Year	Financial Indicator	Suburban Medical Center	St. Francis Medical Center	LA Metropolitan Medical Center	LAC-DHS King/Drew Medical Center
2000	Net Inpatient Revenue per Day	No Data	\$1,293	\$881	\$2,130
2001	Net Inpatient Revenue per Day	\$1,110	\$1,426	\$951	\$1,798
2002	Net Inpatient Revenue per Day	\$1,195	\$1,482	\$1,232	\$2,145
2003	Net Inpatient Revenue per Day	\$1,145	\$1,526	\$1,306	\$2,405
2004	Net Inpatient Revenue per Day	\$1,026	\$1,738	\$1,226	\$3,057

Source National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data and 2004 OSHPD Hospital Quarterly Financial Data

Table 14: Net Inpatient Revenue per Discharge

Year	Financial Indicator	Suburban Medical Center	St. Francis Medical Center	LA Metropolitan Medical Center	LAC-DHS King/Drew Medical Center
2000	Net Inpatient Revenue per Discharge	No Data	\$6,330	\$5,230	\$12,373
2001	Net Inpatient Revenue per Discharge	\$5,620	\$7,247	\$5,809	\$10,723
2002	Net Inpatient Revenue per Discharge	\$5,953	\$7,427	\$8,096	\$14,310
2003	Net Inpatient Revenue per Discharge	\$6,724	\$7,741	\$8,492	\$16,285
2004	Net Inpatient Revenue per Discharge	\$5,704	\$8,275	\$7,432	\$21,804

Source National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data and 2004 OSHPD Hospital Quarterly Financial Data

Table 15: Operating Margin of SPA 6 Hospitals

Year	Financial Indicator	Suburban Medical Center	St. Francis Medical Center	LA Metropolitan Medical Center	LAC-DHS King/Drew Medical Center
2000	Operating Margin	No Data	4.97%	8.60%	-17.63%
2001	Operating Margin	11.45%	7.35%	12.45%	-53.37%
2002	Operating Margin	9.34%	3.11%	22.08%	-41.46%
2003	Operating Margin	2.59%	2.77%	13.11%	-39.80%
2004	Operating Margin	-14.42%	3.93%	19.55%	-45.46%

Source National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data and 2004 OSHPD Hospital Quarterly Financial Data

Table 16: Uncompensated Care as a Percentage of Operating Expenses at SPA 6 Hospitals

Year	Type of Uncompensated Care	Suburban Medical Center	St. Francis Medical Center	LA Metropolitan Medical Center	LAC-DHS King/Drew Medical Center
2000	Charity	No Data	5.99%	9.28%	0.00%
	Charity + Bad Debt	No Data	7.23%	10.14%	2.47%
	Charity + County Indigent Programs	No Data	6.07%	9.28%	26.21%
2001	Charity	6.57%	4.42%	8.82%	0.00%
	Charity + Bad Debt	8.88%	5.57%	9.39%	3.97%
	Charity + County Indigent Programs	6.57%	5.31%	8.82%	30.15%
2002	Charity	2.55%	6.20%	2.22%	0.00%
	Charity + Bad Debt	4.10%	7.07%	3.04%	0.22%
	Charity + County Indigent Programs	2.55%	7.31%	2.22%	38.14%
2003	Charity	2.69%	3.81%	4.86%	0.00%
	Charity + Bad Debt	4.19%	4.61%	5.86%	0.21%
	Charity + Bad Debt + County Indigent Programs	4.19%	6.27%	5.86%	35.94%
2004	Charity	0.98%	4.47%	0.60%	0.00%
	Charity + Bad Debt	3.79%	5.36%	3.22%	0.20%
	Charity + Bad Debt + County Indigent Programs	3.79%	6.13%	3.22%	33.81%

Source National Health Foundation Compiled From 2000-2003 OSHPD Hospital Annual Financial Data and 2004 OSHPD Hospital Quarterly Financial Data