Lessons from the Fight over D.C. General Hospital

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As always, I write and speak only for myself,
not for the Boston University School of Public Health,
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I. INTRODUCTION

District of Columbia General Hospital discharged its last inpatient on Friday 22 June 2001 and closed on the following Monday the 25th.[1]

The closing was forced through by the Congressionally-installed Financial Control Board, acting at the behest of D.C. Mayor Williams, in the face of unanimous opposition from the D.C. City Council.

From time to time between September of 2000 and April of 2001, I served as a paid consultant to the Committee of Interns and Residents, a union (affiliated with the Service Employees International Union) that represented the house staff at D.C. General. I enjoyed complete independence to analyze, write, and speak as I wished.

II. EVIDENCE FOR AND AGAINST THE CLOSING

Mayor Williams asserted that the hospital was mismanaged, costly, not needed, consumed resources that could be better invested in primary and preventive care, and was impossible to salvage.

Opponents of the closing asserted that the hospital was reforming itself and cutting costs; that it was needed; that the mayor's assertions were unsubstantiated; and that the mayor lacked feasible methods of replacing—let alone improving—the hospital's services.

A. The Case for Closing or Radically Downsizing D.C. General Hospital

Arguments against D.C. General can be grouped into four general areas: finances, quality, physical condition, and strategic and political assessment .

1. Finances: cost (efficiency) and revenue

Some believed that public hospitals are often less efficient. The hospital and its health centers were placed under a Public Benefits Corporation (PBC) in October of 1997 in hopes of making it more efficient. These hopes were largely unrealized.[2]

The PBC's eight health centers were over-staffed or under-used.[3]

The PBC generated substantially less revenue than it deserved to collect for serving patients with third-party coverage, particularly Medicaid coverage.[4]

In part, the hospital's revenues were low because so many residents of the District lack health insurance. D.C. General's cost of serving uninsured patients was $47.1 million in 1999.[5]

D.C. General's emergency room was sometimes so crowded that frustrated patients "elope," leave to obtain care elsewhere.[6] When these patients were insured, revenue left with the patient.

For fiscal year 2001, the District's subsidy to the PBC to cover the hospital's deficit was capped much more rigorously than in previous years. The result is that the PBC was predicted to run out of money by 1 April 2001.[7]

2. Quality of care

- Physicians who staff the PBC's own community health centers "reported that they lacked admitting privileges to D.C. General."[8]
- Complaints were voiced regarding difficulty in scheduling appointments for D.C. General's specialty clinics.

3. Physical condition

The hospital was old and badly maintained.[9] Physical plant configuration was ill-suited to the scale of the hospital's operations.

4. Strategic and political assessment

Some claimed that: D.C. General was not needed and that empty beds were available elsewhere. Further, money spent to sustain the hospital should be used to prevent more problems through better ambulatory care, the city's health commissioner repeatedly declared.[10]

Dismayed by years of weak management and by persisting deficits, opponents of the hospital concluded that D.C. General Hospital was too broken to be fixed.

B. The Case for Retaining the Hospital

Closing D.C. General was not safe because it left many citizens too far from care.

A look at the first map displays the loss of five acute care hospitals with 1,100 beds from the eastern half of the District before D.C. General's closing.[11]

This map shows the importance of D.C. General Hospital as a surviving caregiver for a large expanse of the District and its citizens.

Without D.C. General Hospital, the most time-sensitive services—those of a Level I trauma center—would be the farthest away from the citizens of the eastern half of the District.[12]

The second map shows hospital closings against the background of the race of the residents who were living nearby when the 1990 census was conducted.[13] The racial data indicated are the African-American share of each census tract's population in 1990. I have found similar patterns in many other cities in the course of studies of hospital closings in 51 U.S. cities since 1936.

Hospital use data show the value of D.C. General Hospital

- D. C. General Hospital was the second most important trauma center in the District. with 51,596 ER visits in 1999, or 14 percent of the District's ER visits.

- The hospital's share of the District's uncompensated care rose to 37.5 percent in 1998.[14]

- From 1995 to 1999, admissions rose by 5.7 percent, to just over 10,000.

- Nationally, African-American citizens recently have depended twice as heavily on hospitals to organize and deliver ambulatory care (32 percent of their ambulatory care visits were in hospital ERs or OPDs) as did white citizens (15 percent).[15]

- Nearby hospitals lack the financial capacity [16] or willingness [17] to serve patients displaced from D.C. General Hospital.

III. CITY GOVERNMENT EFFORTS TO MAKE THE CLOSING TOLERABLE

Finding it impossible to defend an outright closing, city government developed two successive plans. Neither was adequate. Each seems to have been fueled more by a negative desire to put forward something that would allow the city to close D.C. General than by a positive desire to take practical and well-tested steps to enhance the health of vulnerable patients.

A. The Community Access Hospital

The Public Benefit Corporation (PBC) voted in mid-September 2000 to convert the D.C. General Hospital into a new "Community Access Hospital" (CAH).[18]

That CAH would offer minor ER services, short-term stabilization, and mainly primary care outpatient services.

The PBC expected that reshaping the current D.C. General Hospital into the CAH and a health center, preparing referral and contracting arrangements, preparing eligibility-determination systems, designing and testing needed payment systems, and obtaining needed regulatory approvals could all be accomplished in less than four months.

But the evidence supporting the feasibility of the CAH was grossly insubstantial.

- The CAH proposal approved by the PBC was very ambitious, hasty, and rushed—as even its designers freely admitted—and sometimes boasted.[19]

- Despite assertions to the contrary, [20] no such method of care has been implemented in the United States. [21] [22] [23] [24] [25] [26] [27]

- The proposed timetable for implementing the CAH was so short that it constituted financial, administrative, and possibly medical disasters.

The PBC Board voted to support the CAH proposal without evidence on its medical safety, its financial or administrative feasibility, or its capacity to meet the medical needs of patients served at D.C. General Hospital.

Because the CAH proposal was untested and without precedent, it amounted to treating vital services for vulnerable people as objects of risky experiments.

B. Contracting Services with Greater Southeast Community Hospital and Other Entities

During the winter of 2000 – 2001, the mayor and his allies—particularly the District of Columbia Financial Responsibility and Management Assistance Authority (the Congressionally-mandated Financial Control Board)—apparently realized that the CAH would be a disaster.

They decided to contract out the services provided at D.C. General to Greater Southeast Community Hospital (a for-profit hospital that had taken over a bankrupt non-profit hospital located on the edge of the city). This would be done in association with two other hospitals, an HMO for Medicaid patients, and a cluster of health centers. The contract was estimated at $66 million yearly, but that appears to be an incomplete accounting of the costs.

This contract is flawed in at least four ways:

1. The cost of administration equals two-thirds (67.2 percent) of the cost of clinical services under the proposed contract.[28] [29]

2. Some 27,000 uninsured residents of the District would not be eligible for coverage under the proposed contract. [30]

3. Despite all the primary care and prevention rhetoric, fully 72.5 percent of the money provided to Greater Southeast would be used to pay for in-hospital, surgical, and emergency room care.

4. Greater Southeast is the wrong hospital in the wrong place. It is geographically peripheral. It lacks a Level I trauma service. And its financial and organizational strengths are uncertain.

IV. LESSONS FROM THE FIGHT OVER D.C. GENERAL

D.C. General Hospital was closed mainly because

- Urban public general hospitals are sometimes vulnerable on grounds of finances, efficiency, management, quality of care, and physical plant condition. D.C. General had long-standing problems—many real and some perceived—in each area.[31]

- Efforts to reform and revitalize the hospital came in time to offer reason for hope to hospital supporters but too late to convince committed opponents.

- An inexperienced health commissioner with unrealistic hopes for primary care served a mayor eager to balance the city's books.

- The Financial Control Board was able to undemocratically over-ride the City Council's unanimous demand to keep the hospital open.

- Too little evidence on the costs or efficacy of the various alternatives was put before the public in a timely manner.

As difficult as the debate over the future of D.C. General has been, in several ways, it has, in some ways, been more serious than were discussions two decades ago in cities where public hospitals were closed.

- One reason is that the need to sustain care for vulnerable citizens is more important today, and the demand to close hospitals recklessly is weaker today.

- A second reason is that local politics in the District in 2001 are simply different from those in Philadelphia in 1974, St. Louis and San Antonio in 1980, or New York in the early 1980s.

- A third reason is that the Financial Control Board has been involved in ways that are both negative and positive.

    - On the negative side, the Board adopted the mayor's view that D.C. General should be closed, and did so without adequately considering the effects of the closing, ways to provide substitute services, or the suitability of its contractor.

    - On the positive side, having made this mistake, the Board probably sought more detailed commitments from Greater Southeast than the mayor alone might have sought. The result may be that the District pays more money to the wrong caregiver, in the wrong place, than it would have cost to revitalize D.C. General. But this probably still amounts to more generous financing for more care than the mayor would have provided.

- Unlike what happened earlier in St. Louis or Philadelphia, an outright, stark, simple, and harsh closing did not prove to be politically realistic. Why not?

    - One of the reasons given to close the hospital was to make money available for primary care and other services, so alternative services had to be offered.

    - Opponents of the closing turned enough political light on the hospital to force some scrutiny of the plans to arrange substitute services.

    - After the Community Access Hospital proposal was discredited, the Financial Control Board realized that any alternative to D.C. General must at least seem to deliver and finance appropriate types and amounts of care.

Looking backward, on the down side, the trouble is that two decisions—closing D.C. General and delivering alternative services—were made largely in isolation and at different times.

- Some of this stems from the mayor's decision to close D.C. General without carefully analyzing the consequences.

- The Financial Control Board took an anti-D.C. General position and does not seem to have demanded analysis of the consequences of losing the hospital. This strengthened the mayor's hand on the closing.

- The other decision, which has been evolving over time, has been to deliver and finance alternative services to replace many of those that had been offered at D.C. General.

- The cost, quality, coverage, and acceptability of the two choices were never compared. Instead, a hospital with real strengths and weaknesses was compared with imaginary solutions.

- Subsequently, the promises by Greater Southeast are being analyzed separately.

- From a simple strategic viewpoint, this has been a massive blunder. The city's bargaining position with Greater Southeast was inevitably much weaker after the mayor decided to close D.C. General.

On the positive side, the growing scrutiny of the D.C. General closing, and of the alternatives offered during the months preceding the closing, may have raised the level of the discussion. The results:

- possibly, a greater focus on the need for care by uninsured citizens of the District, on the services required, and on how to finance and deliver those services; and

- possibly, a closer examination of the Greater Southeast proposal and sub-contracts.

Still, I fear that the services to be provided under the contract will be

- inadequate in volume,
- incomplete in scope,
- geographically inaccessible,
- under-financed,
- inadequately managed and coordinated,
- expensive to deliver, and
- costly to administer

We can expect that the contract will be difficult to enforce, and also that the District will not be willing or able to enforce it. Greater Southeast's declared reluctance or unwillingness to upgrade its ER to a Level I trauma unit, and its interest in building a new

110-bed hospital on the D.C. General site, support those who doubted the wisdom of privatizing D.C. General's services.

In conclusion, D.C. General was closed for several reasons:

1. The mayor wrongly assumed a close connection between closing the hospital and promoting the health of District residents. He adduced no evidence for his plans, and did not face serious demands that he do so. He relied on the belief D.C. General was bad and anything else had to be better.

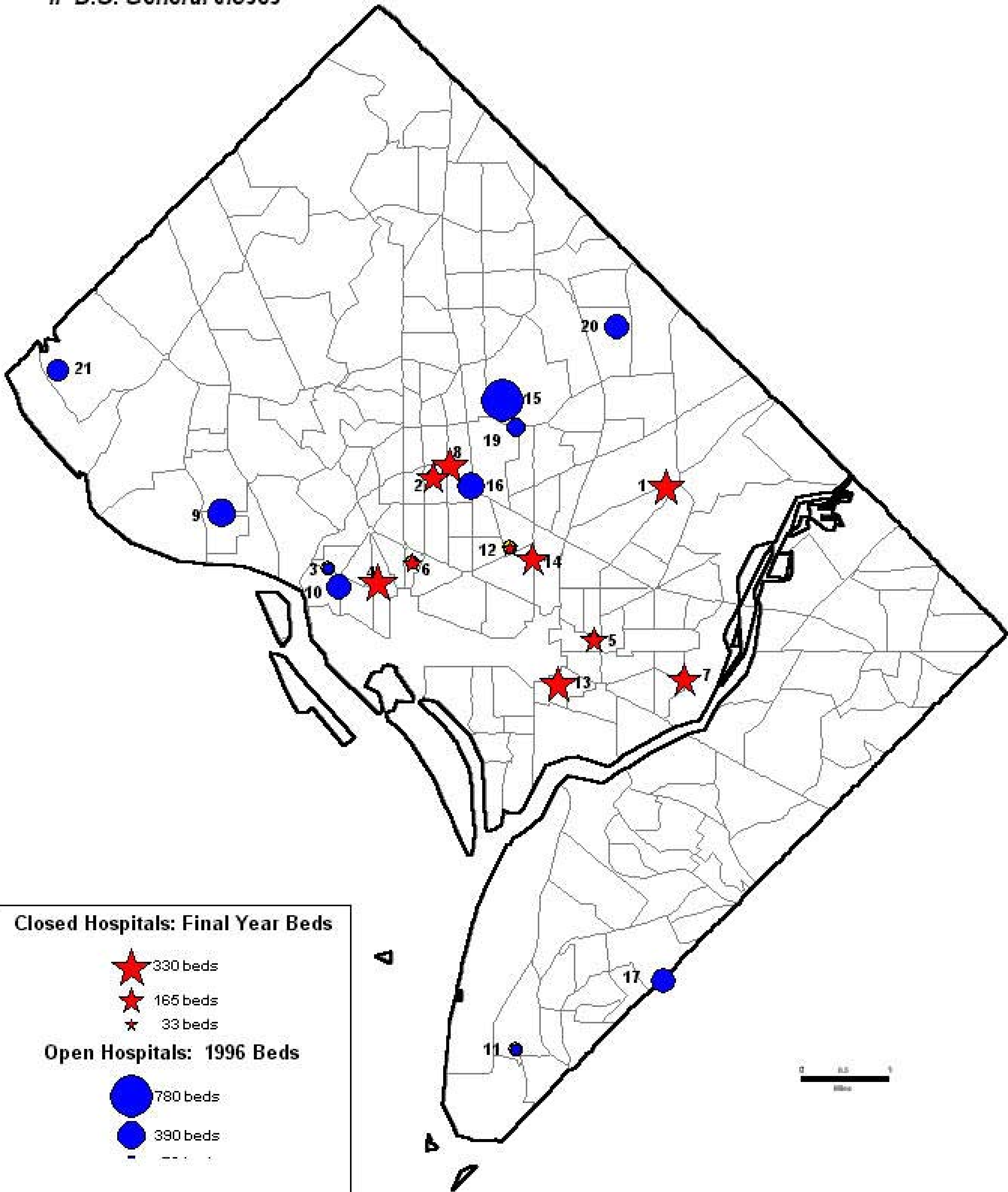
2. Press reports often took the same view. The *Washington Post*'s lead reporter on the story did not always provide full and balanced coverage of the arguments or evidence offered by hospital supporters.

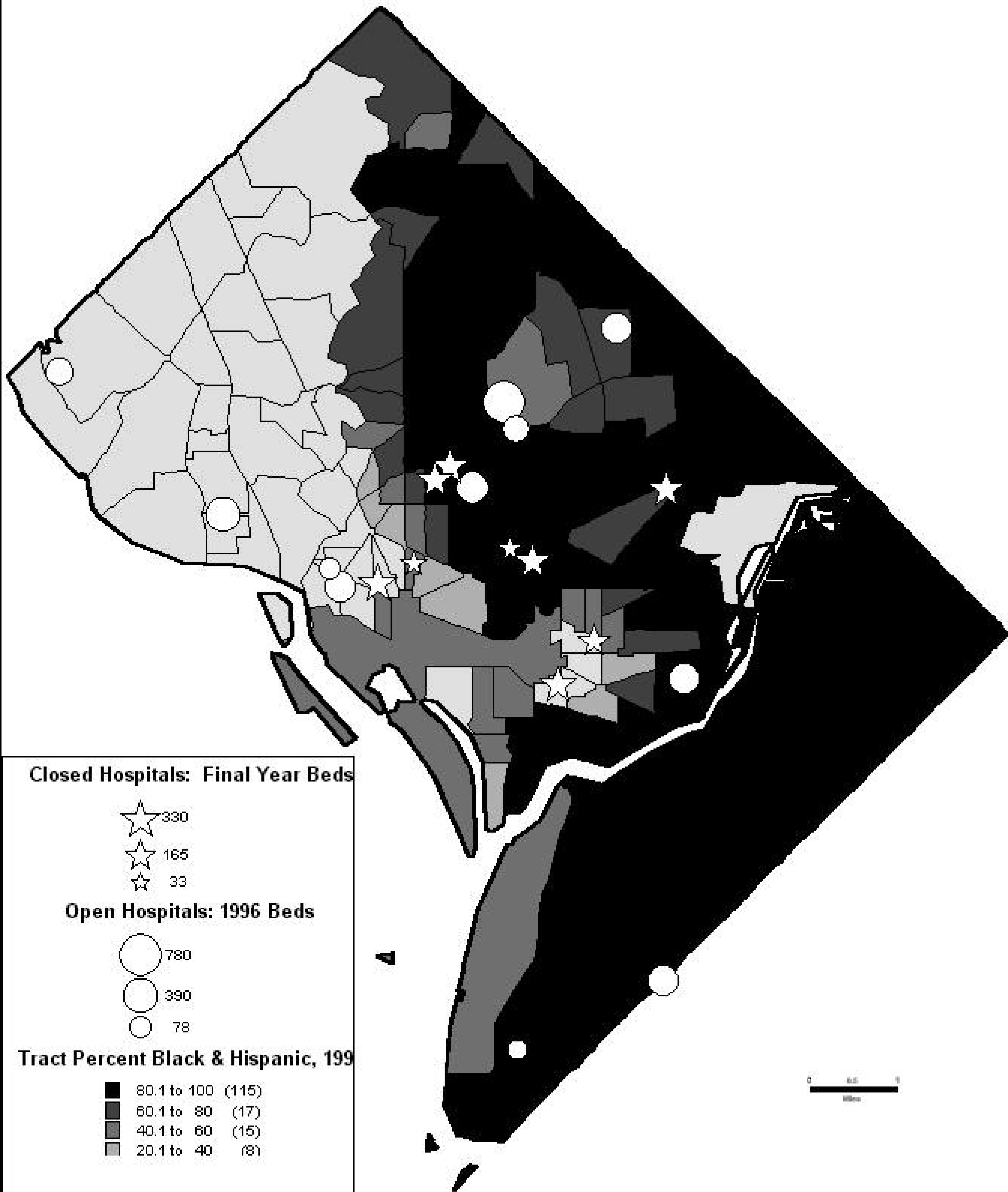
3. The Financial Control Board, like the mayor, became heavily invested in closing the hospital. It, too, was animated more by what was wrong today than by what might be right tomorrow. It had the power to force through the contract with Greater Southeast and to close D.C. General.

4. The fight over D.C. General's future apparently absorbed much more time and energy than did efforts to plan for substitute services. This is shown by the shortage of staff with experience in identifying needed services, designing methods of delivering them, or in estimating the costs of those services. After the CAH was judged politically infeasible, the contract with Greater Southeast was negotiated in desperation in order to advance the closing of D.C. General. The city's bargaining position with Greater Southeast was weak. The Financial Control Board and the mayor settled for a costly, wasteful, inadequate, and unstable alternative.

Washington D.C. Hospitals, ID Codes Used in Mapping, and Beds, Various Years

		Beds in							
ID	**Hospital Name**	**1937**	**1946**	**1950**	**1960**	**1970**	**1980**	**1990**	**1996**
1	Central Dispensary & Emergency	270	310	310					
2	Childrens H of the Distr	182	250	227	200	236			
3	Columbia H for Women	127	125	125	118	153	154	183	75
4	Doctors H		245	232	307	323			
5	Capitol Hill H	150	100	135	152	250	211	180	
6	Episcopal Eye Ear and Throat H	100	92	100					
7	District of Columbia General H	1136	1460	1416	1118	980	600	420	250
8	Garfield Memorial H	268	363	277					
9	Georgetown University H	210	235	360	353	397	442	528	404
10	George Washington University H	92	89	405	417	528	512	483	295
11	Hadley Memorial H				67	77	78	77	70
12	National Homeopathic H	60	62	62	62				
13	Providence H	255	310	297					
14	Sibley Memorial H	210	255	260	248				
15	Washington HC				778	829	804	871	772
16	Howard University H	322	498	476	382	449	433	490	355
17	Greater Southeast Community H					410	400	450	281
19	Children's H						240	279	167
20	Providence H				350	367	352	379	316
21	Sibley Memorial H					346	361	362	234


January 2001--if D.C. General Closes
Washington, DC
Hospitals Closing, 1936-2001
Hospitals Open, 2001
IF D.C. General closes
21
20
15
19
8
2
16
1
9
12
14
3
4
6
10
5
13
7
17
11
Closed Hospitals: Final Year Beds
330 beds
165 beds
33 beds
Open Hospitals: 1996 Beds
780 beds
390 beds
©Alan Sager 2001



Washington, DC
January 1999
Hospitals Closing, 1936-1997
Hospitals Open, 1997
Closed Hospitals: Final Year Beds
330
165
33
Open Hospitals: 1996 Beds
780
390
78
Tract Percent Black & Hispanic, 199
80.1 to 100 (115)
60.1 to 80 (17)
40.1 to 60 (15)
20.1 to 40 (8)
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NOTES

[1] Avram Goldstein, "D.C. General Sends off Its Last Patient," *Washington Post,* 24 June 2001.

[2] Public Benefit Corporation, *Primary Health Care Services Assessment,* 2000, n.d. indicated. This is a report prepared by or resting on evidence compiled by "a multidisciplinary team of consultants with extensive primary care and systems management expertise," hired by the Bureau of Primary Health Care, Health Resources and Services Administration, United States Department of Health and Human Services.

[3] Author's calculations form Public Benefit Corporation, *Primary Health Care Services Assessment,* 2000, n.d. indicated.

[4] Public Benefit Corporation, *Primary Health Care Services Assessment,* 2000, n.d. indicated. This is a report prepared by or resting on evidence compiled by "a multidisciplinary team of consultants with extensive primary care and systems management expertise," hired by the Bureau of Primary Health Care, Health Resources and Services Administration, United States Department of Health and Human Services.

[5] Calculated from District of Columbia Hospital Association, "General Information about Patients Served at D.C. General Hospital, 1999," Washington: The Association, Patient Data System Information, n.d.

[6] Public Benefit Corporation, *Primary Health Care Services Assessment,* 2000, n.d. indicated.

[7] Testimony of Mr. Natwar Gandhi, chief financial officer, District of Columbia, testimony before the Subcommittee on Health and Human Services hearing on D.C. General Hospital, 18 September 2000.

[8] Public Benefit Corporation, *Primary Health Care Services Assessment,* 2000, n.d. indicated.

[9] Barbara A. Ormond and Randall R. Bovbjerg, *The Changing Hospital Sector in Washington, D.C.: Implications for the Poor,* Washington: The Urban Institute, 1998, p. 26.

[10] Ivan Walks, testimony before the D.C. City Council, 18 September 2000. See also Ivan Walks: "The model we have to move to is prevention and primary care." Cited in Avram Goldstein, "Plan to Downsize D.C. General Upsets Staff and Patients," *Washington Post,* 27 August 2000.

[11] Alan Sager, Hospital Closings and Other Reconfigurations in 52 U.S. Cities, ongoing study. See, for example, Alan Sager, "Why Urban Voluntary Hospitals Close*," Health Services Research*, Vol. 18, No. 3 (fall 1983), pp. 451-475; Alan Sager and Deborah

Socolar, “Urban Hospital Closings, Relocations, and other Reconfigurations,” American Public Health Association, New York, 18 November 1996; and Alan Sager, Deborah Socolar, and Jasprit Deol, “Causes of Hospital Closings in 52 Cities,” American Public Health Association, Indianapolis, 10 November 1997.

[12] Telephone conversations with emergency room personnel at Washington Hospital Center, George Washington University Hospital, and Providence Hospital, 17 September 2000.

[13] Data from the 2000 census are not yet available.

[14] District of Columbia Hospital Association, 1999 D.C.HA Annual Hospital Survey. Columbia Hospital for Women and Hadley Memorial did not report uncompensated care for 1998. We conservatively estimated their uncompensated care at reported 1999 levels.

[15] Calculated from David A. Woodwell, "National Ambulatory Medical Care Survey: 1996 Summary," Advance Data from Vital and Health Statistics of the Centers for Disease Control and Prevention/National Center for Health Statistics, Number 295, December 17, 1997, Table 2; Linda F. McCaig and Barbara J. Stussman, "National Hospital Ambulatory Medical Care Survey: 1996, Emergency Department Summary," Advance Data from Vital and Health Statistics of the Centers for Disease Control and Prevention/National Center for Health Statistics, Number 293, December 17, 1997, Table 1; and Linda F. McCaig, "National Hospital Ambulatory Care Survey: 1996 Outpatient Department Summary," Advance Data from Vital and Health Statistics of the Centers for Disease Control and Prevention/National Center for Health Statistics, Number 294, December 17, 1997, Table 1.

[16] Barbara A. Ormond and Randall R. Bovbjerg, *The Changing Hospital Sector in Washington, D.C.: Implications for the Poor,* Washington: The Urban Institute, 1998, p. 2.

[17] Barbara A. Ormond and Randall R. Bovbjerg, *The Changing Hospital Sector in Washington, D.C.: Implications for the Poor,* Washington: The Urban Institute, 1998, p. 32.

[18] Public Benefit Corporation, District of Columbia, “Community Access Hospital,” Draft, 11 September 2000.

[19] Consider the statements by Dr. Ivan Walks, D.C. Commissioner of Health, mentioned during the City Council’s hearing on 18 September 2000 that he and his staff “worked all-nighters and on Labor Day” to get the CAH proposal ready, and that “we have a complete lack of resources” to prepare the CAH. Ivan Walks, D.C. Commissioner of Health, statements in response to questions, D.C. City Council, Subcommittee on Health and Human Services hearing on D.C. General Hospital, 18 September 2000.

Similarly, the proposal’s haste is demonstrated even in the words of the Medimetrix consulting group that prepared a presentation on two models, including an “emergency stabilization and access center” that closely resembles the CAH. According to

Medimetrix, “10 days ago, these two models were just terms.” Rod Wiggins, Medimetrix Consulting, *Review of Models 1 & 2,* presentation prepared for the Public Benefit Corporation: District of Columbia Hospitals, 25 August 2000.

[20] Public Benefit Corporation, District of Columbia, “Community Access Hospital,” Draft, 11 September 2000, p. 2.

[21] I was not able to contact anyone in Illinois to verify claims regarding freestanding emergency rooms in that state.

[22] See INOVA’s web sites, particularly “INOVA Emergency Care Center,” www.inova.com/beyond/iecc.htm.

[23] American Hospital Association, *AHA Guide to the Health Care Field, 2000-2001 Edition,* Chicago: The Association, 2000.

[24] Data compiled by the Virginia Hospital and Healthcare Association. I am grateful for help from Mr. William L. Murray, Vice President, Virginia Hospital and Healthcare Association.

[25] For background on Germantown Hospital and Albert Einstein Medical Center, I relied in part on a information provided by Andrew Wigglesworth, President, Delaware Valley Healthcare Council, Philadelphia, telephone conversation, 15 September 2000.

[26] Information on the two Illinois facilities was provided by Mr. Ron Damasauskas, Illinois Hospital Association, telephone conversation, 20 September 2000.

[27] Please note that the information on the two Illinois facilities was not available in time to prepare the written testimony submitted on Monday 18 September 2000. It is added here to round out the record.

[28] For calculations, see Alan Sager, “Analysis of Proposed Contract between the District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital Corporation,” 30 April 2001.

[29] Access and Affordability Monitoring Project and Solutions for Progress, Inc., *Massachusetts Can Afford Health Care for All: Covering Everyone Comprehensively Without Spending More,* Boston: The Project, 2 November 2000.

[30] Again, please see Alan Sager, “Analysis of Proposed Contract between the District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital Corporation,” 30 April 2001.

[31] See Alan Sager, “Threats to Urban Public Hospitals and How to Respond to Them,” Doctors Day Address, Medical and Dental Staff, District of Columbia General Hospital, Washington, D.C., 30 March 2001.