LEE MEMORIAL HEALTH SYSTEM

Time to Get Real

…and Responsible

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This paper contains personal opinions and public data collated and summarized in an attempt to provide a comprehensive input of information to the Planning Retreat of the Board of Directors scheduled for August 7, 2008. It does not represent policy of the Board, but merely attempts to consolidate the information presented to us in the past two years to assist in discussion and subsequent development of policy and direction for Management and the Medical Staff.

TIME TO GET REAL….AND RESPONSIBLE

INTRODUCTION

Since the acquisition of the HCA facilities and the construction of the new Gulf Coast Medical Center (GCMC), considerable attention has been focused on a facilities plan for the future configuration of health care delivery in Lee County. Input has been sought from the community and the physicians as to what they feel would be an "ideal" realignment of our service delivery. The input has been valuable, but unfortunately suffers from two major defects: it is predicated on reorganizing existing structures within a health care delivery system that will not exist in ten years and it is only two dimensional, ignoring the realities of economics and community development.

FACILITIES PLAN

The presented facilities plan(s) represent a good faith effort on behalf of our medical staff and administration to examine our current assets and determine an ***ideal*** configuration of LMHS ten years down the road. Tribrook Corporation was given a relatively short period for evaluation and a somewhat narrow window through which to view our future care delivery system configuration. They have assisted the development of three scenarios which were presented to the Board at the June planning meeting. Wisely, they have pointed out the narrow mandate that they were given along with a disclaimer that the cost estimates are relative to each other at 2007 value and should not be taken to represent real dollars anywhere down the road.

Some time back I circulated estimated construction costs for various medical facilities stratified into categories of "Completed", "Broke Ground" or "Designed". This has been included in this paper as Appendix A. LMHS would be in a fourth and undelineated category of "Thinking About It". We are two years from any design efforts and seven or eight years from any major construction effort.

Again the numbers do not tell the story, but as Tribrook point out, the ratios are important. In 2007 dollars a new acute care bed at design and out for bidding costs $1.1 Million dollars and this price is the same for acute care expansions. This is a lesson we have already learned at HealthPark Medical Center where the Acute Care Expansion of the NICU to meet 2008 needs and standards required upgrades of the overall relatively new physical plant in addition to the actual NICU construction costs of six beds.

To be taken away from this paper is the next line, whereby renovation of existing beds to 2008 standards at all stages was approximately 55% of new construction costs. In simple terms, in most instances two existing beds can be turned to current standards for every new bed brought onto line and can be done in considerable less time if a CON for renovation is not required.

For the purposes of this paper, it is conservative to use the figure of $1.5 Million per new bed and $750,000 per renovated bed. Both these assumptions would be made if the process were to go ahead in the next two years, although as pointed out, renovation can be done more expediently and therefore the final bill will be smaller. I do not think it is a stretch to predict the

numbers will exceed $2 Million per new bed construction as we approach the end of the ten year window.

A number of assumptions are safe to make:

- The loss of 100 overall beds to Lee County when GCMC opens next year will ensure we are probably going to be at capacity before 2012 and this is before we can bring a new construction bed on line, even if we were financially fat;
- Lee Memorial Hospital currently has 450+/- acute care beds, but these cannot be significantly upgraded without bed loss and huge expenditures;
- To replace LMH and if we started this year will require an expenditure of at least $600 Million dollars without any additional beds, but in fact, whether built at the current location or North of the river, any construction project would be at least "expandable" to 600 beds ($900 Million to $1 Billion);
- We will have to wring 10-15 years out of LMH and will need to do so by upgrading some areas while "downgrading" others into low acuity services such as the suggested Baker Act Medical areas. There will be some bed loss as multiple bed rooms are converted into singles or doubles. We might also convert some of the current ICU facilities into longer term ICU for patients that remain in other critical care areas but impede the flow of the tertiary care unit (Example, post open heart but requiring extended care);
- A "free standing Children's Hospital" will become a permanent charity like our Trauma Unit. Our Pediatric activities need to be integrated into one or more of our acute care facilities. Current and projected needs for a Pediatric tower (a priority in all scenarios of the Tribrook/Medical Staff plan) that does not reuse any existing facilities will require a minimum of $150 Million conservatively (this does not include the backfill costs to recover the abandoned beds at HPMC);
- The idea of moving Trauma is not appropriate unless an external Trauma Unit is built outside the existing structure of GCMC. Dr. Hobbs has communicated that the ER (he participated in its design) is not suitable to house that service. Movement of Trauma and the alignment of services necessary is inappropriate considering that we may well be forced to close this unit for financial considerations and spending money on it is nonsensical unless future funding is guaranteed externally;
- Some facilities service alignment is currently underway by choice of the physicians who provide the services and this process should be fostered and aided with needed structural and personnel changes as productivity improves and consensus is obtained;
- If as part of county development the Board elects to build North but stay with the Cape Coral 250 bed general hospital model, that facility will cost $500 Million plus by 2017 in addition to the costs of dealing with any tertiary care patient load remaining in LMH and the rehabilitation unit;
- The minimum cost to deal with LMH and a Children's tower is going to be $650 Million dollars plus substantial backfill costs.

ECONOMIC REALITY

In 2008 we have taken huge hits and will be lucky to remain profitable into the next few years unless new revenue streams are made available and existing business made more profitable on the revenue side. We have made most of the cuts that are available without a major impact on

quality and jobs. In doing so, we have sacrificed reinvestment in our current operations and our capital available for replacement, modernization and new business has dried up in direct proportion to the cuts we have sustained from both levels of government.

Medicare

Next to undocumented immigrants, Medicare is our worst payer and last year we were forced to shift $97 Million dollars to cover underpayment for services to Medicare patients against the actual dollar cost of providing the mandated services. As we have discussed on many occasions, this is a "Sick Tax" for everyone else that is forced by necessity or by election to use our services. When Medicare makes up ~45% of our total inpatient business it should be obvious we are not going to make these losses up on volume.

Whether anyone seems to appreciate the big picture or not, this "single payer" system is leading all hospitals in the country that deal with large volumes of Medicare to eventual bankruptcy without the insertion of new and adequate funding into the program. It is interesting to note that this is the same pattern observed in most of the world's socialist systems: initial adequate funding undergoes unilateral cuts by the central government(s) until the political cost is too great, at which time token additional funds are made available. The system never recovers; public expectations decline with quality and access limitations.

Public "fundraising" gives only temporary relief when dealing with government. A Children's Hospital in which I previously practiced sponsored a fund drive annually and the public coughed up millions of dollars, supposedly to endow capital projects. In reality, whenever one of these projects was funded by charitable giving the Government reduced that amount from the operating costs it reimbursed the hospital.

"Pay for Performance" (P4P) and "bundling" of payments for hospitals and physicians is the newest Washington scam to further reduce payments. The former gives no additional funds for exceptional care or quality (which most bureaucrats would not know if waved before them) and makes the ludicrous assumption that this aging patient population is homogeneous and healthy when they appear on our doorsteps. It is merely a method of withholding part of the already substantially deficient reimbursement for this care.

Bundling is a methodology of pitting the delivery of care by hospitals versus the practitioners. It carries a single message: "We are cutting reimbursement even though your costs are going up." It will force hospitals to employ doctors to survive or at least slow their demise. Private practitioners will drop Medicare in response.

ECONOMIC REALITY

The Third Dimension of our "Facilities Plan" is our economic situation. This study is meaningless without beginning to talk of what we can afford without sacrificing the delivery of care. The system cannot sustain any major increase in our debt load so it is appropriate to look at where we are now and what we anticipate will happen in the next few years with respect to finances. A number of subheadings are appropriate at this point.

BIG PICTURE

The big picture is bad, but not hopeless and management has been aggressive in the cost control aspect. The grim highlights of the big picture are:

- We lose 18 cents of every dollar of cost expended on Medicare patients and this population occupies approximately 45-50% of our inpatient volume **and** we are going to see additional cuts to our reimbursement with the new sham programs;
- Although Medicaid pays almost the cost of the patients, the Medicaid HMO payments are approximately the same as Medicare **and** the latest legislative changes will do away with the traditional Medipass program which was cheaper and had greater access for children (Florida is dead last in the nation) forcing all subscribers into HMOs. This represents a 10% cut in our Medicaid reimbursement (7-10% of our volume);
- Third party insurance will continue to decline as a payer for our population but the uninsured will become a larger share of our business;
- The Governor's plan is unlikely to make a great deal of positive difference for our revenue stream and will most likely hurt us;
- We will continue to lose money on Trauma and unless additional funds are found future Boards will find it necessary to cut loose the formal program although some form of local service will likely survive;
- Supply and pharmacy costs will continue to increase geometrically although with our supply chain management, at a lower rate locally than nationally;
- Energy costs will increase exponentially and will not come down any time soon;
- Our cost structure can be distorted by a few providers and by a few supply items, whereby these unreimbursed costs have to be taken from otherwise viable clinical programs. The Board is soon going to have to address both of these factors and solve the problems with or without these providers and/or these programs;
- Our current debt structure is such that further additions will begin to impact on our ability to delivery clinical care by diverting clinical funds to debt service;
- Further debt will jeopardize our ability to borrow money at respectable rates;
- Other third party entities will follow the lead of Medicare P4P programs and payment bundling **if we permit them to do so!**
- Bonita Community Health partnership will either have to be dissolved or we will need to reach agreement with NCH on their ceding control to LMHS to stem the losses here.

COST STRUCTURE

As we have been indoctrinated weekly over the past six month by Jim Nathan and John Wiest, LMHS has needed to focus on cost management. While internal vigilance is necessary on an ongoing basis, this process has reaped the major available benefits unless some additional spending commitment is made, primarily in the area of IT. This aspect has now reached the point of diminishing returns within our current administrative structure and policies. Internal management has yielded around $25 Million in economies.

This Board has tackled the three most egregious issues in 2008. They are:

- Use of nursing travelers which last year represented a $22 Million dollar loss to the system. The long term solution includes increased production of qualified nurses locally and the increase in clinical exposure during training;

- Orthopedic implant costs: a work in progress, but one that will be corrected this calendar year even if we have to import our own implants from Mexico or India (same implants at 5-20% of our current cost);
- Payments to physicians or $26.7 Million dollars, most of which will be dealt with under revenue generation and Graduate Medical Education (GME), but all which are correctable within 12 months, mostly by process correction ($22 Million).

BONITA COMMUNITY HEALTH CENTER

As mentioned in the preceding section, Bonita Community Health partnership which we hold equally with NCH is losing money. We own the surrounding land. BCHC suffers from a lack of utilization and organization of potentially huge revenue generators. The facility is underutilized particularly the surgery center. The Anesthesia is below par, staffed with student CRNA's and a single doctor most of the time. Many of the surgical services within the building do not use the surgery facility, in part because of anesthesia.

There has been zero imagination or community development concept invested in BCHC. The services have not been tailored to the population. NCH has a vested interest in *status quo* as 65% of the outflow goes to NCH facilities. Some services would greatly enhance the health of the community and can be instituted at little cost from existing unused space leased by LMHS:

- Diabetes Clinic
- Obesity Clinic
- Woman's Center & Post-menopausal clinic
- Spine clinic

Under the current ownership structure (50-50 partnership), the center is unable to enjoy the benefits of either system. We need to have controlling ownership to provide:

- Sovereign Immunity
- Employee medical benefits
- Anesthesia upgrading
- Hospital contracting and rates (see below)
- Hospital based physician use of surgery center
- Integrated multi-specialty clinics
- Women's center including Breast Clinic

Acquisition of BCHC will have significant advantages, not the least of which we will not be subject to a future capital call merely to keep the doors open. We will not have to put out the funding needed to expand into an ambulatory center. This will add four operating rooms and two endoscopy suites to the South **which we will need to build otherwise** and naturally such construction would be on the land we own adjacent to BCHC. The current OR utilization is less than 20% of capacity. Please refer to various construction costs for Free Standing Facilities in Appendix A to calculate the cost savings over hospital based expansion.

Essentially, when utilized properly this facility will provide high cash flow to investment ratio. It can be developed without substantial investment. Ideally, we can continue our partnership with NCH and acquire a 1% interest and make it part of LMHS. If not we should consider terminating the partnership. Alternatively the real estate can be separated from the clinic entity whereby LMHS will operate the latter.

PEOPLE PROVISIONS

We have devoted considerable resources to examine the bricks and mortar aspect of LMHS. We have done it like teenage boys looking through the Victoria Secrets catalogue: glamorous marble and glass with hidden price tags and no ability to pay for or manage everything that looks exciting. Of substantially more important for healthcare in SW Florida is whether we will have the necessary people, professional and non-professional to operate the system.

Human capital is in fact more important than physical plant investment at this point. What if we built the tent and none came to the party. Before we start building towers and wings we need to have in place and execute a plan to ensure we have a sufficient number of adequately and appropriately trained people at all levels to operate them. We will need to invest real dollars in order to achieve these goals and we must forge partnerships at the State and local level to do so. We need to find methods to guarantee our employees can afford to live near where we deploy them and that they do not spend all of their salary on housing, gasoline, child care and taxes.

Mortar and glass are tangible and visible when completed. We draw pretty designs and we put names on the front of them. Conversely, people projections are tough and requirements change. We know that the public sector is not exactly nimble in response to changing needs, both in qualifications and supply. We have moved in some areas now and have partnered with both private and public institutions to achieve our current successes. Before proceeding with a facilities plan, LMHS needs to establish a “People Plan” and recruit the necessary partners to make it a reality.

GRADUATE MEDICAL EDUCATION (GME)

This aspect of education and people is relatively easy with which to deal: we need to establish first of all an academic culture within LMHS and with it an academic program. After investigation of the various options, the medical school at Florida State University appears to be an excellent fit for our system. They will assist us to establish and administer a GME program that will be locally based on a Fort Myers campus. They will manage the credentialing, curriculum and external relations on our behalf while we manage and educate the program locally, inside and outside of our physical facilities.

FSU in addition to expertise will provide us with available matching funds on a 150% basis, whereby were we to put up five million dollars for our programs we would draw down approximately twelve and one half million in total. The Dean of Medicine at Nova University has offered to provide osteopathic accreditation to match the allopathic accreditation from FSU.

Significant other advantages are gained by the system:

- We will retain approximately 50-60% of graduates within our region;
- We will create a generation of SW Florida academics by sending the best of our own graduates for fellowship training;
- We will solve most of our call issues and the associated financial burden after the first year in the selected specialties;
- We will have continuous quality improvement within the system;

- We might have some insulation from further Medicare cuts, although it would be foolish to assume the current increased funding for GME will be available;
- We will have increased ability to serve the uninsured and/or under insured and to institute preventative programs;
- We can attract research money and capital funding associated with that research.

A survey of the Medical Staff and an inventory of existing subspecialties and support programs undertaken last year reveal considerable enthusiasm to establish the overall concept of GME and a few departments will be ready to proceed without much more than the addition of a Chair. Fortunately, this list includes many of the specialties we need to recruit to the area. Overall, the following specialties are ready or close to ready to commence training:

- Obstetrics and Gynecology
- Pediatrics
- Emergency Medicine
- General Surgery
- Internal Medicine with fellowship in Gerontology and Hospice Care
- Anesthesia

Other specialties that can proceed with some additional investment:

- Cardiology
- Gastroenterology
- Orthopedics
- Family Medicine

Additionally, as soon as we have the appropriate university affiliation we can begin a Fellowship program in Neurosurgery and Neurovascular Intervention. This is entirely due to the investment already made in the Neurosurgical group and the Endovascular Laboratory at HPMC.

Nursing Education

We have made considerable progress in this area and now have three undergraduate nursing programs with the addition of Nova University to the community. We do need to begin to coordinate patient exposure and clinical rotations with the three programs which should not be a problem. We would also like to coordinate specialty training with the programs and we should have input into the training of the final product. We will obtain considerable savings if we can abolish or shorten internship the programs that we are currently conducting to make the current product employable.

We need to encourage and, if needed, finance graduate nursing education for our outstanding nurses in specialty areas. This will allow us to provide the faculty for all three programs in each of the chosen areas of specialization. This should be a win-win-win situation for quality, cost and cooperation with these programs. Nova has a PhD program that it can bring to its Fort Myers facility and FGCU has a Masters Program currently in place.

Midlevel Education

Currently we have in place midlevel programs for:

- Nursing Anesthesia at FGCU

- Nurse Practitioner Program at FGCU
- Physician's Assistant program from Nova University

While we need some coordination there is not investment to be made in this area. The programs are of high quality and will need the needs of our community. Many of our local nurses and other medical professionals still enroll in distance learning programs. Local access can be improved for these students.

MEDICAL EDUCATION

Currently we accept Medical Students from a number of programs but have a formal arrangement with Nova University. While we can expand this program once a GME and departmental structure is in place, this is not a high priority. Less than 10% of medical school graduates stay in the area where they train. Our focus needs to be on GME.

SUPPORTING PROFESSIONALS

Currently we train in a number of areas and our facilities are utilized by both local and national facilities. Some of these include the clinical programs of:

- Occupational therapy
- Physiotherapy
- Respiratory Technology
- Radiography Technology and subspecialties including Radiation Therapy
- Paramedics
- Medical Records
- Emergency Medical Technology
- Nursing Assistants

Additionally, we accept interns in a wide range of medical fields from many universities. A few of them include:

- Hospital Pharmacy
- Social Work
- Child Life
- Hospital Administration
- Music Therapy
- Hospital Dietetics

We do not have any monetary investment here, but considerable intellectual investment which generally, like most educational instruction, improves our own staff and their abilities.

SUPPORT TECHNICIANS

It is apparent that the system will need to recruit and train individuals to provide services both on site and off site. As LeeSar centralizes many of our support activities, an opportunity to partner with community educators for role specific individuals will increase. Areas such as:

- Pharmacy technician and packaging supervision

- Instrument repair technician
- Biomedical repair technician
- Sterilization technician
- Dietary assistant
- Cook
- Transportation technician
- Information Technology installer

And these are just to name a few. Centralization of services off site will present opportunities to provide centralization of instruction and standards. Basically, we should be training our staff to support our needs at every level.

HOUSING AND TRANSPORTATION

These items are going to be increasing problems for our staff as prices go up in the geographic areas in which we need to employ them, particularly for the lower paid support services. We may well need to get into the housing business in some form and we will likely need to look into providing transportation to some of our facilities from outlaying areas of the county. Off site centralization of some of our services will improve this situation as we will have the opportunity to locate facilities in areas where housing availability and costs are reduced.

CHILD CARE

Without child care we will not be able to keep our doors open. At the moment our child care is centered near our existing facilities, but we may need to look at "Employment Hubs". These would be located in the periphery where the child care (and elder care) is centrally provided and transportation leaves for our core facilities. These would all have an after-school program as well to allow parents to work ten or twelve hour shifts without worrying about the children. This may also save considerable fuel for the School System if we set this up properly.

ELDER CARE

More and more of our employees are left looking after mom or dad who are not yet ready for the nursing home but do need some "Day Care". Some require more care than others, but some can assist in the operation of the "Employment Hub". To the surprise of none, this will be win-win for hospital and employee and win again for the senior. Medications can be given on time and nutrition and socialization promoted.

Another big win here is that as a pilot program it should not be too difficult to get assistance funding it.

GULF COAST CENTER

The State is closing this superb facility for the mentally disabled with many of the residents being moved to group home settings. Some residents however are too handicapped for anything other than institutional care. Gulf Coast is a well maintained facility on Buckingham Road.

Lee Memorial needs to develop a plan to put this center to public use and present it with our politicians to the State. Part of the plan needs to be the assumption of ongoing care of those remaining residents in return for title to the property which can then be developed as any one of a number of uses or even multiple uses particularly as it is located on "high ground", at least for this county:

- Low cost housing for employees;
- Employment hub as above with day care and elder care;
- Off-site relocation of Administrative services;
- Rehabilitation services;
- Short term nursing home services;
- Vocational training;
- LeeSar packaging services;
- Biomedical repair facilities;
- Patient safety instruction laboratory;
- Walk-in Clinic or outpatient facility;
- Psychiatric Services;
- Legal Services;
- Board office

REVENUE GENERATION

It is now time to turn over the coin if LMHS is to survive the continuous Governmental underpayment. Essentially, the system needs to acquire an additional piece of the health care dollar. Many of the revenue generation alterations need to be simply to change our current rates for goods and services to a market rate, eliminating those "loss leaders" that are remnants from the "us versus them" days. Others will be obtained by establishing a community-based system of integrated care to respond to market forces particularly in the area of "bundled" care. Finally, we will have to tread into non-traditional areas where many of the Third Space dollars currently reside: health plan management and risk assumption.

RATE ADJUSTMENTS

At the last Finance Committee meeting the topic of "bed rates" was addressed mostly in passing. The acquisition of the HCA facilities in Lee County has brought down the cost of health care ***even though we have increased staffing and quality programs***. It has correctly been pointed out that none congratulate us on having low reimbursement and this is particularly true given that when our margins are reduced capital reinvestment is the first casualty. Without correction of this situation, we will begin to slide behind and quality will be the next casualty. It is difficult to generate sympathy for the Third Party payers whose rates have increased by double digit percentages yearly, knowing that the doctor's and other practitioners are not getting any increases and certainly the hospital has limited its increase in actual revenue to below inflation and well below the cost of doing business.

<u>Medicare/Medicaid</u>: These two entities and some of their hangers-on representing 55-60% of our admissions have actually cut into our revenue stream when comparing those moneys to the actual cost of delivering mandated care. Government continues to be and will persist in being the major parasite on our system in terms of actual dollars, $117 Million of them last year and more this year.

There is little that we appear to be able to do to address these inequities or this hidden tax on the sick, but this doesn't mean we should not look for solutions, including legal ones. The real question to be asked is "Can government mandate a health care entity to provide service on its behalf at less than the cost of providing this care?"

We lose a little ground each year and unless this slide is terminated Lee Memorial Health System will fail. We simply will not have the dollars to shift to cover these increasing losses as fewer folks are left to support increasing numbers of seniors and welfare recipients. We are actively exploring the possibility of suing the Government in Federal court to require they cover the cost of their mandates in hospitals, for frankly if one examines the future demographics of healthcare, we will be better having our costs determined by a Federal judge than Washington functionaries.

Hospital Services: Many of our existing contracts date to the cut throat days of the Columbia HCA wars and still contain many "loss leader" provisions. For example, many of the rates for services like Anesthesia were kept artificially low to induce the signing of contracts for other services to LMHS. The result was that these rates are now less than half statewide market **and this Board is subsidizing the Anesthesia group at the legacy hospitals on behalf of Third Parties!** This type of counterproductive interference is corrected merely by stepping out of the way and allowing the market to correct. Ultimately, our subsidy will be dramatically reduced at really no cost to us.

Charges and revenue for inpatient and outpatient care should reflect true costs and should be adjusted annually to correct for tangible changes. We need to abolish the artificial concept that we have "discounts" for volume from various payers. It costs just as much to look after a PPO patient as it does an HMO patient as we don't differentiate on the basis of quality. In fact the HMO patient may be more expensive as we must pay to deal with the limitations and other forms of care rationing imposed by the Third Party.

A single charge structure with no discounts for any Third Party will also lower the cost to the uninsured and those belonging to various other high deductible entities. While we will still have collection problems for many "self-pay", we are more likely to receive cooperation from many clients that would otherwise walk away from their responsibility. Deductibles and co-payments should be strictly between the Third Party payer and the patient; we need to get out of the middle. We do need to provide the necessary information to both parties, but two other charges need to be levied:

- Fifteen percent surcharge if the Third Party does not assign their payment to us (essentially a collection fee);
- A per contact charge for additional contact or information request for case management beyond a predetermined set of standards released by the patient on admission (this is a "bureaucracy fee" levied as a cost to the HMO not the rest of our patients) coupled with an outright ban on utilization of such length of stay scams such as Millman & Robertson.

This is not to say that our services should not be marked up, but we need to avoid the PR-killer of mythical 3000% premium on the cost of an Aspirin. We must cover the cost of capital replacement, depreciation, regulations, standards, administration, debt service and lawyers as well as the ever increasing need to shift costs to atone for State and Federal negligence. In the end, we should adjust to give a minimum of 3% return on our overall business from clinical

operations. Profits from other sidelines should be segregated and separate, but realistic, targets established for each. Except for the legal fees these are all legitimate costs of doing business and we should make no apologies for charging for them. The patient is getting high quality accessible care in return.

REVENUE GENERATION WITH CURRENT FACILITIES

Before we rush off and begin to throw money we don't have at perceived problems we need to tackle what we have and how we use or don't use it. This section will be divided into a number of subsections as follows:

- Utilization of current physical plants
- Information technology (IT)
- Integration of Physicians services and GME
- Ambulatory Care
- Insurance Business
- Fund raising and community partnerships

As the reader examines this section, one must remember there are four ways to obtain and sustain profitability:

1. We can charge more, but this is not always appropriate. We need to charge "fairly" for all our services;
2. Increase volume. This works well providing quality service is maintained and constantly monitored with realistic goals that are not to be exceeded;
3. We can collect more. Good business practice plus a fair pricing system are keys;
4. We can manage costs. This is absolutely essential, but cost must balance quality and those decisions should ultimately be made by clinicians.

The Administration needs to be directed and empowered to institute and monitor each of the items listed above in conjunction with appropriate and skilled physician input.

UTILIZATION OF CURRENT PHYSICAL PLANTS

The appendix dealing with costs and the paper I wrote previously emphasize the need to maximally exploit our current facilities and to extend their utilization well into the next decade. For those that have filed it away, I have attached a copy as Appendix B. At the time, I understood that there was not to be a lot of money available, particularly if we were to make the investments necessary to generate revenue.

My positions have not changed a great deal and examination of the current clinical priorities has confirmed most of the points that I made previously. They include:

- Build out of those projects at HPMC, CCH and GCMC to maximize revenue within the existing footprints. HealthPark has three shelled in ORs that can be completed within months and brought onto line without alteration in Pre-operative care or the Post Anesthesia area at a fraction of the cost of new facilities. Likewise removal of a wall or two will double the endoscopy suite flow and displace only a few administrators;
- Low acuity services need to be transitioned out of high acuity-capable facilities. Psychiatric/Medical patients need to be shifted to LMH and Obstetrics removed from

HPMC to Gulf Coast with a new 21st Century Level III NICU, back filling with the Pediatric Tower within the existing facility and a full service Level II nursery built at CCH. The existing NICU remains surgical and able to accept babies from other hospitals for NICU care as it does now;

- Birthing Centers in the Cape and at GCMC need to be established to relieve pressure on the inpatient side with or without Ambulatory surgical centers (see construction costs);
- Non-clinical services need to be removed from the high rent districts and placed into off-site or even on-campus office space, backfilling with clinical services. This includes physician office space for those not actively treating in-house patients or involved in clinical teaching at the GME level;
- Hospital space on the entrance level at each facility should be utilized for generic Ambulatory clinic space where appropriate supporting existing services or GME.

Once we have maximally utilized our existing infrastructure, only then should we be considering alterations in footprint. Dave Kistel has planned for the expansion at GCMC and in the long run this would be the first major project undertaken outside of renovations of existing facilities. This will give us beds at the lowest cost per unit as will expansion of CCH.

INFORMATION TECHNOLOGY (IT)

Without the immediate decision to invest in IT Lee Memorial will fail. Our existing IT labyrinth is pretty much like our Pediatric Services, poorly integrated and spread all over the map. We are actually renting from HCA to operate the acquired facilities. We are falling behind the standard daily and are essentially leaving huge savings and quality care on the table while we talk about bricks and mortar. We are not ready for this century and we are eight years into it. We are still making buggy whips, but trying to build rockets on the same production line.

IT MUST BECOME THE NUMBER ONE PRIORITY FOR SYSTEM INVESTMENT!

Currently, our multiple systems don't talk to each other and some cannot talk to each other even with translation services provided. I have inserted as Appendix C the diagram of our current IT disaster to remind all of where we sit and where we need to go.

Huge savings and cost stabilization are actually the result of proceeding sooner rather than later, up to $300,000 per month. In addition to this, the impact on quality is positive at every step of the way. Bar coding of patients ensures the ability to institute Go/No-Go patient care in all of our facilities that bring the patient's history to the provider or nurse. Financial charges are directly related to what was done, what was provided and who delivered the care.

LMHS has made the decision to proceed with the use of the EPIC system. The talking stage is over and we need to now implement the process in accelerated fashion **before** we even discuss where we will tread for facilities. Mike Smith needs to prepare for approval of this Board an IT timeline broken into cost bites of the whole loaf and the Board needs to begin to take every bite it can stomach. The immediate and positive impact on cost and quality will be Maalox to future Boards.

The Board will have to invest an estimated $60 Million dollars to bring us an integrated delivery system. The addition of another 30% to these estimates is not unreasonable. Wireless encrypted

technology will allow us to use paperless charts throughout the system (including the concrete bunker that is LMH). Each time we introduce a new IT feature, the payback is short and the returns immediate.

INTEGRATION OF PHYSICIAN'S SERVICES

Last year Lee Memorial either lost money or subsidized physician's services to the tune of $26.7 Million dollars. Since January of this year we have examined where we spend this money and where we need to be going in a changing market place. We have tried to be mindful of the existing community structure, but with the changes coming from our major client Medicare (and the likely "Me Too" philosophy of the remaining payers) it is more than apparent that we cannot use the current model in the next decade.

There are two aspects to the model that will evolve. The hospital care delivery model which is driven by the hospital medical staff organization(s) and the overall community structure that is all encompassing.

HOSPITAL MEDICAL STAFFS

The hospital model has evolved nicely although not without a few bumps in the road. The PLC is firmly in charge of the processes of quality and credentialing and is nearing a consensus on management of Medical Staff affairs with a bylaw structure. They have done this in a way that will permit this Board or future Boards to further integrate the license process or the Medical Staffs while still retaining a structure that will permit each geographic unit to operate somewhat differently thereby optimizing quality care based on the medical role assigned to that facility.

This process needs to continue. It will not always be smooth, but we have guaranteed physician input at all levels and continue to do so. The Board should continue to request the Medical Staff undertake as partners with the Administration's clinical side resolution of matters that impact both quality and cost.

EMPLOYED PHYSICIANS

Lee Memorial now employs physicians for four reasons:

1. Primary care acquired at the time of Columbia/HCA competition;
2. Certain specialties that require sovereign immunity to function within our community;
3. Certain role specific specialties that are needed in the community, but due to nature of practice or population base served are not economically viable otherwise;
4. Specialists who support hospital function when similar specialties within the community refuse to provide service at a particular facility or within hospital facility.

As a result this *ad hoc* acquisition of physicians and their practices has led to a pretty much non-structured environment and administration. This in turn has engendered some rather impressive financial losses. This Board has two reports coming on these matters, one from Price Waterhouse Cooper's Brett Hickman and the other from our own Jack Eikenberg. Both will point to substantial savings that can be obtained by administrative means without major impact on the role or the function of the group in its current setting. Hickman estimates that there are

over $20 Million in savings and/or additional revenue with changes in how the group is administered and how it does business for its services to be gained in the first year.

What this Board will be required to do is to determine where we are going with the group and what will be its role in LMHS and within the community. There are three factors that must be considered and placed in the context of a possible multi-specialty and multi-role clinic like Oshner or Kaiser. They include:

1. Graduate Medical Education: whereby the Clinic is structured into departments that in addition to the clinical role they would perform the base unit for residency training;
2. Third Party Insurance: The biggest bite we need to take from the healthcare dollar is not from the community providers but from the Third Party payers and the lawyers. A multispecialty clinic would be the nucleus of such a community based health insurance entity in order to manage costs and to remove self-interest decision making;
3. Revenue generation: we continue "compete" with our own medical staff for many of the low acuity, high return patients where the insured are shifted to physician owned surgery centers and the underinsured or non-insured are brought to our facilities. Like in basketball, if you miss a shot and the opposition scores, the shift is four points not two. Interestingly enough, many of these same competitors are demanding we pay them to take call in our facilities. Employment of physicians to compete with these specialists is doubly positive: we improve our patient mix and we do not pay for call.

This is not to say LMHS would hire in all specialties. With bundling of care we will have to reach a fair and equitable relationship with **most** of our specialists. We can assist them by providing them with access to mid-levels and residents, billing, IT and hospital sponsored insurance programs. They might be perfectly comfortable in such a private practice partnership or with an employment model.

It is important to point out that all the successful multi-specialty and primary care clinics are physician managed at all levels of the clinical process and that financial rewards incentivize care givers over the long term. All the unsuccessful models were attempted as employed administrative driven models.

Expect over the next few months for LMHS to make considerable administrative changes without major Board direction. Pretty much everyone knows what needs to be done. Additionally, the hospital needs to consolidate its hospital based contractual model with Anesthesia and Radiology to have financial consistency across the system. If a residency program in Internal Medicine is commenced, our hospitalist program at **all** facilities would be the base unit for this GME.

Likewise LMHS will have to step up and hire additional physicians even under the original models. The Lee County tort system has guaranteed that we will need to offer our sovereignty umbrella to additional OB/Gyn practitioners and other high risk specialties. The problems of "tail insurance" and liability can be solved at minimal cost to the system and can end up being a positive move for us and for the individual practitioners. This would be a quality driven risk management liability fund established off-shore which links quality to return for all employed physicians.

AMBULATORY CARE

LMHS lacks an Ambulatory Care program, but we have made inroads to starting a system. The ideal program will provide the following services all linked to a single IT system:

- Geographic primary care development
- Local secondary care delivery
- Targeted clinics for specific populations using resident mid-levels and regional specialists such as Women's Centers, Diabetes Clinics, Rehabilitation Centers and Wellness Programs, Ambulatory Psychiatric Services, Obesity Clinics
- Diagnostic support to include Diagnostic Imaging, Laboratory, Stress testing etc
- Surgery and Endoscopy as it can be supported

This does not mean LMHS has to employ all the physicians involved. It does mean we have to contract with various providers to make these centers successful and that the practitioners have to be incentivized to guarantee success while maintaining quality.

INSURANCE PROGRAMS

Basically there are two types of Third Party programs that LMHS can provide, risk based and non-risk based. Without complete control of all aspects of care delivery, LMHS should not consider risk based programs. If better control of delivery is obtained by employment and IT integration, risk assumption does pay very well. We have neither at the moment.

Non-risk based insurance is however a viable consideration for LMHS and we have talked about it before this paper. Essentially, we could offer the LMHS employee plan to other government and corporate entities in Lee County/SW Florida. The numbers would indicate that they would save somewhere between 8% and 16% over their current premiums even if we charge a 5% administrative fee. Constitutional officers struggling with their budgets could either use those dollars for their programs, lower their millage rates, lower premiums to employee subscribers or some combination of the above. LMHS would require minimal investment to establish this.

LMHS on the other hand would win in two ways. It would benefit from the administrative charges, but secondarily would gain by having services conducted within the confines of the program, just as it currently does with its own employee program. This improves our patient mix particularly for ambulatory care. This similar self-insurance program can likewise be offered to corporate interests.

Fundraising and Community Partnerships

LMHS and its supporting foundation have mixed grades when looking at these pictures. We underwent a "Visioning Project" where we asked the community for input and we have acted upon many of the recommendations from organizations and individuals from the region. In return, we should expect those same individuals and organizations to step up and partner with us in many of the areas of need. Conversely, we need to be sharing the responsibility with or supporting organizations that may well be more suited than we are for a particular community need or project.

Fundraising is a mixed picture. LMHS Foundation has performed credibly on the major donor and cocktail circuit but poorly on the motherhood level. I have correspondence going back fifteen years encouraging us to shift our emphasis in Children's Hospital fundraising to the grass roots level from the current plan. Nothing annoys me more than going into a store and seeing a box to contribute money to another Children's Hospital or watching our major outlets, Costco, Sam's and Publix hustling money for All Children's Hospital through the Miracle Network and passing this scam off as "100% LOCAL", as I noted in Publix last week.

Collecting coins may not be the biggest money raiser, but it is certainly the biggest awareness raiser. We should have "Change Collection" pits before the Airport Security on each of the concourses for kids to deposit the family change rather than setting off the security alarms. Basically, we need to have the Children's Hospital in front of our citizens every time they turn around. We do good work and we need to promote it.

Financial Timeline

The Board is now faced with the future and the future is financial whether we like that or not. It is time to move beyond the catalogue gazing stage and play for the task ahead. I feel this Board needs to do the following:

Day Zero: We do this regularly. We know our financial picture on a monthly basis. What we do not know is what the external forces of government and the economy will do to and for us. It is entirely safe to assume they are not going to pay us more and at the same time will demand we provide more expensive services and dance through more bureaucratic and nonsensical hoops for less money.

From Day Zero we need to establish flexible goals and tasks with checkpoints down the road to ensure the system remains economically viable and that sufficient funds are available to maintain quality service and access. The Board needs to be nimble and adjust the goals and tasks to ensure financial stability before proceeding to the succeeding phase. Each check point needs to be established as a Go/No Go gate where failure to make financial targets will require reassessment of cost versus value before proceeding.

Each phase outlined needs to be given various timelines and targets by the Board and obviously some projects need to be carried forward. The important part is that the Board monitors progress of each and the larger financial picture. Gains should be reinvested within the phase if possible although projects from succeeding phases in the same area might be started if that might help the bigger financial picture. Acceleration of an entire phase or various components can be undertaken when funds and staff are available.

Period 1: Consolidation and Recovery

We are passing Day Zero and we must direct the start of this phase which will consolidate the system and the people needed to run the future of healthcare in Lee County. The following are recommendations for categories to be addressed immediately:

- Information Technology: funding and development of EPIC system first phase;

- Reorganization and restructuring of Physicians Services including establishment of GME programs. PWC estimates that $22 Million plus can be saved first year on reorganization alone without expansion of services and if so, this should be immediately reinvested into this phase;
- Develop partnerships with existing physicians groups and expand employment to fill gaps in community needs;
- Finish build out of revenue generating projects within existing facilities;
- Move non-clinical (or non-educational) activities from existing facilities to less expensive space, on or off campus;
- Develop Ambulatory or community programs, plan birthing centers and regional hubs;
- Organize and introduce cost plus based pricing and involve Third party payment models;
- Offer LMHS Self-insured model to local government entities;
- Continue current cost containment measures and monitor for negative impact on quality;
- Relocate existing services into reallocated space backfilling with clinical services only;
- Begin "People Mover" project to assist staff with transportation, child care, elder care and housing;
- Partner with community for long term care, psychiatric care, ventilator care;
- Integrate and clarify Administrative and Clinical lines of responsibility within the organization;
- Acquire and bank land in various geographic regions of the county for future use;
- Allocate the human resources to achieve the above program.

Period 2: Expansion of Integrated Service

- Take second bite of the IT apple;
- Expand GME programs as specialties request, as need arises and as departments become prepared for this role;
- Design and build healthcare partnerships with non-employed providers;
- Begin design and build-out of expansion at existing facilities;
- Upgrade clinical technology to EPIC compatible technology replacing those devices and instruments that cannot be integrated;
- Continue and expand off-site functions that can be centralized;
- Continue cost containment;
- Expand Self-insurance model to local employers;
- Study and document regional demographics to plan placement of additional and/or replacement facilities based on need and available financing.

Period 3: Reap the Benefits

- Fully integrate all healthcare in Lee County with the LMHS based IT system with citizen participation and individual accounts;
- Build needed facilities and programs on previously banked land;
- Expand GME and research efforts;
- Expand people programs, housing and transportation and extend successful programs to other taxpayer supported agencies;
- Partner with Government to provide services through Community-based integrated care programs;
- Begin to assume "Risk" in the market

- Extend provider partnerships
- Continue cost control;
- Continue to expand Employment Hub concept sharing with other entities

Timelines

The system at the moment is anything but nimble. We are like an aircraft carrier in many ways: big and powerful, just don't ask us to change course in 500 yards when we are doing thirty knots. We must become responsive.

Management will have to reorganize the decision making process to decide on the needed alterations. The individuals responsible for the "course changes" will have to be empowered and supported while they are undertaken and adequate resources will have to be allocated to achieve a goal. We might well need to develop "surge" capability, particularly when bringing IT onto line and forming our GME programs.

Programs that will give immediate financial return will have to be promoted over those that might take longer to develop, at least in the initial phase. We may well have to sacrifice some efforts to get others in place. Like a puzzle certain key pieces will have to be funded to make it work and any borrowing needs to be firmly ground in "payback".

The role of the Board is to demand development of a phased and coherent planning process that is based on economic realty, to approve that plan once developed, to fund it and to monitor its success and failures. At no juncture can this Board or its successors place at risk the well developed model that currently exists or the high quality of care we current deliver.

At the same time, the Board must be cognizant that *status quo* is really just death by 1000 cuts. Any plan must encompass the entire picture, not just the interests of the popular culture or the most recent television series renderings. The periods I have outlined above don't contain actual times: these must be assigned by the Board and Go/No Go checkpoints established to monitor progress in conjunction with management and providers.

Each phase needs to be monitored for external influences that might positively or negatively impact the various projects. Resources may need to be reallocated "on the fly" to ensure the eventual evidence-based goals are achieved.

The overall task is daunting and no one individual or group can be expected to manage all phases of our plan. The priorization of resource allocation will be an important function that will need to be monitored and a dispassionate scoring system that includes financial implications and community benefit will need to be established and followed.

<u>Personal</u>

With luck, this is the last "Donaldson Manifesto" that will be inflicted upon you as I will not be with you after January of 2009. I wanted to share my thoughts with you to reflect upon during our summer break through July and before the Planning Retreat in August, our next session

together. Again, these are entirely my thoughts, a collection of efforts in which we have all participated over the last few years and an attempt to rationalize where you need to take us. I would like us to start this process in August. There is nothing in here you have not heard me state publicly in the past.

I think we have come a long way in the past few years. Certainly it is a learning process. While I joke that four years ago I thought a "Hedge Fund" was how we paid the landscapers, I have learned a lot from each of you and from the many experts we have brought in from management and from outside.

The one thing that I have learned is that we cannot live out of catalogues and off wish lists. The responsibility of this Board is to ensure that the system remains on sound financial footing and introduce new programs as we can afford them and as they are needed. I originally ran as a "vested interest" to build our children's hospital, but I leave with a broader vision. We still get our Children's Hospital in a tower and in one place, it just doesn't rob the other needs of the community to do so and it makes minor sacrifices to the betterment of the whole.

We will not make everyone happy and we won't make every patient better. We can only do what seems right.

Thanx

john