Presentation to
House Government Efficiency and Technology Committee
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Slide 1 (logo)

Good Afternoon. Thank you for inviting me here. As I understand it, I have been asked to give a brief overview of the success story of The University of Kansas Hospital since we became a Public Authority, and then provide an update on the status of affiliation talks in the Kansas City area.

Slide 2 (1990s)

I have been Chief Executive Officer of the Hospital for eleven years and arrived as the chief financial officer two years before that. The hospital was then part of the University system under the Board of Regents.

What I found was a hospital in serious decline. Patient volumes were dropping so low it made teaching medical students very difficult. Revenues were also in decline. Our medical technology was very much outdated.

Our patient satisfaction rankings were very low, often in single digits. Even our own employees didn't like the place. Many said they would not recommend that a family member or friend come to KU Med as a patient or employee.

We were just a few years removed from the emotional trauma of a newspaper expose about problems in our heart transplant program…problems that destroyed the cardiology program and left the hospital with no heart surgeons at all.

The University hired a consultant, the Lash Group, to analyze the problem. The consultant determined that if nothing was done, the hospital would lose at least $20 million a year by the year 2000.

Slide 3 (1998)

Chancellor Hemenway and I worked with the consultant to develop a solution. That turned out to be the independent hospital authority model used in Colorado and other states.

After a year of debate, the Legislature approved the measure, and then Governor Bill Graves signed it into law.

The hospital was turned over to an independently governed Authority Board of directors, made up primarily of private citizens. A key factor was the ability to borrow money through the issuance of bonds so we could provide much needed capital investment in the hospital.

Generally, our charge was to run the hospital like a business.

Slide 4 (Statute)

The Legislature made our purpose very clear. Our job was to help the Schools of Medicine, Nursing and Allied Health by operating a teaching hospital, focused on providing high quality care, serving as a site for research, and continuing to care for the uninsured.

Slide 5 (October 1, 1998)

So, on October 1, 1998, I was handed the keys to the building and a check for only ten days worth of operating cash. That was all the money we had.

We had no endowment. We were not allocated any unrestricted money donated to KU Endowment on behalf of the medical center.

We were scrambling to set up checking accounts, our own policies, our own payroll and accounting systems, everything.

One thing we did have was a vote of confidence from our employees. All employees were given the opportunity to stay with the State system or join this new organization. Out of more than 2,000 people, only one voted to stay with the state, and she later changed her mind and joined the Authority.

Slide 6 (Organizational Structure)

Let me take a few minutes to explain our structure to explain the role of our board.

The University of Kansas Medical Center remains governed as always…the campus answers to the chancellor in Lawrence. The chancellor reports to the state Board of Regents. We are linked to the University of Kansas Medical Center by a master affiliation agreement, which expires in 2008.

The hospital is governed by an independent authority board of directors. We also own several practice groups including the cardiology practices and their offices around Kansas and the metro area. And we own a number of family practice groups throughout the metro area.

Slide 7 (Board members)

We have a very distinguished board.

- Our chair is Dr. George Farha of Wichita, who built one of the largest physician practices in the country and is a Professor Emeritus in the KU School of Medicine-Wichita.
- Ed Chapman is a prominent attorney.
- Pat Gaunce is a long time community activist in Wyandotte County, who is very active in health care issues.
- Bob Honse retired as CEO of Farmland.
- Eric Jager is an investment executive with Bartlett Grain.
- Betty Keim is the former mayor of Mission Hills and a longtime community leader.
- Dave Kerr is an investment banker and former president of the Kansas Senate.
- Stu Lang is head of First National Bank of Kansas.
- Sharon Lindenbaum of Time Warner Cable and Thomas Murphy of Sprint joined the board last year.
- John Payne just retired as the leading executive with the Bayer Corporation in Kansas City.
- Charles Sunderland is a businessman and part of a prominent Kansas City philanthropic family.

In addition, representing the University are the chancellor, the executive vice chancellor, the provost and the dean of nursing. The chief of the medical staff and the president (me) also serve on the board.

Slide 8 (Patient Care)

The board gave us tremendous advice in many areas, but the overriding one was patient care must come first. That frankly was not the case when we began. So, we changed the culture, the facility and the technology to put the patient first.

Through management training and massive communication, we created a patient oriented culture where one had never existed before. We modernized space to reflect the way modern medicine was practice. We invested in technology, which not only benefited patients but served the education and research functions of the University.

Slide 9 (Quality)

This leadership has led to amazing improvements in care for our patients. The University HealthCare Consortium, a consortium of approximately 100 academic medical centers, has recognized us for overall improvement in quality with at jump from 33rd place to 11th place. This is the biggest improvement in their history, and this is data from 2004. We anticipate jumping up the list in the next two years.

One factor in that jump was our mortality index which was in the top 17th percentile of the best rates among UHC members.
We have repeatedly been asked to speak about our success in the Institute of Healthcare Improvement's campaign to save 100,000 lives.

Press Ganey, the largest patient satisfaction survey company, reports that among hospitals in Kansas City that use its survey, we are in the 99th percentile in patient satisfaction. We were in the bottom ten percentile when the authority began.

We are the first in a six-state region to receive a quality award from the American Heart Association for our stroke program.

And we are one of only eight percent of the hospitals surveyed annually across the country by the American College of Surgeons to receive an Outstanding Achievement Award for cancer care.

Slide 10 (Patient satisfaction)

The focus on quality produced one of the most dramatic turnarounds in patient satisfaction ever. I told you we often dipped into single digits in patient satisfaction. Now we are regularly in the 90th percentile range when compared to other hospitals in the country.

This is even more amazing when you realize that this is a moving target. We are being compared to hospitals across the country that are all implementing programs to improve patient satisfaction. The bar climbs higher all the time.

Slide 11 (Nursing)

One of the keys to our success is our people, especially our outstanding nursing staff. Our hospital has a higher percentage of nurses with bachelor degrees in nursing than any hospital in the region. Almost 60 percent of our nurses have a BSN, much higher than the national average.

Our nursing staff also includes a number of advance practice specialists to support the many advanced medicine programs we have, such as heart care, cancer care and neuroscience.

Many of you have heard a great deal about the national nursing shortage. We are doing very well in meeting the demand for nurses. Surveys show our nursing staff believes we have a great place to work, and we have remarkably low turnover in nursing. In fact, we have the lowest nursing turnover rate among the 11 large hospitals in the greater Kansas City Area

In late December, The University of Kansas Hospital achieved a recognition enjoyed by only three percent of the hospitals nationwide. We were declared a Magnet hospital by the American Nurses Credentialing Center. Magnet recognizes nursing excellence and the importance of our nurses to the success of the entire organization. Magnet designation, however, reaches beyond nursing and reflects the quality of patient care provided by everyone associated with our hospital.

Slide 12 (Turnover)

A key part of our culture change was to give our nurses and other staff a feeling of ownership of providing quality care in the hospital. This method of making sure our staff's ideas and concerns are heard

has not only made a difference in patient satisfaction and medical outcomes but has tremendously improved job satisfaction and reduced turnover.

We have the second lowest overall turnover rate among the 11 large hospitals in the Kansas City area. This obviously has financial implications as well, since it is cheaper to retain employees than to recruit and train new ones.

Slide 13 (Employee satisfaction)

Even with the pressure to continuously improve performance and cut costs, as well as the life and death stress of taking care of patients, employee satisfaction has risen.

A new survey system began last year which compares us with our peer hospitals around the country. It showed our employees feel more committed to our hospital than do employees of comparable hospitals around the country.

Slide 14 (Patient volume)

That push for quality has led to a major turnaround in patient volume. The dramatic shift in 2002 was due to the revitalization of our heart program.

It may look like we dipped a bit last year. But that is misleading. Frankly, we ran out of space to accommodate the demand for beds. And we were seeing sicker patients with longer stays. You can see we are projecting that by the end of fiscal year 2007, we will be climbing again, and setting more patient volume records.

In the last two years, we have shattered every patient volume record in the 100 year history of the hospital.

Slide 15 (Where patients come from)

Where do these patients come from?

Most are from the metropolitan area.

However, many people may be surprised that 20 percent of our patients come from Johnson County.

And, reflecting our statewide mission, nearly another 22 percent come from Kansas counties outside the metropolitan area. In fact, patients come here every year from every county in Kansas.
More than ¼ of our patients come from Missouri.

Slide 16 (Payer mix)

There are other things you need to know about our patients. Because of the investments we have made, the hospital is attracting more insured patients. Notice the third set of bars. This means we have reduced the percentage of the uninsured patients as part of total patient volume, while still seeing more uninsured patients than ever before.

Slide 17 (Uncompensated care)

This means we have been able to absorb steady increasing in the costs of caring for the uninsured without coming to the Legislature asking for help. So far this fiscal year, the jump in our charity care has exceeded the pace of past years.

Slide 18 (Revenue)

The ratio of more insured patients has meant our revenue has risen as well. However, we have no shareholders other than the people of Kansas, so we invest any funds remaining into new or expanded programs, new technology and new space.

Slide 19 (Capital investment)

Let me give you an example. In the last five years as part of the university System, we had only $33 million of capital investments. One year we had just one million dollars for capital and spent several days trying to determine what one thing we would use the money for.

In the first five years of the authority, we spent five times more on capital investment. In the last three years alone, we spent nearly $300 million.

Slide 20 (Heart center)

One of our proudest investments is the Center for Advanced Heart Care…the new heart hospital. Hospital executives from across the country are already coming in to see how we designed it. One reason why that is our chief designers were patients, physicians and nurses.

They were determined that the building first and foremost would benefit patient care…putting services into quick and easy proximity of one another and having a healing atmosphere throughout the building.

Since we opened last October, the building has been full, and we are already getting inquires from the physicians about adding more floors to the building.

Slide 21 (Westwood cancer)

That same process is being used to build the region's largest outpatient cancer center, doubling the size of the current center. Because we were out of space and needed help quickly, we were able to purchase the old Sprint building just a mile and a half from the main campus. This cancer center will include the area's first survivor center, helping patients through issues in the years after successful treatment. It will open this summer.

Slide 22 (cancer investments)

This is just the latest investment we have made in cancer. When the Hospital Authority began, the university had transferred ownership of the outpatient cancer program to a for-profit company named Salick. It cost the hospital $17 million to return control of the cancer program to the campus.

We then invested nearly $10 million dollars in increasing the size and design of the cancer center.

We have provided a million and a half to support recruitment of Dr. Roy Jensen to head the University's NCI effort.

Through a professional services agreement with the faculty physicians in the cancer center, the hospital absorbs all the cost of the physicians' uncompensated care.

And now we are spending $37 million on the new outpatient center, bringing the total to more than $75 million.

Slide 23 (Other key programs)

Heart and cancer aren't the only programs that are growing or responding to challenges.

Our Level I Trauma Center, the only nationally accredited Level I in the Kansas City area, continues to grow.

The Burnett Burn Center is the only facility in the region certified by both the American Burn Association and the American College of Surgeons.

We continue to excel at organ transplantation. We have the only liver transplant program in the region, and our kidney and pancreas transplant programs are highly regarded.

No one in the area offers the depth of radiological technology we offer. Our latest investment is a 64-slide scanner that provides spectacular 3-D images of the heart. Unlike other scanners, ours is jointly managed by radiology and cardiology, providing the best service to our patients. We also have the latest in PET/CT technology, including our own on site cyclotron. We have new MRIs and digital access of imaging at computer screens across the hospital through our PACS system.

Slide 24 (Hospital support)

Technology and professional service agreements are just some of the ways we support the faculty and the university.

As you can see, we have steadily increased the support for faculty and the university over the years to more than $30 million this year.

Slide 25 (% increase)

In fact the growth rate for our support has more than doubled the growth of our revenue.

Slide 26 (Hospital support charts)

During the transition to a more viable organization, the hospital increased its support to KUMC and its faculty. By providing a stable academically oriented environment, KUHA is helping the University's training mission and its goal of advancing new knowledge through its clinical research initiatives.

One thing to note is the increase in Graduate Medical Education funding through Medicare. The key reason for that significant growth was the hospital's investment to revitalize the heart program.

Slide 27 (Affiliations logos)

Of course, the key issue right now if the proposed extension of affiliation of the University to Saint Luke's Hospital. I want to give you the hospital's view on what is happening.

The University and some Kansas City civic leaders have a vision they believe would bring hundreds of millions of dollars into the schools, through greater support from more hospitals, through untapped area philanthropy and through public funds.

Slide 28 (Hospital position)

The board and the hospital leadership are supportive of the collaborative approach to the life sciences in this area. We understand how working together can enhance the position of the School of Medicine.

But, we also understand that the functions of our campus….education, research, clinical care….must be a cohesive whole if any plan is to bring positive impacts here.

No one can split off the interests of the Schools, the Hospital and the faculty physicians without harming the entire enterprise.

Early on we identified risks to the hospital and the faculty clinics from this proposed affiliation.

Slide 29 (Consultant report)

The hospital and the board agreed to hire the same consultant retained by the civic leaders to help us work out ways we could prevent or lessen the harm from the affiliations. The consultant recommended that the immediate focus be on getting the university and hospital issues resolved. We have been meeting in exhaustive sessions to explore the intricate issues involved here.

Slide 30 (Consultant risks)

The consultant also said the risks are real but they can be minimized, but not eliminated, through good faith negotiation.

Such risks as branding and the hospital's niche in the marketplace… Possible recruiting advantages for Saint Luke's…

And maintaining the quality of clinical and education programs under the new affiliations….

All of these have been the subject of these challenging negotiations.

Slide 31 (Letter of intent)

To show our good faith to the university and community, we signed a non binding letter of intent to go forward with these talks. A separate letter of intent was negotiated between the University and Saint Luke's.

We also wanted to get the issues involved out to the public so they can be openly discussed.

As former Senate President Dave Kerr, a member of the Hospital Authority Board, said in December to the Legislative Budget Committee:

> "There is no reason that both the KU Medical Center and the KU Hospital cannot achieve levels of greatness of which we did not even dare to dream in 1997 when the enabling legislation was being debated. ... The potential to achieve the next level of excellence and recognition for our institutions is real, as long as we proceed with sound, well thought out steps designed to ensure that all the Kansas participants are winners. Just like in 1998, there are ways to do it right. Kansans will benefit and be proud.

> There are also ways to get it wrong, and if that is allowed to happen we could exchange the optimism of today for concerns like those that prevailed before 1998. The key is working together to develop proposals that ensure benefits to all Kansas participants and, most especially, the people of Kansas."

As I mentioned, the University and KU Hospital are using a third-party consultant to help us find the way to "do it right." This consultant has recommended a package of two very thoughtful and thorough plans to help us reach a resolution. It is not necessarily what KU Hospital would have designed, but we believe we can live with it, and we thought the University had reached the same conclusion.

Unfortunately, last night we received word from the University that it wants major revisions to the plans we have been working on together. You can appreciate how difficult it is to negotiate when the bar is constantly moving.

I want to outline to you the six issues we are insisting are the way to do it right, as outlined in the Letter of Intent.

Slide 32 (Six vital issues 1-2)

We must clearly define our status as the “Primary Academic Clinical, Teaching and Research Hospital” for KU Medical Center. The phrase sounds nice but we must define clearly what it means.

We must establish a level playing field that allows us to continue to grow programs for our patients and meet their specialized care needs. This involves flexibility in ensuring physician staffing to meet the growing demands of our patients. This involves such areas as the organizational structure, as well as the recruitment and retention of physicians.

Let me explain what that means. In many programs, we do not have the depth of physicians we would like, even though there is a clinical demand.

Now, if a critical physician leaves, we have to wait on the university’s traditional recruitment, which has sometimes closed down programs at the hospital for six months to 3 years while recruiting is going on. Under the new arrangement, our concern is that Saint Luke’s, which has flexibility to recruit physicians, can recruit a physician to fill the gap, which could remove the University's incentive to aggressively a recruit a replacement at KU Hospital.

In that scenario, a good specialty program here suddenly could be housed at Saint Luke's, a competitor. We need the same flexibility as Saint Luke's to respond.

This also means we must have the flexibility to meet critical patient needs when they do not correspond with the needs of KU Medical Center and the KU School of Medicine. In other words, often the university recruiting is tailored to research needs. We need to respond to clinical needs as well.

Slide 33 (Six vital issues 3-4)

We must develop a plan to determine how many residents and fellows can be trained at our hospital. We believe the hospital easily has the patient volume to support another 100 more residents.

As part of its proposed affiliation with Saint Luke's, KU Medical Center would assign residents there. The university has not assured us that we will not lose residents, and we are seeking a firm plan that we will be able to grow. We must work with KU Medical Center to jointly assure that residency and fellowship needs are met.

We must agree on a fair plan of support for KU Medical Center that does not financially harm the hospital. Many of you will recall the

preliminary $400 million proposal we made last year. That was rejected by the university because of the conditions we put upon it.

Now that we are facing this new affiliation arrangement, we need to review the financial impact so that we can agree on a level of support that does not hurt the hospital and one that will end ongoing arguments. We have a very strong "A" bond rating, and we do not want to sacrifice that because of these new affiliations.

Slide 34 (six vital issues 5-6)

We must agree on financial plan that compensates us if the new affiliation structure harms the hospital. We are concerned, as I mentioned, that we are already seeing an increase in uncompensated care. Other hospitals associated with New York University, Tulane, the University of California at San Diego and at the University of Texas Southwest saw themselves become purely safety net hospitals because of university affiliations with other hospitals.

We have not been assured by the University that KU Hospital will be recognized as the National Cancer Institute-affiliated clinical cancer center, and we have concerns that instead Saint Luke's would have the benefit of this affiliation and branding. This issue has been going on for years. We have invested $75 million dollars in the last seven years to bring the clinical cancer program to a high level.

I need to add that we are very supportive of the Midwest Cancer Alliance, which will link Kansas hospitals, physicians and their patients to NCI benefits.

Slide 35 (logo)

As you can see, we still have some very significant issues to negotiate. It is my hope that these issues can be resolved so that we are able to help the university achieve its vision. We have a fiduciary responsibility to this state asset, and we take that very seriously.

We also understand how our partners in the Medical School want to move their program forward. We also want that for them.

We hope to report to you soon that we have found a win/win solution.

I will be happy to answer any questions.

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