Approved: 2-3-97
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on January 29, 1997 in Room 526-S of the Capitol.

All members were present except:
Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Jo Ann Bunten, Committee Secretary
Others attending: See attached list
Conferees appearing before the committee:
Larry Buening, Executive Director, Kansas Board of Healing Arts
Pat Johnson, Executive Administrator, Kansas Board of Nursing
Biagio Pagano, Kansas Public Health Association
Debra Zehr, Vice President, Kansas Association of Homes and Services for Aging
Phyllis Nolan, Chair, Kansas Board of Regents
Donald Hagen, M.D., Executive Vice Chancellor, KU Medical Center Campus
Wayne Lerner, M.D., Vice President, The Lash Group
Irene Cumming, Chief Executive Officer, KU Hospital

Introduction of bills

Larry Buening, Kansas Board of Healing Arts, requested introduction of two bills: (1) statutory maximum for fees paid to the KBHA, and (2) temporary permits under the occupational therapy and respiratory therapy practice act. Senator Steineger made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Langworthy. The motion carried.

Pat Johnson, Kansas Board of Nursing, requested introduction of two bills relating to various aspects of nursing. Senator Becker made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Langworthy. The motion carried.

Biagio Pagano, Kansas Public Health Association, requested introduction of a bill that would require the addition of fluorides in public drinking water. (Attachment 1) Senator Becker made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Langworthy. The motion carried.

Debra Zehr, Kansas Association of Homes and Services for the Aging, requested introduction of a bill relating to facilities for the aging. (Attachment 2) Senator Jones made a motion the Committee recommend introduction of the proposed legislation, seconded by Senator Steineger. The motion carried.

Briefing on Kansas University Medical Center and Hospital

Phyllis Nolan, Chair of the Kansas Board of Regents, addressed the Committee regarding the need to change the ownership/governance structure of the University of Kansas Hospital to respond to the rapidly changing health care market. Ms. Nolan noted that the Board of Regents authorized the Chancellor of the University of Kansas to proceed with the development of legislation to establish a public authority to operate the University of Kansas Hospital. (See Attachment 3)

Don Hagen, M.D., Executive Vice Chancellor, Kansas University Medical Center, addressed the Committee and expressed concern that without the hospital, they cannot teach, and without teaching, they do not have a mission. Dr. Hagen noted that the Lash Group was hired as consultants to obtain recommendations as a frame work or basis for proposed legislation that would establish a public authority to operate the hospital. During Committee discussion regarding care for the poor, Dr. Hagen noted that if a citizen of Kansas needs health care, they will provide it, but costs have increased to such an extent that this becomes a serious problem that needs to be addressed.

Wayne Lerner, M.D., Vice President, the Lash Group, briefed the Committee on major elements and recommendations that the Lash Group made to the University as noted in his report to the Board of Regents. (See Attachment 4)

Irene Cumming, Chief Executive Officer, KU Hospital, briefed the Committee on her background experience and the urgent need to streamline procedures at the hospital.

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for January 30, 1997.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 1-29-97

NAME	REPRESENTING
Tim Carpenter	Lawrence Journal-World
Pat Johnson	Board of Nursing
Margaret Zillinger	SRS/AMS
Jason Pitsenberger	Brad Smoot
Richard Watson M.D.	D.O.O.
Debra Zehr	KAHSA
Marlin L. Rein	KU
Victor Thomas	KU
W. Lerner D.P.H.	LASH GROUP/KU
Jon Jackson	KU
Irene Cumming	KU
Biggio Pagano	Kansas Public Health Ass.
Harold Riehm	KAOM
Larry Buening	Bd of Healing Arts
Charley Young	Via Christi Health System
Steve Potter	KDHE
Keith R Landis	Christian Science Committee on Publication for Kansas
Barb Conant	Ks Bd of Regents
Marvin Burris	Bd of Regents

Terry Humphrey — KTLA - Topeka

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 1-29-97

NAME	REPRESENTING
Steve Montgomery	MCI
Susan M. Baker	Hein + Weir
Rick [illegible]	Health Midwest
Michelle Peterson	Peterson Public Affairs
Janice Nelson Kimball	KU Grad / Menningers
Meg Henson	KMS
Carl Schmitthenner	Kansas Dental Assn.
Pam McCullough DDS	Dentist
D. Wayne Thompson	KDA-Dentist
TAYLOR L. MARKLE	DENTIST
David Hanzlick	KS Dental Ass'n
Ricky D. Smith	Dentist
Callie Jill Denton	Kathy Peterson & Assoc.

Statement by:
Biagio Pagano
Kansas Public Health Association
Before the Senate Committee on Public Health and Welfare
January 29, 1997

Chairman Praeger and members of the Committee, my name is Biagio Pagano. I am here today representing the Kansas Public Health Association, a statewide association of health professionals, public health practitioners and others who are committed to maintaining and improving the health of Kansans through the method of public health.

I am here today to respectfully request introduction by this Committee of legislation that will improve health, save tax dollars, and reduce the amount of pain experienced by Kansans of all ages. I am talking about bringing the benefits of adequately fluoridated water to all Kansans who are served by public water systems.

Currently, nearly one million Kansans use public water systems that are not fluoridated. This fact represents a major public health failure in Kansas.

Community water fluoridation has been in use for more than fifty years. It has been shown to reduce cavities by up to forty to sixty percent in children and by up to 15 to 35 percent in adults. This reduction in tooth decay costs just $0.52 per person per year. It is estimated that every $1 spent to fluoridate communities will save the public $82 in treatment costs. Moreover, the cost of fluoridating communities is generally very small in relation to a city's water department budget.

It is time, we believe, to bring the proven benefits of community water fluoridation to all Kansans who are served by public water systems.

I appreciate your consideration of this important public health legislation. I would be pleased to answer any questions you might have. Thank you.

Session of 1996

SENATE BILL No. 681

By Committee on Public Health and Welfare

2-13

AN ACT concerning public water supply systems; requiring the addition of fluorides; amending K.S.A. 65-171m and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 65-171m is hereby amended to read as follows: 65-171m. The secretary of health and environment shall adopt rules and regulations for the implementation of K.S.A. 65-162a, 65-163, 65-163a, 65-170b and 65-171m et seq., and amendments thereto. In addition to procedural rules and regulations, the secretary may adopt rules and regulations providing for but not limited to: (a) Primary drinking water standards applicable to all public water supply systems in the state. The primary drinking water standards may (1) identify contaminants which may have an adverse effect on the health of persons; (2) specify for each contaminant either a maximum contaminant level that is acceptable in water for human consumption, if it is economically and technologically feasible to ascertain the level of such contaminant in water in public water supply systems; or the treatment techniques or methods which lead to a reduction of the level of the contaminant sufficient to protect the public health, if it is not economically or technologically feasible to ascertain the level of the contaminant in the water in the public water supply system; ~~and (b) establish the~~ *(b) the establishment of* requirements for adequate monitoring, maintenance of records and submission of reports, sampling and analysis of water, citing criteria and review and inspections to insure compliance with the contaminant levels or methods of treatment and to insure proper operation and maintenance of the public water supply system; and (c) the definition of different categories of public water supply systems such as community water supply systems and noncommunity water supply systems and may provide for varying requirements for monitoring, maintenance of records and reporting, sampling and analysis of water, citing criteria, and review and inspections based on numbers of persons served, source of supply whether surface or groundwater or other conditions as the secretary may determine to be in the interest of public health and welfare and economic benefits.

The standards established under this section shall be at least as stringent as the national primary drinking water regulations adopted under public law 93-523. ~~No primary drinking water standard or rule and regulation may require the addition of fluorides to public water supplies.~~

New Sec. 2. (a) In order to promote public health through the protection and maintenance of dental health, the secretary of health and environment shall adopt rules and regulations requiring fluoridation of all community public water systems where natural fluoride levels are less than the minimum level necessary to protect and maintain dental health. All public water supply systems required to fluoridate their drinking water, shall do so no later than July 1, 2001. Upon request by the public water supply system, the Kansas department of health and environment may offer technical assistance and training on system installation, operation and funding.

(b) The rules and regulations shall include, but not be limited to, the following:

(1) The minimum level of natural fluoride to be provided by a public water supply system to be exempted from the requirement to install fluoridation equipment.

(2) Minimum and maximum permissible concentrations of fluoride to be maintained by fluoridation of public water supply systems.

(3) Requirements and procedures for maintaining proper concentrations of fluoride, including equipment, testing, recordkeeping and reporting.

(4) Requirements for the addition of fluorides to public water supply systems where the natural level of fluorides is less than the minimum level specified in the regulations for exemption from fluoridation requirements.

Sec. 3. K.S.A. 65-171m is hereby repealed.

Sec. 4. This act shall take effect and be in force from and after its publication in the statute book.

KANSAS ASSOCIATION OF
HOMES AND SERVICES FOR THE AGING

MEMORANDUM

TO: Senator Sandy Praeger, Chair, and
Members of the Senate Public Health and Welfare Committee

FROM: Debra Zehr, Vice President, Policy and Education

RE: Request for Bill Introduction to amend K.S.A. 39-923

DATE: January 29, 1997

Thank you Madam Chair, and Members of the Committee. The Kansas Association of Homes and Services for the Aging is a not-for-profit assocaition which represents over 150 not-for-profit long-term health care, housing, and community service providers throughout the state.

Senate Bill 8, passed by the 1995 Kansas Legislature and supported by KAHSA, expanded the settings in which older Kansans can receive nursing care and other less intensive services. K.S.A. 39-923, the resulting statute, created assisted living, residential health care, and other new licensure categories.

Today I respectfully request that the Committee introduce legislation to address the following concerns expressed by our membership related to K.S.A. 39-923:

1. K.S.A. 39-923 requires that a facility convert an entire wing or floor to residential health care or assisted living. Many nursing facilities, especially in rural areas, that are considering conversion to assisted living/residential health care report that this provision is a major barrier.

KAHSA recommendations: **A facility may designate a contiguous section of a wing or floor of an existing facility as residential health care. A facility with less than 60 beds may convert less than 6 beds to residential health care, with the beds being clustered together in a contiguous section of the facility.**

2. Existing nursing facilities that are changing licensure categories must provide private bathing facilities in a minimum of 20% of individual living units. KAHSA members wishing to convert older construction to residential health care report that installation of private bathing will add significant costs.

KAHSA recommendation: **Facilities in existence at the time of enactment of Senate Bill 8 will be exempt from providing private bathing facilities in a minimum of 20% of the individual living units.**

3. Assisted living/residential health care operators are charged with oversight of care and services for residents with complex needs. Our members have serious concerns about the minimal education and experience requirements for operators of these facilities (i.e. completion of a 21 hour course and passing a test.)

KAHSA recommendation: **The operator must be a licensed nursing home administrator, or have 60 hours of college credit, or have five years of experience in a health care field and a 40 hour field placement, and complete 60 hours of continuing education every two years. In addition, operators will be accountable to the Board of Adult Care Home Administrators.**

Thank you. I would be happy to answer questions at this time.

700 SW HARRISON, SUITE 1106
TOPEKA, KANSAS 66603-3759

Senate Public Health and Welfare
Date: 1-29-97
Attachment No. 2

Remarks by Phyllis Nolan, Chairman, Kansas Board of Regents
Re: Proposed Changes in KU Hospital Governance
January 29, 1997

Good morning/afternoon, I am Phyllis Nolan, Chairman of the Kansas Board of Regents. Regent John Hiebert and I are here with representatives of the University of Kansas and the Lash Group consultants to discuss with the Committee the need to change the ownership/governance structure of the University of Kansas Hospital to respond to the rapidly changing health care market. Much of the impetus for the proposal you will hear comes from the 1994 Arthur Andersen Consulting study of the Hospital, which was requested by the Legislature and commissioned by the Board of Regents. Andersen's recommendations were clear and specific. The Hospital needed to take specific steps to remain viable in the evolving medical environment. When Chancellor Bob Hemenway was hired two years ago, he was given three charges, one of which was to determine how to position the Hospital to fulfill its mission of providing high quality medical care and training future Kansas medical professionals. The Board asked him to study the issue and come back with recommendations. On January 22, 1997, the Board heard a compelling presentation from the University and the Lash Group, which outlined options for the University of Kansas to maintain its mission.

Senate Public Health and Welfare
Date: 1-29-97
Attachment No. 3

Following considerable discussion, the Board unanimously passed the following motion:

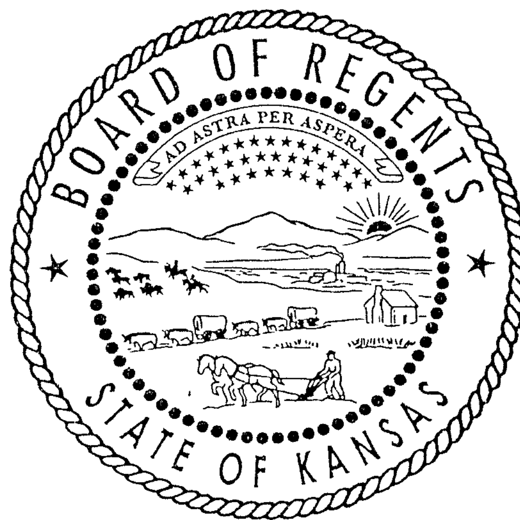
> "That the Board of Regents authorize the Chancellor of the University of Kansas to proceed with the development of legislation to establish a public authority to operate the University of Kansas Hospital, such legislation to include the attributes set forth in the "Report to the Board of Regents, The Need for Ownership/Governance Change at KU Hospital," dated January 22, 1997 and presented to the Board during its meeting [of that date], including alternatives regarding frequency of meetings and method of appointments of [public authority] Board members, and further that the Chancellor provide the proposed legislation to the Board for final approval prior to introduction to the legislature."

The Board is united in its position that the Hospital governance structure must be changed to allow the Hospital to deliver on its mission. The public authority governance structure proposed by the University of Kansas will provide the Hospital the management flexibility to achieve this goal, while continuing to make the Hospital accountable to the State and its citizens.

Because the health care environment is changing so rapidly, the Board and the University believe that enabling legislation should be enacted during this Session. This puts the legislation on a fast track, but it is essential that the Legislature have the opportunity to fully comprehend and carefully consider the proposal in order to make informed decisions on the way the KU Hospital will do business in the future. It is the Board's desire that members of the Legislature hear from the University and the Lash Group as soon as possible and that these presentations serve to initiate dialogue between members of the Legislature and the Board and the University. This will assist the Board and the University in developing the legislation it will propose, pursuant to the Board's action of January 22.

Now I will turn the presentation over to Executive Vice Chancellor Don Hagen.

Senate Public Health and Welfare
Date: 1-29-97
Attachment No. 4



Report to the Board of Regents

The Need for Ownership/Governance Change at KU Hospital

January 22, 1997

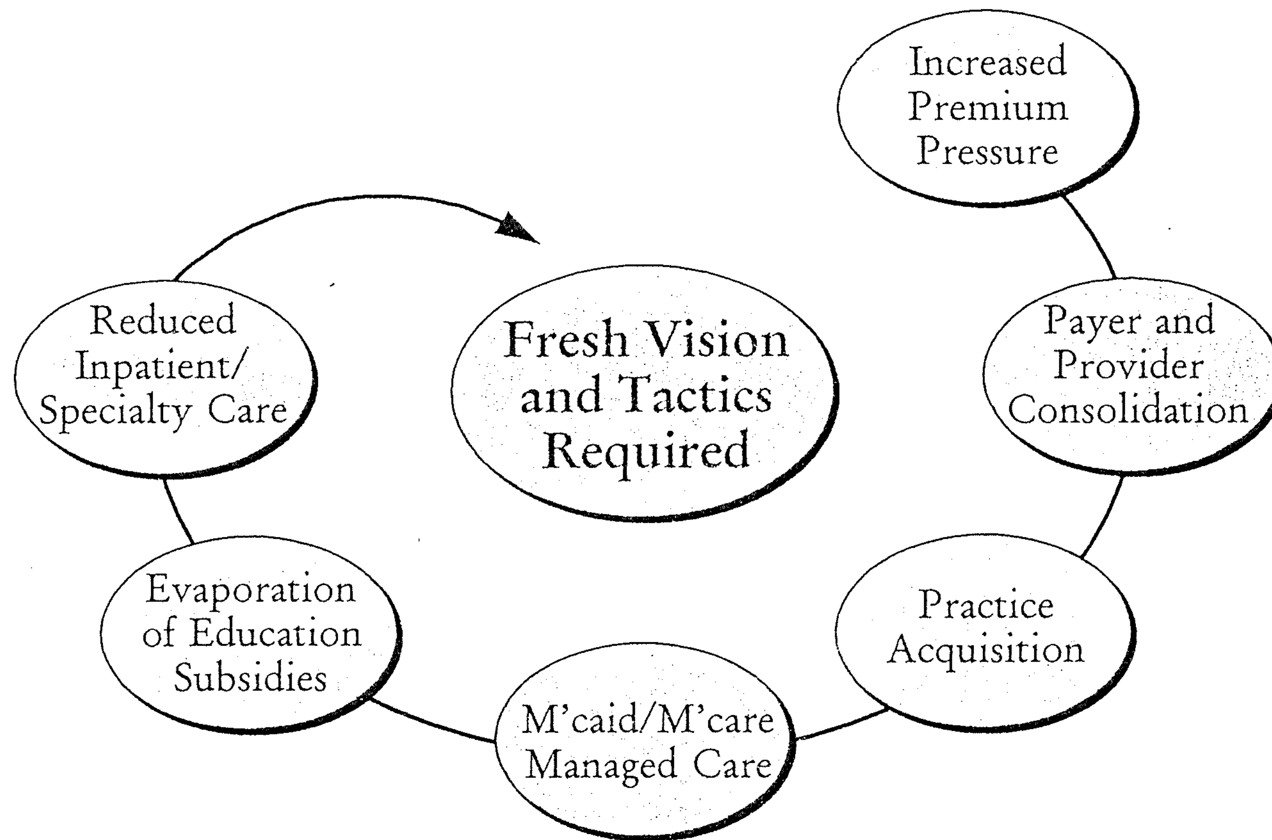
Lash Group

The following report details findings and recommendations from a study conducted by Lash Group and KUMC to address two questions.

- What issues must be addressed or barriers removed to ensure KU Hospital's ability to sustain and enhance its mission effectiveness in service, education, and research in a market increasingly characterized by managed care and heightened levels of competition?

- What ownership/governance structure best enables KUMC to serve the health related education and research needs and interests of the citizens of Kansas and maintain an economically viable clinical enterprise?

Health care continues its transformation to a market driven industry.



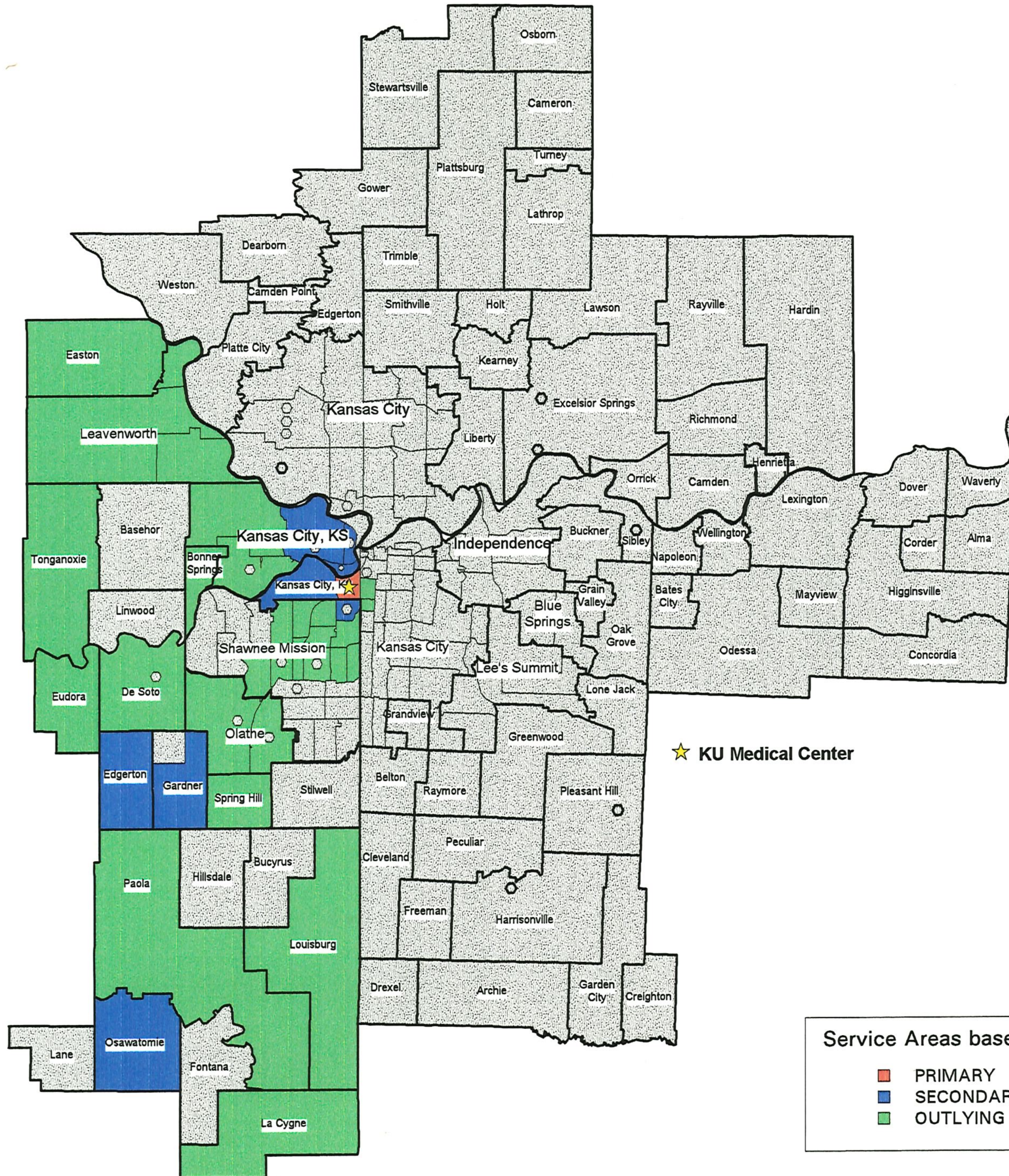
Source: University HealthSystem Consortium

Using UHC's staging model, Kansas City has evolved into an early Stage III managed care market.

Stages	Stage I	Stage II	Stage III	Stage IV
	Unstructured	Loose Framework	Consolidation	Managed Competition
Characteristics	Independent hospitals, physicians, employers, and HMOs	Lead HMOs or PPOs emerge, loose provider networks and weak hospital affiliations form Excess inpatient capacity develops Hospital discounts widen	Lead HMOs or PPOs achieve critical mass, begin to consolidate; hospital systems form; all aggressively recruit/compete for primary care group practices Selective contracting by major purchasers Development of large multi-specialty, primary care, and IPA groups Specialist practices under-utilized; discounts increase Beds close, hospital profits increase	Purchasers contract with integrated hospital/physician systems to provide comprehensive services to their beneficiaries Financial risk shifts to primary medical groups/provider networks Beneficiaries have strong incentives to use contract network (extensive channeling) Capitation model becomes prevalent
Pricing	Fee for service (FFS)	Discount, per diem	Per diem, per case, physician capitation	Stage III plus capitation
Basis for Healthcare Purchasing	Encounter, cost of claim Volume	Encounter, cost of claim	Cost per covered life per health plan	Beneficiary health status, total healthcare costs

So: *Jniversity HealthSystem Consortium (UHC); Future stages still in development.*

KU Medical Center Service Area



Service Areas based on Market Share by Zip

PRIMARY	30% or more	(1)
SECONDARY	15% to 29.9%	(9)
OUTLYING	5% to 14.9%	(30)

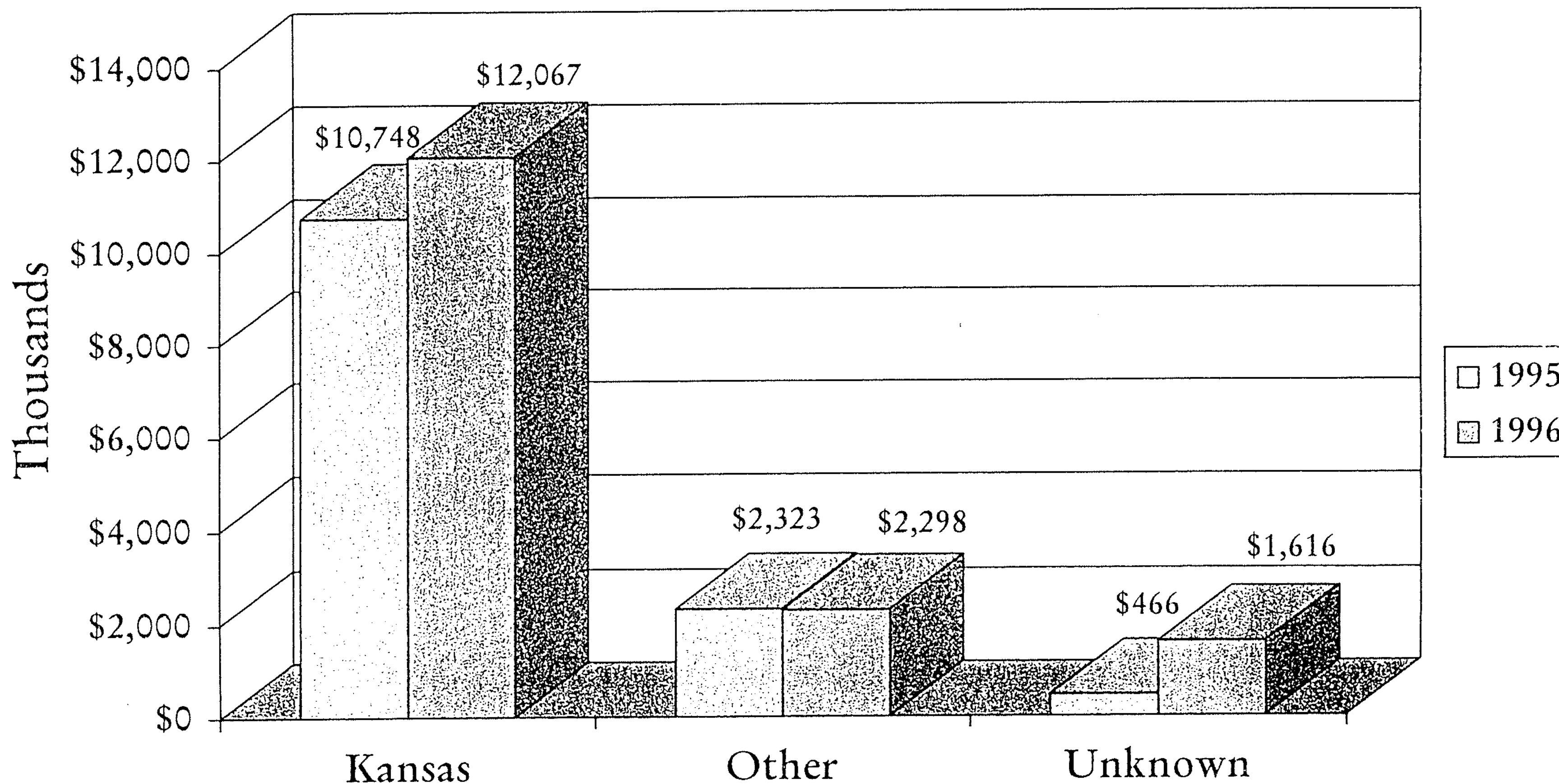
Business & Strategic Development 8/96

Lack of provider linkages and modest geographic coverage pose serious threats to KU Hospital and KUMC physicians.

Buchanan
Caldwell
Clinton
Atchison
St. Luke's/Shawnee
Jackson
Pottawatomie
Platte
Ray
Clay
Health Midwest
Jefferson
Leavenworth
Wyandotte
Shawnee
Health Midwest
Jackson
Lafayette
Wabaunsee
Douglas
Johnson
St. Luke's /Shawnee
Johnson
orris
Osage
Cass
Franklin
Miami
Lyon
Henry
Chase
Coffey
Anderson
Linn
Bates

4-7

Over the past two years, KU Hospital had a total of 2,221 uninsured inpatient cases from 46 counties in Kansas, with write-offs totaling $22.7 million.*



* Based on gross charges. KU Hospital's overall cost-to-charge ratio approximates 60%.

4-8

As managed care penetration increases, pressure to reduce inpatient utilization will intensify.

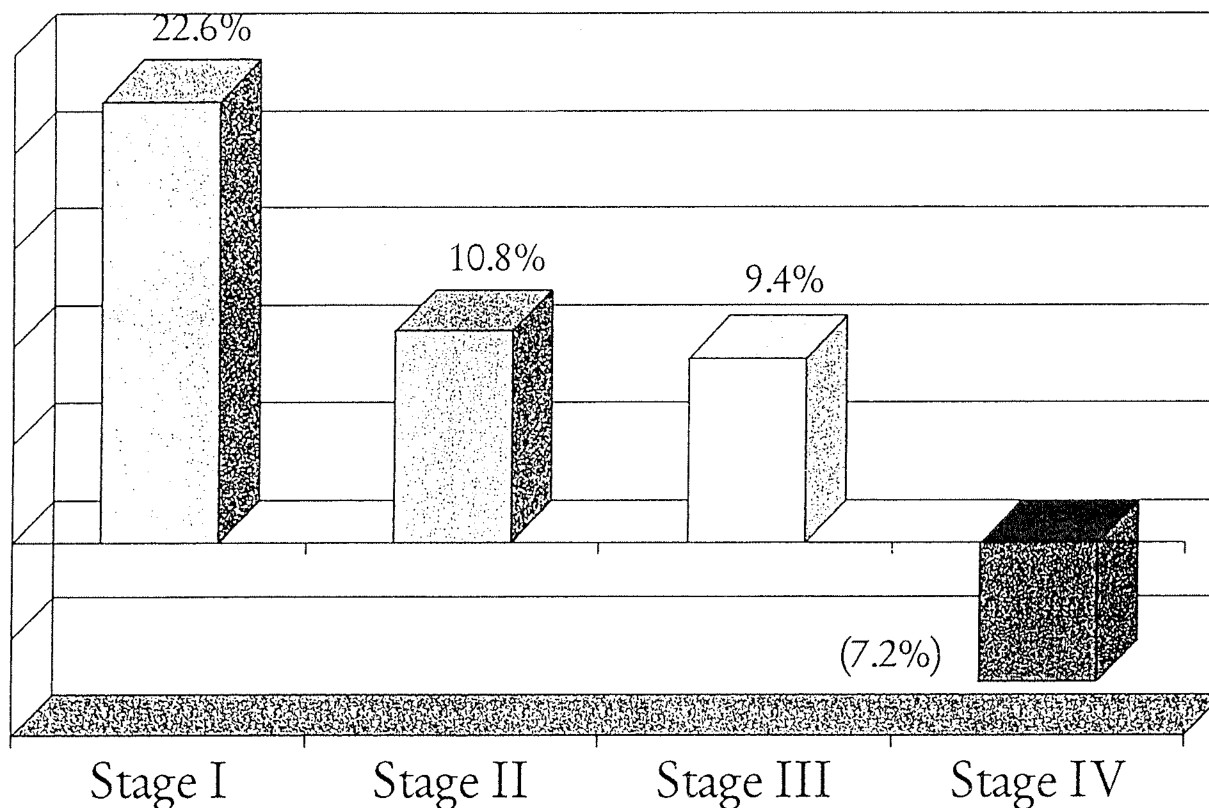
Comparison of Selected Market Characteristics by Stage

Location	Market Stage[1]	Hospital Days/ 1000 Population[2]	Beds/ 1000 Population[3]
Little Rock	II	1258.2	5.4
Indianapolis	III	992.5	3.8
Kansas City	III	818.0	3.9
Denver	IV	545.7	2.4
Tucson	IV	583.9	2.5
Minneapolis	IV	597.9	2.5
Portland	IV	469.4	1.9

Source: [1] *UHC*
[2] *The Competitive Edge, Part III: Regional Market Analysis*
[3] *1995/96 Hospital Stat: Emerging Trends in Hospitals*

4-9

Declining inpatient use and deep price discounts have a significant impact on revenue potential in late stage markets.

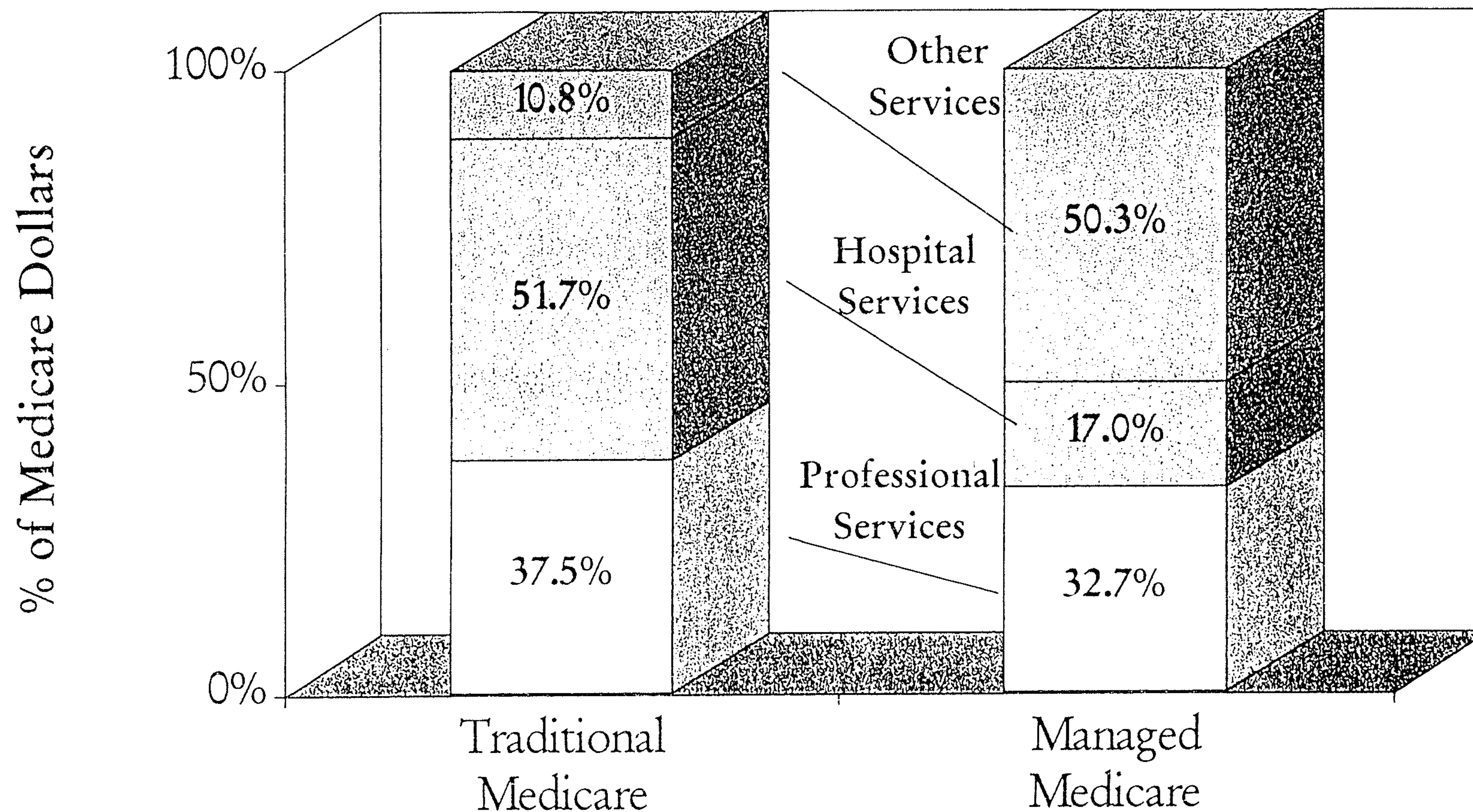


Note: Does not reflect future changes in funding for government programs

Source: HCIA, UHC Financial Database

4-10

Inpatient revenue will be further constrained as Medicare and other government payers shift to risk contracting.

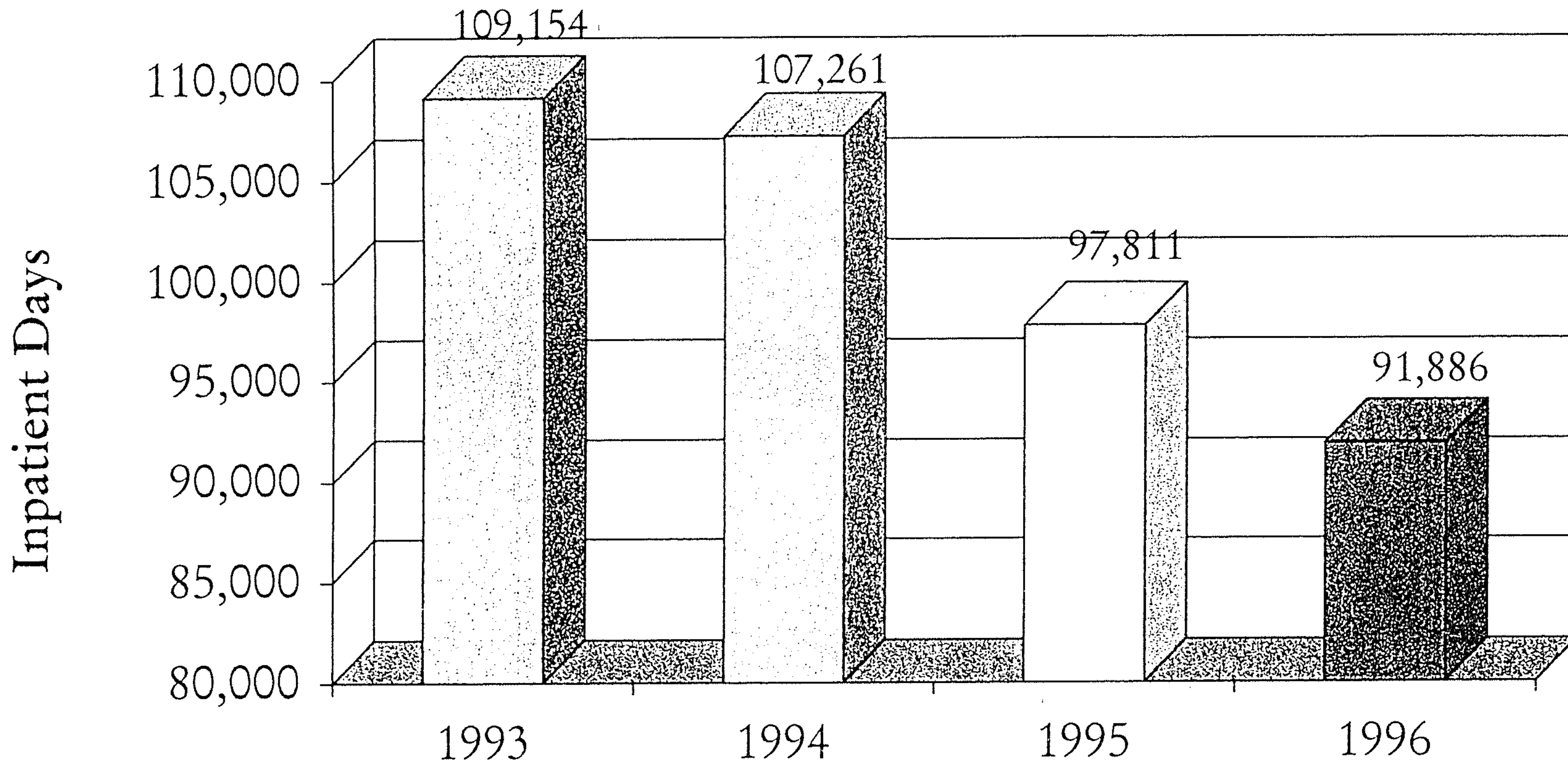


Whole dollar expenditures are greater with traditional Medicare.

Source: Stanford Health Services Model, UHC

4-11

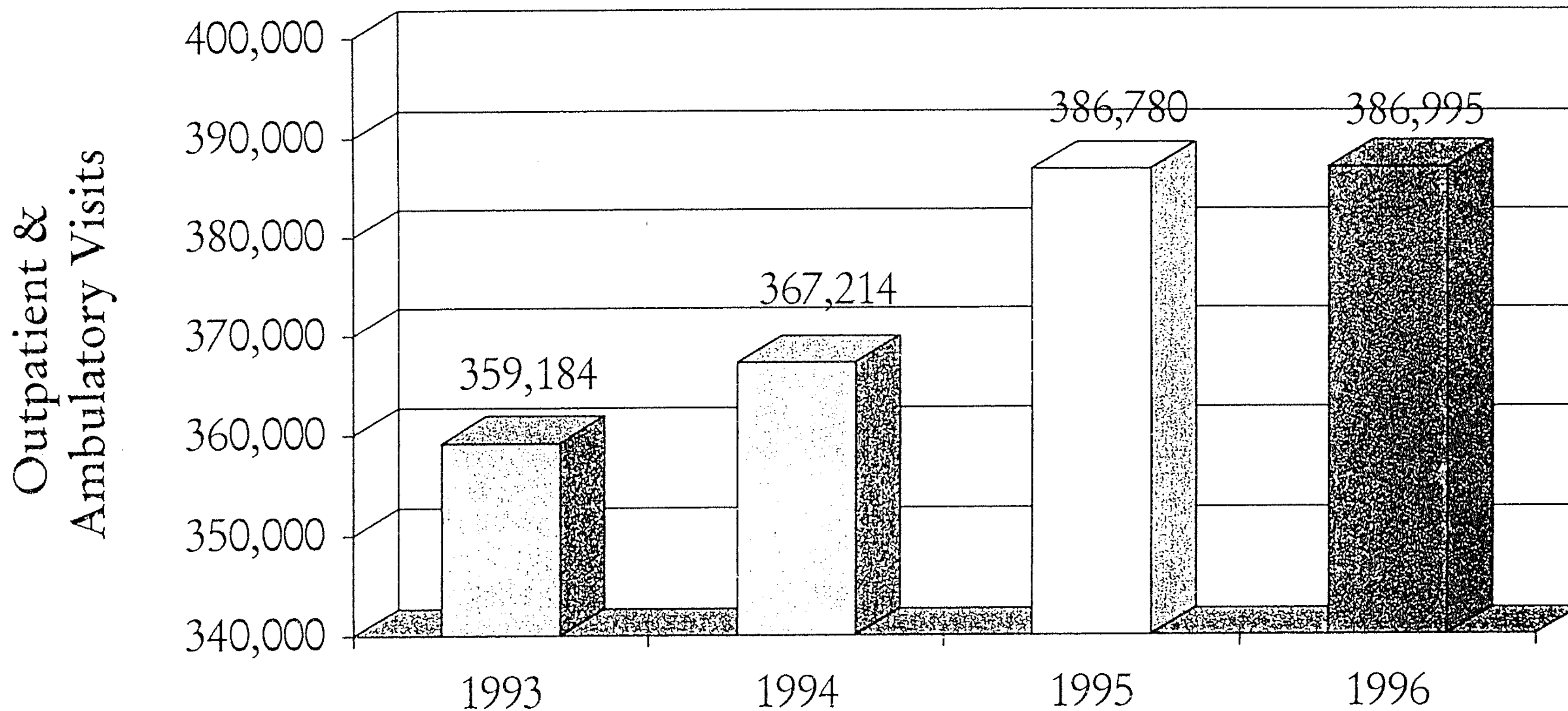
Declining admissions and length of stay have combined to significantly reduce KU Hospital's inpatient utilization.



Source: Hospital Statistics, 1993-1996 fiscal year

KU Hospital's outpatient utilization has grown, but has not off-set revenue losses from reduced inpatient activity.

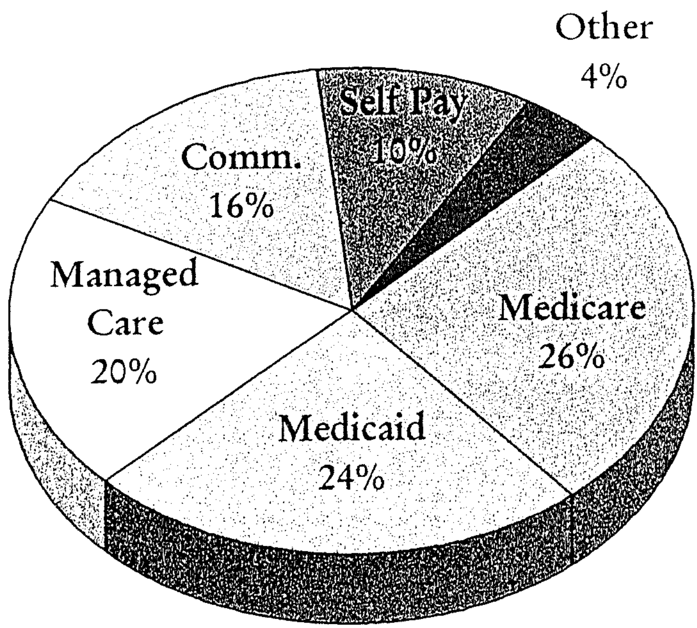
4-12

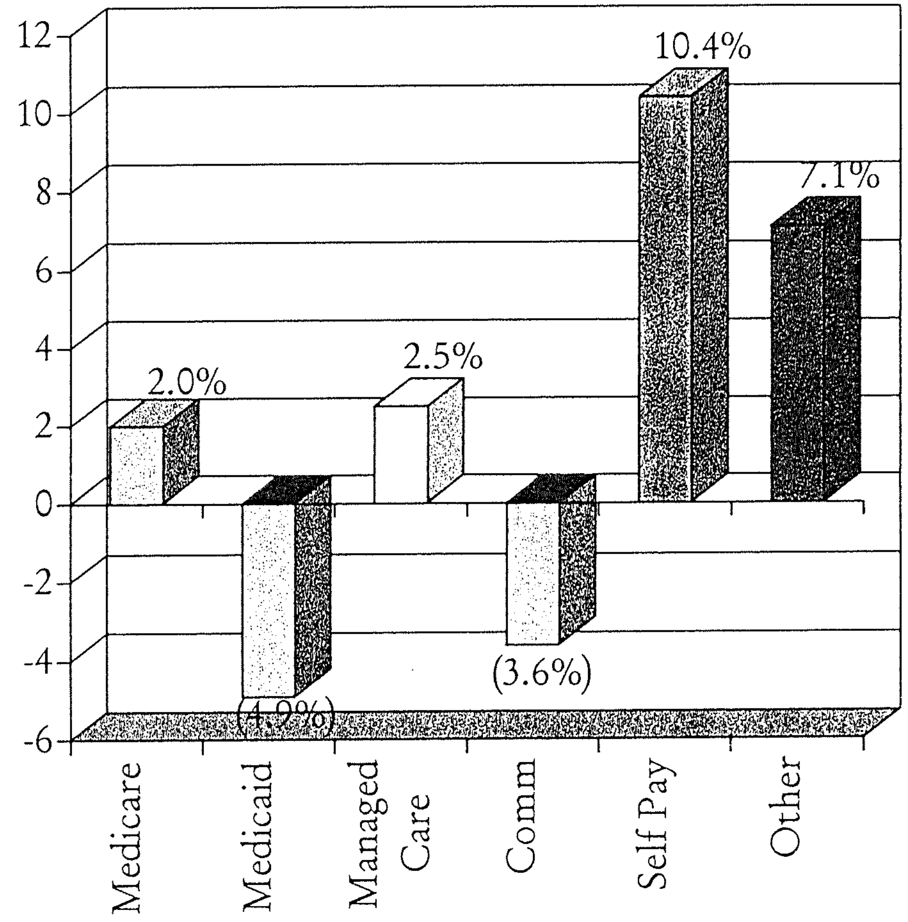


Source: Hospital Statistics, 1993-1996 fiscal year

4-13

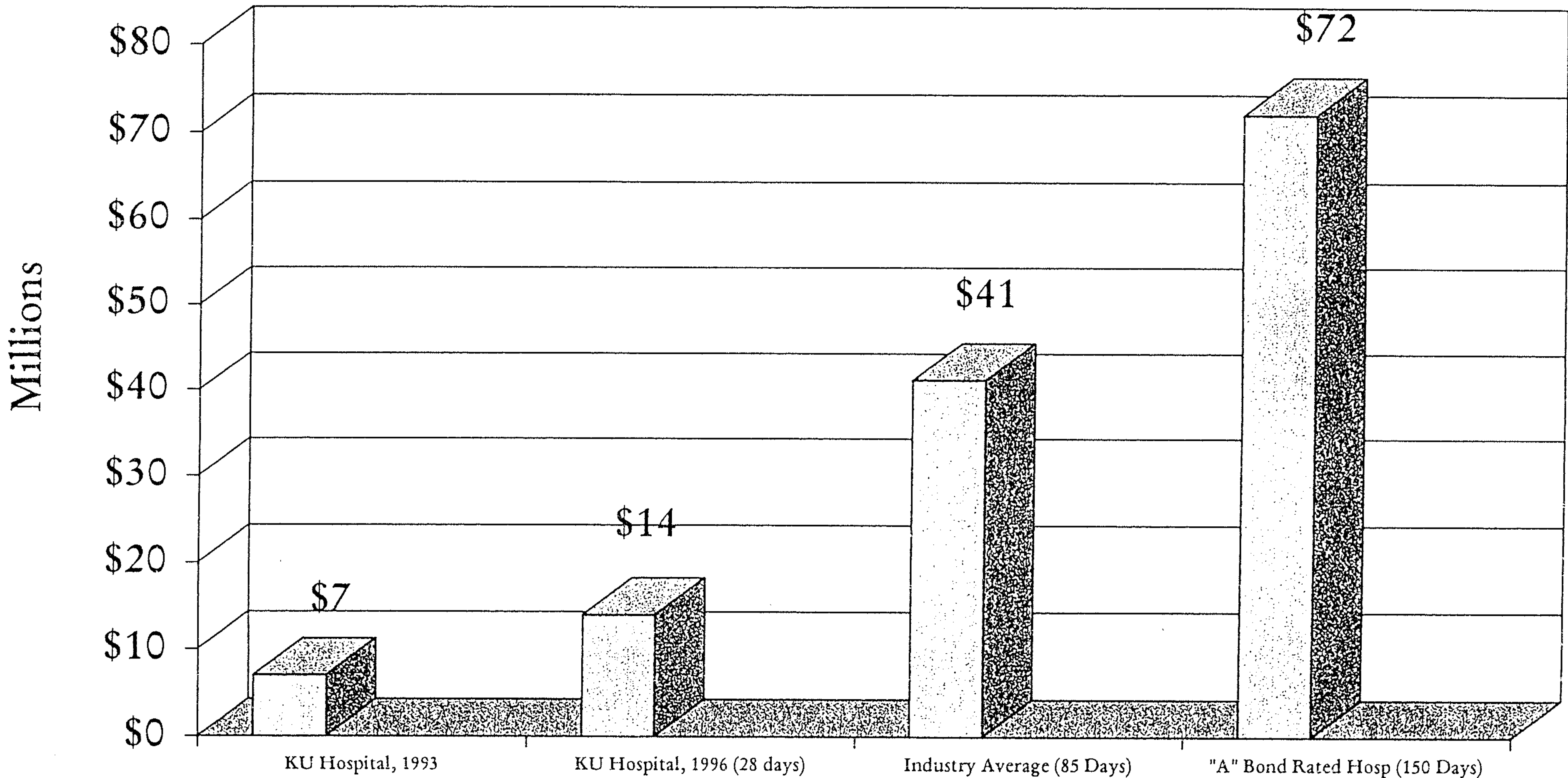
The shift in KU Hospital's payer mix from Medicaid and commercial to managed care and self pay continues to reduce reimbursement.





Source: Hospital Statistics, 1993-1996

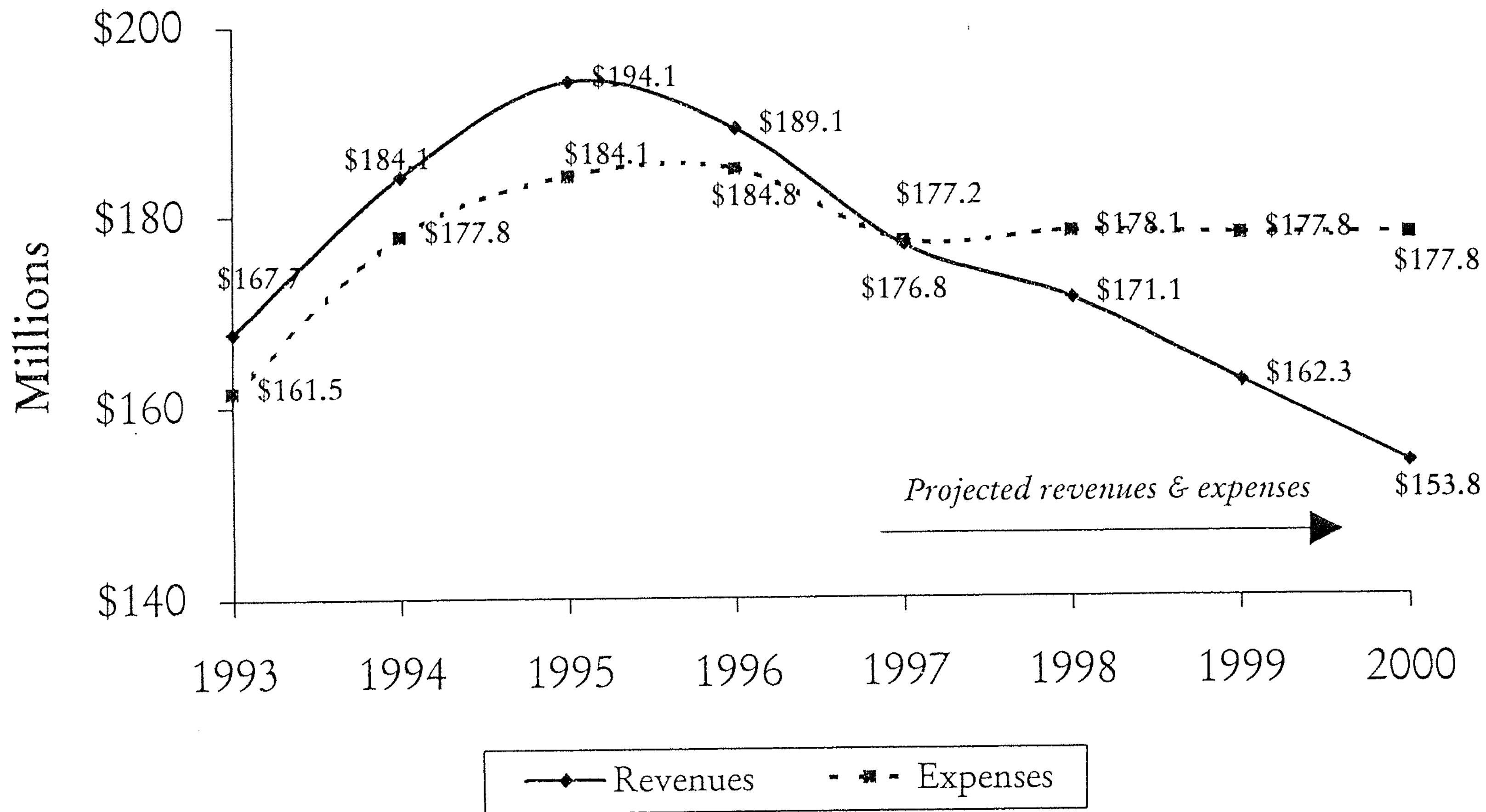
Since 1993, KU Hospital has generated cumulative margins of over $26 million, but available cash balances have increased only $7 million. This balance falls well below industry and "A" bond rated hospital averages.



Source: *Hospital Statistics, 1993 - 1996*
The Center for Healthcare Industry Performance Studies (CHIPS)
Moody's Inventors Services

5-15

Projected baseline operating losses are substantial and cannot be reversed without significant market share growth and cost reduction initiatives.



Source: Hospital Statistics, 1993-1996
KU Hospital and Lash Group Projections

4-16

Over the past decade legislators have responded to KU Hospital's request for regulatory relief to address changing market conditions.

Legislative Change	Year	Relief Granted	Impact
Authority to move any classified position to unclassified status.	1980	Hospital unclassified positions in order to address salary constraints	Limited use because no funds were provided to offset expenses associated with benefits, retirement, and salary.
State established separate classifications for nursing personnel.	Early 1980's	Medical Center Nurse positions established with slightly higher salaries than at other state agencies	Provided short term relief - KUMC was not able to address continued escalation in salaries.
Authority to establish Health Care Employee category with unclassified service.	1989	Achieved salary freedom from state civil service pay structure while retaining benefits of classified employees	Hospital has taken advantage of opportunities available to reclassify employees into this category.
Removed expenditure limit from Hospital Revenue Fund.	1990	Hospital expenditures not limited by State appropriation	Hospital able to adjust its budget to support program needs subject to availability of adequate hospital revenue.
Granted KU Hospital authority to negotiate, enter into contracts and leases for purposes of affiliation, joint ventures, partnerships, and equity ownerships with other health care providers and third parties for purposes of providing medical services or partricipation in medical networks. *	1995 SB 171	Exempted such ventures from state purchasing statutes	Ventures subject to Board of Regents approval. Hospital used this authority to develop Jayhawk Primary Care.

ıthority for change initially granted through proviso and later made statutory

4-17

Regulatory relief (continued)

Legislative Change	Year	Relief Granted	Impact
Exemption from state purchasing approval for all acquisitions of data processing hardware or software by KUMC for KU Hospital. *	1995 SB 170	Allows sole source acquisition.	Requires medical center to file plan for future acquisitions with Director of Purchases. SMS contract negotiated under this exemption.
Authority to enter into contracts to lease and operate off campus medical care facilities. *	1995 SB 173	Leases not subject to state purchasing statutes or approval of Secretary of Administration.	
Authority to make direct purchases for goods and services in amounts up to $25,000 for any individual purchase.	1995 SB 174		Not very effective because very few purchases are between $10,000 and $25,000.
Authority to enter into contracts with consortiums of health care providers and other purchasing groups for acquisition of supplies and other materials.	1995 SB 174	Enabled hospital to go into contract with UHC.	
Authority to make expenditures for renovations, remodeling, or improvements to existing hospital physical plant from Hospital Reserve Fund.	1995 Proviso to Appropriation Bill on Hospital Reserve Fund	Able to expend moneys for capital improvements without a specific appropriation and allowed to make capital expenditures from general operating appropriations.	Subject to approval of Board of Regents and Department of Administration, expenditures must be presented to Joint Legislative Committee on State Building Construction.

* Authority for change initially granted through proviso and later made statutory

Source: Correspondence from KUMC 9/25/96

4-18

Regulatory barriers remain, however, and continue to threaten KU Hospital by reducing its ability to rapidly develop and implement strategic initiatives.

Industry experts note that government owned teaching hospitals require greater management flexibility in five areas to address market conditions. KU Hospital lacks management flexibility and decision making autonomy in four of the five areas.

- [x] Capital financing and acquisition strategies
- [x] Human resources management
- [x] Procurement practices
- [x] Information system development
- [ ] Managed care contracting

Source: The Webb Associates/Arthur Andersen, 1994

4/19

Regulation intended to ensure fair business practices and to protect public assets has a number of unintended consequences within KU Hospital.

Internal - Operational inefficiencies

- Lack of flexibility to manage personnel for maximum productivity
- Constrained development of state-of-the-art administrative and support services
- Service delays, interruptions, and re-work which negatively affect clinical service delivery and increase operating costs
- Inter-departmental conflict over customer service priorities -- internal (hospital) versus external (state)

External - Limited attractiveness as a potential business partner

- High fixed administrative and personnel costs
- Complex and time consuming decision making processes
- Limited access to capital
- Limited debt management capacity
- Increased costs of running dual accounting systems to meet state and Medicare requirements (cost based and accrual)
- Outdated and labor intensive procurement practices

4-20

In summary, KU Hospital must overcome a significant number of vulnerabilities to sustain mission effectiveness under new market conditions.

- **Vulnerability 1 - No defined linkage strategy**

  Providers are rapidly consolidating in the Kansas City market. The absence of a strategic partnership places KU Hospital in an "at risk" position.

- **Vulnerability 2 - Lack of service differentiation**

  KU Hospital is not perceived to be strongly differentiated in the market by unique services or by quality of care delivery. This perceived lack of differentiation limits the hospital's negotiating leverage with payers.

- **Vulnerability 3 - Declining admissions/minimal outpatient growth**

  Changing market dynamics will likely contribute to a material erosion of KU Hospital's inpatient utilization to below break-even levels.

- **Vulnerability 4 - Shifting payment mechanisms**

  Growth of managed care and risk based contracts has shifted payment from fee for service to fixed payments. Aggressive negotiations are reducing already dangerously narrow margins at many teaching hospitals.

4-21

Vulnerabilities (continued)

- **Vulnerability 5 - Eroding subsidies for education**

  Historical income sources for the cross-subsidization of education and research from patient care revenues are eroding.

- **Vulnerability 6 - Inadequate funding for charity care**

  KU Hospital receives no state support for uncompensated care for indigent patients. The hospital's ability to support this important part of its teaching and service mission is becoming endangered.

- **Vulnerability 7 - Limited cash reserves**

  KU Hospital cannot close projected revenue gaps through expense management alone. KU Hospital must be able to obtain the capital, either internal or external, necessary to make investments needed to increase market share and develop clinical initiatives that provide service differentiation.

- **Vulnerability 8 - Limited management flexibility and decision autonomy**

  KU Hospital is subject to a significant degree of state government oversight of all aspects of its operation, limiting managerial autonomy in a market that demands rapid decision making.

Vulnerabilities (continued)

- **Vulnerability 9 - Lack of timely access to capital**

  KU Hospital must receive legislative approval for bond indebtedness. Competitors are able to access the same debt markets using the same conduit - Kansas Development Finance Authority (KDFA) - without incurring the time required for legislative approval.

- **Vulnerability 10 - Limited attractiveness to potential business partners**

  Private sector providers are unlikely to partner with an institution whose strategic agenda and operating practices are constrained by a high degree of regulatory control.

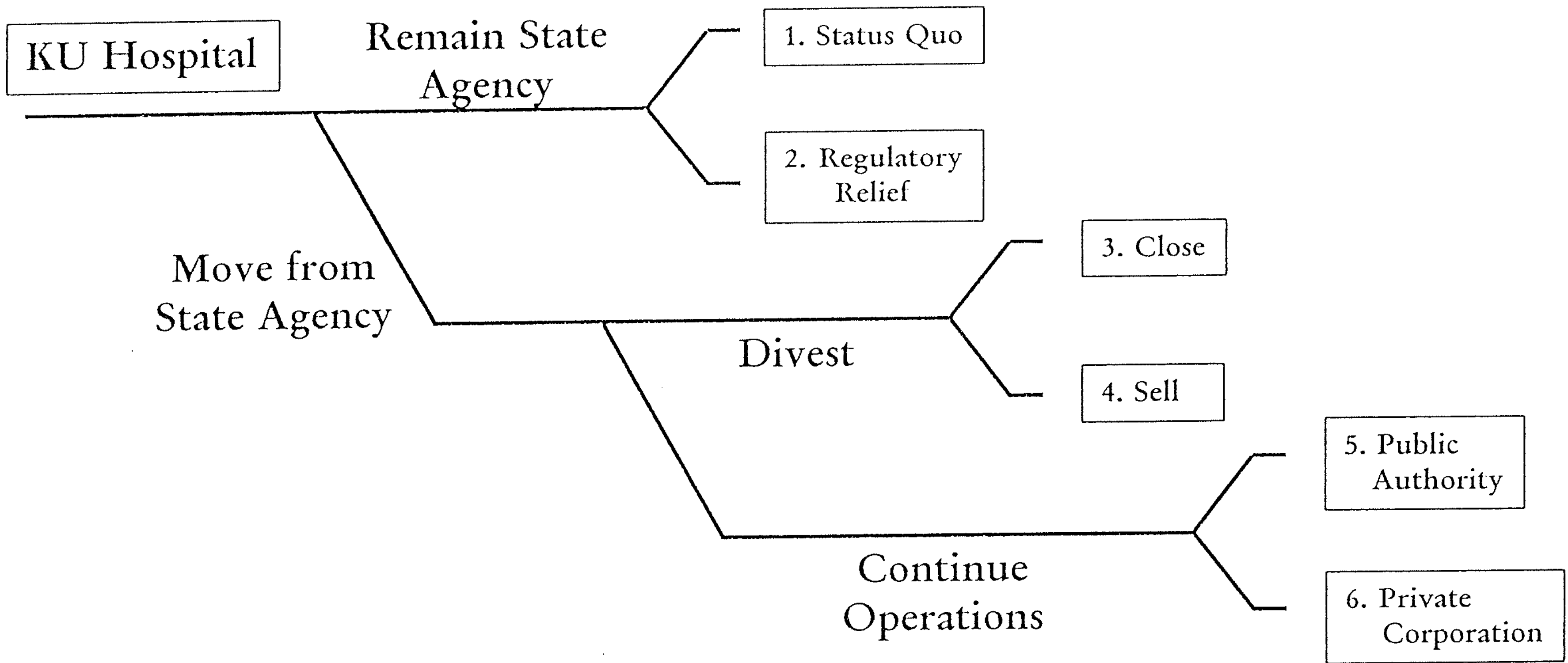
- **Vulnerability 11 - Inefficient and costly operating practices**

  State regulations and administrative practices add complexity and cost to department operations as compared to private sector operations, resulting in inefficient use of scarce resources and poor internal customer satisfaction.

- **Vulnerability 12 - Reduced innovation**

  Introducing cost saving innovations in departments with a high degree of state oversight is difficult and time consuming. State regulation establishes an organizational climate in which managers believe they have little ability to "think outside the box", resulting in status quo operations in a rapidly changing industry.

Six change options grouped in three categories are typically considered.



4-24

Six teaching hospitals operating under differing ownership/governance models were studied to gain insight into model attributes and their impact on organizational performance.

- University of Arkansas -- regulatory relief model
- Indiana University Hospitals-- divestiture (merger)
- University of Minnesota -- divestiture (sale)
- University of Colorado Hospital -- public authority
- Oregon Health Sciences University -- public authority
- University of Arizona Health Sciences Center -- private corporation

4-25

Market conditions for each study site varied but those in more advanced managed care markets instituted ownership/ governance change in response to current or anticipated economic pressures.

Market	% HMO Enrollment[1]	Average Length of Stay[1]	Admits/ 1000 pop.[2]	Hospital Days/ 1000 pop.[1]	Beds/ 1000 pop.[2]	Primary Care Physicians/ 1000 pop.[3]	Specialist Physicians/ 1000 pop.[3]
Little Rock	13.6	7.0	179.9	1258.2	5.4	1.6	2.7
Indianapolis	16.6	6.6	150.4	992.5	3.8	1.1	1.5
Kansas City	**20.9**	**7.1**	**115.2**	**818.0**	**3.9**	**1.0**	**1.3**
Denver	27.4	5.6	97.4	545.7	2.4	1.0	1.4
Portland	41.8	4.9	95.8	469.4	1.9	0.9	1.4
Minneapolis	39.4	6.3	104.1	597.9	2.5	0.77	0.96
Tuscon	42.0	5.1	114.5	583.9	2.5	1.2	1.6
Group Average	**28.81**	**6.09**	**122.47**	**752.23**	**3.2**	**1.08**	**1.55**

[1] Source: The InterStudy Competitive Edge, Part III: Regional Market Analysis
[2] Source: 1995/96 Hospital Stat: Emerging Trends in Hospitals
[3] Source: Claritas, Inc: 1995 MEDEC Physician List and Database -- includes FPs, GPs, Internists, OB/GYNs, and Peds; Minnesota Medical Association
(NOTE: data is not case mix adjusted)

4-26

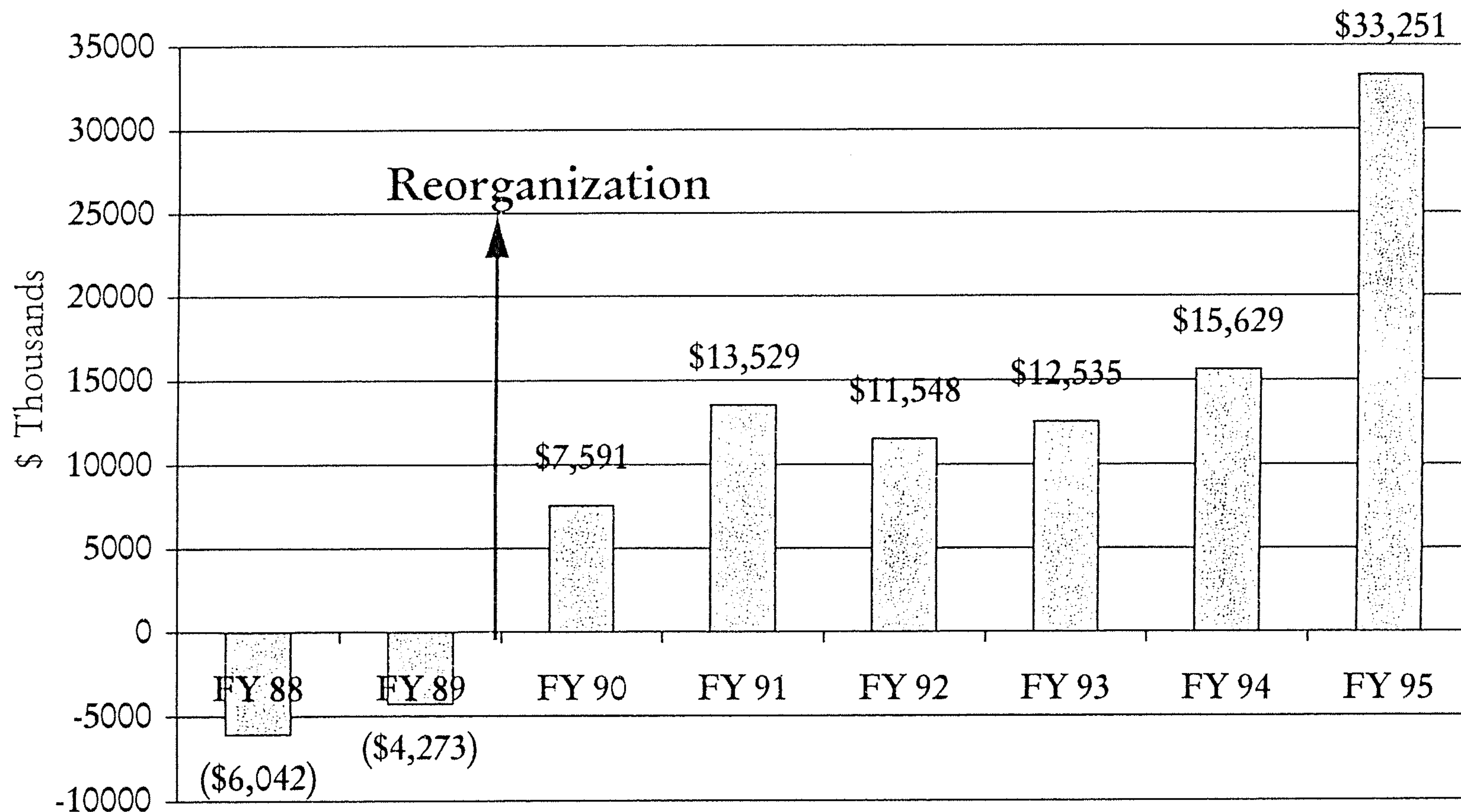
Several consistent themes emerged from the case studies.

- Two factors drove the decision for change in nearly all settings:
  - Inadequate access to capital to invest in programs
  - Inability to respond to market conditions in a timely manner
- Conversion to a new structure resulted in significantly greater managerial autonomy, but all states retained some degree of reserve power.
- Hospital performance improvements were swift and sustained.
- The change process required consensus building which took time, attention, and patience from all organizational leaders.

4-27

UH net income has been positive every year since the reorganization.

Net losses prior to the reorganization have turned to substantial net income.



Public Authority Advantages

- Meets identified goals for an ownership/governance change:

  - Sustains mission effectiveness
  - Protects public assets
  - Maintains financial viability for hospital
  - Develops a customer driven culture
  - Enhances management/governance flexibility and timely decision making
  - Supports ease of implementation