MINUTES
JOINT MEETING
DURHAM COUNTY HOSPITAL CORPORATION
BOARD OF TRUSTEES
and
DURHAM COUNTY BOARD OF COMMISSIONERS

FEBRUARY 10, 2005

TRUSTEES PRESENT:
MaryAnn E. Black
Robert A. Buchanan, Jr.
Mary T. Champagne, Ph.D.
Lewis A. Cheek
Eugene F. Dauchert, Jr.
Kenneth R. Hammond
Joseph S. Harvard, III
C. Edward McCauley, Chair
Robert E. Price, Jr., M.D.
Evelyn D. Schmidt, M.D.
Ira Q. Smith, M.D.

TRUSTEES ABSENT:
Cedric M. Bright, M.D.
Arnett Coleman, M.D
Exter G. Gilmore, Jr.
Penelope A. Keadey

DCHC ADVISORY BOARD MEMBER PRESENT
William J. Donelan, Executive Vice President & COO, DUHS
Charles E. Murphy, M.D. Medical Staff President, DRH

DCHC ADVISORY BOARD MEMBER ABSENT
None

COMMISSIONERS PRESENT
Lewis A. Cheek
Becky M. Heron
Michael D. Page
Ellen W. Reckhow, Chairman

COMMISSIONERS ABSENT
Philip R. Cousin, Jr.

OTHERS PRESENT:
Susan W. Avent, Interim Chief Nursing Officer, DRH
Ernest J. Baptiste, Chief Operating Officer, DRH
Deborah Craig-Ray, Director-Public Information, Durham County
John L. Crill, Attorney, Wyrick-Robbins-Yates-Ponton, LLP and DCHC Counsel
Don Dalton, Vice President-Public Relations, NCHA
G. Gregory Damron, Chief Financial Officer, DRH
Wendell M. Davis, Deputy Durham County Manager
Victor J. Dzau, Chief Executive Officer, DUHS
Jean Fisher, Reporter, *News & Observer*
Kathleen B. Galbraith, Director, Marketing and Corporate Communications, DRH
S. C. Kitchen, Durham County Attorney
Mary E. Kritsch, Administrative Assistant to the CEO, DRH and Assistant Secretary, DCHC
Edward N. LaMay, M.D., Chief Medical Officer, DRH
David P. McQuaid, Chief Executive Officer, DRH
William A. Pully, President, NCHA
Michael M. Ruffin, Durham County Manager
Jim Shamp, Reporter, *Herald-Sun*
Pamela M. Sutton-Wallace, Chief of Staff for the Chancellor for Health Affairs, DUHS
Garry E. Umstead, Clerk to the Board of Durham County Commissioners

CALL TO ORDER

Mr. McCauley and Mrs. Reckhow respectively called to order a joint luncheon meeting of the Durham County Board of Trustees and the Board of Durham County Commissioners at 11:10 a.m. on Thursday, February 10, 2005, in the 1st Level Classroom of Durham Regional Hospital (DRH).

WELCOME & INTRODUCTIONS

Mr. McCauley welcomed those in attendance. On behalf of the County, Mrs. Reckhow thanked DCHC for the invitation to get together. Everyone around the table then introduced themselves.

ISSUES IN HEALTHCARE TODAY

Mr. McCauley formally introduced Mr. Pully and Mr. Dalton from the North Carolina Hospital Association and called upon Mr. Pully for an overview of hospital issues including government policy and leadership's opportunity relative to the current healthcare climate. Copies of the slide presentation were made available at each seat, and one is attached to the original set of these minutes.

Mr. Pully first spoke to the national as well as North Carolina challenge of increased costs. The overall demand for healthcare services in this state grew 38% from 1997 to 2002 reaching $40-billion in 2002.

Higher demand—including population growth, an aging population, backlash of managed care easing restrictions on access, and the explosion of technology—are driving expenses ever increasingly higher. Health care costs double after age 65 and double again after age 85. Hospitals' costs are climbing dramatically due to increases in cost to provide care, wages, benefits, pharmaceuticals, and other supplies and services including liability insurance. There are Increased efficiencies yet declining margins.

Labor shortages are driving costs up, and Mr. Pully shared the forecast involving registered nurses. It is anticipated that there will be a shortage of 800,000 nurses by 2020.

Drug spending has soared during the last decade. The cumulative annual percentage change in national spending on prescription drugs from 1991 to 2001 is staggering and continuing to climb.

New devices raise costs. Stents are one example of technology development. Analyst estimates suggest there will be $2.6-billion in coated stent sales next year in the United States.

Liability insurance costs are escalating. High jury awards combined with the aftermath of 9/11/02 are prompting increases as much as 800%. Average malpractice premium increases in the Carolinas for the period of August 2001 – January 2002 were 125%.

While hospitals are very efficient, margins are slipping downward. According to statistics available for 2003, 43% of hospitals experienced a negative margin, 28% functioned at only a 0-5% margin, and 29% operated at a greater than 5% margin.

The reasons for system formulation were reviewed, and Mr. Pully noted that healthcare systems in North Carolina are common. Of the 133 NCHA hospitals, 84 are part of a system.

Uncompensated care provided by hospitals aid communities. A NCHA needs data initiative revealed that in 2003 the total community benefit value was $1.488-billion.

Payer mix comparisons for net patient revenue and for inpatient charges were reviewed and explained. The fact that the percentages are out of balance was highlighted.

Most payments are below cost. North Carolina hospitals are dependent on the commercial private segment. Revenues from this segment must offset losses from government payers and the uninsured. Cuts in Medicaid spending would put more of the payment burden on business and industry. For every dollar Medicaid cuts the NC economy loses $5.40.

The total hospital effect on the NC economy is significantly positive--$30.849-billion. The impact of NC hospitals includes 134,278 jobs, $5.96-billion in payroll, and $5.92-billion in expenditures.

Mr. Pully then shifted to speaking about hospitals' increasing emphasis and focus upon quality and patient safety, how NC hospitals are centering attention on this important subject, and the role the NCHA has assumed in this regard. The purpose of the "100k lives" initiative was explained, and the goal is to make NC hospitals the safest in America. The aim for quality healthcare and patient safety for all and the ways to reach established quality standards were explained. Benefits received as part of a larger effort were reviewed. Mr. Pully then devoted time to addressing the public trust agenda and what local leaders can do including the following:

- encourage insurance carrier(s) to shop for quality not just price
- buy local as much as possible
- encourage representative in Raleigh to:
  - ▹ fully fund the Medicaid program
  - ▹ enact meaningful tort reforms
  - ▹ preserve Certificate of Need law
  - ▹ increase the healthcare workforce
  - ▹ support mental health reform

Mr. Pully fielded and responded to questions. In conclusion Mr. McCauley thanked Mr. Pully for his outstanding presentation, and he also included Mr. Dalton in his words of appreciation for the time both individuals took to participate in this meeting. In turn Mr. Pully praised the efforts of Duke and DRH. In terms of leadership statewide, the NCHA often turns to Durham, and he thanked its healthcare institutions—management and boards—for all of the outstanding work and examples set for others to follow.

VISION FOR THE DUKE UNIVERSITY HEALTH SYSTEM

Dr. Dzau was introduced and called upon for remarks. He began by commenting upon several of the items mentioned by Mr. Pully in his presentation and the implications for the Duke University Health System (DUHS) and its entities.

Dr. Dzau moved on to defining and explaining the scope of what he refers to as Duke Medicine. Duke Medicine has many components—academic entities, major teaching hospital, community hospitals, non-acute care, physician practices and network, community health outreach, and regional specialty outreach.

After providing a brief history of the DUHS, Dr. Dzau spoke to where DUHS is today. It ranges from a world-class specialty center to community care, to home infusion care to hospice care. He then listed the numerous components of the DUHS: Duke University Hospital (DUH), Durham Regional Hospital (DRH), Durham Health Raleigh Hospital (DHRH), Duke University Affiliated Physicians (DUAP), Private Diagnostic Clinic (PDC), Duke Health Community Care (DHCC), and Duke Health Technology Solutions (DHTS).

Dr. Dzau then provided an assessment of what DUHS has achieved and what it has not accomplished. He focused ultimately upon the challenges faced in moving forward. Duke is certainly a leading medical center, a foremost medical school, an outstanding research facility, and an institution which has increased diversity.

DUHS has not yet, though, adequately addressed many of the key issues related to a system such as redundancy/duplication, physician integration, common standards, common information technology and infrastructure, uniform safety standards, and recognition for its impact upon the health status of Durham or active involvement with the community.

The overall challenges ahead for DUHS include the following:

- Funding from NIH, Medicare and Medicaid, payors
- Changing demographics
- Uninsured patients and charity care increases
- Increasing healthcare and technology costs
- Need for capital
- Lack of IT infrastructure
- Current delivery system focuses on acute health; what is the focus of the future?
- DUHS capital plan heavily focused on hospital facilities
- Workforce/labor
- External competition
- Wake County

Dr. Dzau outlined his approach for addressing the challenges ahead—building a strong team and articulating clearly and consistently the value, mission, vision and goals of the system. Noting that while work on developing a new mission statement continues, he shared the draft as information. Dr. Dzau stressed that his emphasis is upon building a culture of trust, teamwork, and excellence. Socialization is a key factor. Getting to know one another as individuals only strengthens the relationship for working together. He spoke of the process for developing a strategic plan and of bold aspirations for the future of the DUHS and all of its entities.

In a review of his first seven months at the helm of DUHS, Dr. Dzau remarked upon accomplishments that he considers have been made to date. Those include increased engagement, more transparency in funds flow and management, physician involvement in decision making, reaching out to the community, system alignment, and key personnel recruitments.

Referencing system alignment, Dr. Dzau explained his meaning and intentions in this regard. Activities in this regard have involved:

- Clinical quality infrastructure, including patient safety
- IT support
- Financial planning
- Facilities planning and investment strategy
- Technology investments
- Specialized manpower requirements and attendant compensation system

For Dr. Dzau organizing principles include the following, and he commented briefly on each:

- Patient centric, quality and safe care--“right care, right place and right time”
- System alignment
- Community focus
- Innovation
- Priorities
    - Patient centric, system-wide, seamless care
    - Build robust infrastructure
    - System-wide view to allocate resources and manage portfolio of services
    - Adapt current delivery model to one more aligned with shifting care patterns
    - Better alignment of physicians (partnerships with community physicians)
    - Enterprise wide standards on use of Duke Brand
    - New revenue sources
- Focused goals
    - Durham services
    - Wake development
    - Ambulatory services
    - Integrated service lines

- Excellence in interventional medicine
- Physician model

In terms of a strategy for Durham, Dr. Dzau mentioned the following:

- See Durham as single health care unit
  - Hospitals as continuum
  - Community health care as important part of equation
- Need to provide seamless care (outpatient and inpatient)
- Need to improve IT, systems support
  - Balance the diversity of services across the hospitals
  - Movement of physicians across the system
- Need to develop a team approach with participation in decisions and prioritization of resources
- Need to get broad input (e.g. establishment of a community advisory group)

Dr. Dzau acknowledged and dispelled various myths which have obviously circulated for a long time. The important truth is that DUHS is here to be part of the community. He then reflected upon some of the support given to and challenging issues ahead as it relates specifically to Durham and DRH:

- Capital needs
- Operating costs—citing figures since 1999 related to cumulative operating loss, charity care, bad debt, in-kind support to Lincoln Community Health Center, and Emergency Medical Services support.
- In addition, cumulative capital expenditure by the DUHS at DRH since 1999 is $33,371,000
- Physician relationships
- Long-term vision in Durham

Dr. Dzau stressed that he did not review financial figures to be provocative. Rather, he presented them to put things into context. He indicated that claims need to be put aside that DUHS is only here to make money. The reality is that the DUHS is here to be a good citizen and to create a system.

In conclusion Dr. Dzau fielded and responded to questions.

DURHAM COUNTY HOSPITAL CORPORATION BOARD CHAIR UPDATE

In honing the focus even a bit closer to home, Mr. McCauley provided the annual report for the 2003-2004 year. The written report dated September 8, 2004, focused upon the retained responsibilities under the affiliation agreement between Duke, the DCHC, and Durham County. This report was presented last fall to the DCHC Board and then mailed at that time to the Commissioners. Another copy was placed at each attendee's seat at this meeting. A copy is also attached to the original set of these minutes.

It would be ideal if this joint meeting would occur in late summer or late fall. Such would afford a more timely report upon the conclusion of the previous fiscal year. Thus, the reported presented at this time is for FY 2003-2004.

Mr. McCauley spoke on behalf of all Trustees in stating what a privilege it is to serve on the DCHC Board and expressed appreciation for the confidence placed in each individual Trustee by the Durham County Commissioners. Mr. McCauley assured the Commissioners that there is not a person on the DCHC Board who does not take their responsibilities seriously or does not welcome the opportunity to serve and make a contribution in that way to the overall community.

Mr. McCauley then proceeded to speak to all of the DCHC Board's retained responsibilities and highlighted information contained in the written report referred to above. He began by acknowledging and introducing committee chairs.

The twelve retained responsibilities can be divided into five different categories. First, deals with operations. In this category falls strategic planning, and Mr. McCauley briefly described the non-stop planning cycle and process. The current strategic plan focuses upon four issues: superior quality of care, excellent customer service, a diverse work culture, and financial health. Mr. McCauley indicated that the Board is confident that it is dealing appropriately with all of them. The second area under operations is the capital budget. Last year's bottom line came in at just slightly over $10-million or a 5.2% positive margin. Capital expenditures were slightly in excess of $5-million. Addition and/or deletion of clinical programs is another area which falls into this category. The past year saw a reassignment of inpatient pediatric patients. The fourth area involves operational performance against established parameters. Again through monthly committee meetings and bi-monthly full Board meetings, standards have been set and are consistently evaluated. The last item under this category is the at least annual evaluation of the Chief Executive Officer (CEO). In terms of the CEO's performance review, the Board looks at three primary classifications: success of the organization as a whole, the improvement of community health, and personal and professional development.

The second major area of responsibility involves quality of care. One aspect involves credentialing of the medical staff. During the report period, the Performance Improvement and Credentialing Committee reviewed the paperwork of 545 individuals—appointments, reappointments, resignations, etc. Each requires individual action. This committee and the Board also deal with the Joint Commission and Accreditation of Healthcare Organizations (JCAHO) and numerous other regulatory agencies. During the JCAHO's survey of Durham Regional Hospital in late 2003, the organization received a 97% rating.

Another major area of responsibility relates to community care. This links to a commitment to indigent care. DRH had $28.7-million in uncompensated care. Of that figure more than $18.5-million was in bad debts, and $10-million was in charity care. DRH provided $6-million in support of LCHC and EMS. DCHC serves as the official fiduciary agent for the federal funds received by LCHC. Mr. McCauley emphasized and highly praised the good services provided by LCHC.

External relations capture the essence of the fourth area of retained responsibilities. This includes community and government relations of which this meeting is certainly a part as well as marketing of DRH services. This year one major objective of the marketing effort was to focus upon the rapidly expanding Latino population within our community.

The final area of responsibility is to monitor the compliance of DUHS with its commitments. Through bimonthly Board of Trustee meetings and through regular scheduled committee meetings to which have been assigned specific primary responsibilities, the Board has received and reviewed reports, has monitored progress against established objectives and has benefited from the participation of hospital trustees as community representatives, members of the medical staff, and employees. Evaluation of financial performances, capital contributions, support of clinical and medical education programs, employee wage and benefit structures, and operating policies and procedures lead to the conclusion that all parties complied with and met the intent of the Operating Agreement during the 2003-2004 fiscal and operating year. From the DCHC Board's perspective all commitments have either been met or exceeded.

In closing Mr. McCauley made the following comments:

- External pressures upon healthcare delivery are immense and continue to build.
- DCHC Board is committed to working with the DUHS as part of the system.
- It is the Board's desire and pledge to have DCHC be an integral part of the system which serves all Durham citizens well.
- It is imperative that we focus not on what we were but on what we can become.

On behalf of the Commissioners Mrs. Reckhow accepted and expressed appreciation for the annual report. A brief question and answer period concluded this portion of the agenda.

DURHAM REGIONAL HOSPITAL OVERVIEW

Mr. McQuaid was called upon and provided a DRH specific overview. He first recognized the individual members of senior management and commented upon their commitment to teamwork. He also singled out Dr. Murphy and praised him for his effective leadership.

Mr. McQuaid initially presented financial highlights (FY 1999 – FY 2004), reviewed payor mix at DRH and the implications thereof, admission statistics, surgical volume numbers, discussed patient satisfaction and the customer service initiative implemented at DRH, examined integration activities to date, and provided a detailed account of capital projects. Information in this regard was distributed at the meeting, and a copy is attached to the original set of these minutes.

Mr. McQuaid then focused upon the priorities to move DRH forward. First is quality. The objective is to foster a culture of responsibility, accountability and collaboration at all levels of the organization that proactively and continuously improves care by meeting six essential outcomes: safety, patient-centeredness, equity, effectiveness, efficiency and timeliness. Areas of focus in this regard are:

- Regulatory
- Comprehensive Safety Program
- Performance Improvement Initiatives
- Care Management
- Service Lines
- Master Facility Planning Assessment
- Information Technology

The next priority is service. It is essential to foster a culture of service excellence which anticipates and responds to the needs of our internal and external customers. Surveys are conducted and initiatives are underway to address patient, employee and physician satisfaction. This also involves DRH being a leader of and participating in initiatives that will improve the heath of our community. This organization will continue its participation in community planning and advocacy initiatives, and it will put emphasis on targeted marketing of programs.

Another priority is people. It is imperative that DRH retain, recruit, develop and motivate skilled, customer-oriented employees to meet our quality and customer goals. Initiatives are in place addressing recruitment and retention, leadership development, communication, and rewards and recognition.

The final priority is finance. Emphasis is being placed upon achieving financial targets and developing strategies that focus on ways to improve the economy of care. Some areas of focus involve developing physician partnership models for growth, achieving budgeted operating margin, and attaining financial/operational targets.

Mr. McQuaid paused and entertained questions. He spent time on explaining the rationale for and purpose of the Hospitalist Program at DRH and describing its patient care benefits.

ADJOURNMENT

In the interest of time dialogue was brought to a halt. In conclusion, Mr. Ruffin commented upon the quality of this meeting's content and the helpful information provided. Commissioner Heron thanked the DCHC Board for this opportunity to communicate. Commissioner Reckhow expressed appreciation to the DCHC Board for being the eyes and ears of the County in this most important matter, and she expressed that the DCHC can be considered one, if not the, hardest working of the Commissioner appointed bodies. In bringing the meeting to closure, Mr. McCauley again thanked everyone for their interest and participation. Everyone was provided with a one-page DRH reference sheet which included key contact information. There being no further business to come before the joint meeting at this moment, the meeting was adjourned at 1:11 p.m.

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Eugene F. Dauchert, Jr., Secretary
Durham County Hospital Corporation

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Garry E. Umstead, CMC, Clerk to the Board
Durham County Commissioners