

MINUTES

Meeting of the Board of Trustees
Of the Medical University Hospital Authority

October 13, 2006

It Is Understood that the Minutes Herein Recorded Have Not as
Yet Been Approved and Cannot be Considered as Official Action
Of the Board Until Such Approval Has Been Given

101 Colcock Hall
Medical University of South Carolina
Charleston, South Carolina

MINUTES
MEDICAL UNIVERSITY HOSPITAL AUTHORITY
BOARD OF TRUSTEES MEETING
October 13, 2006

The Board of Trustees of the Medical University Hospital Authority convened Friday, October 13, 2006, with the following members present: Dr. Charles B. Thomas, Jr., Chairman; Thomas L. Stephenson, Esquire, Vice Chairman; Dr. Stanley C. Baker, Jr.; Mr. Melvyn Berlinsky; Mr. William H. Bingham, Sr.; Dr. Cotesworth P. Fishburne, Jr.; Dr. Donald R. Johnson II; Dr. E. Conyers O'Bryan, Jr.; Dr. Paula E. Orr; Dr. Thomas C. Rowland, Jr.; Mr. Charles W. Schulze; The Honorable Robin Tallon; Dr. James E. Wiseman, Jr. Absent: Mr. William B. Hewitt.

The following administrative officials were present: Dr. Raymond S. Greenberg, President; Dr. John Raymond, Vice President for Academic Affairs and Provost; Dr. Jerry Reves, Vice President for Medical Affairs, and Dean, College of Medicine; Ms. Lisa Montgomery, Vice President for Finance and Administration; Mr. Stuart Smith, Vice President for Clinical Operations and Executive Director, MUHA; Mr. Jim Fisher, Vice President for Development and Dr. Frank Clark, Vice President for Information Technology and CIO.

The following deans were present: Dr. Jack Sanders, College of Dental Medicine; Dr. Becki Trickey, Interim Dean, College of Health Professions; Dr. Perry Halushka, College of Graduate Studies; Dr. Jerry Reves, College of Medicine; Dr. Gail Stuart, College of Nursing; and Dr. Arnold Karig, College of Pharmacy.

Item 1. Call to Order-Roll Call.

There being a quorum present, Chairman Thomas called the meeting to order. Ms. Celeste Jordan called the roll.

Item 2. Secretary to Report Date of Next Meeting.

The date of the next regularly scheduled meeting is Friday, December 8, 2006.

Item 3. Approval of Minutes of the Regular Meeting of the Medical University Hospital Authority of August 11, 2006.

Board Action: It was moved that the Minutes be approved. The motion was seconded, voted on and unanimously carried.

Dr. Thomas thanked the Board for electing him Chairman and stated he is proud to serve in this new role. He identified three goals as follows:

1. The target date for the dedication of Phase I of the new hospital is October 2007. Dr. Thomas discussed the factors making the building of Phase II a priority and asked that everyone work together to determine how to accomplish the task.
2. Dr. Thomas commented that Medicine is a business and discussed the importance of making more money from the enterprise in order to survive and grow in a competitive healthcare market.
3. While the University does a great job educating doctors and researchers, Dr.

Thomas noted that there are significant doctor shortages in many areas of the state and nation. He distributed an article on the shortages (attached) and stated the University needs to look at ways to help solve the problem. He said one part of the solution is to educate more doctors at MUSC.

With the increased need for services due to an aging population, sicker people and the obesity epidemic coupled with physician shortages, Dr. Thomas encouraged the University to work together to "survive the onslaught of fat baby-boomers."

Dr. Greenberg stated that four years ago the University was at the planning stage of the new hospital. He commented that the progress since that time has been dramatic and emphasized how far the University has come under Dr. Johnson's leadership as Chairman. Dr. Thomas and Dr. Greenberg presented Dr. Johnson a resolution of appreciation for his service as Board Chairman.

RECOMMENDATIONS AND INFORMATIONAL REPORTS OF THE PRESIDENT

OLD BUSINESS: None.

NEW BUSINESS:

Item 4. General Informational Report of the President.

Dr. Greenberg called on Dean Reves to introduce MUHA's new Chief Medical Officer. Dean Reves introduced Dr. Pat Cawley. Dr. Cawley attended medical school at Georgetown, trained at Duke and worked in general medicine at Duke with Dr. Feussner. Dr. Feussner was instrumental in recruiting Dr. Cawley to MUSC.

Dr. Cawley discussed important strategic initiatives: physician alignment, information technology and patient safety. Every physician leader in the hospital will have measurable objective evaluations based on Studer goals. Information technology (IT) will allow the hospital to capture performance measures to be able to move to the next level of patient safety. The hospital will also use IT to facilitate change and improve processes.

Dr. Greenberg asked Lisa Montgomery to provide an update on the VA. In July, the VA charged the University to move to the next level in planning for Phase II. The University was asked to define, more specifically, the model with respect to volumes, size, location and construction phasing. That report is due April 2007. It was noted that, without a collaborative effort, it would probably be 2010 or 2012 before the University could fund Phase II. Dr. Greenberg thanked Mr. Tallon for his efforts in Washington with this project. He will keep the Board updated as progress is made.

Dr. Greenberg reported that one of the most important grants this institution has ever sought was recently submitted. MUSC partnered with McKesson Health Solutions (McKesson) and Enhanced Care Initiatives in responding to a request for proposal from the Centers for Medicare and Medicaid Services (executive summary attached). If the University and its partners are awarded the grant, more detailed information will be presented to the Board. Dean Reves commented that MUSC would not have

been in a favorable position to apply for the grant without Dr. Greenberg's ability to obtain McKesson's support.

Recommendation of Administration: That the reports be received as information.

Board Action: Received as information.

Item 5. Other Business. None.

MEDICAL UNIVERSITY HOSPITAL AUTHORITY OPERATIONS AND FINANCE COMMITTEE. CHAIRMAN: DR. STANLEY C. BAKER, JR. (Detailed committee minutes are attached to these minutes).

OLD BUSINESS: None.

NEW BUSINESS:

Item 6. MUSC Medical Center Status Report.

Statement: Mr. Stuart Smith said he had reported to committee on four areas: MUSC Excellence, statistical data, the referral call center and the recent JACHO survey.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

Item 7. MUSC Medical Center Financial and Statistical Report.

Statement: Ms. Lisa Montgomery reported that after the first two months of the fiscal year the hospital is doing well and has a stronger cash position. She cautioned everyone that in the very near future expenses for the new facility will begin to impact the hospital financials. She also reported that the external audit is almost complete and it will be presented in December to the Audit Committee.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

Item 8. Revisions to MUHA Expenditure Authority Policy.

Statement: Ms. Montgomery presented the revisions to the MUHA Expenditure Authority Policy and asked for approval.

Recommendation of Administration: That the revisions to the MUHA Expenditure Authority Policy be approved.

Recommendation of Committee: That the revisions to the MUHA Expenditure Authority Policy be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the revisions to the MUHA Expenditure Authority Policy (now to be known as the MUHA Budget Policy).

Item 9. Performance Improvement Plan 2006-2008.

Statement: The Performance Improvement Plan was reviewed by the committee and Dr. Baker recommended approval.

Recommendation of Administration: That the Performance Improvement Plan 2006-2008 be approved.

Recommendation of Committee: That the Performance Improvement Plan 2006-2008 be approved.

Board Action: A motion was made, seconded and unanimously voted to approve the Performance Improvement Plan 2006-2008.

Item 10. Report of the Vice President for Medical Affairs and Dean, College of Medicine.

Statement: Dr. Baker stated that in Dean Reves provided the committee an update on service lines.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

Item 11. Report on University Medical Associates.

Statement: Dr. Baker stated Dr. Feussner had presented a report to committee.

Recommendation of Administration: That the report be received as information.

Recommendation of Committee: That the report be received as information.

Board Action: Received as information.

Item 12. Legislative Update.

Statement: Dr. Baker stated a report had been given to the committee by Mr. Faulkner.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

Item 13. Other Committee Business. None.

Item 14. Medical University Hospital Authority Appointments, Reappointments and Delineation of Privileges (consent item).

Statement: Appointments, reappointments and delineation of privileges to the medical staff were presented for approval.

Recommendation of Administration: That the appointments, reappointments and delineation of privileges to the medical staff be approved.

Recommendation of Committee: That the appointments, reappointments and delineation of privileges to the medical staff be approved at presented.

Board Action: Dr. Baker moved that the appointments, reappointments and delineation of privileges to the medical staff be approved. The motion was seconded, voted on and unanimously carried.

Item 15. Medical Executive Committee Minutes (consent item).

Statement: Minutes of the Medical Executive Committee meetings of July and August, 2006 were presented to the Board.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

Item 16. Medical Center Contracts and Agreements (consent item).

Statement: Contracts and Agreements which have been signed since the last board meeting were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

**MEDICAL UNIVERSITY HOSPITAL AUTHORITY PHYSICAL FACILITIES COMMITTEE.
CHAIRMAN: MR. WILLIAM H. BINGHAM, SR. (Detailed committee minutes are attached to these minutes).**

OLD BUSINESS: None

NEW BUSINESS:

Item 17. Facilities Procurements/Contracts Proposed.

Statement: Mr. Bingham presented the following leases for approval:

- Lease renewal for 7,843 square feet of office space located on the 4th floor of 135 Cannon Street for 5 years – for a total of \$974,271.11
- Lease amendment for additional 23,500 square feet of warehouse space at 230 Albermarle Road for 7 years totaling \$2,039,373.20

Recommendation of Administration: That the leases be approved as presented.

Recommendation of Committee: That the leases be approved as presented.

Board Action: A motion was made, seconded and unanimously voted to approve the leases as presented.

Item 18. Update on Projects.

Statement: Mr. Bingham reported that Mr. Frazier had presented an update to the Committee and it was received as information.

Recommendation of Administration: That this report be received as information.

Recommendation of Committee: That this report be received as information.

Board Action: Received as information.

Item 19. Other Committee Business. None

Item 20. Facilities Contracts Awarded (consent item).

Statement: Facilities contracts awarded since the last board meeting were presented for information.

Recommendation of Administration: That this be received as information.

Recommendation of Committee: That this be received as information.

Board Action: Received as information.

OTHER BUSINESS FOR THE BOARD OF TRUSTEES:

Item 21. Approval of Consent Agenda.

Statement: Approval of the Medical University Hospital Authority consent agenda was requested.

Recommendation of Administration: That the consent agenda be approved.

Board Action: It was moved, seconded and unanimously voted that the consent agenda be approved.

Item 22. Report of Internal Auditor.

Statement: Mr. Paul Taylor presented a report in Executive Session.

Board Action: Received as information.

Item 23. New Business for the Board of Trustees. None

Item 24. Report from the Chairman.

There being no further business, the Hospital Authority meeting was adjourned.

Respectfully submitted,

Hugh B. Faulkner III
Secretary

/wcj
Attachments

**Medical University Hospital Authority
Operations and Finance Committee
October 12, 2006
Minutes**

Attendees

Dr. Stanley Baker, Chair	Mr. Dennis Frazier
Dr. Charles B. Thomas, Jr.	Dr. Sabra Slaughter
Thomas L. Stephenson, Esq.	Mr. Bruce Quinlan
Mr. Melvyn Berlinsky	Dr. Frank Clark
Mr. William H. Bingham, Sr.	Mr. Steve Hargett
Dr. Cotesworth P. Fishburne, Jr.	Ms. Rosemary Ellis
Dr. Donald R. Johnson	Ms. Marilyn Schaffner
Dr. E. Conyers O'Bryan, Jr.	Mr. John Cooper
Dr. Paula E. Orr	Mr. Betts Ellis
Dr. Thomas C. Rowland, Jr.	Ms. Joan Herbert
Mr. Charles W. Schulze	Ms. Alexis Grant
Hon. Robin M. Tallon	Ms. Hope Colyer
Dr. James E. Wiseman, Jr.	Ms. Sandra DeAntonio
Mr. H. B. Faulkner	Dr. Pat Cawley
Dr. Raymond Greenberg	Dr. John Feussner
Mr. W. Stuart Smith	Ms. Chris Murray
Dr. Raymond Greenberg	Mr. Paul Taylor
Ms. Lisa Montgomery	Ms. Susan Barnhart
Dr. J. G. Reves	Ms. Annette Drachman
	Mr. Mark Sweatman
	Ms. Sara King

The Meeting was called to order at 9:40 a.m. by Dr. Stanley Baker, Chairman

Election of Chair:

The Committee voted to re-elect Dr. Stanley Baker, Chair of the Operations and Finance Committee of the Board.

Item 6. MUSC Medical Center Status Report

Personnel: Mr. Smith reported that after a nationwide search, Dr. Pat Cawley was selected as the new Medical Director of the MUSC Medical Center.

JCAHO: Ms. Rosemary Ellis, Director of Quality and Patient Safety, reported on the recent unannounced survey by the Joint Commission on Accreditation of Healthcare Organizations. The unannounced survey was conducted during the week of September 11, 2006. The survey team identified eight areas which require some type of corrective action. The Medical Center is already putting actions in place to correct these issues and

will report back to the JCAHO within 45 days of the survey. While the average Academic Medical Center has received 14 recommendations by the JCAHO this year, MUSC's performance with only eight recommendations is considered a very successful survey.

Statistical Data: Mr. Smith briefed the committee on statistical data for the first two months of the fiscal year. As compared to the same period last year, the Medical Center admissions have increased as well as outpatient visits and imaging procedures.

MUSC Excellence: Mr. Smith briefed the committee on the MUSC Excellence program. This is a management development process which should lead to increased patient and employee satisfaction. Mr. Smith explained the goals which will be used to evaluate the performance of approximately 300 MUSC leaders. The goals will be well defined and will be measurable in order to hold leaders accountable. While some of the measures are still being developed, the Medical Center has set overall goals for turnover, mortality, operating margin, FTE's per Adjusted Occupied Bed, and increased admissions.

Referral Call Center: Mr. Betts Ellis introduced Ms. Hope Colyer who briefed the committee on the Referral Call Center. Ms. Colyer reported that the Call Center's mission is to facilitate access for consumers and physicians to the Medical Center's services. The Call Center's service lines include Meduline, Health Connection, Med-u-Nurse, and Marketing phone lines. All of these service lines have increased volumes with Meduline's physician referral volume being 65,000 calls in FY 06 and Health Connection's consumer call volume being 100,000 calls.

Action: Report received as information

Item 7: Financial and Statistical Report

Ms. Montgomery reported that the Medical Center was doing well after the first two months of the fiscal year and that in the first two months the increase in net assets was \$9.3 million as compared to \$4.6 million for the same period last fiscal year. Cash was \$49.2 million through August which exceeds the amount required by HUD in the feasibility study.

Mr. Steve Hargett, Controller, reported that the external audit had been completed with an unqualified opinion. The change in net assets is \$30.6 million. The audit will be presented to the Board in detail at the December meeting.

Ms. Montgomery reported that MUHA has again been recognized as one of the top 200 institutions in the country for the completeness and compliance of its coding practices.

Action: Report received as information

Item 8. Revisions to MHA Expenditure Authority Policy

Ms. Montgomery presented a revised Expenditure Authority Policy to the Committee. She also noted that a line item has been added to the FY 07 capital budget for \$3 million to cover unexpected or emergent expenditures. Ms. Montgomery will periodically present the Board a list of these unexpected or emergent expenditures for information.

Mr. Berlinsky made a motion to approve the changes as indicated on the revised Expenditure Authority Policy and the motion was seconded by Dr. O'Bryan.

Action: Recommend approval

Item 9. Performance Improvement Plan 2006-2008

The performance improvement plan which had been discussed at the August board was presented for approval.

Action: Recommend approval

Item 10. Report of the Vice President for Medical Affairs and Dean, College of Medicine

Dr. Reves presented a draft of the service line organizational structure which featured the partnership between the physician and administrative leader. The purpose of this structure is to ensure improved patient care, enhanced physician and staff morale, increased recognition, and improved financial performance. The first four service lines will be Children's, Heart and Vascular, Digestive Disease, and Transplant. Implementation will occur over the next 12 months. The administrator and physician of the service line will report to the Medical Director of the Medical Center, and an Advisory Committee co-chaired by the Vice President for Clinical Operations and the Vice President for Medical Affairs will provide advice and guidance to the Medical Director. After a thorough review of the four service lines, other service lines may well be implemented.

Action: Received as information

Item 11. Report on University Medical Associates

Dr. Feussner reported on progress on the North Area Specialty Care Clinic. He and Mr. Quinlan continue to have discussions with various primary care groups and the leadership of other hospitals. He requested that the board allow the lease of an additional 6000 square feet of space amending the original lease from 20,000 square feet to 26,000 square feet and that they also allow UMA to develop a business plan for constructing a specialty care medical office building in East Cooper.

Action: Committee recommended approval of increasing lease in North Area to 26,000 square feet and recommended approval to prepare a business plan for constructing medical office building in East Cooper. Board requested that this business plan be completed within six months and brought back to the Board for action.

Item 12. Legislative Update

Bo Faulkner introduced Mr. Mark Sweatman who has replaced Casey Martin.

Action: Received as information

Item 13. No Other business

CONSENT

Item 14. Medical University Hospital Authority Appointments, Reappointments, and Delineation of Privileges

The committee reviewed the appointments, reappointments and delineation of privileges as presented by the Medical Executive Committee. These have been approved by all internal committees.

Action: Recommend approval

Item 15. Medical Executive Committee Minutes

The committee reviewed the Medical Executive Committee minutes from July and August 2006.

Action: Received as information

Item 16. Medical Center Contracts and Agreements

The committee reviewed the contracts and agreements entered into since the last meeting of the Board.

Action: Received as information.

There being no further business, the committee adjourned at 11: 00 a.m.

Respectfully Submitted,

Teresa K. Rogers

**Medical University Hospital Authority
Physical Facilities Committee
October 12, 2006
Minutes**

Attendees:

Mr. William H. Bingham, Sr., Chair	Mr. Dennis Frazier
Dr. Stanley C. Baker, Jr.	Mr. Joe Good
Mr. Melvyn Berlinsky	Mr. Steve Hargett
Dr. Cotesworth P. Fishburne, Jr.	Dr. Arnold Karig
Dr. Paula E. Orr	Mr. Chris Malanuk
Dr. Thomas C. Rowland, Jr.	Mr. John Malmrose
Mr. Charles W. Schulze	Mr. Stewart Mixon
Thomas L. Stephenson, Esquire	Ms. Lisa Montgomery
The Honorable Robin M. Tallon	Ms. Jennifer Pearce
Dr. Charles B. Thomas, Jr.	Dr. John Raymond
Dr. James E. Wiseman, Jr.	Dr. Jerry Reves
Mr. Hugh B. Faulkner III	Ms. Marilyn Schaffner
Dr. Raymond S. Greenberg	Dr. Sabra Slaughter
Ms. Susan H. Barnhart	Mr. Mark Sweatman
Mr. John Cooper	Mr. J. Paul Taylor
Ms. Annette Drachman	Mr. Patrick Wamsley

Mr. Bingham called the meeting to order. The committee members re-elected Mr. Bingham Chair of the Medical University Hospital Authority Physical Facilities Committee..

REGULAR Items

Item 17 Facilities Procurements/Contracts Proposed

Mr. Dennis Frazier presented the procurements/contracts for approval. It was noted that the lease for space on the second floor of 163 Rutledge Avenue was pulled from the agenda and approval was not sought.

Recommendation of Committee: That the two leases be approved as follows:

- Lease renewal for 7,843 square feet of space located on the 4th floor of 135 Cannon Street - \$974,271.11
- Lease amendment for additional 23,500 square feet of warehouse space at 230 Albermarle Road - \$2,039,373.20

Item 18 Update on Projects

Mr. Dennis Frazier presented an update on projects.

Recommendation of Committee: That the report be received as information.

Item 19 **Other Committee Business**

None

CONSENT Items for Information:

Item 20 **Facilities Contracts Awarded**

The facilities contracts since the last board meeting were presented for information.

Recommendation of Committee: That this report be received as information.

With no further business, the meeting was adjourned.

DISAPPEARING DOCS THE PHYSICIAN SHORTAGE IS REAL

HOW TO RECRUIT IN A TOUGH MARKET

BY PAMELA L. MOORE, PhD

Perry Farb is, no doubt, a very good family-practice physician. Still, as he completed his training, he was astounded by the number of “faxes and e-mails [he received] daily for months,” alerting him to job opportunities.

Farb ended up at Fallon Clinic in Boston. Chief Medical Officer Marc Greenwald was happy to have him. Just before Greenwald started his job two and a half years ago, the group had 23 openings and could fill only 11 of them.

It’s a new world for those trying to recruit. The long-rumored physician shortage is upon us and likely to worsen. The newly formed Council on Physician and Nurse Supply says the United States may lack as many as 200,000 needed physicians (and 800,000 nurses) by 2020. The Bureau of Labor Statistics predicts there will be 212,000 physician openings by 2014 due to growth and net replacement of retiring physicians. That number represents more than 25 percent of the current physician work force. And this is in a country whose population continues to grow. The American Medical Association (AMA) says that as the U.S. population rose 31 percent between 1980 and 2003, its number of medical school graduates remained static.

That’s good news for those of you looking to change jobs — scarcity drives up salaries and perks — but bad news if you want to expand your practice or replace a soon-to-retire partner.

PHYSICIAN SHORTAGE

YOU DO THE MATH There are now more people who need more care and there are fewer physicians trained to treat them.

THE SHORTAGE IS REAL

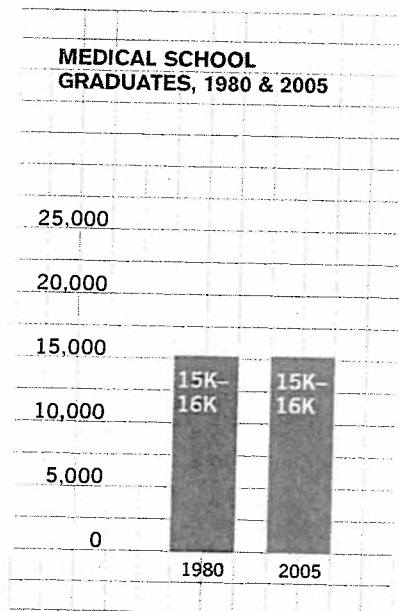
There are now more people who need more care, and there are fewer physicians trained to treat them.

Many of today's patients are baby boomers whose aging bodies require more therapy, treatment, and surgery. The National Ambulatory Healthcare Administration says people aged 66 and older average six physician office visits per year; individuals aged 46 to 65 average 5.4 visits annually; and people 25 to 35 years old average 2.2 visits a year. Increasing numbers of older patients mean heightened healthcare demand.

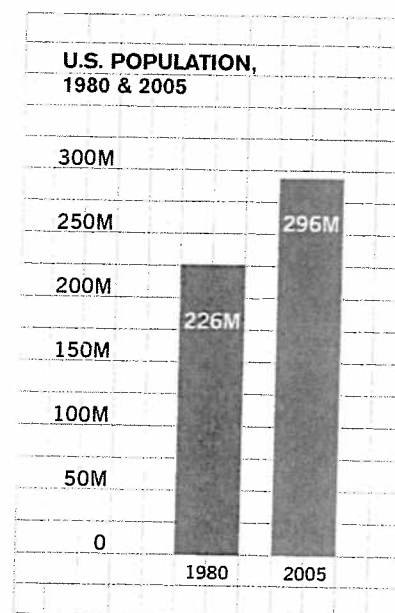
IN SUMMARY

The long-feared physician shortage is upon us. Practices and young physicians need to change tactics to meet new market realities.

- Recruiting practices should have in place creative, well thought-out recruitment plans and shouldn't be afraid to sweeten the deal with signing bonuses, salary guarantees, a seat at the management table, quick and easy partnerships, paid relocations, and better lifestyle balance.
- If you can't afford to hire, improve patient access by expanding your use of clinical support staff and hospitalists. Or consider dropping your worst managed-care contracts.
- New physicians should know their priorities and the going rate for their specialties. Don't be afraid to ask hard questions about perks and the business practices you personally value.
- A physician shortage has serious consequences for patients. Do your part by boosting efficiency and improving access to your practice.



are just not willing to see as many patients and work the same hours as the older physicians," says Kurt Mosley, vice president of Merritt, Hawkins & Associates, a physician recruitment firm. "It's not an apple and an apple. It's a lifestyle issue."



And older patients typically have multiple chronic conditions that require complex office visits and administrative care — often unreimbursed — such as prescription refills and phone conversations.

Of course, as boomer patients are aging, so are boomer physicians. Many of today's practicing physicians are retiring, or soon will. The AMA's data state that "matures" (people over age 61) and baby boomers (people between age 42 and age 60) now make up 67 percent of the existing physician population. Generation Xers (age 27 to age 41) make up only 33 percent of today's practicing physicians.

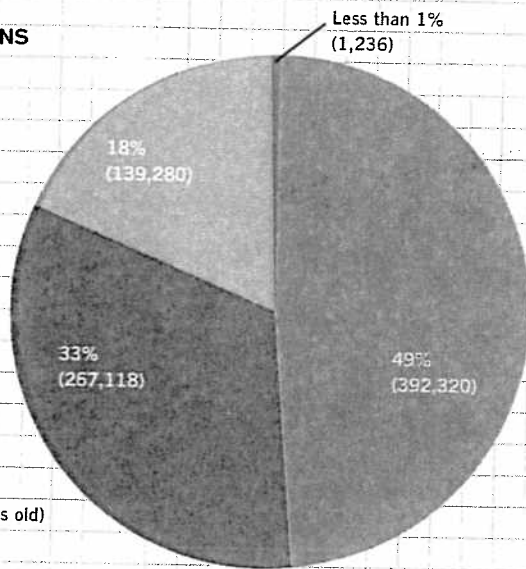
And keep in mind that Gen X doctors (and those even younger) aren't exactly replacing all of the work performed by older physicians. "Some of the new doctors coming out — and this is not a slam —

When Merritt Hawkins surveyed physicians over age 50, 64 percent said the doctors trained today are less dedicated and hardworking than the physicians who entered medicine when they did. *None* said they were more dedicated.

The fallout of all this is plainly evident. Patient wait times for specialist appointments are growing almost as fast as specialist recruiting incentives. For example, wait times for appointments with cardiologists reached or exceeded 21 days in six of 15 metropolitan markets surveyed by Merritt Hawkins in 2004. Patients needing to see dermatologists waited at least 21 days in 60 percent of the same markets. Specialist income is rising accordingly, from an already high average of \$320,000 in 2004-2005 to \$342,000 in 2005-2006. Gastroenterologists are now starting at \$315,000, up from \$298,000 last year.

PHYSICIAN SHORTAGE

AGE OF CURRENT PRACTICING PHYSICIANS



- 44% Baby Boomers (42-60 years old)
- 33% Gen Xers (27-41 years old)
- 18% Matures (Over 61 years old)
- Less than 1% Less than 26 years old

Total number of physicians: 799,954

Patient demand is clearly outpacing specialist output, forcing practices and hospitals looking to recruit physician specialists to pay top dollar.

But shortages aren't limited to the specialties. Primary-care physicians are also feeling the effects.

Merritt Hawkins conducted 55 percent more searches for family physicians from March 31, 2005, to April 1, 2006, than during that same period the previous year. Searches for internal medicine positions rose 46 percent. In fact, the company performed more searches in internal medicine than in any other field.

"What we've seen is a shift back to primary care," says Mosley. "In the past two to three years, we made an effort to get specialists. Now those specialists are asking, 'Where are our feeders? Where is our base?'"

"Everywhere I go I hear people talking about how hard it is to get internists and that they are getting concerned about family practice," agrees David Cornet, regional vice president for Cejka Search, another physician recruiting firm.

The pinch is being felt across all markets. The data show primary-care physicians being as heavily recruited in larger markets (e.g., cities) as in smaller, more rural towns. The need is not confined to remote Appalachian communities.

HAVE A RECRUITING PLAN

So if you are trying to fill a position in these tough times, what do you do?

Have a plan and sweeten the pot, say experts.

You have to be committed to the search, says Cornet. "It's not something you can start and stop. ... When you have a candidate, that is an extremely scarce resource, and if you don't drop everything you are doing and treat it like gold then you will lose out because somebody else will."

"It's hard to recruit physicians in many specialties," agrees Fallon Clinic's Greenwald. "That being said, it's easier now than when I came here ... largely because we put in place a system. And systems tend to work."

Indeed, Fallon has filled 50 positions in two years with its

plan in place, exceeding its own expectations. What's its secret?

Fallon starts by very precisely identifying its physician needs — not only by specialty, but also by experience and personality. "Can it be an inexperienced physician because [we have in place] others who can coach, or is the place crazy and needs an experienced physician or they will sink? We decide first who we need, and who we need means every aspect of that person," Greenwald explains.

Once Fallon has identified several candidates, it conducts interviews using scripted questions designed to get physicians to reveal their attitudes and real experience. For example, says Greenwald, the interviewer will ask, "Tell me about a specific patient who came to you unhappy with the care they received elsewhere. How did you handle it?" rather than, "Can you deal well with worried patients?"

Fallon also has in place a proactive plan for its future recruiting needs based on its physicians' ages, likely retirement, and expected turnover. This allows it to anticipate its needs a year or two in advance.

That approach won over Farb. Fallon's whole process reflected his approach to medicine. "My wife and I had an idea of a group we were looking for and wanted to go up north," he says. "The description of Fallon jumped out at us. ... I could tell from the little recruitment blip that they weren't just looking for people who wanted the most money; they were looking for caring primary docs."

Farb says his worst interview experience was with an organization not far from Fallon. He found the physicians there to be arrogant, and they immediately put him off. "Oh my gosh, it was terrible," he recalls. "I couldn't wait to get out of there. The focus seemed to be what I could do for them. It really was more of an attitude. It was, 'Who are you and what are you doing here?'"

PHYSICIAN SHORTAGE

TOP FIVE PHYSICIAN SEARCHES BY MEDICAL SPECIALTY

SPECIALTY	2005/06	2004/05	2003/04	2002/03
Internal Medicine	274	188	124	113
Family Practice	257	166	165	122
Radiology	237	218	202	230
Orthopedic Surgery	207	210	210	191
Cardiology	174	231	181	188

Source: Merritt, Hawkins & Associates, 2006

PRIMARY CARE IS BACK Merritt Hawkins conducted 55 percent more searches for family physicians from March 31, 2005, to April 1, 2006, than during that same period the previous year.

BE PREPARED TO WOO YOUR CANDIDATES

Like Fallon, Trinity Mother Frances Health System in Tyler, Texas, has a comprehensive recruitment plan. The multispecialty clinic, which employs roughly 250 physicians, has recruited about 67 doctors over the past two years, says David Teegarden, MD, president and chief medical officer of the group.

"We made a strategic commitment to make recruiting a professional line in the organization with management and performance accountabilities," explains Teegarden. Two full-time recruiters work from an outside firm but are on location every day. There are weekly recruitment meetings that include marketing staff, physician leaders, credentialing people, and human resources representatives. They review spreadsheets on candidate selection and are told where each new potential hire is in their recruiting process. "It's a very tight, process-driven endeavor," says Teegarden.

When candidates arrive for a visit at Trinity Mother Frances, its recruiting team has already identified their key drivers — salary, schools, family concerns — and makes sure those needs are addressed. If a particular candidate is especially desired, the health system will arrange visits with local school principals, tours of parks, whatever it takes.

And Trinity Mother Frances is unafraid to sweeten a deal to land a desired candidate. Compensation itself usually stays within the going range, says Teegarden, but he adds, "We are raising signing bonuses above average if we need to." He'll also offer a one- or two-year salary guarantee. And newly hired physicians are encouraged to take leadership roles right away. Teegarden says he wants new recruits to feel like, "Gee, I have a chance to put my feet under the table and get involved in decision-making."

That's what won over new recruit Sauyu Lin. The gastroenterologist was flooded with offers as he finished

his residency. He knew he wanted to be in the Southeast, near his family. But it took him a while to decide what type of practice he wanted to join.

"Because I was just coming out, I wasn't sure that I wanted to go into solo practice. I didn't feel like I was ready [to take on all the business aspects]," says Lin. "Then, as far as single-specialty groups, I didn't go that way partly because there were people already there, founders and others, who had been there for years before me, so it felt like I wouldn't have as much decision-making power, not as much voice." For Lin, Trinity Mother Frances offered the ideal combination: the safety of a group and the opportunity to exert real influence.

GOING THAT EXTRA MILE

Practices across the country are making whatever accommodations they have to lure the candidates they want. "More recruits than ever before are looking for lifestyle — limited hours, being able to have some balance in their lives. They'll take less money for more life balance," says Keith Borglum, a consultant with Professional Management and Marketing in Santa Rosa, Calif.

Mosley witnessed one situation in which "a group wanted the doctor, and he had three horses to relocate, so they relocated the horses as well as the physician. It's whatever people can do to close the deal."

Mosley says he is seeing increasing signing bonuses and rising relocation amounts. Signing bonuses were offered in 58 percent of the searches Merritt Hawkins represented over the past 12 months, compared with 46 percent the previous year. The average signing bonus increased from \$14,030 in 2005 to \$20,480 in 2006. And education loan forgiveness, offered in 14 percent of the searches the firm represented in 2005, was offered in 34 percent of its searches this year.

PHYSICIAN SHORTAGE

INCOME OFFERED TO TOP 15 RECRUITED SPECIALTIES

SPECIALTY	LOW	AVERAGE	HIGH
Anesthesiology			
2005/06	\$275,000	\$306,000	\$375,000
2004/05	\$240,000	\$303,000	\$340,000
Cardiology			
2005/06	\$175,000	\$342,000	\$500,000
2004/05	\$234,000	\$320,000	\$525,000
CRNA			
2005/06	\$87,000	\$156,000	\$210,000
2004/05	\$75,000	\$150,000	\$190,000
Emergency Medicine			
2005/06	\$130,000	\$230,000	\$270,000
2004/05	\$140,000	\$246,000	\$270,000
Family Practice			
2005/06	\$115,000	\$145,000	\$220,000
2004/05	\$125,000	\$150,000	\$200,000
Family Practice with Obstetrics			
2005/06	\$115,000	\$145,000	\$220,000
2004/05	\$125,000	\$150,000	\$200,000
Gastroenterology			
2005/06	\$175,000	\$315,000	\$500,000
2004/05	\$230,000	\$298,000	\$340,000
General Surgery			
2005/06	\$150,000	\$272,000	\$350,000
2004/05	\$220,000	\$255,000	\$310,000
Hospitalist			
2005/06	\$140,000	\$175,000	\$190,000
2004/05	\$150,000	\$171,000	\$210,000
Internal Medicine			
2005/06	\$130,000	\$162,000	\$250,000
2004/05	\$130,000	\$161,000	\$210,000
Neurology			
2005/06	\$150,000	\$210,000	\$250,000
2004/05	\$155,000	\$209,000	\$230,000
OB/GYN			
2005/06	\$175,000	\$234,000	\$450,000
2004/05	\$200,000	\$247,000	\$320,000
Orthopedic Surgery			
2005/06	\$250,000	\$370,000	\$515,000
2004/05	\$250,000	\$361,000	\$650,000
Otolaryngology			
2005/06	\$175,000	\$272,000	\$350,000
2004/05	\$235,000	\$304,000	\$350,000
Psychiatry			
2005/06	\$130,000	\$174,000	\$230,000
2004/05	\$140,000	\$176,000	\$250,000
Radiology			
2005/06	\$240,000	\$351,000	\$500,000
2004/05	\$250,000	\$355,000	\$500,000
Urology			
2005/06	\$250,000	\$320,000	\$375,000
2004/05	\$250,000	\$329,000	\$340,000

Source: Merritt, Hawkins & Associates, "2006 Review of Physician Recruitment Incentives"

Other practices will offer almost immediate partnerships at rock-bottom prices. "Partnership track is continuing to shorten," says Cornet. "It's not uncommon to see one-year partnership tracks. ... And anything longer than two years I would consider to be an outlier." Buy-ins are also dropping; Cornet recently saw one go for \$1,000.

"Four or five years ago it was, 'Come in and put in your dues,'" says Mosley. Now Merritt Hawkins marketers are instructed to turn down clients looking to fill radiology jobs that have a three-year partnership track.

A GOOD TIME TO BE YOUNG

In a market this tight, young physicians need to understand how much leverage they have and how to use it wisely. New job-hunting physicians should take a look at the going rate in their area and review their buy-in potential carefully. Bad deals still exist — but now there's no reason to settle for them.

"Last week, I was teaching at the American Academy of Allergy Asthma and Immunology and many of the physicians there that were offering jobs were offering between \$120,000 and \$140,000 a year with bonuses, while median compensation for allergists is \$350,000, and my experience is that a new practice can open and an allergist can make \$350,000 within 12 to 18 months," says Borglum. "I have allergy clients making \$500,000 a year. People take those jobs sometimes because they don't know any better."

Borglum says he also sees plenty of bad buy-in opportunities. He warns that senior physicians can easily pick up bad advice from brokers who aren't knowledgeable about medicine. "They go based on general business principles and are grossly overvaluing practices. ... Get an expert — someone who specializes in medical practice. I see so many bad appraisals, so many.

They almost never undervalue; they almost always overvalue. I see maybe one undervalued appraisal every three or four years. I see overvalued appraisals every week."

Management consultant Paul Angotti in Castle Rock, Colo., also advises young physicians to "ask the

CAN'T HIRE? GET CREATIVE.

With new recruits in such demand, some practices just won't be able to bring in new physicians. "Many recruiters are stuck in an impossible situation," says Borglum. Even in the attractive Bay Area, he says that "to recruit a new physician with

you can't take care of everyone. If the physician doesn't take care of himself, there will be no one around to take care of the patients."

Another idea: Boost revenue to make it possible to bring in another physician. Consider adding ancillaries such as ambulatory blood pressure monitoring, Holter monitoring, or echocardiograms. "Keep more of that revenue in-house that you would normally farm out," says Borglum. And then use the proceeds to hire an ancillary provider for added support.

Indeed, nurse practitioners and physician assistants are more abundant than physicians — at least for now — and can help expand a practice. Hospitalists — if provided by a hospital — can also boost physician efficiency by keeping practice docs focused on outpatient work. That means increasing patient access without having to hire another physician.

DO YOUR PART

A physician shortage will have serious consequences for the U.S. healthcare system. As a partner in that system, you should do your best to protect patient access while staying financially afloat. The last thing we need is to lose another practicing physician to bankruptcy. So consider carefully whether you need to grow, how to grow if recruiting remains a challenge — as it most likely will — and what you can do to protect the patients you already have. You can no longer simply assume that retiring physicians are easily replaceable. Each little proactive step to face new market realities provides more security for you and your patients.

Pamela L. Moore, PhD, CPC, is senior editor, practice management, for *Physicians Practice*. She can be reached at pmoore@physicianspractice.com.

PROJECT YOUR VALUES "I could tell from the little recruitment blip that they weren't just looking for people who wanted the most money; they were looking for caring primary docs."

Perry Farb, MD

hard questions about the strategy of the practice. For example, "What are your payer contracts? Are you planning to get an EMR? Why or why not? What are your goals for cash-based procedures?" Look at strategy. If they don't have a good strategy to survive, you'll join a practice that may not be able to support you."

New physician Lin says the new top issue for many young doctors today is less about getting a job than selecting the best one based on personal priorities. "There are so many jobs out there that, theoretically, if you just opened it up to all of them, you'd be just flooded," he says. "So the first thing to do is to figure out what's most important to you. Is it to be close to family, to be in an academic setting, or compensation? Once you've cut that number down — say you want to be in the Southeast in a large city — then you can look at the other parameters. ... As far as getting the right deals, I think most fellows understand that, given the demand, they have a little bit more leverage than they did a couple years ago."

\$100,000 in education debt is tough; they can't buy a house." Worse, in such heavy managed-care markets, reimbursement continues to be dismal.

For some practices, a better strategy may be considering growth options that don't require hiring new physicians.

Like what? Well, you could start dropping bad managed-care contracts. You will lose some patients, but you'll still be OK financially since you'll retain a more lucrative patient base.

"Stop accepting the bottom 20 percent" of your plans, suggests Borglum. "If you are still too full, cut another 20 percent. I have some groups who have cut themselves down to three HMOs, and that's it. They are paid pretty well and have negotiated an elimination of the hassle factor. For example, they get rid of preauthorizations. They improve their efficiency and get paid better. ... It's hard to do because patients will complain, and there are patients with hardships, but

3. Executive Summary

Through the establishment of the South Carolina Low Country Senior Health Network, the Medical University of South Carolina and our partners seek to achieve more cost-effective, high quality care for Medicare beneficiaries in the region through modifications to the current care delivery model and changes to Medicare payment mechanisms. The program's target population is the 57,411 Medicare beneficiaries and related provider community in Berkeley, Charleston and Dorchester, three counties of the South Carolina 'Low Country.' This area was specifically chosen because of the diverse demographics of its seniors and its particularly high prevalence of health disparities. A large portion of beneficiaries in this area are poor, have extremely low health literacy, and face significant health inequities, whether ethnic/racial, socio-economic or gender-related. The program centers on coordinating care between primary care providers, principal provider specialists, hospitals, nursing homes, hospices and other health care resources within a delivery system that is at present poorly organized, with little Medicare managed care experience and little formal health care services integration. Due to the character of the beneficiary population in the region, coupled with the nature of the provider community, results that demonstrate improved quality and reduced cost of care in this region would yield noticeable value to the region and would be applicable to the broader Medicare fee-for-service population.

The proposed major system innovations are: 1) implementation of a new model of primary care, the 'Patient Centered Medical Home' (PCMH), 2) deployment of information system infrastructure for health professional and beneficiary care coordination, and 3) an introduction of an innovative long-term care management model designed to reduce hospitalizations and address transitions between care settings.

Specific objectives across all system components include fostering usage of evidence-based

practices, introducing continuous quality and patient safety improvement, increasing shared decision-making between providers and patients and improving the delivery of culturally and ethnically appropriate care. Through the three main intervention areas listed above, and utilizing the combined strengths of the participating organizations, we will also seek to address three overarching, patient-centered areas in desperate need of attention in Medicare: health literacy, medication safety, and end of life care.

The new primary care delivery model, the Patient Centered Medical Home, will improve access to office-based care and enhance patient knowledge and self-management skills. PCMH providers will be compensated for efforts expended as they more closely follow their patient's care across the entire health care system. Providers will be paid for new types of patient centered visits and for managing their patient's care over time and across sites of care. In addition, new financial incentives tied to quality measures will reward providers for improved performance.

The Senior Health Network will support the health professional by adding resources to coordinate care, creating a multidisciplinary team that is connected to the physician and to each other through a sophisticated information system infrastructure. As part of the program, the network will provide patient education materials, which will assist the patient in improving self-management skills. Information technology infrastructure will give health care providers timely information about patients and their care across all sites of care. IT tools will help physicians facilitate their use of best practice guidelines and improve practice workflow, give patients access to both personal and general health information, enable patients to communicate electronically with their doctors, and tie together system-wide information in ways that will support more shared decision making. Multi-disciplinary resources will be especially focused on highest risk beneficiaries and concentrate on care transitions.

The long term care management strategy brings the multi-disciplinary team and IS infrastructure to long-term care facilities. The program will provide in-facility nurse case management and pharmacist services, and improve communication with physicians. These steps will improve responsiveness to beneficiary and facility staff needs and reduce the incidence of preventable emergency department visits and hospitalizations.

This program is designed to be at least budget neutral to CMS. It includes changes to the Medicare reimbursement system designed to support program objectives. In particular, providers will be compensated for efforts expended as they more closely follow their patient's care across the entire health care system. In return for agreeing to serve as a 'Patient-Centered Medical Home' for a Medicare patient, a provider will be paid a Management fee that corresponds to the level of effort a patient will require. This per-beneficiary monthly management fee has two-components: a fixed fee based on meeting the criteria of the PCMH, and a variable fee based on achieving quality of care process and outcomes measures. This performance fee will link financial incentives to quality measures and improved performance for these patients and will give providers an opportunity to be compensated for their increased effort. Enhanced payment levels for certain visit codes will create opportunities for providers to be correctly reimbursed for staying more involved in their patient's care over time, especially as they transition across healthcare venues. These payment changes will reinforce the care delivery changes, encourage care coordination, and be offset by anticipated savings.

The Medical University of South Carolina (MUSC), the oldest academic health center in the south, is the prime contractor and a major provider of care to Medicare beneficiaries in the region. MUSC also brings the academic resources of the Departments of Family Medicine and Internal Medicine, and the Center on Aging, Center for Health Disparities Research, and the

Center for Medication Safety. Additional physician primary care practices will be recruited to the network based on new or existing relationships with MUSC faculty.

Partnerships with McKesson Health Solutions (McKesson) and Enhanced Care Initiatives (ECI) strengthen this proposal. McKesson, the nation's largest provider of health care information systems and services, brings its experience in delivering care management and coordination services to risk-stratified populations. McKesson also provides technology infrastructure to the program. ECI contributes proven staff and programs in the long term care setting. In addition, we are developing partnerships with country's foremost physician membership organizations representing primary care physicians: the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and the Society of General Internal Medicine (SGIM).

In addition to these partnerships, the following stakeholders have expressed support for the project: the South Carolina Primary Care Association, the American College of Physicians, the Society of General Internal Medicine, American Academy of Family Physicians, MUSC leadership, and the Honorable Senator James DeMint. Letters are included in Appendix 1.

This proposed model of care provides physicians with the support, incentives, and technology to deliver high quality, cost effective care. By combining a provider directed care model with a population perspective, we intend to empower beneficiaries and communities to attain higher levels of health status through informed and guided decision making. The success of this model can serve as a test case for wider applicability in other Medicare fee-for-service settings as well as with other payers within South Carolina who have expressed interest in exploring adopting this model of care for their populations.

Medical University Hospital Authority Budget Policy

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Operating Budget:

Each fiscal year, the Authority shall submit an Operating Budget to the Board of Trustees for approval. The Operating Budget will be submitted to the Board prior to the start of the fiscal year, unless otherwise authorized by the Board of Trustees. The Operating Budget shall be approved in aggregate for all operating expenses up to the approved amount. The Authority must maintain documentation of their budgeting process in sufficient detail to allow the tracking of expenses at an appropriate organizational level (i.e., entity-wide, department, or unit). Should the Authority determine that operating expenses will exceed the aggregate amount of the approved Operating Budget, permission to exceed the approved Operating Budget shall be sought prior to expending funds in excess of the approved Operating Budget. The Operating Budget shall include operating leases and will include details of each operating lease, such as the lease term and total extended cost of the lease. Additionally, separate schedules detailing the following budgeted operating expenses will be included in the operating budget:

- Consulting contracts of \$50,000 or more, including all expenses; and
- Real estate leases where the value exceeds \$150,000 for the term of the lease including options.

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In compliance with the Board of Trustees retained authority, leases of real estate where the value exceeds \$150,000 for the term of the lease including options that were not detailed in the operating budget, shall have prior approval of the Board of Trustees.

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The decision to incur operating expenses that will continue into subsequent years shall receive prior written approval of the Board of Trustees.

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Capital Budget:

Each fiscal year, the Authority shall submit a Capital Budget to the Board of Trustees for approval. The Capital Budget will be submitted to the Board prior to the start of the fiscal year, unless otherwise authorized by the Board of Trustees. This budget will include expected Capital Improvement projects (as defined below) and capital equipment purchases. The Board's approval of the Capital Budget is line-item approval for the specified capital purchases. The Capital Budget must provide sufficient line item detail to track capital purchases back to the line item Capital Budget. Each year, management may include in the Capital Budget an amount for unspecified capital purchases. This amount will not exceed \$5 million and the line-item will be included in the Capital Budget that will be brought to the Board for approval. For all line-items over \$250,000,

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administration must seek additional approval for capital purchases if the purchase exceeds by 10% or \$250,000, whichever is less, the line-item amount approved in the Capital Budget prior to expending any funds on the item. Any additional cost over the line item amount will come from the Board approved allowance for unspecified items unless other funds are identified, disclosed, and available. For line items under \$250,000, amounts in excess of the line item approved amount will come out of the Board approved allowance for unspecified capital purchases as long as the total cost does not exceed \$250,000. The Capital Budget shall include capital leases and will include details of each capital lease, such as the lease term and total extended cost of the lease.

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Capital (Permanent) Improvements are defined as:

1. Any acquisition of land, regardless of cost;
2. Any acquisition (as opposed to the construction) of buildings or other structures, regardless of cost;
3. Construction of facilities and any work on existing facilities including their renovation, repair, maintenance, alteration or demolition in those instances where the total cost of all work involved is \$100,000 or more;
4. Architectural, engineering and other types of planning and design work, regardless of the cost, which is intended to result in a permanent improvement project. Master plans and feasibility studies are not permanent improvement projects and, therefore, are not to be included;
5. Capital lease purchase of any facility acquisition or construction; and
6. Equipment that either becomes a permanent fixture of a facility, or does not become permanent but is included in the construction contract.

Any capital equipment purchases or Capital Improvement projects valued at more than \$250,000 which were not included in the annual Capital Budget shall have prior approval of the Board of Trustees. Unspecified capital purchases (those items that were not specified in the Capital Budget) up to \$250,000 must be approved in writing by the President or the Executive Director until the aggregate amount of these unspecified expenses meets the Board approved allowance for unspecified capital purchases (not to exceed \$5 million) as provided for in the Capital Budget. The President or the Executive Director of the Hospital may designate an individual in writing to approve unspecified capital purchases between \$5,000 and \$50,000 on his/her behalf. In the event of urgent circumstances, the President may approve Capital Improvement projects or capital equipment purchases valued at more than \$250,000 with the concurrence of the Chairman of the Board, and seek the full Board's approval at the next Board of Trustees meeting.

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When a Capital Improvement project has been submitted to and approved by the Board of Trustees, consequential individual construction contracts (sub-contracts), which shall be awarded to the lowest reasonable and responsible bidder and which have followed all established selection criteria, shall not require a second Board of Trustees approval (unless the cumulative amount of such contract exceeds the initial approval by 10% or \$250,000, whichever is less).

The Total Budget for the Authority shall be the sum of the Operating Budget and the Capital Budget. And the total budget shall not exceed expected revenues unless management identifies additional funding and the Board approves such excess.

Grant Expenditures:

Expenditures that are fully funded from active grant funds for grant specified equipment, supplies, services, etc. do not require separate approval by the Board of Trustees if the grant contains sufficient detail regarding the items to be purchased, except consultant and construction services. All purchases for consultant services in excess of \$50,000 and construction services in excess of \$100,000, including expenses, shall receive prior approval of the Board of Trustees.

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Affiliated Organizations:

At a minimum, all purchases, Capital Improvement projects, contracts, and leases in excess of \$50,000 will be presented as information to the Board of Trustees. All affiliation agreements between the Authority and its affiliate organizations shall have prior approval of the Board of Trustees.

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Leases of real estate where the value exceeds \$150,000 for the term of the lease ¶ (including options), shall have prior approval of the Board of Trustees. ¶
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Consultant Services: ¶
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Consultant services are professional services performed by an expert (one who is very skillful and knowledgeable in a special field), who is generally not employed by the institution, and performs an advisory role or acts as a counselor in a situation in order to add value. All purchases for consultant services in excess of \$50,000 shall receive prior approval of the Board of Trustees. ¶

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MUSC MEDICAL CENTER

PERFORMANCE IMPROVEMENT PLAN

2006-2008

The Medical University of South Carolina Medical Center is committed to fostering an environment that promotes high quality care and patient safety. This commitment has developed into an institutional strategy that aligns governance, managerial, and clinical support functions and personnel to continually assess our performance and proactively identify opportunities for enhancing quality of care and patient safety by preventing medical errors before they occur. Recognizing the inevitability of adverse events and some medical errors in complex healthcare settings, we stand committed to learning from these events, developing safeguards to prevent their recurrence, and addressing the impact of adverse events on patients and families.

This Performance Improvement Plan establishes a network for continually and systematically planning, designing, measuring, assessing and improving performance of hospital wide key functions and processes that support high quality and safe patient care. Central components of this network are as follows:

- Incorporate quality planning throughout the Medical Center;
- Create an organizational structure that allows personnel and clinical units to integrate their efforts in performance improvement and collaborate across departmental boundaries;
- Communicate performance improvement efforts throughout the Medical Center to foster institutional learning and encourage innovation and problem solving at the clinical unit level;
- Assure project prioritization, process design and redesign are consistent with the Medical Center's mission, vision and values;
- Foster institutional self assessment exercises that benchmark our performance against the "dimensions of performance" that direct care to be safe, effective, efficient, patient-centered, timely, and equitable.

- Reduce unexplained practice variation by promoting best clinical practices that are consistent with current professional knowledge as defined by evidence-based reports, practice guidelines, information from relevant systematic reviews and high-quality clinical investigations, and professional standards;
- Integrate error reduction procedures in healthcare processes; and
- Integrate the utilization of performance improvement principles in the daily activities of the work place.
- Link the education of our trainees to the science of performance improvement.
- Foster clinical research that examines processes of care and performance improvement.

This plan follows the “structure-process-outcome paradigm” of performance assessment and monitoring first described by Avedis Donabedian (1979, National Center for Health Services Research; 1983, Evaluation & the Health Professions). This paradigm provides the network for describing the MUSC Medical Center’s plan for continuously improving the safety and quality of our care processes.

I. SCOPE OF SERVICES

The MUSC Medical Center provides a full continuum of inpatient and outpatient care including:

Acute Inpatient Services:

Surgery (including Level I Trauma)
 Medicine
 Women’s
 Children’s (including a Level III Neonatal ICU)
 Cancer
 Cardiovascular
 Transplant
 Digestive Disease
 Psychiatric

Emergency Services:

Level I Trauma (including Adult and Pediatric Services)
 Air and Ground Transport

Outpatient Services:

Hospital Ancillaries
 Physician and Other Clinician Services as defined in Acute Inpatient Services

Partial Hospitalization Services:

Psychiatry
 Transplant

II. MISSION STATEMENT

The mission of the Medical Center of the Medical University of South Carolina is to provide excellence in patient care, teaching, and research in an environment that is respectful of others, adaptive to change, and accountable for outcomes.

III. VISION STATEMENT

The clinical enterprise of MUSC will be a leading academic health care organization that is part of a geographically dispersed patient care delivery system. The clinical enterprise will offer a full range of services, including nationally and internationally recognized specialty services.

MUSC will establish strategic alliances to serve the state of South Carolina and will provide an educational environment that is at the forefront of academic health sciences and supports MUSC's role in cutting-edge scientific discoveries.

MUSC's clinical enterprise will include:

- A flexible structure that allows MUSC to achieve its vision.
- Excellent and safe patient-focused care.
- A broad based provider network.
- Integrated decision-making.
- A commitment to health promotion and illness prevention.

IV. ORGANIZATIONAL VALUES

In the development and operation of the State's premier integrated delivery system, the Medical Center relies upon a core set of values to achieve its stated mission. These values are as follows:

Accountability

Accepting responsibility for actions and using resources prudently to ensure the success of the organization. Each Medical Center employee is dedicated to the collaborative effort of providing health services in a manner which maximizes operational efficiency, demonstrates quality through teamwork, assures a safe environment, and thrives in a competitive market.

Respect

Relationships with all customers, both external and internal, are vital assets. Satisfaction with the ability to serve patient needs in a respectful and caring manner determines the success of the Medical Center.

Excellence

Success is measured by the ability to be recognized for excellence in clinical outcomes within a setting which maintains high ethical standards and is sensitive to the importance of patient rights.

Adaptability

Services are focused on the needs of customers. The ability to be collaborative, creative, and flexible in a changing market is a trait which positions the Medical Center as the premiere provider of health services in the community and region.

V. QUALITY DEFINITION

MUSC Medical Center formally adopts the Institute of Medicine's definition of quality which is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Committee on Quality of Health Care in America *Crossing the Quality Chasm*, Washington, DC, National Academy Press, 1999, p. 232).

The Medical Center translates this formal definition into an operational phrase that "brands" our efforts to integrate quality, safety and performance improvement.

"Do the right thing the right way".

Technically competent care, grounded in a context of good communication and shared decision-making in a culturally sensitive model, characterizes the quality and safety of the patient care culture at MUSC Medical Center.

Specific information related to error prevention and error reduction is found in the Patient Safety Program.

VI. ORGANIZATION

The MUSC Medical Center Quality and Safety Network is the interdisciplinary structure that drives and coordinates the error reduction and performance improvement activities within the medical center. This structure represents a systematic organization-wide approach to planning for quality results.

The Quality and Safety Network focuses on the patient and organizational functions that promote positive patient outcomes by standardizing processes of care across the medical center. Through the committees and communication channels of the Quality and Safety Network, improvement efforts and error reduction activities within these functions are identified, prioritized, and quantified. This Network represents a transition from an approach in which performance improvement is a distinct set of activities to one

in which performance improvement is integrated into the operational structure of each service as well as across the organization. This cross-organizational approach ensures that monitoring and evaluation of important functions occur within existing operational and medical staff committees.

There are two types of performance improvement projects. The first are the large-scale, organization-wide performance improvement projects. These projects are initiated by senior management to support key strategic and operational objectives. Progress on these projects is reported to the Quality Council. The second type of project are the smaller-scale, service projects. These smaller projects are initiated from within any component of the organization and are reported annually to the Quality Council, the Medical Executive Committee and the Board of Trustees.

THE BOARD OF TRUSTEES

Purpose:

The MUSC Board of Trustees is responsible of the quality of patient care provided. The Board of Trustees requires the medical staff to implement and report on the activities and mechanisms for monitoring, assessing and evaluating patient safety practices and the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care and services or performance throughout the facility.

The Board of Trustees is supported by the medical center policies, Medical Staff Bylaws and this Performance Improvement Plan. The MUSC Board of Trustees delegates and directs the Hospital Administration and the Medical Staff to:

- Recommend the strategic direction.
- Require reports and mechanisms for monitoring and evaluating the quality of patient care services to include the frequency of monitoring.
- Provide resources and support systems for performance improvement functions related to patient care services and safety.
- Require mechanisms to assure that all patients with the same health problem are receiving comparable levels of care in the Medical Center.
- Review information needed to educate the Board members about their responsibility for the quality and safety of patient care.
- Evaluate the Performance Improvement Plan biannually.

THE MEDICAL EXECUTIVE COMMITTEE (MEC)

Purpose:

The MUSC Medical Center MEC is comprised of senior physician and administrative leadership from all components of the clinical enterprise. The MEC has responsibility for overseeing, supporting, and evaluating the Quality and Safety Network structure and outcomes. This committee is the structure that ensures medical staff leadership and involvement in performance improvement and that ensures coordination and accountability among department chairs, faculty, and residents.

The MEC delegates the responsibility of performance improvement to the Department Chairs. More specifically, the purpose of the MEC is to ensure high quality, safe, patient-centered, cost-effective care throughout the MUSC's clinical enterprise.

QUALITY COUNCIL (QC)

Purpose:

The MUSC Medical Center Quality Council, made up of administrative and physician leaders, oversees and coordinates the performance assessment and improvement activities within the organization. This group ensures that improvements are planned, designed, measured, analyzed, and sustained. More specifically, the Quality Council:

- Operationalizes improvement activities that are consistent with the MUSC Medical Center Strategic Plan.
- Receives reports and takes action on issues and initiatives that address patient rights, patient assessment, patient care, education, continuum of care, performance improvement, leadership, environment of care, human resources, resource utilization, information management, and infection control among others.
- Uses performance data in the design and evaluation of new services or programs.
- Identifies improvement actions to be taken, assigns in writing responsibility for each action, and ensures accountability for follow through.
- Oversees analyses of sentinel events and ensures appropriate risk reduction strategies are implemented.
- Oversees organizational Failure Mode Effects and Analysis and ensures appropriate risk reduction activities.

- Supports education for key personnel on the approaches and methods of performance improvement.
- Selects, prioritizes, and monitors the progress of the organization-wide quality improvement projects.
- Allocates financial resources necessary to support organization-wide quality improvement projects.
- Manages the flow of information to ensure effective communication and follow-up.
- Communicates performance assessment information and improvement activities to the MUSC Board of Trustees.
- Ensures that the performance improvement infrastructure meets JCAHO and other regulatory standards.

PATIENT SAFETY COMMITTEE

Purpose:

With designated responsibility from the Quality Council, the Patient Safety Committee will operate as a subcommittee of the Quality Council dedicated to the implementation and monitoring of the effectiveness of the Patient Safety Program.

ORGANIZATION-WIDE PERFORMANCE IMPROVEMENT TEAM

Purpose:

Organization-wide Performance Improvement (PI) Teams at the MUSC Medical Center are multidisciplinary teams that are charged by senior leadership to use the I.M.P.R.O.V.E. MODEL (See Section VII below) to make improvements in a specific process. PI teams use the principles, concepts, and tools of basic statistical and performance analysis to define, analyze, measure and improve the key processes that achieve the outcomes that meet our patients', families', and health care providers' needs.

Selection of organization-wide projects is based on alignment with strategic initiatives as well as those processes that are known to jeopardize the safety of the patient or are associated with sentinel events as published in the literature.

SERVICE AND PATIENT POPULATION COMMITTEES

The MUSC Medical Center Service and Patient Population Committees are organized around specific patient populations with the purpose of overseeing efforts to continuously assess and improve patient outcomes. Department Chairs are responsible for the development and oversight of these committees.

The committees will:

- Identify and review on-going performance measures.
- Review high volume, high cost, and/or problem-prone invasive and non-invasive procedures.
- Prioritize and select performance improvement projects in alignment with the organization's strategic improvement priorities.
- Select one project annually that will focus on enhancing the safety of the care through error reduction or error prevention.
- Oversee these I.M.P.R.O.V.E. projects.
- Collect data and perform comparative analysis.
- Determine if action is necessary based on comparisons and patterns of variation.
- Evaluate the effectiveness of action plans for organization-wide implementation.
- Focus on processes and activities that affect quality of patient care and services with an emphasis on reduction in variation of outcomes through the integration of evidence-based practice.
- Emphasize important patient care functions such as assessment, nutritional care, treatment, patient and family education, patient rights/advocacy and the continuum of care.
- Partner nurses, physicians, ancillary support services, and patients to monitor safe and effective care based on established standards.
- Assure appropriate resource utilization.
- As appropriate utilize Clinical Pathways and Variance Records to document opportunities and performance improvements.

- Participate in continuing education opportunities related to patient care process improvement and outcomes.
- Establish effective communication channels.
- Report annually to the Quality Council, Medical Executive Committee and the Board of Trustees.

KEY FUNCTIONS

There are many key functions that support positive patient outcomes. These functions are performed by many different clinical and support staff, with appropriate input, participation, and leadership by physicians. Some of these functions are managed through committees, while others rely on advisory panels or other mechanisms. Regardless of the method, those responsible for key functions report relevant performance information through the Quality Council and Medical Executive Committee, to the Board of Trustees. Those responsible for these functions will:

- Identify and review on-going performance measures.
- Prioritize and select performance improvement projects in alignment with the organization's strategic improvement priorities.
- Oversee these I.M.P.R.O.V.E. projects.
- Collect data and perform comparative analysis.
- Determine if action is necessary based on comparisons and patterns of variation.
- Evaluate the effectiveness of action plans for organization-wide implementation.
- Focus on processes and activities that affect quality of patient care and services.
- Monitor safety and effectiveness of care based on established standards.
- Assure appropriate resource utilization.
- Establish effective communication channels.
- Coordinate with and support the improvement efforts of the patient population committees.
- Report frequency as indicated in Appendix #1.

Key Functions that act in support of patient care include the following:

Human Resources, Environment of Care, Operating Room, Ethics, Pharmacy and Therapeutics, Nutritional Therapy, Infection Control, Blood/Pathology, Medical Records/IM, Acute Care/Utilization Management, Policy Review, Ambulatory Care and Patient Safety.

VII. PERFORMANCE IMPROVEMENT METHODOLOGY

The Improvement Process

In an effort to continually improve organizational performance and maintain the safety and quality of patient care, MUSC Medical Center evaluates the development of new processes as well as the redesign or improvement of existing processes.

A systematic approach is utilized to:

- Problem solve, identify the new process or potential improvement.
- Assess/test the strategy for change.
- Analyze data from the test (to determine if the change produced the desired result).
- Implement the improvement strategy system-wide when applicable.
- Monitor for sustained change.

Improvement projects use the ***I.M.P.R.O.V.E.*** model described below and are documented with the forms on the Quality Network web page (www.musc.edu/qn/).

- I Identify a problem or an opportunity
- M Establish a measurement
- P Problem analysis
- R Remedy Selection
- O Operationalize the interventions
- V Validate the effectiveness of your interventions
- E Evaluate whether your improvement is sustained

VIII. SELECTION OF IMPROVEMENT PRIORITIES

Organizational improvement priorities are selected both proactively and in response to problems that are identified through ongoing assessment of data and analysis of adverse events. More specifically, the following sources of information are used to identify improvement opportunities:

- Strategic planning process
- Benchmark and other external comparative data
- Patient satisfaction data/complaints
- Occurrences, Near Misses and Safety Concerns
- Sentinel events
- Staffing Effectiveness Indicators
- Other performance data

To support the selection of projects that are consistent with these priorities as well as other patient care issues, the following rating form is a tool that facilitates the systematic evaluation and selection of projects when there are multiple opportunities for improvement that are competing for resources.

Initiative Rating

Project Title: _____

Criteria	Guidelines for Scoring	Score	Mean
I. Mission/Strategy: Degree to which initiative is supportive of:			
a) MUSC Mission	1= not related 5= highly supportive		Mean Category Score: _____
b) Strategic Plan	As above		
c) Patient Population of strategic importance	1= minimal strategic importance 5= major strategic importance		
II. Outcome: Degree to which initiative will improve:			
a) Medical outcomes	1= small improvement 5= large improvement		Mean Category Score: _____
b) Patient perceived functional status	As above		
c) Access to Care	As above		
d) Patient Family Satisfaction	As above		
e) Patient Safety	As above		
f) Healthcare professional satisfaction	As above		
III. Process Improvement Degree to which initiative:			
a) Improves a key process	1= low impact process 5= key process		Mean Category Score: _____
b) Facilitates system integration	1= small scale impact 5= large scale impact		
c) Facilitates the full continuum of care	As above		
d) Is redundant with other efforts	1= duplicates other efforts 5= new areas		
IV. Financial Outcomes: Degree to which initiative will improve:			
a) MUSC financial status	1= small improvement 5= large improvement		Mean Category Score: _____
b) MUSC attractiveness to payors	1= no request from payors 5= numerous requests from payors		
V.. Project Feasibility Estimated:			
a) MUSC Outlay of resources/personnel	1= large personnel/resource needs 5= few personnel/resource needs	_____	Mean Category Score: _____
b) Length of study/project	1= long duration 5= short duration	_____	
c). Impact on aligned or associated programs	1= significant negative impact 5= significant positive impact	_____	
d) Leadership availability	1= significant barriers to identifying an effective leader 5= effective leader available	_____	
	Overall Score (sum of average scores)		

IX. MONITORING AND EVALUATION PROCESSES

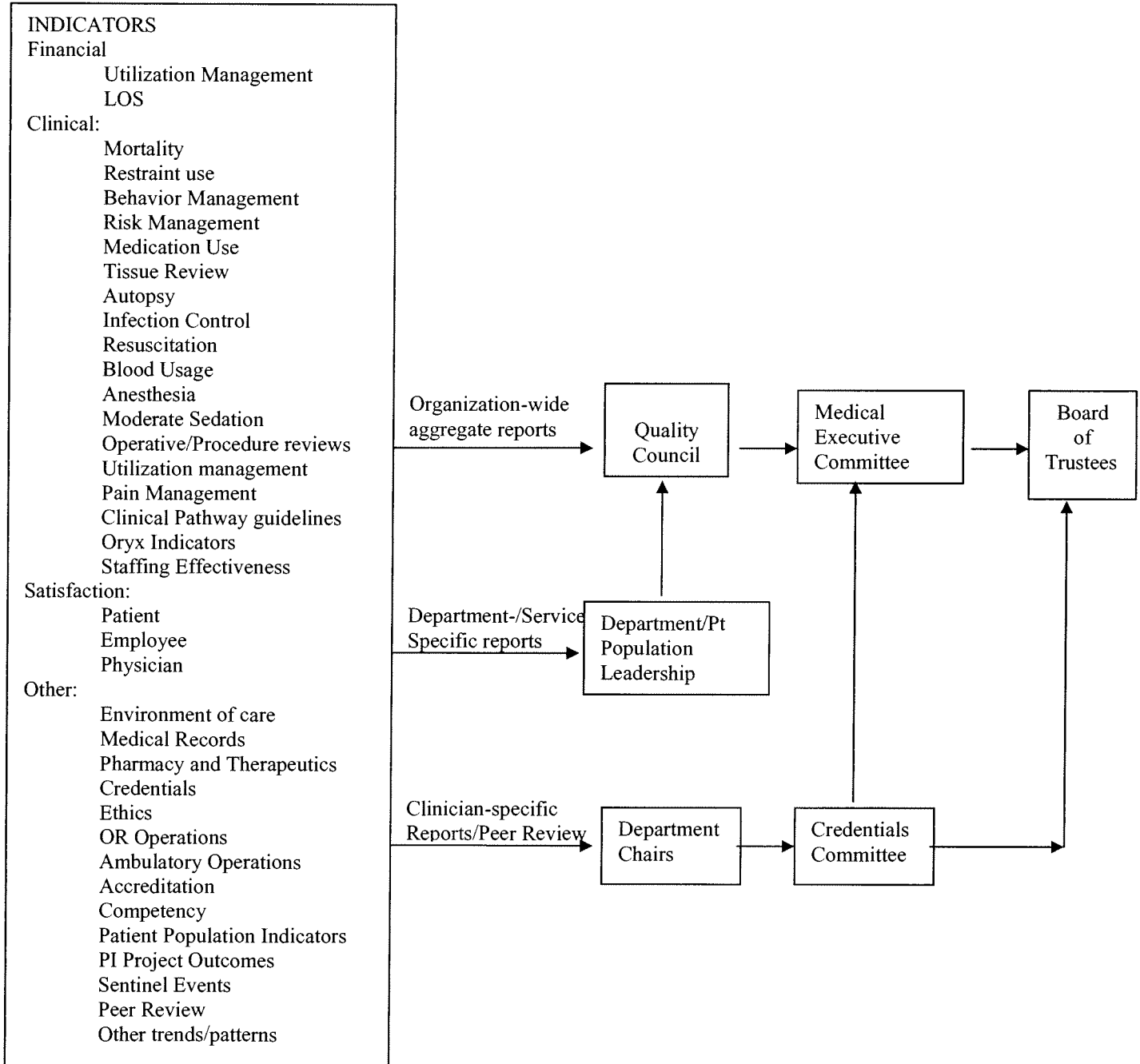
The Board of Trustees, management, clinical, and support services believe that indicators are central to the performance improvement process. The MUSC Medical Center leadership has identified a number of organization-wide performance indicators that will be monitored on an ongoing basis. These indicators have been identified to assess and measure the performance of key services and functions within the organization. The MUSC Medical Center leadership appreciates that indicators are not direct measures of quality, but instead are flags that may suggest areas for potential analysis.

The MUSC Medical Center leadership through the Quality Council and the Medical Executive Committee monitor the organization-wide performance indicator data which are coordinated through the Quality Management Department. In addition, these groups determine if the data reveal acceptable statistical means and variation and if the data display any statistically unusual patterns. If any unusual patterns are detected, further investigation is conducted to determine the cause. Improvement efforts would subsequently bring the function under control. Improvement efforts might also be initiated to improve the mean and/or amount of variation. Once the areas that require improvement are confirmed, an action is planned and then implemented. A reassessment effort and episodic monitoring is completed to ensure that the changes have had their intended effect and have been sustained.

X. INFORMATION FLOW:

Multiple departments and disciplines contribute to the evaluation and improvement of clinical care delivery through their participation in the monitoring process and interdisciplinary committees and teams. The organizational indicators, level of analysis and flow of information are summarized in the following chart.

MUSC Medical Center Performance Information Flow



XI. ANNUAL EVALUATION:

The Performance Improvement Plan will be reviewed and evaluated biannually by the Quality Council and the Medical Executive Committee. In addition, participation of department committees will be monitored and evaluated.

The following criteria will be used in the evaluation of this plan:

- Utilization of IMPROVE methodology
- Dissemination of Important lessons learned across the organization
- Project initiation was driven by the data or literature
- Teams and individuals evaluated the effect and sustainability of the change
- Increased development of evidence based practice guidelines
- Statistically significant improvement should be achieved on the organizational improvement priorities
- Use of the literature in the prevention of adverse events

Approved:

Medical Executive Committee, August 16, 2006

Board of Trustees, October 13, 2006

MEDICAL EXECUTIVE COMMITTEE

Credentials Committee Report

MEDICAL EXECUTIVE COMMITTEE

Credentials Committee Report

16-Aug-06

The Credentials Committee reviewed these applicants for appointment/reappointment/change in privileges on August 9, 2006, and recommend approval by the Medical Executive Committee.

Status Legend: AC=Active; PA=Prov. Active; AF=Affiliate; PF=Prov. Affiliate; AFC=Affiliate [CFC]; PAFC=Prov. Affiliate [CFC];
AH=Allied Health; PH=Prov. Allied Health; HE=Allied Health [External]; PE= Prov. Allied Health [External]
SB=Sabbatical; AD=Administrative

Application Type: APPT=Appointment; REAP=Reappointment; REIN=Reappointment with Increase; INCR=Increase; CHNG=Change

EXPEDITED APPLICANTS FOR APPOINTMENT

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Cuoco, Theresa M.	MD	PA	MED	IMED	8/9/2006	8/16/2006	10/13/2006	NEW
Owens, Jack R.	CRNA	PH	ANES		8/9/2006	8/16/2006	10/13/2006	NEW
Singleton, Kelly	OD	PH	OPHT		8/9/2006	8/16/2006	10/13/2006	NEW

APPLICANTS FOR APPOINTMENT

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Allen, Cynthia L.	FNP, PhD	PH	PEDS		8/9/2006	8/16/2006	10/13/2006	NEW
Amlicke, James A.	MD	PA	ORTH		8/9/2006	8/16/2006	10/13/2006	NEW
Edwards, Nyala	PA-C	PH	MED	EMER	8/9/2006	8/16/2006	10/13/2006	NEW
Erbe, Lee A.	FNP	PH	MED	ENDO	8/9/2006	8/16/2006	10/13/2006	NEW
Field, Larry C.	MD	PA	ANES		8/9/2006	8/16/2006	10/13/2006	NEW
Furse, Cory M.	MD	PA	ANES		8/9/2006	8/16/2006	10/13/2006	NEW
Lee, Kimberly G.	MD	PA	PEDS	NEON	8/9/2006	8/16/2006	10/13/2006	NEW
McPherson, Rebecca J.	MD	PA	PEDS	NEON	8/9/2006	8/16/2006	10/13/2006	NEW
Murphy, Jennifer K.	MD	PA	MED	RHEU	8/9/2006	8/16/2006	10/13/2006	NEW
Olson, Rick L.	MD	PA	PEDS	PGEN	8/9/2006	8/16/2006	10/13/2006	NEW
Rhodes, Dolores Y.	MD	PA	MED	GAST	8/9/2006	8/16/2006	10/13/2006	NEW
Ruth, Natasha M.	MD	PA	PEDS	RHEU	8/9/2006	8/16/2006	10/13/2006	NEW
Stewart, Scott H.	MD	PA	MED		8/9/2006	8/16/2006	10/13/2006	NEW
Ward, Jr., Daniel B.	MD	PA	DERM		8/9/2006	8/16/2006	10/13/2006	NEW
Williams, Amy A.	PNP	PH	PEDS	PULM	8/9/2006	8/16/2006	10/13/2006	NEW
Woolf, Shane K.	MD	PA	ORTH		8/9/2006	8/16/2006	10/13/2006	NEW

APPLICANTS FOR REAPPOINTMENT

<u>Practitioner</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
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There were no applicants for reappointment

MEDICAL STAFF/ALLIED HEALTH PROFESSIONALS - Increase/Decrease/Change in Privileges

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Bachman, David L. Sleep Studies	MD	AC	NSCI	NEUR	8/9/2006	8/16/2006	10/13/2006	INCREASE

MEDICAL EXECUTIVE COMMITTEE

Credentials Committee Report

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Maniu, Calin V. Moderate Sedation	MD	AC	MED	CARD	8/9/2006	8/16/2006	10/13/2006	INCREASE
McGary, W. Brett Moderate Sedation	MD	AC	MED	EMED	8/9/2006	8/16/2006	10/13/2006	INCREASE
Sullivan, Scott A. Repair Ventral of Incisional Hernia, Incision/Excision Region of Abdominal Wall, Peritoneum, Omentum, Partial Cystectomy, Repair Fistula,	MD	AC	OB/GY	MATE	8/9/2006	8/16/2006	10/13/2006	INCREASE
Unal, Sheref H. Moderate Sedation Additional privileges to work in the Pediatric ER.	MD	PA	PEDS	PEMG	8/9/2006	8/16/2006	10/13/2006	INCREASE

MEDICAL EXECUTIVE COMMITTEE

Credentials Committee Report

MEDICAL EXECUTIVE COMMITTEE

Credentials Committee Report

20-Sep-06

The Credentials Committee reviewed these applicants for appointment/reappointment/change in privileges on 09/13/2006, and recommend approval by the Medical Executive Committee.

Status Legend: AC=Active; PA=Prov. Active; AF=Affiliate; PF=Prov. Affiliate; AFC=Affiliate [CFC]; PAFC=Prov. Affiliate [CFC];
AH=Allied Health; PH=Prov. Allied Health; HE=Allied Health [External]; PE= Prov. Allied Health [External]
SB=Sabbatical; AD=Administrative

Application Type: APPT=Appointment; REAP=Reappointment; REIN=Reappointment with Increase; INCR=Increase; CHNG=Change

EXPEDITED APPLICANTS FOR APPOINTMENT

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Borg, Keith T.	MD	PA	MED	EMER	9/13/2006	9/20/2006	10/13/2006	NEW

APPLICANTS FOR APPOINTMENT

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Beall, Ashley D.	MD	PA	MED	RHE	9/13/2006	9/20/2006	10/13/2006	NEW
DeLambo, Amy Jo.	ANP	AH	MED	CAR	9/13/2006	9/20/2006	10/13/2006	NEW
Gregg, David	MD	PA	MED	CAR	9/13/2006	9/20/2006	10/13/2006	NEW
Hartzog, Timothy H.	MD	PA	PED		9/13/2006	9/20/2006	10/13/2006	NEW
Michael, Fred A.	MD	PA	FAM		9/13/2006	9/20/2006	10/13/2006	NEW
Schaefer, Julie L.	CRNA	AH	ANE		9/13/2006	9/20/2006	10/13/2006	NEW

APPLICANTS FOR REAPPOINTMENT

<u>Practitioner</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Acierno, Ronald E.	PhD	AH	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Afrin, Lawrence B.	MD	AC	MED	HEM	9/13/2006	9/20/2006	10/13/2006	REAP
Ahmad, Naseer	MD	PA	PATH		9/13/2006	9/20/2006	10/13/2006	REAP
Ahmed, Quanta A.	MD	PA	MED	PUL	9/13/2006	9/20/2006	10/13/2006	REAP
Anderson, William D.	MD	AF	FAM		9/13/2006	9/20/2006	10/13/2006	REAP
Arthur, John M.	MD	AC	MED	NEP	9/13/2006	9/20/2006	10/13/2006	REAP
Bailey, Byron N.	MD	AC	NSCI	NEU	9/13/2006	9/20/2006	10/13/2006	REAP
Bailey, Kelly L.	PA-C	HE	ORTH		9/13/2006	9/20/2006	10/13/2006	REAP
Baird, Rebecca G.	MD	PF	OB/G		9/13/2006	9/20/2006	10/13/2006	REAP
Baker, Deborah W.	MD	PH	FAM	PGEN	9/13/2006	9/20/2006	10/13/2006	REAP
Blessing-Feussner, Carol L.	PA-C	AH	OB/G		9/13/2006	9/20/2006	10/13/2006	REAP
Book, Michael R.	MD	AFC	FAM		9/13/2006	9/20/2006	10/13/2006	REAP
Bowlby, Deborah A.	MD	PA	PED	END	9/13/2006	9/20/2006	10/13/2006	REAP
Boylan, Alice M.	MD	AC	MED	PUL	9/13/2006	9/20/2006	10/13/2006	REAP
Bratton, Charles F.	MD	PA	SURG		9/13/2006	9/20/2006	10/13/2006	REAP
Brooks, Gladney	FNP	AH	SURG	CAR	9/13/2006	9/20/2006	10/13/2006	REAP
Carmichael, Jill	CRNA	AH	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Carrick, Christina R.	MD	PA	PATH		9/13/2006	9/20/2006	10/13/2006	REAP
Chiaramida, Salvatore A.	MD	AC	MED	CAR	9/13/2006	9/20/2006	10/13/2006	REAP
Cortes, Cristina N.	MD	PA	MED	IMED	9/13/2006	9/20/2006	10/13/2006	REAP

MEDICAL EXECUTIVE COMMITTEE

Credentials Committee Report

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Craig, Brian A.	MD	PA	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Davis, Matthew P.	MD	AF	PED	PGEN	9/13/2006	9/20/2006	10/13/2006	REAP
DeAntonio, Miriam F.	MD	AC	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Dimashkieh, Haytham H.	MD	PA	PATH		9/13/2006	9/20/2006	10/13/2006	REAP
Disco, Deborah	PNP	AH	PED	HEM	9/13/2006	9/20/2006	10/13/2006	REAP
Edwards, James E.	MD	AC	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Geier, C. David	MD	PA	ORTH		9/13/2006	9/20/2006	10/13/2006	REAP
Giles, William C.	MD	AF	OTOL		9/13/2006	9/20/2006	10/13/2006	REAP
Goedecke, Aimee A.	MD	AFC	PED	PGEN	9/13/2006	9/20/2006	10/13/2006	REAP
Grubaugh, Anouk L.	PhD	PH	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Hagerty, Richard C.	MD	AC	SURG		9/13/2006	9/20/2006	10/13/2006	REAP
Halford, Jonathan J.	MD	AC	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Harvey, Susan C.	MD	AC	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Headden, Gary F.	MD	Ac	MED	EMER	9/13/2006	9/20/2006	10/13/2006	REAP
Heldrich, Cynthia M.	MD	AF	PED	PGEN	9/13/2006	9/20/2006	10/13/2006	REAP
Hinson, Vanessa K.	MD	AC	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Kitten, Lester	CRNA	AH	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Kittle, Kymberley L.	PA-C	AH	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Koya, Deepika Laxmi	MBBS	PA	MED	IMED	9/13/2006	9/20/2006	10/13/2006	REAP
Lemon, Henry M.	MD	AC	PED	PGEN	9/13/2006	9/20/2006	10/13/2006	REAP
Livengood, Suzanne E.	PA-C	AH	SURG		9/13/2006	9/20/2006	10/13/2006	REAP
McKenna, Dennis J.	CRNA	PH	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Monnier, Jeannine	PhD	AH	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Moran, William P.	MD	PA	MED	IMED	9/13/2006	9/20/2006	10/13/2006	REAP
Nessmith-Kitten, Nancy A.	CRNA	AH	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Owczarski, Stefanie M.	PA-C	AH	SURG		9/13/2006	9/20/2006	10/13/2006	REAP
Perot, Phanor L. Jr.	MD	AC	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Resnick, Heidi S.	PhD	AH	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Reigart, J. Roult	MD	AC	PED		9/13/2006	9/20/2006	10/13/2006	REAP
Reves, Joseph G.	MD	AC	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Rittenberg, Charles S.	MD	PA	OB/G		9/13/2006	9/20/2006	10/13/2006	REAP
Rodden, Ann M.	DO	PA	FAM		9/13/2006	9/20/2006	10/13/2006	REAP
Rowland, Amelia K.	CNM	PH	OB/G		9/13/2006	9/20/2006	10/13/2006	REAP
Shoemaker, Owen S.	PhD	AH	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Skoner, Judith M.	MD	PA	OTOL		9/13/2006	9/20/2006	10/13/2006	REAP
Smith, F. Mason	OD	HE	OPHT		9/13/2006	9/20/2006	10/13/2006	REAP
Soper, David E.	MD	AC	OB/G		9/13/2006	9/20/2006	10/13/2006	REAP
Spampinato, Maria V.	MD	PA	RAD		9/13/2006	9/20/2006	10/13/2006	REAP
Stickler, David E.	MD	PA	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Stickler, Laura L.	MD	PA	OB/G		9/13/2006	9/20/2006	10/13/2006	REAP
Takacs, Istvan	MD	AC	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Taylor, Brandie J.	ANP	PH	SURG	GSTS	9/13/2006	9/20/2006	10/13/2006	REAP
Tillman, Mary K.	MD	AF	PED	PGEN	9/13/2006	9/20/2006	10/13/2006	REAP
Tobin, David Patrick	CRNA	AH	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
Tolley, James H.	MD	AC	MED	EMER	9/13/2006	9/20/2006	10/13/2006	REAP
Tuite, Gerald F.	MD	PA	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Tyler, Mike O. Jr	MD	AF	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP
Velez, Juan Carlos Q.	MD	PA	MED	NEPH	9/13/2006	9/20/2006	10/13/2006	REAP
Virella-Lowell, Isabel L.	MD	AC	PED	PPUL	9/13/2006	9/20/2006	10/13/2006	REAP
Vogt, Mary Jean A.	MD	AC	MED	PULM	9/13/2006	9/20/2006	10/13/2006	REAP
Ward, Andrea R.	PA-C	AH	SURG	CSUR	9/13/2006	9/20/2006	10/13/2006	REAP

MEDICAL EXECUTIVE COMMITTEE

Credentials Committee Report

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Weiss, Edgar J.	MD	AC	PSYC		9/13/2006	9/20/2006	10/13/2006	REAP
Wendorf, Karen S.	CRNA	AH	ANES		9/13/2006	9/20/2006	10/13/2006	REAP
White, David R.	MD	PA	OTOL		9/13/2006	9/20/2006	10/13/2006	REAP
Widenhouse, Brian G.	MD	AF	SURG	PLAS	9/13/2006	9/20/2006	10/13/2006	REAP
Woodard, Frances K.	PNP	AH	PED	PCAR	9/13/2006	9/20/2006	10/13/2006	REAP
Woody, Jamie I.	PA-C	AH	OTOL		9/13/2006	9/20/2006	10/13/2006	REAP
Worthington III, W. Curtis	MD	AF	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	REAP

MEDICAL STAFF/ALLIED HEALTH PROFESSIONALS - Increase/Decrease/Change in Privileges

<u>Practitioner Name</u>	<u>Degree</u>	<u>Status</u>	<u>Dept</u>	<u>Div</u>	<u>CC</u>	<u>MEC</u>	<u>BOT</u>	<u>App Type</u>
Graves, Sherry Change Dept/Protocols from Neuroscience to Plastic Surgery	FNP	AH	SURG	PLAS	9/13/2006	9/20/2006	10/13/2006	CHANGE
Kohler, Matthew F. Addition of privileges for diagnostic and operative laparoscopy including use of electrocautery.	MD	AC	OB/G		9/13/2006	9/20/2006	10/13/2006	INCREASE
Brett-McGary, William Addition of limited emergency ultrasound	MD	AC	MED	EMER	9/13/2006	9/20/2006	10/13/2006	INCREASE
Devlin, Mitchell Moderate Sedation	MD	AF	MED	CARD	9/13/2006	9/20/2006	10/13/2006	INCREASE
Murphy, Pamela K. Addition of pharmacological therapy	CNM	PH	OB/G		9/13/2006	9/20/2006	10/13/2006	INCREASE
Resnick, Heidi S. Addition of Level 1 and Level 2 privileges omitted on last reappointment	PhD	AH	PSYC		9/13/2006	9/20/2006	10/13/2006	INCREASE
Skoner, Judith Addition of laser privileges	MD	PA	OTOL		9/13/2006	9/20/2006	10/13/2006	INCREASE
Takacs, Istvan Addition of omitted privileges: abdominal incision, bone debridement and incision, disectomy, spinal fusion, skeletal traction, local anesthetic injections, suturing of skin, muscle biopsy, CT & MRI interpretation, Halo placement, Neuroendoscopy	MD	AC	NSCI	NEUR	9/13/2006	9/20/2006	10/13/2006	INCREASE
Van Bakel, Adrian B. Moderate Sedation	MD	AC	MED	CARD	9/13/2006	9/20/2006	10/13/2006	INCREASE

**FACILITIES
HOSPITAL AUTHORITY
LEASE RENEWAL
FOR APPROVAL**

OCTOBER 13, 2006

DESCRIPTION OF LEASE RENEWAL: This lease renewal is for 7,843 square feet of office space located on the fourth floor of 135 Cannon Street. The purpose of this lease is to provide space for Business Development/Marketing Services and the Referral Call Center. The per square foot rate for this renewal is \$24.84 (rounded). The monthly rental rate will be \$16,237.85, resulting in an annual rent amount of \$194,854.22. Rental rate is subject to an annual CPI increase not to exceed 3%.

NEW LEASE AGREEMENT _____
RENEWAL LEASE AGREEMENT X

LANDLORD: University Medical Associates

LANDLORD CONTACT PERSON: Marty Phillips, Financial Analyst, 852-3109

DEPARTMENT NAME AND CONTACT: Business Development/Marketing Services,
Christine Murray, Manager, 792-7499

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

INITIAL TERM: Five (5) years
COST PER SQUARE FOOT: \$24.84
ANNUALIZED LEASE COST: \$194,854.22
TOTAL COST OF INITIAL TERM: \$974,271.11

EXTENDED TERM(S): N/A

OPERATING COSTS:
FULL SERVICE _____
NET X

**FACILITIES
HOSPITAL AUTHORITY
LEASE AMENDMENT
FOR APPROVAL**

OCTOBER 13, 2006

DESCRIPTION OF LEASE AMENDMENT: This lease amendment will add an additional 23,500 square feet of warehouse space to the current lease at 230 Albermarle Road resulting in a total square footage amount of 56,100. This additional space is needed for additional storage, staging and delivery of equipment for Phase I of the new hospital as well as storage for equipment as departments vacate the Medical Center and move to the new facility. The per square foot rate shall remain the same, \$5.62 a square foot. The new monthly rental rate to include the total square footage will be \$26,273.50, resulting in a new annual rent amount of \$315,282.00. Rent shall increase 3% on an annual basis.

NEW LEASE AGREEMENT _____
LEASE AMENDMENT X

LANDLORD: The Porter Academy

LANDLORD CONTACT PERSON: Al Trivette, Property Manager, 402-4718

DEPARTMENT NAME AND CONTACT: Support Services, John Lawrence, Manager,
792-9592

SOURCE OF FUNDS: Hospital General Operating Funds

LEASE TERMS:

INITIAL TERM:

COST PER SQUARE FOOT: \$5.62

REVISED ANNUALIZED LEASE COST:

Year 2 -2007	\$315,282.00
Year 3 -2008	\$324,740.46
Year 4 -2009	\$334,482.67
Year 5 -2010	\$344,517.15
Year 6 -2011	\$354,852.67
Year 7 -2012	\$365,498.25

TOTAL COST OF INITIAL TERM: \$2,039,373.20

EXTENDED TERM(S): N/A

OPERATING COSTS:

FULL SERVICE _____

NET X