Oaklawn Hospital Presentation Outline

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Hospital Neighborhood Committee Meeting
September 21, 2010

I. Passion, Caring and Healing
   a. Our focus is "patients first"
   b. Providing excellent service is our mission. Examples include
      i. Providing education and care for acute and chronic illnesses
      ii. Playing a role in the most joyous times of life; e.g. birth of a child
      iii. Wound treatment to save a limb
   c. Responding to our patients' needs is critical
      i. Elderly with breathing disorders or other chronic diseases can't walk across the street to get to their doctor's appointments
      ii. Family members struggle to get frail patients into the hospital
      iii. Pregnant patients in labor with no nearby parking
   d. Community support has been expressed routinely
      i. Marshall area residents opposed to expansion have publicly commented on the value of the medical care provided by Oaklawn
      ii. Zoning referendum to form Health Care and Human Services District in 2005 passed 70:30
   e. Excellence is exemplified by our accomplishments and awards
      i. Governor's Award for Improving Patient Safety and Quality of Care in Michigan Hospitals
      ii. Modern Healthcare's Top 100 Places to Work in Healthcare
      iii. Michigan Health Council for Nurse Retention
      iv. Adolescents in Action
      v. High Performance in Hospital Revenue Cycle
      vi. Magnet Recognition for the Quality of our Nursing Care
      vii. Patient satisfaction results have been 95th percentile nationally

II. National Healthcare
   a. Statistics
      i. 5010 non-federal hospitals in the US
      ii. 2200 of these hospitals were technically insolvent in 2008
      iii. $17 billion – total profit of the 5010 hospitals
      iv. $16 billion – amount that payments to hospitals will be reduced under the 2010 health reform legislation
      v. $1 billion – the amount of profit remaining for the 5010 hospitals; this is the money available for things like maintaining buildings, new construction and obtaining new equipment and technology.
      vi. $32 billion – the amount of care provided by hospitals to Medicare and Medicaid patients that isn't paid for by the Medicare and Medicaid programs (i.e. the "shortfall").
      vii. $26 billion – the amount of uncompensated care provided annually by US hospitals

III. Healthcare Reform
    a. Oaklawn's Payer Mix
        i. 41% Medicare
        ii. 15% Medicaid
        iii. 3% uninsured
    b. Impact of reform on payer mix
        i. Intends to convert most of the 3% uninsured to a plan that pays between Medicare and Medicaid rates, neither of which covers what it costs to deliver that care
    c. Impact of reform on payment
        i. Much of the 3% uninsured will convert to an insured rate that doesn't cover costs
        ii. The Medicare reimbursement rate is expected to go up by about 1% per year, while inflation is expected to go up 3% per year
        iii. Effectively, Medicare reimbursement is expected to fall behind inflation by 2%, meaning it will cover even less of the cost of providing care in the future
        iv. Revenue from the "newly insured" will be higher than it is currently, but not enough to cover costs of providing care.
        v. The effective decrease in Medicare's contribution to covering the costs of health care creates a greater negative impact on reimbursement than the slight positive impact produced by the "newly insured". The overall impact is an effective decrease in covering the costs of providing health care, i.e. a "loss".
        vi. Only hospitals with a very high uninsured and indigent population are expected to do better after health care reform
    d. Growth is the only answer to offset these losses
IV. Healthcare in Michigan
    a. MetroHealth
        i. Built new hospital outside of town earlier this decade
        ii. Had sufficient funding and borrowing capacity to do so
        iii. Moved to location with better payer mix
    b. Lakeland – Niles
        i. Planning extension and renovation of emergency department and new medical office building
    c. Trillium Hospital
        i. Closed by Foote Hospital (Allegiance) in 2002
    d. Quincy Medical Center, Massachussets
        i. Historic community
        ii. Hospital surrounded by residential area
        iii. Community dedicated to having local control of community hospital
    e. News in the past week
        i. Watervliet, St. Joseph hospitals begin integration talks
        ii. Zeeland Community Hospital explores merger options
        iii. Munson to release merger information re talks with Spectrum

iv. For-profit firm closer to buying Detroit Medical Center

f. Physical location characteristics of hospitals in south central Michigan
   i. Pennock Hospital, Hastings, MI
      1. Considered moving out of town to larger location
      2. Community fought vigorously to keep hospital in town
      3. Currently located adjacent to neighborhoods, with extensive onsite parking
   ii. Hillsdale Community Health Center, Hayes Breen Beach, Community Health Center of Branch County, Battle Creek Health Systems, Sturgis Hospital
      1. Located amid homes and neighborhoods
      2. All with onsite parking
   iii. Allegiance Health, Ingham Regional Medical Center, Sparrow Hospital
      1. Bigger city hospitals
   iv. Oaklawn Hospital
      1. Located amid homes and neighborhoods
      2. Minimal onsite parking
   v. Committee question: "How much of what kinds of growth does Oaklawn anticipate/plan for/want in the next 5/10/20/etc. years? What if any possibility do you see for growth by Oaklawn to affect the community in ways that could reduce or limit Oaklawn's patient/customer/client base? What if any possibility do you see for growth by Oaklawn to reach a point of saturation of the available market and/or a point of stability with other providers?"
      1. Growth comes from adding health care services to meet the needs of the community, e.g. dialysis center
      2. Growth comes from expanding current services
         a. Inpatient days of care: 9,699 in 1997; 14,977 in 2009 (54% increase in 12 years)
         b. Radiology exams: 27,000 in 1997; over 60,000 in 2009 (>100% increase)
         c. Lab, emergency department and overall outpatient visit growth: 119% to 169% in same 12 years
      3. Growth comes from changes in technology and in how medical and surgical care are delivered; changes require increased space, for example:
         a. Operating rooms of 375 SF in 1997 were standard; with modern equipment such as DaVinci operating robot, anesthesia equipment, etc. rooms now need to be 680 SF
         b. Simple film x-ray machines from the past take less space than CT scanners, MRI scanners, etc.
      4. Growth in numbers of employees and physicians
         a. 125 employees in 1972; 908 in 2010 (308 of these employees live in 49068)

b. 6 active staff physicians in 1972; 97 active staff and 191 total medical staff in 2010.

5. Market saturation risk
    a. Market demand is considered for every new service

vi. Committee question #15: What *other* processes -- i.e., aside from city zoning requirements (and related items like variances, building code, etc.) -- does Oaklawn have to meet if it wants to add or expand (or eliminate or reduce) some service? Who are the players involved in each other process, what is the timeframe of the other process, and how could a more open public process with the city be made to work within the framework of that other process?

1. Certificate of Need places requirements on hospitals before they can expand certain services. The CON process is public and is the purview of the State of Michigan. MRI is an example of a CON service; so are operating rooms and the number of licensed beds.

V. Evolution and Growth of Oaklawn Hospital

a. Oaklawn's history

i. Dedicated July 25, 1925

ii. Original, all female Board, named the entity the "Ella E. M. Brown Charitable Circle"

iii. Original hospital sufficient to provide hospital services for 15 years

iv. Harold Brooks and Sam Leggitt led fund drive to build new hospital

v. 47 bed, approximately 30,000 SF hospital, opened in 1953 with 3 physicians, obstetrics, lab, and medical/surgical patient beds

vi. Additions

1. 1960s – 13,000 SF for intensive care and additional patient rooms
2. 1972 – 10,000 SF for obstetrics and administration
3. 1980s – 33,000 SF for medical building and new intensive care unit
4. 1990s – 39,000 SF for radiology and other patient care areas
5. 2000s – 99,000 SF: 42,000 SF for Wright Medical Building; 15,000 SF for obstetrics; 5,000 SF for lab, intensive care, radiology and emergency department; 36,000 SF to add 3rd and 4th floor; 1,000 SF for new 3T MRI

b. Committee question #2: "Why is there so much green space on the current Oaklawn property, when we continually hear how there is not enough room for needed expansion?"

i. City has setback requirements to maintain a certain amount of open space

ii. Current available green space will be essentially gone with our next project, the surgery expansion project
    1. 44,000 SF, with capacity to add 2nd, 3rd and 4th floor
    2. Increases capacity to six operating rooms from our current three. Bringing additional surgical suites on line requires CON approval
    3. Includes private recovery and pre-operative rooms, new front entrance, new waiting room space

c. Projected 20-year growth needs
    i. Methods used to evaluate growth needs
        1. Historic growth
        2. Department by department review
    ii. Department by department analysis suggests 144,000 SF additional is needed for core hospital services (not including the services that can be accommodated offsite)
        1. Adding one floor to Wright Medical Building, and 3 more stories to surgery addition, provides 59,000 SF
        2. Gap is 85,000 SF that can't be accommodated on our current site

d. Community benefit provided by Oaklawn
    i. >$2 million in charity care
    ii. >$6 million in unpaid patient bills
    iii. >$65,000 financial support to Marshall Public Schools
    iv. Total community benefit nearly $16 million (report available from Keith Crowell)
    v. Community benefit reported annually to Michigan Hospital Association and to IRS to maintain our tax exempt status

e. Examples of investments in our community
    i. Employee volunteerism
    ii. Hospitality Classic
    iii. Bike, Wagon and Pet Parade
    iv. United Way
    v. GIFT program to restore the fountain

f. Committee question: "Comparing the existing site to an ideal facility built from new, what compromises have been made as the current site has expanded? What are the worst aspects, considered from a business and traffic logistics viewpoint, of the current site? What are the best aspects? What would you most like to change?"
    i. Challenges; things to change:
        1. Parking – covered in detail later
        2. ED access – minimal nearby parking
        3. Inadequate direction to main entrance
        4. Amount of buildable space available on current site
    ii. Best aspects
        1. Proximity to downtown makes us part of the community
        2. Supports downtown business

a. 653 Oaklawn outpatients every weekday; 49% (318) come to main hospital site
b. Average of 283 employees each weekday day shift
c. Average of 324 employees and patients daily to Wright Medical Building offices
d. Total of 925 patients and employees (plus families, friends and visitors) coming to main hospital campus every weekday, some of whom will use downtown businesses

iii. Tax considerations
1. Moving hospital to different location would cause property to revert to a park under the terms of the original deed. Taxes would not be paid on park property
2. Hospital property tax payments for 2011 are expected to be approximately $91,000, with about $80,000 of that being paid on properties in the City of Marshall

g. Committee question: "Why can't a parking garage be built on the existing site that would be integrated into the current facilities? Has construction of underground parking been considered?"
i. Inadequate room will exist after the surgery expansion project for anything other than 8-10 handicapped parking spots
ii. Surface parking costs about $3000 per parking space
iii. Parking ramps cost $12,000-15,000 per parking space
iv. Underground parking has not been thoroughly evaluated. Preliminary information is that the cost per space would be significantly higher than for an above ground parking ramp.

VI. Parking Considerations
a. Statistics
i. 348 – number of spaces in parking ramp
ii. 135 – number of surface spaces on hospital grounds and Ricketson lot after surgery renovation project
iii. 483 – total number of Oaklawn-owned parking spaces near hospital
iv. 796 – number of spaces required by code
b. Projected 20-year parking needs
i. Estimated to be between 960 and 1,160 spaces
ii. Shortage of 500-700 spaces in the next 20 years
c. Committee question: "Will Oaklawn consider taking over the parking ramp now that expansion efforts will require additional parking spaces for Oaklawn patients and visitors? Will Oaklawn consider renegotiating the current contract between the city and Oaklawn with regards to the parking ramp? "
i. Oaklawn owns the parking ramp, having built it in 1999 at a cost of about $4 million, and added 1.5 floors in 2003 at a cost of about $1.5 million. We spent an additional roughly $800,000 for architectural details that made it fit better into the historic

ambience of the neighborhood, and lost a number of parking spaces to accommodate those architectural details.

ii. Oaklawn also owns the lot west of the Franke Center

iii. Need for public parking for the Franke Center and other businesses in the area still exists, making the agreement between the hospital and the Downtown Development Authority as mutually beneficial today as it was when the agreement was adopted

d. Committee question: "Why is there so much resistance to moving major facilities to a greenfield site on the interstate, similar to what many other hospitals in the region are doing? Would this not be much more convenient and efficient from the standpoint of approvals required for new buildings and expansions?"

i. Cost to build a new hospital, estimated by Granger Construction, is $150 - $200 million. We do not have the money or the borrowing capacity to move to a new site

e. Committee question #13: "What plans, studies, etc. have been done about which services can be kept/put on the "home campus"? About which services need to be kept/put there and which don't, and why? About which services combine best with each other? About which could be combined in a secondary center -- e.g., could most or all administrative and/or financial/billing functions be grouped in a separate location? (Who did these plans/studies/etc. and when?)"

i. Evaluation for placement at an offsite location is part of the analysis for every service we consider

ii. Multiple services are currently located off the main campus

1. Billing, scheduling and certain back office functions
2. Psychological services, both outpatient and partial hospitalization
3. Dialysis
4. Home health
5. Hospice
6. Home medical equipment
7. Fitness center
8. Physical and occupational therapy
9. Wound Center
10. Laboratory and radiology services in Albion
11. Laboratory services at various physician offices
12. Sleep center
13. Physician offices

iii. Administration remains onsite due to the need for proximity to staff and patients. It is a key aspect of our culture and, therefore, our success

f. Committee questions: "Why does Oaklawn own so many homes in the historic neighborhood? How does this expense support the core business model of providing health care services to the community? (In past meetings Oaklawn has said several times that they lose money on these

rental properties.) What are the plans for these properties?" "What was Oaklawn's logic for purchasing houses on High Street? Will expansion activities head east?" "Did Oaklawn Hospital buy the Vincent property for eventual expansion, to put everything on one campus or for other reasons? "

i. We acquire properties for future expansion and to meet current operating needs. Since proximity to the hospital is important for many of these services it is prudent for the hospital to acquire such properties.
ii. Vincent property was considered for an assisted living facility, but is now being retained for unknown future community health care needs.

g. Committee question: "Is there a database or other organized and sortable list of all the properties in Calhoun County owned by Oaklawn and/or its affiliated entities (including the Ella E. M. Brown Charitable Circle)?"
   i. This list is included in the Committee's binders

VII. Oaklawn and the National Historic Landmark District
   a. Adaptive reuse and preservation activities of Oaklawn
      i. Brooks Rupture Appliance Building
         1. Houses our dialysis center and some of our back office functions
         2. Renovation and construction cost of over $2 million
         3. Consulted twice with State Historic Architect's office to seek their input prior to final construction plans. He sent a letter of commendation for our historic preservation efforts (included in Committee's binders)
         4. Made multiple changes to original plan based on State Historic Architect's feedback
            a. Size of canopy
            b. Location of elevator tower
            c. Preservation of windows and door that serve no functional purpose
         5. Reasons for using the Brooks Building in spite of the additional cost
            a. Best healing atmosphere for our patients
            b. Opportunities for patients' drivers to enjoy the downtown while waiting for dialysis treatment to be done
            c. Benefit to downtown businesses
      ii. Brooks House
         1. Houses Home Care and Hospice offices
         2. Columns completely replaced; structure and fence painted several times
         3. Has been on Home Tour
      iii. Ricketson Medical Building (former Kempf Funeral Home)

1. Houses Oaklawn Medical Group Pulmonology offices, Pulmonary and Cardiac Rehabilitation and Women's Diagnostic Services
2. Changes to exterior were limited to those necessary for handicap accessibility and signage

iv. Oaklawn Sleep Center
1. Formerly a video store and tanning salon

v. Oaklawn Life Improvement Center
1. Formerly the Conley Elementary School in Marshall Township

vi. Oaklawn Home Medical Equipment
1. Formerly Palmer Door and Window

vii. Oaklawn Medical Group Gastroenterology
1. Formerly Kidder Heating and Cooling

viii. Clark Radiator Building
1. Currently used for storage

ix. Dean House and Methodist Parsonage
1. Preservation
2. Moved prior to formation of National Historic Landmark District (NHLD)
3. Accepted as a contributing structure with the original application for NHLD status

x. Strong House
1. Preservation
2. Moved outside of boundaries of NHLD, but contiguous. Not eligible to be a contributing structure due to location outside district

b. Oaklawn's impact on NHLD
i. Before NHLD formation
1. Three houses moved
2. Two are included as contributing structures

ii. After NHLD formation
1. Four structures moved
a. Humphrey House (outside the district, contiguous)
b. McNary House (outside the district)
c. Moore House (Casket House: outside district)
d. 223 N. Madison (moved within the district; financial loss of $58,000 borne by Oaklawn)
2. Two structures razed
a. Tanner House
i. Not a contributing structure
b. Carriage house of 223 N. Madison
i. Lacked structural integrity to move it without significant reinforcement. Buyers not interested in moving it to the new location

ii. Was a contributing structure

iii. Committee question: "The committee has also heard that a building has to be in its location for 50 years or more to qualify to be a contributing structure for Marshall's National Historic Landmark District. Would any of the main/original Oaklawn building qualify for that? And if so, would Oaklawn want to be included in the NHLD?"

1. Per Dena Sanford, National Parks Service: "Buildings are not automatically included in an NHL district once they become 50 years old. The period of significance, 1831 to 1940 in Marshall's case, and the criteria for inclusion determine what resources will be included."
2. Oaklawn Hospital was not constructed during the "period of significance" for our NHLD. It has also undergone such extensive renovation as to be nearly unrecognizable from the original structure. Thus it would not be eligible for status as a contributing structure.

iv. Potential for redesignation

1. Based on the "period of significance", and the fact that recently moved structures were included as contributing structures on the original application, it may be possible to redesignate historic homes that have been moved within the district.

VIII. Additional Committee questions:

a. "What plans are there for use of the buildings SW of the Brooks Rupture building, in the same block?"

i. There are no specific plans to change the current use of the buildings at this time. The gastroenterology office will probably move to the Wright Medical Building, so that office will be open for other uses. The radiator building serves as storage.

b. "What is Oaklawn willing to contribute to the success of this committee? For one example, what is Oaklawn willing to do to address and ease the concerns of part of the community that more openness is necessary to bring more trust? (NOTE: I'm sorry I didn't think to phrase a question along these lines for the previous meeting's presenters. Trust is a two-way street -- at least – more when there are more sides than two. Is there any way we can go back and ask the Historical Society if, for example, they would be willing to help design – and commit to support -- a process that would incorporate public review and input into Oaklawn project planning before individual project items are finalized with backing from the Historical Society?)"

i. We are committing considerable time and resources to openly engage in the process underway with this Committee in order to help ensure its success.

ii. Plans at an appropriate stage of development can be shared with the public. For strategic and business reasons there are constraints on sharing information too soon.

c. "The committee has heard that at least one time a more open discussion of Oaklawn's plans has let another provider steal a march on Oaklawn and claim the service expansion/addition for itself instead. When was this, what happened, what was the particular problem with open or public discussion that caused the result, and how do you think a process could be designed to avoid such problems but still satisfy any need perceived by the community for greater openness?"
   i. When Oaklawn announced we would be opening a Wound Clinic, BCHS started heavily marketing their Wound Clinic services in our primary market area to establish referral patterns to Battle Creek before we could get them established in Marshall.
   ii. This committee is a key step in working to address needs for communication

d. "When are the meetings of the Oaklawn Hospital Board? Are they open to the public to attend? (To speak at?) If not, could they be?"
   i. Oaklawn is a 501(c)(3) organization meaning it is private and not for profit
   ii. Private corporation's Board meetings are not open to the public
   iii. Other venues for community input are appropriate and something we desire

IX. Summary
   a. Passion
   b. Health care industry and reform
   c. Health care economics
   d. Other hospitals
   e. Growth through the decades
   f. Parking needs and short falls
   g. $150 - $200 Million
   h. Adaptive reuse