Guam Memorial Hospital Authority
Aturidåt Espetåt Mimuriåt Guåhan

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Board of Trustees
Official Resolution
04-066

"Relative to approving the FY2004-2006 strategic plan"

WHEREAS, the Authority is committed to excellence in healing and caring; and

WHEREAS, the commitment is manifested through goals and objectives, most currently for the next two years as proposed in the Guam Memorial Hospital Strategic Plan for 2004-2006; and

WHEREAS, five major goals and objectives map out the processes and/or activities to be undertaken the next two years, and expressed below in outline format as follows:

GOAL NO. 1: FINANCIAL SECURITY

Objective 1. Increase in Cash Flow

- a) Billing accuracy & timeliness
- b) Improved payor account management
- c) Outsource self-pay credit and collection
- d) CDM cleanup & maintenance

Objective 2. Increase Revenue

- a) Fee increase
- b) CDM update
- c) Charge capture tactics & technology
- d) Tax-based funding
- e) New business development
  - a. Cardiac service line
  - b. Diabetes & ESRD service lines
  - c. Oncology service line
  - d. Physician recruitment
  - e. LPN certificate program
  - f. Primary care/family practice residency program
  - g. Patient & family education services
- f) Medicare reimbursement optimization

Objective 3. Uncompensated Care Relief

a) Partial cost shift via fee increase
b) Partial tax based funding
c) Hospitalist program

Objective 4. Financial Efficiency

a) Outsourcing
b) Manage labor productivity at >50th percentile
c) Use improved cash flow to pay down receivables and obtain better pricing and terms

GOAL NO. 2: CLINICAL DEVELOPMENT

Objective 1. Competency Assessment and Development

a) Clinical Nurse Specialist (Nurse III)
b) Migrate to team nursing from functional nursing
c) Achieve acceptable staff-to-patient ratios (JCAHO H.R.1.10)
    a. Recruitment & retention
    b. Regulatory relief for compensation, position development
d) Training and development (JCAHO H.R. 2.10,2.30)
    a. On-going NCLEX review classes for local and off-shore nursing candidates.
    b. Development of a licensed practical nurse diploma program

Objective 2. Surveillance, Prevention and Control of Infection

a) Develop a coordinated process to reduce nosocomial infection risk
b) Re-develop the Infection Control Committee
c) Develop Infection Control staff
d) Training and development

Objective 3. Improve Organizational Performance

a) Implement a useable "data dashboard"
b) Implement department and cross-cutting analysis and corrective action
c) Institute cultural change for organizational improvement

Objective 4. Improve the Management of Human Resources

a) Improve assessment of staff effectiveness to that job competence is assessed, demonstrated and maintained (H.R. 1.30, 3.10)
b) Training and development activities (H.R. 2.10, 2.30)
c) Job competence assessed, demonstrated and maintained
d) Regulatory relief to develop independent classification and compensation system for health care professionals.

GOAL NO. 3: IMPROVE THE ENVIRONMENT OF CARE

Objective No.1. Outsource Environmental services so that there are adequate resources to man the hospital's cleanliness.

Objective No. 2. Improve the preventative maintenance cycle and link the repair or replace cycle with capital funding cycle.

Objective No. 3. Insure that patient staff and visitors are safe

a) Outsource security services so that there are adequate resources for security.
b) Reduce inventory/material shrinkage.

Objective No. 4. Plan for adequate bed capacity

a) Fast track room renovation
b) Multi-use beds; Med/Surg to Med Telemetry
c) Capital plan to increase bed capacity to 275

GOAL NO 4: JCAHO ACCREDITATION

Objective No.1. Complete extranet survey and statement of conditions in 3rd quarter, FY04
Objective No. 2 Successful site survey in 2nd quarter, FY05 resulting in accreditation
Objective No. 3 Eighteen (18) month extranet survey in FY06
Objective No. 4 Recertification in FY08

GOAL NO. 5: REORGANIZATION

Objective No.1 Introduce a stream-lined management structure
Objective No. 2 Outsourcing for value

Objective No. 3 Independent personnel classification and compensation system for healthcare professional staff and administrators

and

WHEREAS, the above mentioned goals and objectives have been reviewed by the Executive Management Council and the Planning & Finance Committee; and

WHEREAS, the Planning & Finance Committee has recommended approval of the strategic plan at the regular meeting of the Board of Trustees on May 27, 2004; now, therefore be it

RESOLVED, that the Board of Trustees approves and adopts the goals and objectives stated in the Guam Memorial Hospital Authority Strategic Plan 2004-2006 along with the task sheet presented at its regular meeting on May 27, 2004; and be it further

RESOLVED, that the Hospital Administrator/CEO is authorized to initiate processes and/or implement policies and procedures to effectuate said goals and objectives; and be it further

RESOLVED, that copies of the 2004-2006 strategic plan be forwarded the Chairperson of the Committee of Rules & Health of the 27th Guam Legislature, President of the GMHA Medical Staff, President of the GMHA Volunteers Association, and GMHA Executive Management Council; and be it further

RESOLVED, that the Chairman certifies and the Secretary attests to the adoption of this resolution.

Duly and regularly adopted on the 27th day of May 2004.

Certified by:

Philip J. Flores
Chairman, Board of Trustees

Attested by:

Brihida C. Aguigui, RN
Brihida C. Aguigui
Trustee/Secretary, Board of Trustees

GUAM MEMORIAL HOSPITAL AUTHORITY

STRATEGIC PLAN

2004 - 2006

ENVIRONMENTAL ASSESSMENT

The Guam Memorial Hospital is a community-based hospital. Its primary service market is the civilian population on Guam. The secondary markets are the residents of the neighboring Pacific Islands. As the population changes, the Hospital must prepare to accommodate changes in healthcare needs. The Hospital's planning efforts focus mainly on Guam's civilian population although utilization by regional neighbors is certainly taken into consideration.

COMMUNITY SERVED

Guam's civilian population has grown steadily over the years and is expected to reach 180,000 by the end of the decade. Population in our secondary market is 196,000 including Saipan, Palau and the Federated States of Micronesia. Table 1 tracks the population growth experience since 2000 and projected through 2010.

TABLE 1
Civilian Population
Projections
Guam: 2000 - 2010

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Population	154,178	156,931	160,015	163,941	166,996	169,969	172,874	175,721	178,513	181,257	183,959

Source: Census and Population, Department of Commerce

The growth in the Island's civilian population indicates an increase in the need for healthcare services, and especially signals GMHA's need to evaluate the availability of acute care and skilled nursing beds. By examining the aging of the population, the Authority can project the types of services GMH may be expected to provide. Table 2 details Guam's civilian population by age from 1996 through 2002. Although the island's population is relatively young, the population projections indicate that the

community is aging. GMHA currently provides 3 Skilled Nursing Beds per 1000 population sixty-five years of age or older. By contrast Hawaii provides 1.83 SNF beds per 1000 65+.

TABLE 2

Civilian Population by Age Groups Guam: 1996 - 2002

Age Group	1996	1997	1998	1999	2000	2001	2002
0	4,145	4,247	4,199	4,054	3,918	3,824	3,761
1 - 4	16,097	16,263	16,509	16,501	16,380	16,233	15,883
5 - 9	15,465	16,290	17,357	18,459	19,165	19,628	20,162
10 - 14	12,714	12,804	13,027	13,393	14,109	15,023	16,048
15 - 19	10,884	11,087	11,445	11,762	12,010	12,289	12,549
SubTotal	**59,305**	**60,691**	**62,537**	**64,169**	**65,582**	**66,997**	**68,403**
20 - 24	9,627	9,310	9,394	9,552	9,785	10,157	10,616
25 - 29	12,177	11,176	10,300	9,570	9,011	8,695	8,729
30 - 34	12,355	12,214	12,215	12,080	11,793	11,320	10,674
35 - 39	11,320	11,347	11,429	11,501	11,522	11,599	11,745
40 - 44	10,065	10,193	10,373	10,522	10,694	10,878	11,047
SubTotal	**55,544**	**54,240**	**53,711**	**53,225**	**52,805**	**52,649**	**52,811**
45 - 49	8,293	8,654	8,999	9,312	9,583	9,813	9,998
50 - 54	5,623	6,078	6,618	7,147	7,627	8,064	8,451
55 - 59	4,615	4,633	4,684	4,800	5,017	5,364	5,832
60 - 64	3,860	3,949	4,057	4,159	4,243	4,301	4,342
SubTotal	**22,391**	**23,314**	**24,358**	**25,418**	**26,470**	**27,542**	**28,623**
65 - 69	3,248	3,303	3,357	3,408	3,471	3,552	3,643
70 - 74	2,228	2,373	2,509	2,631	2,736	2,814	2,885
75+	2,207	2,407	2,629	2,865	3,114	3,377	3,650
SubTotal	**7,683**	**8,083**	**8,495**	**8,904**	**9,321**	**9,743**	**10,178**
TOTAL	**144,923**	**146,328**	**149,101**	**151,716**	**154,178**	**156,931**	**160,015**

Source: Department of Public Health and Social Services

The youngest segment of the population is growing despite a projected decrease in the population **below the age of 1**. Although this may result in the decreasing demand for maternity services, as well as nursery and neonatal care over time, the rise in those from **ages 1 through 19 years** has different implications. The Hospital expects that there will be an increase in pediatric services as well as increases in the number of incidents from motor vehicle accidents and suicides. The load of patient care services for this group would be most evident in the Hospital's pediatrics unit and the emergency room, and is consistent with the Hospital's current experience.

The population of young adults, from **ages 20 through 44 years,** is increasing as well. This segment of the population includes women of childbearing ages who comprise nearly one third of GMH's inpatient discharges. GMH records approximately 300 live births per month. In addition, the Hospital is seeing more patients, from **ages 45 through 64 years,** with complications of chronic diseases of diabetes and hypertension (i.e. Myocardial Infarction, Cerebral Vascular Accident & ESRD). Accordingly the demand for medical telemetry beds is consistent. The senior population **ages 65 years and above,** has been growing steadily. As the population ages and the life expectancy increases, there is a growing need for long stay care beds, especially intermediate care , nursing home beds, and support for terminal conditions such as cancer care and Hospice. GMHA does not provide ICF, Long Term care or Hospice services.

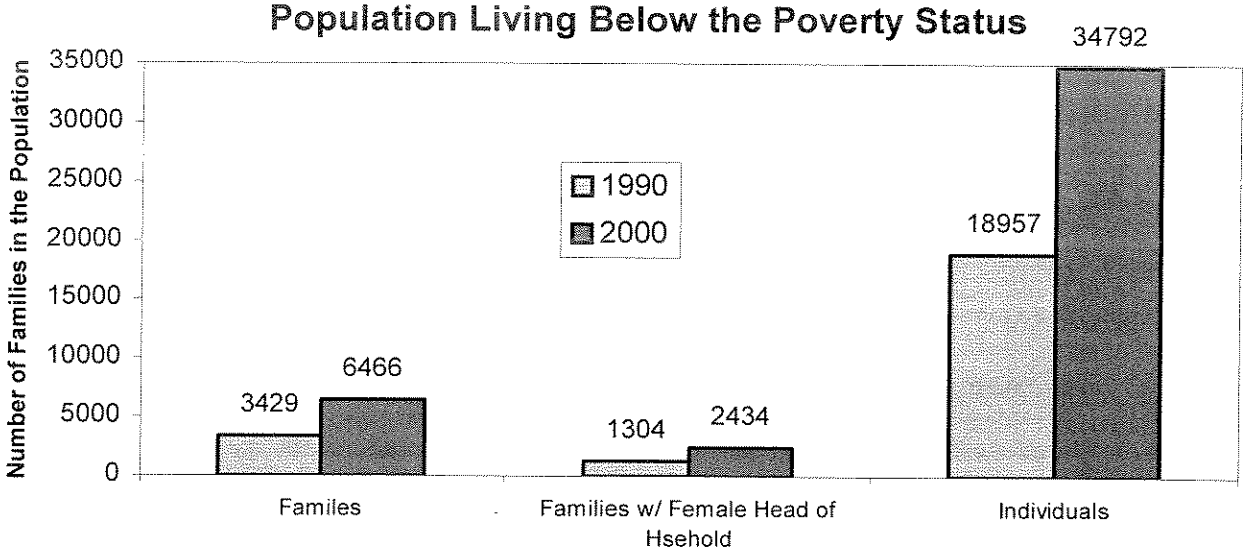
The changes in the Island's population affect the demand for hospital services. This is evidenced in the comparison of inpatient acute care beds to the population. Pre Typhoon Pongsona, GMHA provided .97 beds per 1000 population. Post typhoon (2003), GMHA provided .85 beds per 1000 population due to physical damages. Reconstruction is expected by mid 2004, but will reduce GMHA's acute care capacity to 172 beds from 192 due to conversion of the 4-bed wards to semi private rooms, for a ratio of 1.02 beds per 1000 population. With Guam's expected increase in population by 2010 GMHA will provide .92 beds per 1000 population.

By comparison, Hawaiian hospitals provide more than double the bed availability at 2.6 beds per 1000 population. The beds per 1000 population are 2.1 for the U.S. Pacific census division hospitals, 2.3 in Alaska and 2.1 in California. GMHA must address bed capacity, and bed capacity by services such as ICY/CCU, Med-Tele, SNU & ICF as part of its plan.

Changes in demographics will also drive utilization. **Seniors** will be requiring skilled nursing care at the Skilled Nursing Unit; **adults** will continue to use emergency room services as well as receiving treatment for complications of chronic diseases; and **children/young adults** will also require services in the emergency room in addition to the pediatric unit. GMHA also needs to identify and address the acute care needs of individuals who are disabled.

The population below the poverty level nearly doubled from 23,690 in 1990 to 43, 693 in 2000 as shown in Figure 1. Based on the 2000 census report, persons living below the poverty level comprised of 28 percent of the population in 2000. In the 1990 census, 18% of the population fell below the poverty level. The number of poor and uninsured people rose as education attainment, employment opportunities, childcare and cost of living may have contributed to the increase.

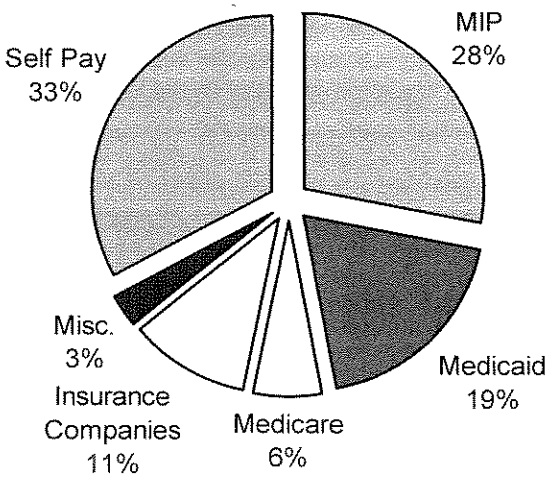
FIGURE 1
Population Living Below the Poverty Status



Source: Guam Annual Economic Review 2000-2001, Bureau of Statistics

Figure 2 illustrates the types of hospital discharges by financial class for FY03. The Hospital is seeing a large proportion of people with poverty status below the poverty level. Eighty percent of GMHA's patients were uninsured self-payors or received medical assistance from the Department of Public Health. Often the poor or uninsured seek health services when their condition has deteriorated to the point where emergency treatment or hospitalization is required.

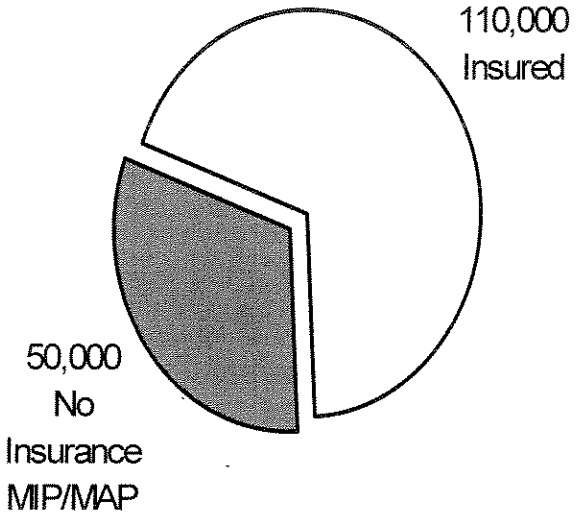
FIGURE 2
DISCHARGE BY FINANCIAL CLASS
FISCAL YEAR 2003



Source: GMHA, Patient Affairs Department

In Figure 3 the Department of Public Health and Social Services estimates 50,000 individuals on Guam are uninsured or underinsured. The uncompensated cost of care for this population is borne by GMHA's and private providers, at an expense of $30 million per year (inpatient services only) and is non-funded by GovGuam.

Figure 3
Insured vs. Uninsured/Underinsured Population



Source: Department of Public Health and Social Services

LEADING HEALTH ISSUES

When planning health care for a community, it is also important to consider the patterns of illnesses within the community. There are two health indicators that GMHA includes in its environmental assessment: the Island's leading causes of death and the Hospital's most common discharge diagnoses. Evaluating and understanding this information offers insight as to where the Hospital will need to focus its efforts and plans for the future.

Leading Causes of Death

Guam's Office of Vital Statistics reports that **heart disease** and **neoplasm** (Cancer) have consistently ranked as the top two causes of death on Guam (refer to Table 3). **Cerebrovascular disease** and **diabetes** are high on the list of leading causes of death. Although the leading causes do not necessarily represent the most common reasons for hospitalization, the statistics do reflect the community's health status and are therefore taken into consideration when planning for the Guam Memorial Hospital's services.

TABLE 3

10 LEADING CAUSES OF DEATH
Guam: 1994-1997

	1994	R	1995	R	1996	R	1997	R
All Causes	628		626		627		639	
Disease of the Heart	163	*1*	175	*1*	145	*1*	183	*1*
Neoplasm	88	*2*	100	*2*	107	*2*	83	*2*
Cerebrovascular Disease	37	*4*	43	*4*	40	*4*	52	*3*
Diabetes Mellitus	39	*3*	29	*6*	41	*3*	31	*4*
Suicide	23	*8*	23	*7*	31	*6*	30	*5*
All Other Accidents	32	*6*	49	*3*	34	*5*	28	*6*
Motor Vehicle Accidents	28	*7*	31	*5*	20	*8*	25	*7*
Other Disease of the Central Nervous System ALS/PD	9		9		9		16	*8*
Pneumonia	23	*5*	23	*7*	14	*10*	16	*8*
Homicide	11		8	*9*	15	*9*	13	*10*
Perinatal Conditions	16	*9*	16		21	*7*		
Chronic Liver Disease and Cirrhosis	16	*9*	16	*9*	14	*11*		
Congenital Anomalies	12		8		7			

Source: Office of Vital Statistics, Department of Public Health & Social Services

Leading Discharge Diagnoses

In addition to the leading causes of death, GMHA analyzes the Hospital's Leading discharge diagnoses. Table 4 lists the top 25 discharge diagnoses for fiscal years 1998 through 2002. More than half is directly related to childbirth. In fact, the three most common diagnoses are: Single Live Birth; Normal Delivery; and Primary C-Section. The volume of childbirth services most certainly impacts upon the maternity and

nursery units. In recent years, maternity services have decreased in the number of discharges. The same with deliveries, the numbers have gradually decreased each year from 3,478 births in FY98 to 2,486 births in FY02. Families relocating off-island and the Sagua Managu private birthing center, the only other childbirth source on Guam may have contributed to the decrease of GMH deliveries.

Excluding discharges that relate to childbirth, the next three leading discharge diagnoses for GMH patients are **pneumonia**, **hypovolemia** (dehydration) and **congestive heart failure**.

Patients with respiratory conditions such as pneumonia, asthma and bronchitis have been admitted to the adult medical units as well as pediatrics. Dehydration due to

TABLE 4

Top 25 Discharge Diagnosis

	FY98	R	FY99	R	FY00	R	FY01	R	FY02	R
Single LB-In Hosp NEC	3406	*1*	3079	*1*	2793	*1*	2137	1	1795	1
Pneumonia	457	*5*	413	*6*	453	*3*	533	4	611	2
Single LB, Hosp, Del By CD							714	2	590	3
Normal Delivery	923	*2*	943	*2*	821	*2*	590	3	552	4
Hypovolemia (Dehydration)	238	*10*	209	*10*	192	*10*	364	5	293	5
Congestive Heart Failure	274	*7*	298	*8*	273	*8*	281	7	277	6
Previous CD Nos-Del					313	*7*	319	6	263	7
Delivery with 1deg Laceration	460	*4*	475	*4*	374	*4*	226	8	191	8
AC Bronchiolitis	142	*13*	132	*13*	104	*14*	116	14	169	9
Cellulitis of Leg	116	*16*	166	*11*	142	*12*	147	11	153	10
Delivery with 2deg Laceration	377	*6*	461	*5*	317	*6*	193	9	147	11
Urinary Tract Infections	83	*21*	96	*19*	92	*17*	147	10	124	12
Septicemia	96	*17*	115	*16*	77	*21*	127	13	113	13
Early Onset Delivery-Del					75	*25*	101	16	113	14
OCB w/Acute Exacerbation					94	*16*	70	24	107	15
Gastrointestinal Hemorrhage			96	*21*	80	*19*	73	23	97	16
Cor As-Graft Type NOS					75	*23*			96	17
Threat Premature Labor			118	*14*	79	*20*	90	18	92	18
Asthma Nos w AC Exacer									91	19
GU Infection-Delivered									91	20
Asthma	188	*11*	218	*9*	149	*11*	132	12	87	21
Sngl LB- Before Adm									72	22
Chemotherapy Encounter					83	*18*			69	23
Anemia - Delivery			84	*23*	77	*22*			68	24
Cereb Art Occl w Infarct									67	25

Source: GMHA Medical Records Department

gastroenteritis infections such as food poisoning rose in admissions to the pediatric and medical wards. Most of the discharges comprised of those less than 16 years old. Congestive heart failure as well as other cardiac conditions have resulted in growing admissions to the ICU, the telemetry unit and the medical ward.

UTILIZATION

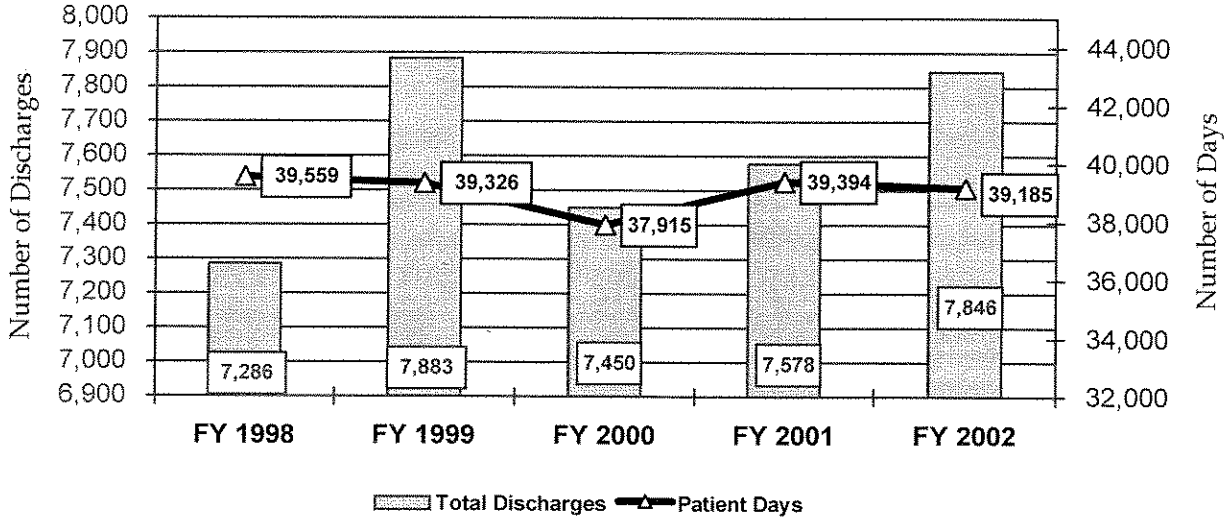
In addition to evaluating the leading discharge diagnoses, GMHA must assess the volume of hospital services. The Authority monitors the utilization of inpatient services, the number and type of Emergency Room visits, the number and type of surgeries, and trends in the use of outpatient services. Data related to hospital utilization is a significant factor in the Authority's plans for services and programs.

Inpatient Care: Discharges and Patient Days

When evaluating inpatient statistics, the Hospital considers patient days and discharges for each unit. Figures 4, 5 and 6 depict the trend in patient days and discharges for Acute Care, the Skilled Nursing Unit and the Obstetrics Ward.

FIGURE 4
DISCHARGES AND PATIENT DAYS
IN ACUTE CARE UNITS
Guam Memorial Hospital:
FY 1998 - FY 2002

Source: GMHA Medical Records Department

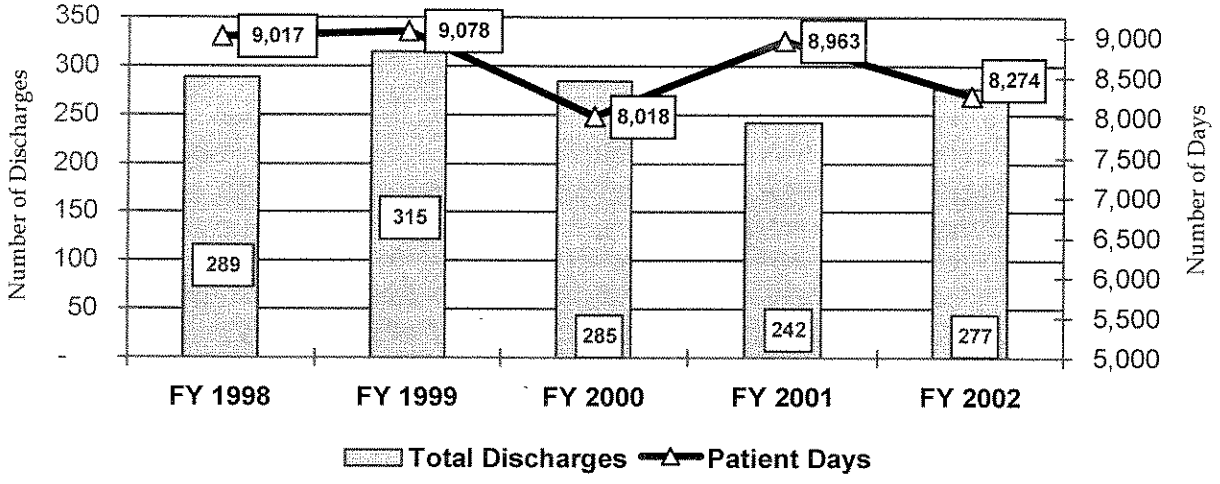


The GMHA uses the number of discharges and patient days to measure inpatient utilization. GMHA has experienced increases in the total discharges and the total patient days. Between the 5-year period from FY98 through FY02, the acute care discharges increased by 15 percent. This reflects a 3 percent average annual growth.

The total number of patient days increased 12 percent from FY98 through FY02. This represents an average annual growth of 2 percent between the 5-year period. The increases may be attributed to the rise in respiratory ailments especially among the Island's youth. Another may be an increase in the number of acute medical conditions associated with heart failure, diabetes, strokes and accidents.

In the Skilled Nursing Unit (SNU), the total number of patient days fell 8 percent from FY98 through FY02.

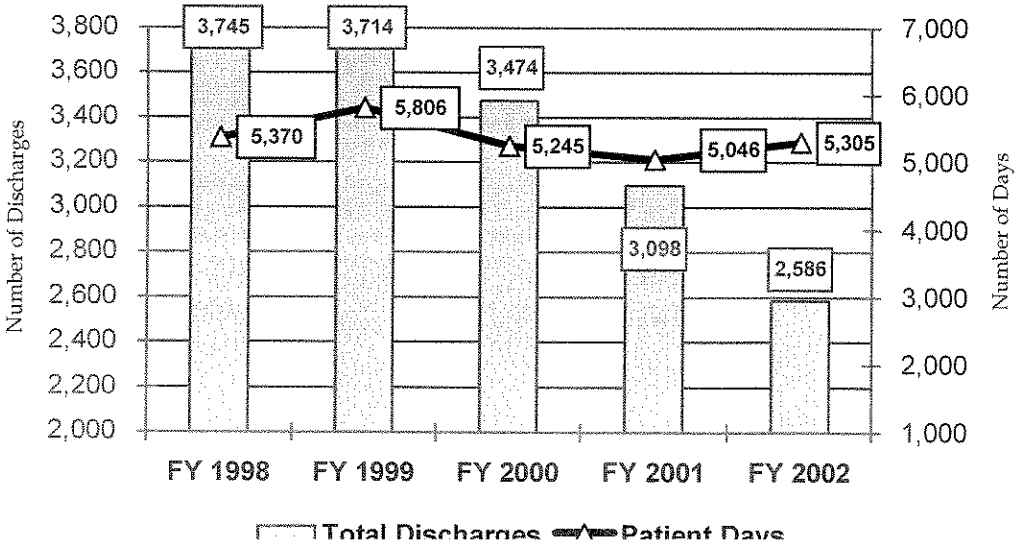
FIGURE 5
DISCHARGES AND PATIENT DAYS IN THE SKILLED NURSING UNIT
Guam Memorial Hospital: FY 1998 – FY 2002



Source: GMHA Medical Records Department

However, the total number of discharges increased 42 percent from FY98 through FY02. The drop in patient days and the considerable increase in the number of discharges suggest the length of stay may be becoming shorter. More aggressive discharge plan and the increase in home health care services contributed to a shorter stay in skilled nursing.

Figure 6 represents utilization within the Hospital's Obstetric Unit. Since obstetric cases comprise nearly one-third of the Hospital's inpatient discharges, the utilization for the mate

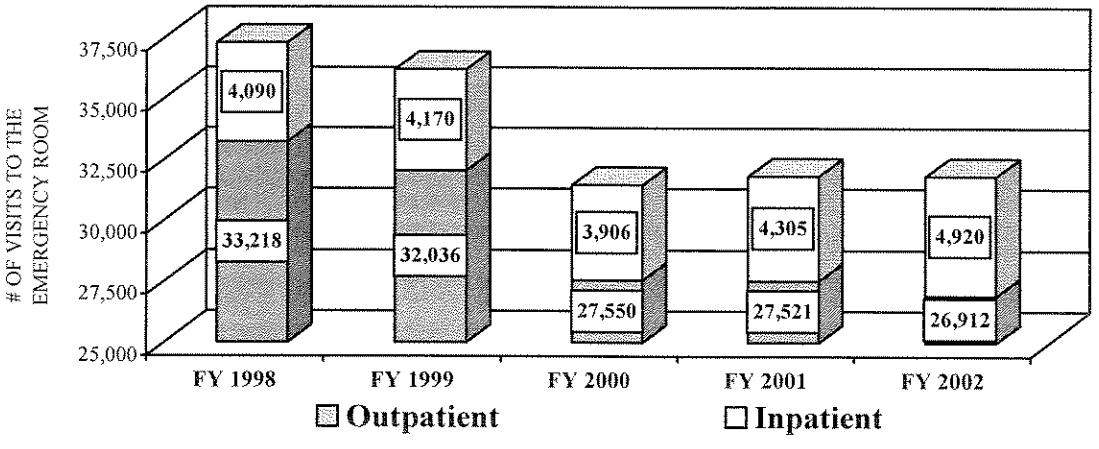


Obstetrics patient days range from a low 5,046 to a high 5,806 spread over the five-year period. Overall, the Unit experienced a less than 1 percent growth from FY98 through FY02. However, the number of discharges fell considerably. From FY98 through FY02, the total number of discharges experienced a 32 percent decline. This reflects an average 6 percent decrease in obstetric discharges each year. Hospital deliveries have gradually fell with the new birthing center accepting low risk mothers. In addition, high-risk mothers with little or no prenatal care represent half of the obstetric admissions and require longer hospital stay.

Emergency Services

Figure 7, reflects that the Emergency Room (ER) has experienced a decrease in the number of outpatient visits and an increase in the numbers of admits.

FIGURE 7
EMERGENCY ROOM VISITS
Guam Memorial Hospital:
FY 1998 - FY 2002



Source: GMHA Emergency Room Department

The number of outpatient visits dropped each year from 33,218 in FY98 down to 26,912 in FY02. Overall, ER has experienced an average annual decrease of 2 percent between the five-year period. The Department of Public Health's Northern Regional Health Center primary care provider has extended its services to include urgent care for MIP and Medicaid patients. This group represents a large proportion of the ER visits and as Department of Public Health's patient capacity expands, ER visits will continue to decline. The decrease in outpatient visits also is due in part to the private clinics and the opening of a private urgent care clinic. More private clinics have extended their hours of operations for urgent care. This allows outpatients to see their own physicians at a more personal level offered by the clinics.

Inpatient visits, or admissions through the Emergency Room, experienced an average annual growth of 4 percent over the five-year period. It took a dip in FY00 but the inpatient visits gradually rose in FY 01 and in FY02. Despite the availability of primary care on the Island, many of the patients who are admitted through the ER do not come to the Emergency Room until their illness is at an acute stage. By that time, these patients must be admitted to the hospital and are generally expected to have longer hospital stays.

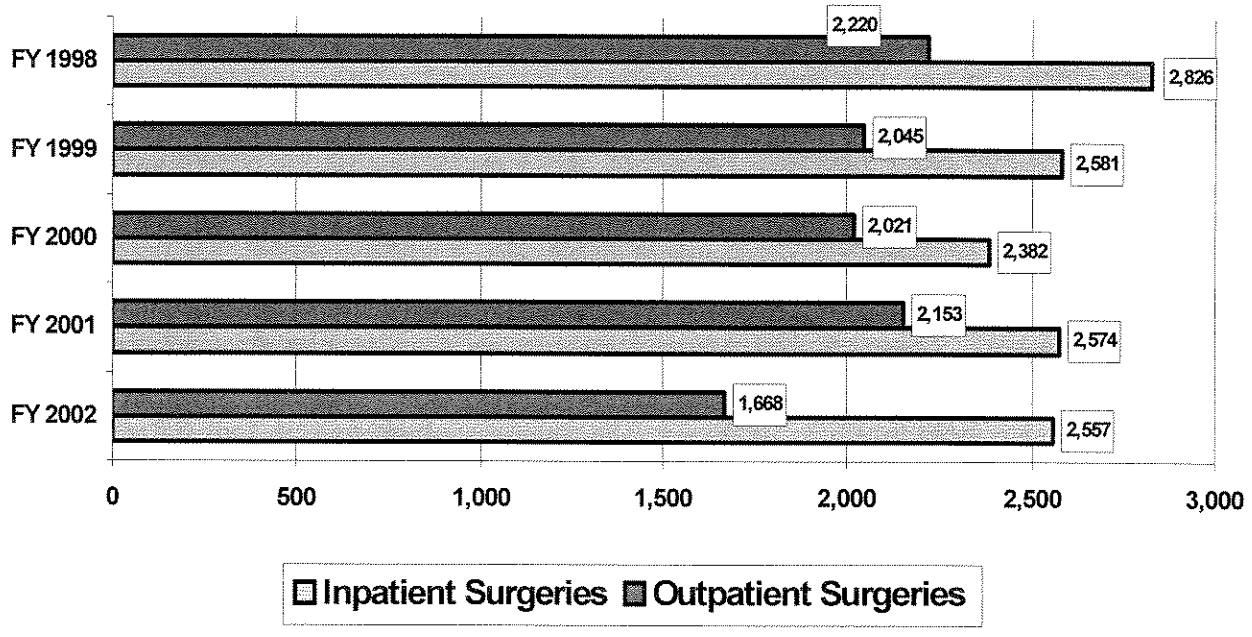
Surgical Services

Figure 8, reflects that the Operating Room (OR) has experienced a decline in outpatient surgeries. The OR observed the largest drop in the last two years. The number of outpatient surgeries sharply fell from 2,153 in FY01 to 1,668 in FY 02. This represents a 22 percent decrease, due primarily to the opening of Guam Surgicenter, a Medicare approved ambulatory surgery center. OR experienced an average 6 percent annual decrease in outpatient surgeries from FY98 through FY02. GMHA may expect this trend to continue, as outpatient procedures are more frequently being performed in

surgi-centers and physicians' offices. These private clinics are able to perform special surgery procedures that at one time were only performed in the Hospital.

The proportion of inpatient surgeries at GMH also has decreased over the years. Overall, OR has experienced a 7 percent decline in inpatient surgeries from FY98 through FY02. This represents an average 1 percent annual decline each year during the 5-year period. Island insurers are increasingly promoting off-island services, particularly in the Philippines.

FIGURE 8
SURGICAL SERVICES
Guam Memorial Hospital:
FY 1998 - FY 2002



Source: GMHA Operating Room

Outpatient Visits

In addition to evaluating outpatient services in the Emergency Room and Operating Room, the GMHA reviews ambulatory services in the following departments:

Rehabilitative Services, Respiratory Care, Radiology and Hemodialysis. For planning purposes, GMH monitors the number of procedures or treatments provided in these departments as an indication of service volume.

The **Hemodialysis** Unit continues to service a large number of patients with end-stage to FY98 and renal disease (ESRD) as GMH is one of the only three sources of dialysis on Guam. Over the five-year period, GMH's Hemodialysis Unit has experienced the only decrease in FY02. The Unit's operations cut down to three shifts instead of 4 contributed to the decline in dialysis treatments. With the reduction of shifts, we can expect the number of treatments to continue a steady decline over the next years.

Radiology statistics overall show a 1.3 percent total growth from FY98 through FY02. Significant increases took place in FY98 and in FY00. In FY98, the sharp increase was due to the reinstatement of the Hospital's mammography program and the emergency procedures provided in the aftermath of Typhoon Paka. In FY00, the Hospital was the only source on Guam that provided ultrasound services that contributed to the increase in outpatient procedures. Decline in Radiology services occurred in FY99 and FY01. This is attributed to private clinics expanding their radiology program specifically Guam Radiology Consultant outpatient imaging clinic.

Respiratory Care's outpatient services increased 4.6 percent from FY98 through FY02. Much of the increase stems from procedures in the Emergency Room for cases related to asthma and pneumonia. The low number of adult and pediatric blood gases and echo cardiogram procedures contributed to the decline of outpatient services reported in FY02.

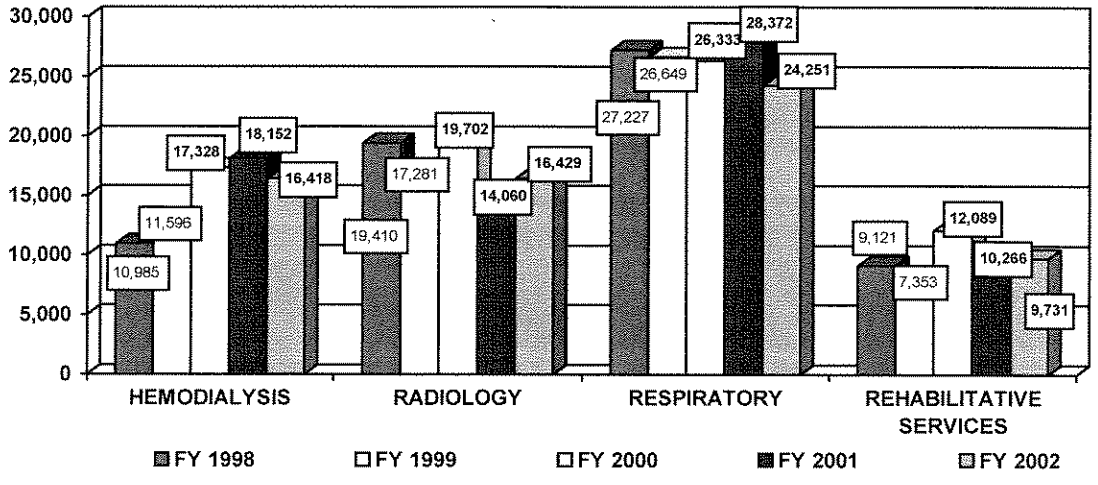
Rehabilitative Services has experienced a 66 percent growth in outpatient procedures over the 5-year period. This represents a 13 percent average growth each year from

FY98 to FY02. The last two years have shown a decline of outpatient procedures due largely to the lost of two physical therapists during the period.

It should be noted that The Cancer Institute of Guam, a private chemo and radiation therapy clinic suspended operations after Typhoon Pongsona and is not expected to resume services. Thus there is no availability of Radiation Therapy. There is no Chemotherapy available for indigent and MIP/MAP covered patients as the sole oncologist does not provide service to MIP/MAP clients.

FIGURE 9

OUTPATIENT PROCEDURES
Guam Memorial Hospital Authority
FY 1998 - FY 2002



Source: GMHA Hemodialysis, Radiology, Respiratory and Rehabilitative Services

AVAILABILITY OF RESOURCES

In addition to examining the use of hospital services, GMHA must consider the resources available for delivery of services when outlining its plans for the future. The Hospital reviews the number of physicians as well as hospital employees.

Physician Resources

Table 5, indicates that as of December 2003, there were 158 members of the Hospital's medical staff. The members represent broad spectrums of clinical specialties, notably absent are neurosurgery and cardiovascular internists - adult and pediatrics.

Of the total medical staff membership, the Hospital employs forty-four (44) physicians including pathologists, anesthesiologists and ER physicians. Board certification has been achieved by nearly (71) percent of all physicians. This percentage will be increased over the next five years as the medical staff has established a goal of (80) percent board certification for its members.

The growing percentage of board certified physicians attests to the quality of care provided. These certifications, combined with the fact that the members of the medical staff are relatively young, suggest that the community will receive quality and continuity in the delivery of medical care over the next several years.

In spite of the medical staff's size and diversity, there are still critical physician shortage areas within the community that need to be filled, such as, orthopedics and neuro-surgery, cardiac surgery and urology. Although GMHA has previously not been responsible for recruiting physicians for the Island, there is an active effort among the administration and the medical staff to recruit qualified physicians who can address the needs of the community.

TABLE 5
GMHA Medical Staff
By Specialty, Board Certification & Age
December 2, 2003

CLINICAL SPECIALTY	BOARD CERTIFIED	OTHER	AVERAGE AGE OF MEMBERS	% BOARD CERTIFIED
Anesthesiology	2	6	54	25.0%
CAPD Nurse	0	1	52	
Cardiology	4	0	47	100.0%
Certified RN Midwife	3	1	49	
Clinical Psychologist	0	1	54	
Emergency Medicine	8	2	52	80.0%
Endocrinology	1	0	42	
Family Practice	16	5	43	76.2%
General Dentistry	0	1	48	0.0%
General Surgery	4	4	50	50.0%
Hand Surery	1		51	100.0%
Infectious Disease	2		44	100.0%
Internal Medicine	17	7	46	70.8%
Neonatology	1	0	35	
Nephrology	2	1	49	66.7%
Neurology	1	2	59	33.3%
Neurosurgery	0	1	49	
Obstetrics & Gynecology	11	7	54	61.1%
Opthamology	1	1	60	50.0%
Oral/Maxillofacial Surgery	0	1	40	0.0%
Orthopaedics	1	3	42	25.0%
Otolaryngology	2		57	100.0%
Pathology	3		56	100.0%
Pediatrics	15	3	44	83.3%
Plastic Surgery	1		40	100.0%
Podiatry	0	3	44	0.0%
Psychiatry, Child	1		52	100.0%
Pulmonary Disease	1		39	
Radiology	4	2	50	66.7%
Surgical Assistant		1	50	
Surgical Emplyed Assistant	1		35	
Urology	1	1	49	50.0%
TOTAL	**104**	**54**	**57**	**71.2%**

Source: Guam Memorial Hospital Authority
Medical Staff Department

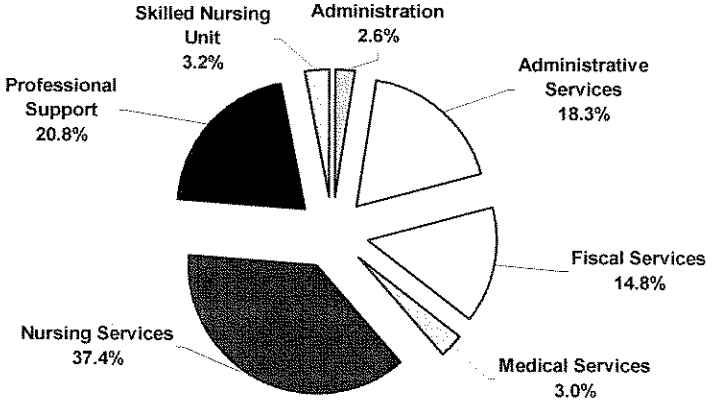
There are practice development opportunities in Urology, Neurosurgery (the sole neurosurgeon on GMHA staff is based in Hawaii.) and Cardiac Surgery.

Support Staff

Understanding that a successful hospital requires management of patient care and the staffing of professionals who perform these services, GMHA is also concerned with the ratio of health care providers in relation to the staffing level of the entire hospital. Therefore, the Hospital continues to monitor the staffing patterns of both full time clinical and non-clinical employees in an effort to meet the Hospital's staffing requirements for the provision of quality patient care.

Figure 10 depicts the staffing levels for full-time employees (FTEs) by division and in relation to the Hospital's total budget. A greater percent of full-time employees are distributed among Nursing Services (37.4%) and Professional Support Services (20.8%). These divisions make up 58.2% of the Hospital's total budget and are directly related to patient care services.

FIGURE 10
FULL TIME EMPLOYEES
Guam Memorial Hospital and Skilled Nursing Unit:
FY 2002



Source: Guam Memorial Hospital Authority Fiscal Services

An ongoing challenge that GMHA faces is how to balance its employment levels with the service demands. On a macro basis the hospital is over staffed with over 6 FTE's per occupied bed as compared to 4.5 FTEs per occupied bed, which is the 50th percentile for hospitals of a similar size and patient severity. On the micro basis we currently cannot provide nuclear medicine services, 24-hour coverage for ultrasound, outpatient physical therapy and outpatient laboratory service because we lack the needed staff. Our nursing vacancy rate is currently 12% and our LPN vacancy rate is 45%. Exit interview analysis as well as feedback from prospective candidates indicates that compensation rates are a primary detractor. The Civil Service Commission determines GMHA's compensation rates using wage data from the early 1990's. While The Legislature did provide for 25% increases for nursing and other licensed personnel several years back, GMHA has been unsuccessful in recruiting candidates for key clinical and professional positions from off-island because of the compensation issue.

S.W.O.T ANALYSIS

(Strengths, Weaknesses, Opportunities and Threats)

STRENGTHS

Strong Board of Trustees The Authority's nine board members are appointed by the Governor, with recommendations by the Guam Medical Society, Guam Nursing Board, the Allied Health community and the business community. The new Board came into office in January 2003. Lead by Philip Flores, Chairman and CEO of Bank Pacific the Board works effectively with the Administrator and as a team. Board members in 2003 are:

Florencio (Larry) Lizama, MD (Vice-Chair)
Brihida Aguigui, RN
Brian Bates, MD
Jon Stranhagen
Jeff Moylan (Treasurer)
Sally Tsuda, RN
Noel Silan, D.P. M.
Gloria Mortera

Professional Administration As with the Board, the Governor of Guam appoints the Administrator. 2003 marks the first time in many years that the incoming Administrator meets the qualifications as set forth in the Authority's enabling legislation. Both the Assistant Administrator for Nursing Services and the Associate Administrator for Operations have Masters degrees in the appropriate field, and the Hospital has recruited a candidate for Chief Financial Officer who meets the criteria for SFO as set forth in the enabling legislature.

Volunteers Association GMHVA has consistently raised funds for projects at GMHA that have supported the Infant Transportation System and the Maternal Child program.

Political Support GMHA is supported by the Governor and Lieutenant Governor and their staffs, and by the leadership in the Legislature.

Popular Support The Hospital's Board and Administration are widely recognized by the private sector as being a focused, progressive and effective team.

Funding Access GMHA received a $3.8 allocation from the Healthy Futures Fund in the FY 2004 budget. This allocation was put forward in response to a proposed 5% fee hike. While it is far short of the $15 million in additional Cash Revenue GMHA needs, it is the first step in recognition of and dialogue about how GMHA is to off set the increasing demands of uncompensated care, and establishes a platform for GMHA to receive ongoing, tax-based revenue.

Compact of Free Association Agreement Madeline Z. Bordallo, Guam's Congresswoman, championed new This Federal legislation. When fully realized GMHA will have access to reimbursement for services provided to FAS residents, a share of the expected $14 million annual Compact Impact Funding, and an ability to transfer selected patients to US Navy Hospital for services.

WEAKNESSES

The Financial Situation GMHA has a chronic cash flow problem due to uncompensated care, slow payments from MIP/MAP, under billing, and inefficient collection practices, high inventory costs due to inability to pay in a timely manner, high payroll costs due to excess staff and an inability, to date, to effectively reduce expenses because of GovGuam personnel regulations.

Management Team Depth Executive staff positions of the hospital number four; Administrator, Assistant Administrators for Nursing, for Operations, for Professional

Services and for Financial Services (CFO). It has taken a year to secure a candidate for CFO, and the Professional Services position remains unfilled. GMHA feels the lack of depth in its senior management team, and in critical middle management positions. This keeps the Hospital in a reactive, rather than pro-active stance, and limits the Hospital's ability to develop new business, improve productivity, and strengthen clinical quality and service.

Training & Experience Deficiencies There are no locally available training programs for professional positions such as Radiology Technologist, Laboratory Technologist, Physical Therapy Assistant, Respiratory Therapist, and Pharmacy Technologist. Accordingly the Hospital has many workers in these services who are only on the job trained. Additionally many of our staff have only worked at this hospital, and have not trained or worked in any other hospital. This also holds true for non-clinical staff as well. As a consequence many core competencies expected in health care workers are inadequately demonstrated.

Labor Shortage In addition to the national shortage of nursing personnel, the Hospital is impacted doubly by its isolated location, and non-competitive compensation practices even when compared to private sector positions on island.

Government Regulations and Procedures JCAHO regulations are very clear about the need for Hospital leadership to be able to manage hospital operations with respect to the numbers of staff, the qualifications of the staff, and the assessment and demonstration of staff competencies. The Hospital operates within a web of Government regulations and procedures that are contrary to JCAHO standards; for example in 1998 PL 24-327 imposed a hiring freeze on all autonomous agencies without legislative consent. While subsequently amended, this is an example of how the Hospital is restricted in its requirement to determine the necessary number of staff to insure patient safety. In another example the position of Mammography Technologist

was mandated by legislation. However more than two years have passed since this was mandated and the Civil Service Commission has yet to specify the qualifications for the position and to authorize the position. Again, another example of how the Hospital is restricted from determining the need and qualifications of staff.

Inefficient Work Practices For a host of reasons work processes are not efficient within the hospital. This drives our costs up, increases error rates and decreases our ability to perform work.

JCAHO GMHA lost its accreditation years ago and despite a number of efforts, as not achieved the necessary momentum to bring about accreditation.

OPPORTUNITIES

3-year window for change The Governor's term expires in 2005. The Hospital has a 3-year window of opportunity to make changes needed before the possibility of a new Governor (and a new Board of Trustees and a new Administrator) interferes with our progress.

Re-Organization/Outsourcing Recently enacted changes in the law now allow Government agencies to contract out for services. This will allow the Hospital to outsource a number of functions that can be performed at lower cost and with higher quality by the private sector. There is potential for re-organizing and amending the enabling legislation to make the Hospital more compliant with JCAHO regulations in the area of Human Resources management.

Reimbursement With the advent of a Chief Financial Officer and the ability to enhance our Medicare cost report, and the potential for regulatory relief from the TEFRA cap coming from proposed US Congressional Hearings in February there is

potential for the Hospital to maximize its Medicare reimbursement. This in turn increases the reimbursement from MIP/MAP as these payers derive their payment from the Medicare rate.

New Business Development The environmental analysis highlighted service gaps in Cardiac Services and Oncology Services, long with an on-going need for ESRD and Diabetes services. Development of formal education programs such as a LPN certificate and a primary care residency program also hold promise. These create business opportunities for the hospital.

Internal Change Process In 2004 GMHA began sending its managers through a management development program conduced by Laurie Duenas, Director of the HLATTE Project of the University of Guam. This training introduced CQI techniques based on Edward Deming methodologies. The initial training group of twenty managers have developed and implemented __ process improvement projects from an initial brainstorming list of ____ . It is anticipated that each year a total of ___ such CQI projects will be implemented.

THREATS

Blockage of Outsourcing via Employee Civil Service Appeals Both the Housekeeping and Security outsourcing will require some downsizing that will result in appeals by affected employees to the Civil Service Commission. The Commission has the ability to void management action.

Uncompensated Care GMHA experiences $20 million in bad debt annually. A significant portion is this ($10, million in FY '03) is attributable to citizens from Freely Associated States.

Off-island referrals for services the hospital provides, or could provide A health insurance executive recently estimated that island payers spend 30% of their revenue on off-island services. This is approximately $40 million per year.

Competing Services GMHA has lost most of its outpatient imaging business, its ambulatory surgery, and a portion of its OB business and all of its outpatient laboratory services to competing private services. Further erosion of the business base, especially with paying patients is a threat to the Hospital.

Loss of employees due to military deployment GMHA will face the loss of key employees due to military deployment. In the case of Army deployment the time period is at a minimum one and one half years. We could also face loss of employees who are family members of deployees who re-locate.

GOALS AND OBJECTIVES

Goal #1 – Financial Stability

Objective 1. Increase in Cash flow

a) Billing Accuracy & Timeliness

b) Improved Payor Account Management

c) Outsource Self-Pay Credit & Collection

d) CDM Cleanup & Maintenance

Objective 2 – Increase Revenue

a) Fee Increase

b) CDM Update

c) Charge Capture Tactics & Technology

d) Tax-Based Funding

e) New Business Development

a. Cardiac Service Line

b. Diabetes & ESRD Service Line

c. Oncology Service Line

d. Physician Recruitment

e. LPN Certificate program

f. Primary Care/ Family Practice Residency Program

g. Patient & Family Education Services

f) Medicare Reimbursement Optimization

Objective #3 - Uncompensated Care Relief

a) Partial Cost Shift via Fee Increase

b) Partial Tax Based Funding

c) Hospitalist Program

Objective # 4 Financial Efficiency

a) Outsourcing

b) Manage labor productivity at > 50th percentile

c) Use improved cash flow to pay down receivables and obtain better pricing and terms

GOAL # 2 Clinical Development

Objective 1 - Competency Assessment and Development

a) Clinical Nurse Specialist (Nurse III)

b) Migrate to Team Nursing from Functional Nursing

c) Achieve Acceptable Staff: Patient ratios (JACHO H.R. 1.10)

a. Recruitment & Retention

b. Regulatory relief for compensation, position development

d) Training and Development (JACHO H.R. 2.10, 2.30)

a. Ongoing NCLEX Review Classes for local and off-shore nursing candidates

b. Development of a Licensed Practical Nurse diploma program

Objective 2 - Surveillance, Prevention and Control of Infection

a) Develop a coordinated process to reduce nosocomial infection risk

b) Re-develop the Infection Control Committee

c) Develop Infection Control Staff

d) Training and Development

Objective 3 – Improve Organizational Performance

a) Implement a useable "Data Dashboard"

b) Implement department and crosscutting analysis and corrective action.

c) Institute cultural change for Organizational Improvement

Objective 4 – Improve the Management of Human Resources

a) Improve assessment of staff effectiveness to that job competence is assessed, demonstrated and maintained (H.R. 1.30, 3.10,)

b) Training and Development activities (H.R. 2.10, 2.30)

c) Job competence assessed, demonstrated and maintained

d) Regulatory relief to develop independent classification and compensation system for health care professionals.

Goal # 3 – Improve the Environment of Care

Objective #1 – Outsource environmental services so that there are adequate resources to main the hospital's cleanliness

Objective # 2 - Improve the preventative maintenance cycle and link the repair or replace cycle with capital funding cycle.

Objective #3 - Insure that Patient Staff and Visitors are safe

a) Outsource security services so that there are adequate resources for security

b) Reduce inventory / material shrinkage

Objective # 4 - Plan for adequate bed capacity

a) Fast track room renovation

b) Multi-use beds; Med/Surge to Med Telemetry

c) Capital plan to increase bed capacity to 275

Goal # 4 - JCAHO Accreditation

Objective #1 - Complete Extranet Survey and Statement of Conditions in Q3, FY 04

Objective #2 - Successful Site Survey in Q2 FY 05 resulting in Accreditation

Objective #3 - 18 month extranet survey in FY 06

Objective #4 - Recertification in FY 0'8

Goal # 5 - Reorganization

Objective # 1 - Introduce a streamlined management structure

Objective # 2 - Outsourcing for value

Objective # 3 - Independent personnel classification and compensation system for Healthcare professional staff and administrators

Review and Approval

Department Head Level	March 2004
Executive Management Level	May 2004
Boar of Trustees	MAY 27, 2004 RESOLUTION NO. 04-066 Philip J. Flores, Chairman