HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Ben W. Latimer

BEN W. LATIMER

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
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Ben W. Latimer

CHRONOLOGY

1940	Born Atlanta (Lawrenceville) GA, August 3
1962	Georgia Institute of Technology, BE, ME
1962-1963	Proctor & Gamble, Department of Industrial Engineering
1964	Georgia Institute of Technology, Instructor Work Measurement & Quality Control
1965	Georgia Institute of Technology, MScIE
1965-1969	Methodist Hospital, Memphis Division of Management Systems
1969-1978	Carolinas Hospital and Health Services (CHHS) Executive Director
1978-1983	CHHS, President
1979	Sun Alliance founded
1983	SunHealth Inc. founded as planned successor to CHHS
1985	Sun Alliance merged into SunHealth and SunHealth Corporation founded

MEMBERSHIPS AND AFFILIATIONS

American College of Healthcare Executives, Member

American Hospital Association

- Assembly of Shared Services Programs, Governing Council, Chairman of the Board
- House of Delegates, Member, 1981
- Governing Council of Section for Health Care Systems, Chairman, 1987
- Quality Measurement Task Force

American Institute of Industrial Engineering, Memphis Chapter, President, 1966

American Management Association, Member

Carolinas Hospital and Health Services 1969

- Carolinas Affiliated Purchasing Program (CAPP) 1974
- CHHS Data Processing 1976
- CHHS Management Services Division 1974
- Carolinas Hospital Engineering Support (CHESS)
- Carolinas Hospital Improvement Program (CHIP) 1969
- INSIGHT (Computerized productivity monitoring system)
- SIGMA (CHHS services to hospitals outside Carolinas) 1978
- The Duke Endowment

Kate B. Reynolds Health Care Trust

Mental Health Management Inc (Corporation to corporation contract management of inpatient mental health services)

North Carolina Hospital Association

Pacific Review Services, Cyprus, CA (Utilization management consulting services)

MEMBERSHIPS AND AFFILIATIONS (Continued)

Presbyterian Hospital, Charlotte, NC

Professional Research Consultants (Healthcare opinion research)

Project Development Construction Inc (PDC)

Design and construction of MRI and other facilities

SAMM (Sun Health Automated Maintenance Management)

Equipment maintenance monitoring systems

South Carolina Hospital Association

Sun Alliance 1986

Tyler & Co., Atlanta (Executive and physician search)

United Health Services Inc. (Hospital support services management)

Virginia Insurance Reciprocal (TVIR)

Malpractice and workers' compensation insurance

Washington University Hospital Administration Program

Adjunct Instructor

W.K. Kellogg Foundation

HONORS AND AWARDS

Alpha Pi Nu

Member

South Carolina Hospital Association

Merit Award 1980

BOOK CHAPTERS

Multi-State, Multi-Service Corporation

with Pat Poston in Health Care Financing: Shared Services
Aspen, 1976

with Pat Poston in Multi-hospital Systems by Brown and McCabe
Aspen, 1980

Contribution to H.E. Smalley and John R. Freeman: Industrial Engineering in Hospitals

Stategies for Clinical Engineering through Shared Services
with Burt Dodson, Jr., W.K. Kellogg Foundation, Monograph, 1976

WEEKS:

The way we usually start these oral history interviews is to have a brief biographical sketch. I have made a chronology of your professional life. We can work from that, and then go back later to pick up different segments to go into greater detail.

You always have to begin with a birth date. I have yours down as August 3, 1940. I found one confusing thing: I am not sure where you were born. One place said Atlanta, another Lawrenceville. I came to the conclusion that Lawrenceville must be a suburb of Atlanta.

LATIMER:

That's more than a conclusion, that is correct. It is a suburb of Atlanta.

WEEKS:

In your early days was there any inclination toward what might become engineering?

LATIMER:

My father was with the Georgia Power Company, the utility that serves Georgia. My mom was a school teacher. Probably she had an analytical or mathematical bent. Those things may have influenced me a great deal. Perhaps growing up with an uncle who was a Georgia Tech graduate and seeming to have, in my high school days, much greater comfort with mathematics and things of this nature than the liberal arts. I think it is what led me to an engineering education.

WEEKS:

There is usually something in the early days that will point the way.

You went to Georgia Tech yourself, didn't you?

LATIMER:

That's correct.

WEEKS:

I have you down as receiving your bachelor's degree in mechanical engineering.

LATIMER:

That's correct.

WEEKS:

In 1962, and your Master of Science in industrial engineering in 1965.

LATIMER:

That's correct. By the way, during the time I was obtaining that degree, I determined that fluid mechanics and heat transfer were not the kinds of things that I was interested in dealing with for the rest of my life -- but I am a very committed, some may say stubborn kind of person and I wanted to go ahead and finish that degree, and then be able to say that is not where I want to spend the rest of my life. After I finished the degree in mechanical engineering at Tech, I spent a little over a year at Procter & Gamble in Cincinnati, Ohio, in their management training program. After I had been with P&G for a time -- while that was a very fine experience at P&G -- I determined that further schooling would aid my career and would allow me to develop other interests. I was fortunate enough to get an assistantship in the school of industrial and systems engineering at Tech. Colonel Grosclose was the head of the industrial engineering department at Tech at the time. I went back to Tech, and taught part-time while I was working on my graduate degree.

My graduate certificate does say 1965, but actually I completed my coursework by the fall of 1964. Dr. Harold Smalley, who led me to my interest

in health care and who, I think, was certainly one of the pioneers in introducing industrial engineering and quantitative techniques to health care at that time, made it possible for me to participate in an interview with Methodist Hospital in Memphis, Tennessee, in 1964. I went to Memphis over the holiday season at the end of 1964. I had one last paper to write to complete the graduate education. I finished that paper in Memphis and did the defense of it. It wasn't a full thesis but it was an original paper. I did the defense of that paper while I was in the employment of Methodist in Memphis. Even though most of my coursework was completed in 1964, the grade does say 1965.

WEEKS:

I am glad you mentioned Harold Smalley. Was he the first engineer to use the term management engineering? Did he use industrial engineering?

LATIMER:

I guess we used both terms. Certainly we did in the school of industrial engineering at Tech. The concept of industrial engineering skills goes all the way back to the Galbreths. The "cheaper by the dozen" stories and many of the studies that he did in operating rooms and other sites back in the very, very early days of quantitative management of this country. I think we found that the term management engineering was more readily accepted by hospital managers, by physicians -- better reflective of what we were doing. The term management engineering, although many of the same techniques were used, was adopted during that time.

WEEKS:

I was glad to hear you mention the fact that Harold Smalley probably helped you become interested in the use of management engineering in health

care. Somewhere later on I have a note about the chapters you have written for various books and I have run across the phrase that you contributed to Harold Smalley and John Freeman's famous book on engineering in hospitals.

LATIMER:

I believe that one was Hospital Industrial Engineering instead of management engineering. Certainly they were responsible for the majority of the work there. They used the textbook within the school for other folks like me. They actually created a separate department of hospital systems engineering for a time. I believe that has now been folded back into the school of industrial and systems engineering at Tech. They drew upon many of their associates and former students for contributions to the book. I was one of several who had the opportunity.

WEEKS:

Years ago, back about 1965, when you were in Memphis is when we started the Abstracts of Hospital Management Studies. Practically all of the planners for this journal were industrial engineers, most of them from Michigan. That was when management engineering was beginning to be an important thing in Michigan. Dick Jelinek -- do you know Dick?

LATIMER:

I did.

WEEKS:

There were several companies started by these men. What is the name of the professor, Johnson was it, who was the head of.... Maybe you are not familiar with it.

LATIMER:

I was. I didn't have any personal contact that I remember. I think he

was active in that area. Maybe an associate who worked with Harold Smalley some. There were a few other institutions of higher learning that were active about the same time.

WEEKS:

It was a very active group at Michigan I know. As I say, several companies started up.

You talked about Procter & Gamble. I have had friends who have worked at Procter & Gamble. I had one very close friend who was a chemist. He was brought over from Denmark to become a part of Procter & Gamble's staff. He was recruited over there. From him I got the impression that it is a very methodical place. They have their management system set up pretty rigidly.

LATIMER:

My experience was limited. I was there less than two years, but I was very much impressed with their organization. There was responsibility, and there was an opportunity to build your career, but it was very structured. It was very organized. I think of numbers of things from my brief time at P&G that influenced me and the organizations I have been with. I was impressed with the way that they brought in young people at entry level positions, like the positions that I was in, and had a career development plan for them. I think one of the things that SunHealth has been fortunate with is that we have been able to go to the institutions of higher learning within our service area and bring in a number of the leaders of those individual classes, and have them with us for their entire career. A senior vice president in our organization has never worked for any other external organization since graduation except ours. That experience and continuity, I believe, is very important. That kind of career development, that kind of planning, I think

were influenced by the time at P&G.

WEEKS:

I think you mentioned somewhere that there was a man at P&G -- was his name Hottum?

LATIMER:

The person who had the biggest influence on my going to Methodist Hospital in Memphis, Tennessee, in the 1964-65 time-frame was Henry Hottum. Henry Hottum was among the senior managers of Methodist in Memphis. Jim Crews, who was the chief executive officer, and Henry Hottum. Mr. Hottum had a financial background. He had been an accountant. He probably impressed upon me in those very early days the importance of financial management. It was his thinking, along with the conversations and exchange that he had with Harold Smalley, that the change in payment by the government, the Medicare program if you would, was going to make it more important than ever before to analyze staffing, to manage with techniques that hospitals hadn't used before, in many, many expense areas. Mr. Hottum put faith in many of the studies and the work that I did at a very early age, and I think gave me an opportunity to have some impact, number one, but was an influence upon the development of my career.

WEEKS:

It is good to remember who helped you up the ladder, isn't it?

LATIMER:

That's correct.

WEEKS:

I'm glad you are not forgetting them.

In 1965 is when you went to Methodist Hospital. What did you find there

with -- the expression I was thinking was 'ground-breaking' -- or was this position pretty well established before you came there? Did the hospital think in terms of management engineering or did you bring fresh ideas in there?

LATIMER:

There were no management systems or management engineering applications of any nature prior to my arrival. I had the opportunity to initiate many types of reviews of staffing needs, of planning activities from a quantitative background, scheduling techniques. Certainly the things I remember earliest on were working in the nursing area, working with nursing management. You can imagine the questions that nurses who had never had any external influence upon staffing might have about what someone with industrial and systems engineering says about our staffing patterns. What do engineers know about patient care? Can we do things in the same fashion that other industries have done when we have no control over the demands for our work time and we don't know how sick the patients are going to be, etc.? Those are the things that I remember. I remember following the work that others in other sites had done, whether that was all the way back to the Gilbraiths or Harold Smalley or the work that the Kellogg Foundation sponsored in those early days with programs like CASH, a program in Chicago, and other state hospital association work of that kind that I remember being of benefit. I also remember that it wasn't very long until we were bringing management or industrial engineering in the staffing area together with management information systems in data processing, because just as those management techniques were beginning to be fully utilized in hospitals, technology, in terms of management information systems and computers, was just coming upon the scene. Hospitals were beginning to

move from just sophisticated accounting machines to keep the records and do the billing into systems that would provide management information and that we could use to learn more about patient care, about charting, about needs for services, communication among the departments in the hospital. Those are some of the experiences that I remember from those days at Memphis.

WEEKS:

Were there any persons there that you want to recall?

LATIMER:

I think that certainly people like Henry Hottum, Jim Crews, the director of nursing at Methodist in those days who was Dorothy Griscom. Miss Griscom was a leader in the professional nursing organizations in the state of Tennessee and nationally, I believe. I remember communications with her to be sure that she was willing to listen and accept the quantitative skills on one hand, while she was careful to be sure that they didn't have an adverse impact on care.

WEEKS:

Your big career move came in 1969, of course, when you became the executive director of Carolinas Hospital and Health Services -- is it Corporation or is that all the title?

LATIMER:

It was Carolinas Hospital and Health Services, Inc. It was only a few years until we began to refer to it as CHHS. We used acronyms substantially back in those days. One of the things that I remember is that we established the first operating program which was to be a management or industrial engineering service for about twenty hospitals in North and South Carolina. We adopted the name Carolinas Hospital Improvement Program. That comes out

CHIP. Ir was known as the CHIP program very early on. One of our second programs was known as Carolinas Hospital Engineering Support Services, which comes out CHESS. Our first purchasing program was Carolinas Affiliated Purchasing Program, which comes out CAPP. We had more acronyms and initials than anybody, with the possible exception of the government, I guess. We have tried to stay away from those in more recent times. Too many acronyms and initials become confusing.

WEEKS:

You always have to explain them.

LATIMER:

That's correct.

WEEKS:

How did this organization come about?

LATIMER:

As industrial and management engineering techniques were being introduced to the health care field and they were held to be beneficial, the W.K. Kellogg Foundation had been instrumental in organizations in several parts of the country. There was one in California -- Commission for Administrative Services to Hospitals (another acronym as CASH). I believe Bob Edgcombe was the senior manager of CASH, and Sam Tibbitts was a leader in getting it organized. In different sections of the country similar organizations had sprung up.

The South Carolina Hospital Association organized a committee to study these organizations. That group was led by D. Kirk Oglesby, Jr. Kirk was the administrator, chief executive officer, of the hospital in Anderson, South Carolina. He visited some of the other programs and determined that it was a

worthwhile activity. He approached The Duke Endowment, a foundation that has had far more impact upon health care, not only in the Carolinas but throughout the country. than most people realize. The group in South Carolina approached The Endowment about helping them develop an organization similar to the ones in other parts of the country.

Jim Felts and Bill McCall were the leaders of The Duke Endowment at the time. When they met with the group from South Carolina, they gave them encouragement, but they weren't sure there were enough hospitals or enough commitment from just that one state. The Endowment, as you know, works directly in both North and South Carolina. There was a similar group in North Carolina that was conducting an evaluation at the same time. Bill McCall was instrumental in bringing those two groups together and in bringing together the chief executive officers of those two state hospital associations. Bill Yates, who is still at SCHA today, active and, in my judgment, one of the premier state association executives in the country. The CEO of the North Carolina Hospital Association at the time was Marion Foster. The Endowment brought Bill and Marion together and proposed one organization for the two states, with a board composed of hospital executives from the two states. Bill and Marion met in Pinehurst, North Carolina, in a hotel restaurant to develop the plan and the by-laws for the organization. They put together a governing board and selected a professor from North Carolina State University, Dr. John Canada, to do the initial development and planning work for them. They selected Kirk Oglesby as the first chairman of the board of that organization. It was known as Carolinas Hospital and Health Services, Inc., under charter.

Dr. Canada put together some plans for them, put together a proposal for

introducing management industrial engineering to hospitals in the two states, and put together a plan for introducing management education programs that were part of the North Carolina State Extension Service that Dr. Canada was related to. He took the responsibility for finding their first staff. Dr. Canada had considered a number of folks, I understand, but he had had some contact at Georgia Tech with Dr. Smalley and had completed some of his graduate education there. He made contact with me in Memphis. I came to Charlotte and met with that eight-member board. There were three hospital executives from each state plus the CEO of the two state hospital associations, then the representatives of The Duke Endowment who were included for informational purposes. They had already made a commitment for philanthropic support. I was fortunate enough to be selected by that group. It has been a very pleasant career for me, since 1969.

WEEKS:

Did anyone else besides Duke give you financial support in those early days?

LATIMER:

For the first program, the management engineering program that we called CHIP, all the development support was from The Duke Endowment. But that was followed by other programs, and we were fortunate enough to be able to work with the W.K. Kellogg Foundation -- Andy Pattullo and Bob DeVries. The Duke Endowment staff, Jim Felts and Bill McCall, had a very close working relationship with the management and staff of the Kellogg Foundation. They talked to them about our activities, and as we moved to the biomedical engineering and clinical engineering area, the two foundations joined hands and provided that support. In addition, there are other foundations in North

Carolina, for example, the Kate B. Reynolds Health Care Trust. Early on, the Kate B. Reynolds Health Care Trust made it possible for us to bring in entry level engineers into our consulting program for training and orientation to health care. It has been one of the programs that we continue to this day. It involves going to the technical institutions in our service area trying to recruit the best and brightest of those classes. The experience that we had through the support from the Kate B. Reynolds Health Care Trust was highly positive in terms of providing young people an early career entry to health care. Many have stayed with us, but others have gone on to other important positions. I think that was a major contribution of one philanthropic experience.

Back to the work of The Duke Endowment and the W.K. Kellogg Foundation. Our second program was called Carolinas Hospital Engineering Support Services, involving biomedical equipment services and clinical engineering activities. That was jointly supported by Kellogg and Duke. Once the program was established, Kellogg asked us to do a monograph on our experience. I believe Bob DeVries and/or Andy Pattullo used the monograph method to record and share many of the activities of that day. They published a similar one in the management engineering area that my good friend Pat Ludwig prepared called "Dollars and Sense." Pat and I collaborated in many different areas. He preceded me as the president of the HMSS, Hospital Management Systems Society. Down through the years we have worked together on many different areas.

The W.K. Kellogg Foundation also supported our activities in contract management and several other programs that we developed since 1969.

WEEKS:

Before we leave Kate Bidding -- it is Bidding, isn't it?

LATIMER:

That's correct.

WEEKS:

The Kate B. Reynolds Health Care Trust. I heard a story from Haynes Rice. Do you know him?

LATIMER:

I know of him.

WEEKS:

He was in the Carolinas in those days running a black hospital, very small. He was telling me that they depended on the support that they got, sort of a patient day type of support, something like seventy-five cents a day per patient, help from this Kate Bidding Reynolds Trust. Then, of course, when insurance came along and Medicare and Medicaid, that seventy-five cents a day, which back in the early days had been the major portion of a daily rate, then it became sort of insignificant. I wondered, did the foundation divert some of that money into this educational support?

LATIMER:

Both the Kate B. Reynolds Health Care Trust and The Duke Endowment originally operated on the principle of a specific amount of support, seventy-five cents for the Kate B. Reynolds Health Care Trust and one dollar for The Duke Endowment, for charity or indigent care. As the government stepped in with programs like Medicare and Medicaid and the price of health care went up so dramatically, both of them made arrangements to change that. So, yes, they no longer provide that kind of per day support and their funds are used for education as well as other programs and risk-taking research. The Duke Endowment still provides a certain amount to not-for-profit hospitals in North

and South Carolina for charity care. They go through a very elaborate fact-finding determination about the amount of care that they provide. From that they make allocations to the hospitals in North and South Carolina.

WEEKS:

It was an interesting thing that I ran across -- that seventy-five cent figure -- and, of course, when you compare rates of that day with rates of today, there is no comparison.

LATIMER:

The seventy-five cents and one dollar per day were significant amounts when those foundations were founded.

WEEKS:

What kind of a corporation was CHHS? Was that a 501(c)(3) or what? How did that operate financially?

LATIMER:

We've gone through a long and interesting exchange with the government about our corporate structure and tax status since 1969. When we were first organized, we were committed to working only with not-for-profit hospitals -- a practice which we essentially continue to follow today. Since we believed that our services and programs were simply an extension of what hospitals might be doing individually, we initially sought a 501(c)(3) tax exemption. Actually, after some appeals and hearings based on our educational activities also, we received that designation. As time went by and more of our programs were service oriented, we had further exchange with the government about whether CHHS should be classified as a shared services cooperative under Section 501(e). We resisted that because Section 501(e) did not allow for development and retention of earnings and because of other kinds of

constraints that we thought would hamper our growth and development. We went through a great deal of exchange and debate with the government. Finally, we settled on tax status but had begun a process of restructuring to meet our needs. Today, we are a traditional, taxable, stock corporation. But there are provisions that only not-for-profit hospitals may be equity owners -- 501(c)(3) or governmental equivalents can own the stock. If for any reason one of our owner organizations -- we like to call them partners --changes its tax status, or even if it becomes contract managed by an organization that is investor-owned, it loses the privileges of stock ownership and the stock either reverts back to us or can be sold to some other eligible organization. We did go through a period of time as a 501(c)(3) considering or 501(e) until finally evolving the traditional industrial stock model, with certain limitations and provisions on who could be the owners of the corporation.

WEEKS:

I wondered, because in certain places I read the term shareholder and then I began wondering if there were any dividends and this sort of thing. Then I began wondering about your ability get grants if you weren't the right kind of corporation. Kellogg or Duke might not be able to give it to you legally.

LATIMER:

Clearly, in the early days, it was important for us to be 501(c)(3) to benefit from that direct philanthropic support from The Endowment and the W.K. Kellogg Foundation. As time has gone by and those early seed monies have borne fruit and we have adopted tax-paying status, we are no longer directly eligible for that kind of philanthropic support. But, of course, all of our organizations are eligible. You can use the term network member, or

shareholder, or partner interchangeably. I like partner, because I think it reflects our hospitals working together in the kind of joint effort that this phrase denotes. Those organizations are certainly eligible for grant support. If there are opportunities in the future where philanthropic support is appropriate, we would support those individual partner organizations' grant projects rather than our receiving philanthropic support directly. Our organization is certainly the result of some early support and guidance from the foundations, and probably I value the guidance of people like Bill McCall and Jim Felts and Andy Pattullo and Bob DeVries as much as their money. Couldn't have made it without either, I don't think.

WEEKS:

I can see where you had problems, but I can see now that you are generating revenue that allows you to invest and expand and so on without direct grant possibly. I can see the indirect -- I hadn't thought of that as a procedure, but that works pretty well too, doesn't it?

LATIMER:

It will work that way. I think we owe a great deal of our heritage to the philanthropic support that we received from The Duke Endowment and the W.K. Kellogg Foundation and the efforts of the state hospital associations. I think we were particularly fortunate in three things about our activities for the state hospital association. First of all, they set CHHS up as a separate organization. It was not directly a part of the state hospital associations. Second of all, they didn't give us any money. From the beginning our services had to be of sufficient value for hospitals to purchase and use them of their own choice, without dues and without mandate. Our founders also set up no geographic boundaries. The separate organization, the no dues support, and no

geographic boundaries -- all, I think, contributed to allow us the freedom and the charge to develop into the organization that we are today.

WEEKS:

Hospitals really became clients, didn't they?

LATIMER:

In a sense, they certainly did.

WEEKS:

You were making a "profit" on this, hopefully. You were charging a fee for your services so that hopefully you were looking down the road a bit to see it would come to the day when you would be self-supporting.

LATIMER:

Absolutely. The plan all along was that we would use philanthropic support just as development capital, and that we would always charge appropriately for our services so that we would be self-supporting and so there would be additional funds for the development of new services or refining those that we had. Very much in the traditional model of American business development.

WEEKS:

Somewhere there must be a statement of the goals of CHHS, but I assume that they say, in one way or another, that they are trying to bring management skills and support services to hospitals so they, the hospitals, can use their facilities to the best degree possible in furnishing quality care. Would that take in what your goals might have been?

LATIMER:

I think that that is a fair paraphrasing of our original goals and certainly a great deal of that carries on today. What I particularly like

about what you just said is supporting the hospital or provider organization in reaching its goals, not goals for the central unit. I think that is one of the things that distinguishes SunHealth from other multi-hospital organizations and arrangements. We are so committed to helping our partners reach their goals.

That comes about in a number of ways. It comes about by our administering and building what we call The SunHealth network, those partners who work together. It comes about by our providing needed services, services that hospitals and other providers are willing to pay for on the basis of their value. It comes about by facilitating the working together of the various parts of the network, whether it is developing ways that patient referrals can occur or bringing partners together in smaller groups to work together for improved patient care. That is certainly placing the goals of the partners and our members paramount. That is a very, very important principle to us.

WEEKS:

You are in existence really for their benefit.

LATIMER:

That is correct.

WEEKS:

In the very beginning, about the time you went to CHHS in 1969, were the services of this new organization to be confined to the Carolinas? Was there anything distinct about understanding that?

LATIMER:

In the beginning, since the philanthropic support for creating the organization came from The Duke Endowment, and its support is limited to North

and South Carolina, and since our governing board members were restricted to North and South Carolina, in terms of demonstrating the value of our services and in terms of those who were committed to using them, it never crossed our mind to serve anyone other than North and South Carolina. As the services proved to be successful and for a variety of reasons were not readily available in some of the contiguous states, in the mid-1970s the question of offering the services beyond those two states was asked. The governing board, even though it was made up completely of people from only North and South Carolina, determined that it was appropriate to expand on the rationale that the services would do no harm, that we would have a larger nucleus of staff, that the staff could gain from those experiences, and that we would have the opportunity of additional forums for development and expansion.

One of the most significant things that happened to us in our early days -- it happened during the time that Jack Skarupa with the Greenville (S.C.) System was chairman of our board -- was the expansion of our board beyond just hospital CEOs. The addition of the first non-CEO came from an educational institution. Since those very early days, we have had governing board members from academia, from business and industry, from medicine and from law, for example. Their influence, I think, has been very profound. That is another distinguishing characteristic of our organization. Today, it is very important, I believe, for us to work closely with the medical community, just as health care management does. We have had physicians on our governing boards since those very early days. I think that having that kind of balance and diversity in our governing board was part of the reason that we could expand and grow, in terms of scope of service, depth of service, and geographic service area.

WEEKS:

I think you are wise to work with the physician, because I learned early that you can't do much in a hospital unless you have sold the medical staff first. They have to feel a part of it. You can't ignore them. They are difficult sometimes to work with, even when they are a part of it.

LATIMER:

Certainly everyone is quick to point out that hospital management doesn't admit or discharge patients and doesn't make selection decisions about referrals either. Having the physician's perspective, I think, is very, very important -- whether you are talking about service improvements, whether you are talking about selection of corporate partners to provide goods and services to hospitals, whether you are talking about ways that you might join the provision and financing of health care together. If you don't include the physicians and their perspectives, you are going to have a most difficult time making progress.

WEEKS:

Could we go over that list of support services again? Was your first program the one you called CHIP?

LATIMER:

Our first program, in the early days, was called Carolinas Hospital Improvement Program, CHIP. That was the management and industrial engineering activity. That program also had substantial involvement with management education. It was followed in 1973 by Carolinas Hospital Engineering Support Services, CHESS. It is known as our plant and clinically engineering support services today. Those were followed by our group purchasing activity in the mid-1970s. In 1974 we originated our comprehensive management program, our

contract management services. I guess we are still, if not the only, one of the very few organizations controlled by only not-for-profit hospitals that provides comprehensive management services. Some of the investor-owned chains contract manage hospitals, and we compete with them very actively. Our comprehensive management program has stood the test of time and is still adding new clients today. We have had experience in the data processing and management information systems area, and with mobile CT scanning services in which we have provided circuit-riding services to smaller hospitals to meet their imaging needs. Each one of these divisions has become self-sustained. Today we are geared into "corporate partnerships" and relationships with other organizations in services such as liability insurance and durable medical equipment services -- a wide range of diversification. I think your primary question was concerning those five or six early divisions.

WEEKS:

I noted some things. May I ask you about purchasing?

LATIMER:

Sure.

WEEKS:

This is making arrangements for your network members to buy supplies needed in their business, but you do not enter into the actual materials handling? You don't warehouse any material, do you?

LATIMER:

We do not warehouse or keep inventory. We negotiate terms and conditions overseeing the quality of goods and services, and seeking value-added arrangements also. The individual partners, or individual member hospitals, make the direct commitment to purchase, and they receive supplies directly

from the selected suppliers.

WEEKS:

But you make the contract arrangements, the price?

LATIMER:

Yes. When you buy Band-Aids by the boxcar load and MRIs by the dozen, obviously you get better terms -- price, quality, delivery schedules, and commitments from suppliers to keep your program and hospitals competitive, to keep you on the leading edge of their services. We are very proud of the experience that we have had in the group purchasing and procurement area.

WEEKS:

I couldn't help but wonder in the talks I have had with various persons on this point of group or shared services, I wonder if there is anyone left who pays the full price? Can anyone afford to be outside of a system?

LATIMER:

I think that everyone has to join together in some way to leverage volume. Today, the amount of commitment that a group program's members have and the amount of leverage that you exercise certainly varies. Your ability to standardize, your ability to bring about consistency in supply usage within your medical staffs and individual institutions varies, but I think few who are in group programs pay full price. One of the challenges today is to measure the impact or effectiveness of the various purchasing organizations -- multiple hospital organizations, the alliances, shared services -- that are active in the field. If virtually no one is paying full price, what is the benchmark that you use to determine your benefit? We have hospitals that have been doing the majority of their purchasing with us since 1974 or 1975. How do we reflect the increasing benefits today, versus last year? For a new

partner or member coming in, the measurement is very easy. Although they might not have been paying full price or even though they might have been in some other purchasing group, we can determine what they paid last year and what they will pay when they avail themselves of our programs and practices. But for those organizations that have been with us for a long, long period of time, finding that benchmark by which to quantify all of the benefits is a real challenge.

WEEKS:

If you are in the market to buy Band-Aids, do you have a standard price throughout your group?

LATIMER:

We do. One of the techniques that we think we have pioneered in recent times is the concept of corporate partnerships or relationships, an arrangement in which we go to the marketplace and describe the organizations that are a part of SunHealth and their particular needs, and then receive proposals from the organizations who provide specific goods and services. We select a very small number of corporate partners, and they attempt to give us their best prices for their goods and services, knowing the volume that we represent. Everyone within our alliance is then eligible for that price; we don't have a series of different prices at different locations. Everyone has the opportunity for the same terms.

As individual corporate partners make stronger commitments to encourage hospitals to use even more of their goods and services, they may move to a sliding scale. As the hospital group constitutes a larger portion of the market share, the terms and conditions improve for all. But everyone in the group has the same opportunities to benefit from the terms and conditions that

we have developed.

WEEKS:

I was looking at a list of your corporations...

LATIMER:

We call our main suppliers "corporate partners" to denote relationships that go beyond simply trade volume for price.

WEEKS:

I noticed one thing: You have Johnson & Johnson, of course, and that takes in a lot of territory. Then I was noticing Abbott Laboratories. As I remember, a few years ago they and Baxter used to be highly competitive on intravenous solutions. Then I didn't see any other full-line pharmaceutical house, such as Parke-Davis. Are you cooperating with Abbott as far as standard pharmaceutical things that everybody makes? Do they come through Abbott? How about Baxter and Abbott on intravenous?

LATIMER:

There was a substantial amount of competition for the SunHealth group IV solution arrangement. Certainly Abbott and Baxter were two of the competitors. Our arrangement in the solution area is the centerpiece of our arrangement with Abbott Labs, but Abbott has other divisions that are also very important. In arrangement with Du Pont, the x-ray film component is the centerpiece, but we also buy natural gas through Du Pont's Conoco subsidiary. Du Pont is also moving into the drug area, and is in the laboratory and equipment areas.

The concept of "corporate partnerships" that are illustrated by Abbott Labs, Du Pont, Johnson & Johnson, and our single preferred distributor, General Medical, has not yet been carried over to the drug area. That is one

of the issues we are studying right now. Certainly we are using Abbott and Du Pont's offerings in the drug area, but we currently take more of a line-by-line approach including the generic drugs that are available, et cetera, as opposed to a broad-line corporate partnership. We continue to examine that, and it may be that we will move in the drug area similar to the way we have moved in consumables. We will have to see what happens in the market place, and determine what is best for our hospitals.

WEEKS:

What seems to be a favorable move is for the major pharmaceutical outfits like Abbott and Lilly and Parke-Davis and Upjohn, many of them are going into the generic field themselves. A hopeful sign is that I look at these big outfits and think, well they have good quality control. I would rather buy a generic that is made by Abbott than I would buy one that is made by someone that doesn't have a control system.

LATIMER:

They certainly have the experience, and they have quality control procedures. I think another thing that pleases us in our relationships with today's corporate partners is their commitment to staying on the cutting edge, their commitment to research and development. We hope one hallmark of SunHealth is thinking long-term; that means keeping our members on the cutting edge and a commitment to new and innovative ways of doing things. We look to the Du Ponts and J&Js and Abbotts to make major contributions toward future innovations.

WEEKS:

I think there is a tremendous field there. One fact you mentioned: most of the major pharmaceutical companies do a lot of research, whereas the

companies that just make generic products probably aren't doing research. Then the question comes to my mind, if I were in the purchasing business, I probably would -- I used to be a drug buyer, so I keep watching these things -- I probably would say I could afford to pay five percent more to get a mainline product rather than an unknown supplier of a generic that didn't know about control.

I was interested in your use of mobile CT, I still call them CAT scanners. Is there any other imaging technology that is on a mobile basis?

LATIMER:

The industry is using mobile MRI units today. We are providing advice and consultation services; we aren't acquiring any of those mobile units ourselves. While it is not imaging, the lithotripter is also being used on a mobile basis. I think that some of the experience that we and other organizations developed in terms of mobile equipment techniques are being applied to other areas. MRIs are one example.

WEEKS:

How about dialysis? Do you have mobile units on that?

LATIMER:

We don't have any, and I don't know much about available dialysis.

WEEKS:

I know some places do have it.

LATIMER:

I don't have any personal experiences.

WEEKS:

I wondered if you are among the pioneers in the repair and sale of nuclear technology?

LATIMER:

Certainly, SunHealth has been involved in the evaluation, mainenance and and repair, and group purchasing of many different kinds of technology devices, although not in the sale. It is not our place to acquire or resell medical technology. Certainly, we have helped our network partners in the nuclear medicine area in terms of their acquisition of technology. I don't know whether it is fair to say we are a pioneer, but we have been very active with our partners as they moved in that area.

WEEKS:

One point we haven't talked enough about, I think, is the contract management of hospitals. According to the last figure I saw you have twenty-two, isn't it?

LATIMER:

That's correct.

WEEKS:

They are mostly smaller hospitals, aren't they?

LATIMER:

No, I think you will find that there is a variety of sizes, including a number of small ones.

WEEKS:

You started out with small ones.

LATIMER:

We certainly did. The hospitals that we started out with were those that were concerned about their survival. In the early days -- the 1974 and 1975 time period -- they virtually all were less than 100 or 125 beds. Today among the hospitals we manage are one over 500 beds and several over 250 - 300 beds.

I'm particularly pleased about the long-term relationship we've had with many of them. Over time, for some, we have worked out different relationships including some linkages to larger tertiary referral centers and things of this nature. Overall, our experience with contract management has been very positive. It has offered not-for-profit community hospitals and their governing boards a way to get a depth of management that they had difficulty getting on their own. It has offered them a way to get a level of experience and training in their personnel that I don't think they could have gotten just by themselves. A system can offer career opportunities. We can bring in financial expertise; we can bring in communications and public relations expertise, staffing expertise, capital financing expertise. The list goes on and on of the resources that we can bring to those facilities for which we have management responsibilities that they might have had difficulty in finding and assembling on their own. We also can bring a certain level of continuity in management and strategies. I can think of some facilities with perhaps an average census of less than seventy-five patients a day to which we have brought some of the premier young administrators in the region. Today they have much larger and greater positions of responsibility. Throughout this succession through the smaller institutions, the system maintained progress and continuity. I don't think that without the kind of support that a central organization like ours can provide that these hospitals could attract that succession of consistently high quality management. Our hospitals have had that experience; we have provided continuity so that there haven't been any dips when there has been a change, and there hasn't been delay in filling management vacancies.

Our experience in contract management, I think, has brought quality

people to the institutions we have been involved with.

WEEKS:

It seems like that. You have done this without having any ownership or leasing, or have you gotten into that?

LATIMER:

We had a brief experience with ownership and leasing of hospitals. In the mid-'80s we explored and were involved with three facilities in at-risk operation through ownership or lease. Overtime, we determined that this was not our primary mission. If we became involved in at-risk patient care ourselves, we were afraid that SunHealth would lose the focus of supporting all network participants, not just those we operated. We believe our primary mission is to support the goals of others who are at risk for local hospital operations, to help them reach their missions.

WEEKS:

The legal ownership then is in the community?

LATIMER:

All of the participants in our network are not-for-profit facilities that are either public, religious, or private not-for-profit entities with the ownership and the governing boards coming from those local communities. We believe very deeply in the strength of those local governing boards and that local commitment.

WEEKS:

The administrator is your employee?

LATIMER:

Yes.

WEEKS:

But he has to report both to the board and to you?

LATIMER:

Well, there is that dual reporting, if that is the way you wish to characterize it. I would prefer to say that he or she reports on our behalf to the local governing board. Certainly the administrator's paycheck comes from us, but there would be no paycheck if we as an organization didn't report satisfactorily to that local governing board. There is never any question that the local governing board has the final say. There is never any question that we recommend and they decide. We bring to them the individuals to serve on their management team. We bring our recommendation for their local CEO or administrator, and they can accept or reject that individual. We also bring to the board our recommendations for the administrator's merit reviews, compensation, and benefits. The board can accept or reject that. It is interesting that more often than not, when our recommendations are not followed, it is because the board wants to provide greater reward or additional benefit or more compensation for jobs well done than it is because the board does not want to be in step with our policies and the consistency of the system.

WEEKS:

That is an interesting twist, isn't it? How do you base your charges? Do you base it on patient count or bed size?

LATIMER:

Our management services fees have two components. The basic management service fee is a flat amount over time, normally per year. Our management agreements have mechanisms to adjust that component for inflationary factors

and things of this nature. In determining this component, we develop a budget based on the individual circumstances of the facility. We say it will take these kinds of expertise and this amount of attention from the corporate office and this amount of oversight from our circuit-riding managers and this amount of support from management engineering or clinical engineering -- then develop a budget. That's the basis for the flat service rate component for the facility. The second component is directly for in-hospital staffing. That's for the administrator and the chief financial officer. Generally we always include those two positions in our contract management arrangements. Sometimes we will include additional staff -- an assistant administrator or vice president, a director of nursing, or maybe a management specialist. These personnel are paid for on a direct pass-through basis. We share the compensation levels and the benefits with the local governing board, and the hospital reimburses us directly for their expenses.

WEEKS:

I see. How about your consulting services outside of the management field? If one of your network hospitals wants some advice on a certain situation do you have it set up on a daily, so much a day, or do you take into consideration the elements that enter into this like the number of experts? This must be rather complicated.

LATIMER:

Our arrangements with our network hospitals and other users of our services are not unlike the commercial arrangements used by other consulting firms. There are three ways that come to mind by which participating hospitals pay for services. One of these three ways is the per diem rate or so much per expert day. Each staff member, just as in a law firm, has a

unique billing schedule. The hospital pays for the number of days it uses. Certainly, there is also the per-project charge. We commit to do a job for a committed amount, and then we go at risk if it takes more than our budgeted time. Or there is an advantage to us if we are able to do it in a shorter period of time. We contract to do the job for a final amount. The third way, probably more common to SunHealth than other consulting organizations, is our continuing in-hospital arrangement or resident services. We put full-time consultants -- industrial or management engineers -- on-site in our network facilities, sometimes even multiple persons in one organization. In other cases it may be half time or some other substantial fraction of a person's time. This is not unlike our hospital contract management arrangements -- we are providing the senior management for the department in this case. Based on the compensation levels of the individual filling the slot, we are reimbursed. To summarize, the per diem, the fixed fee for a project, and the continuing service arrangement are all used depending on individual circumstances.

WEEKS:

I have another item on the list of support services that I have come across somewhere and that is called productivity management. Is that another service?

LATIMER:

Much of the work that we do is directly aimed at improving the productivity of hospitals -- whether that is improved staffing, providing a greater amount of patient care for the amount of time and other inputs involved, or getting better productivity from the dollars invested, whether in equipment or supplies or human resources. SunHealth has a long history of what we call productivity management. Often that is staffing analysis or

systems or industrial engineering. That is determining the skill levels and the amount of staff it takes to provide some facet of patient care. We spend a great deal of time in developing standards and comparisons, not only among our own partners and our own region but often nationally. We participated in work with the American Hospital Association that compares the productivity reports that they distribute.

Recently we have been concentrating on productivity management by certain diagnosis, sometimes even by specific DRGs, identifying the resources, the amount of staffing time for given procedures, the supplies, all of the various elements that are necessary to treat a specific DRG at a specific facility, then comparing them with the practices and policies at other network facilities. Sometimes the same operation, the same surgical procedure varies among hospitals -- in one facility, patients may be sent to the recovery room for a certain period of time, but in another facility that won't be required or the time period will be substantially different. We won't see any difference in the recovery rates or the discharge rates, or we won't be able to find any valid reason for the difference in costs of the DRG at the two facilities. comparison. So, rather than our saying one should change, we present the data and comparison. We put together teams of physicians and nurses and workers and say, "Look what is happening at your sister facility. What about possible changes?"

All of these are forms of productivity studies and productivity improvements that SunHealth continues with.

WEEKS:

One question spontaneously comes to mind is what do you do about nurses? I have found that in different hospitals nurses have different privileges or

do different procedures. For instance, if a nurse is hired by hospital A and the nursing supervisor learns that this nurse doesn't do certain procedures or does certain procedures that they don't do in hospital A -- with a partnership of 135 hospitals you must run into the need for inservice education. Do you have any way of steering facilities into in-service training? Do you do any of this yourself?

LATIMER:

We don't do any clinical training ourselves. We have nurses on our staff that assist us in many of our studies. We leave the procedural training to nursing educators. Certainly we see differences in practices, differences in what procedures various skilled and qualified people are able to perform from partner facility to partner facility. We make proposals for adjustment and change. Today the industry is talking about the certified patient care technician who would be another classification of care-giver doing certain procedures that are today done by nurses or nurses aides. We try to share among our hospitals the policies and practices that are being followed at various locations among our network. We help identify tasks that may be done by someone who is more available, less expensive, or available. Lots of questions like that. We don't provide centralized in-service education at our corporate office. We don't have circuit-riding in-service education.

WEEKS:

This brings up another question: Do you have some method of internal communication? Do you have a newsletter or something similar?

LATIMER:

We communicate with our partners through a wide variety of means. Certainly, I communicate in writing on a fairly frequent basis with the CEOs

of our partner members -- a network update. We have polished, typeset journals that we distribute throughout our constituent organization. We have specialized ones that go either to purchasing departments or only to the clinical engineering units. We are developing an electronics communication system. We are certainly initiating that around our purchasing and procurement needs, but we look forward to the ability to query our partners on their individual situations, individual strategies, and their response to problems, electronically.

The communications between the partners and the central unit and among the partners follows a variety of means and techniques. We are finding there is more and more interest in bringing the partner CEOs together for a day for exchange. We call them round tables. At these discussions, CEOs talk about their problems, their successes, the things that haven't worked. They can have that kind of exchange with their network colleagues because they know that the other people around that table are equally concerned about their success, will be very candid with them, and will give them sound advice. I am told that in former times that kind of exchange took place within state hospital association gatherings. As there is more and more competition developing among hospitals in the state associations or within individual service areas, the opportunity for that kind of exchange is diminishing. That need is being addressed by alliances like SunHealth.

WEEKS:

Do you encourage your staff people to write articles?

LATIMER:

Sure. The comment that I make to our staff when I have the opportunity to recruit them and I hope that it is being carried on by others today is that

we expect every member of our staff to be very active in their respective professional organizations. We want them to write articles, make presentations, attend meetings. We want them to lead, not just be members. We are very proud of the track record that our staff has in terms of leadership positions within their professional societies.

WEEKS:

That is very interesting.

On your data processing, how far have you gone in your use of computers? Have you gotten into the clinical side of it at all?

LATIMER:

The more sophisticated use of computer technology is based within our individual partner hospitals. Within our large number of partners you will see a wide variety of computer technology. We have some partners who have real time, on-line communications from the doctors' offices directly to the chart and directly to the individual hospital departments.

We don't standardize or recommend one single vendor or one single software. Our current computer involvement from the SunHealth central unit is more and more involved with mini or personal computers -- PCs -- and exchange in that area as PCs become more and more powerful. We do have a central intermediate-sized computer on which we keep certain records and accounting facilities. We keep a data bank of the characteristics of the hospitals and our network so that we can scan that and make comparisons. I think that kind of data exchange is going to be more and more important in the future. Our partners are going to want to be able to make inquiries, to determine what other partners have done with some problem, plus their current status, what strategies have they tried, what other members of the group have these

characteristics in common. It is going to be important to collect information as quickly as possible and to evaluate it and be sure it is accurate, and we will continue to be involved with that.

I think that the more sophisticated EDP systems are largely self-contained within our individual partner facilities and organizations.

WEEKS:

There is always danger in the information business in collecting a lot of information and codifying it and indexing it some way, but then the next question is who is going to use it. My experience has been limited, but that is the conclusion I came to. In setting up a system of that sort, you have to have a collection system of course, but you also should have a dissemination system so that it can be used. You should also probably review the types of information that you are putting in to see if they are really useful and necessary.

LATIMER:

I agree. Market research is critical -- being sure that the participants or users are actively involved, whether it is a data processing service or any other activity that we or others are involved in. If you don't continue to stay in touch with those who are going to use the service you can expend a great deal of resources, you can collect data that will never be requested, you can organize data in means that will not be taken advantage of.

WEEKS:

You also have a claims and collections service too, don't you?

LATIMER:

We have an arrangement for collections of bad debts. We found that we could assemble expertise in the collection area just as we did in management

engineering and purchasing and other areas. We have not publicized our activities in the collection area perhaps as much as in our engineering and other areas, but we have had good experience.

WEEKS:

I have run across a term that I haven't seen before. That is FDS, Facility Development Services.

LATIMER:

We have provided assistance, particularly to smaller hospitals, in the plant engineering area. We have helped them evaluate their facilities to determine if they meet codes. We have worked with them in Joint Commission accreditation processes. We have helped them plan and develop new facilities -- sometimes it is nursing homes, sometimes a skilled nursing facility. These are services in which once again we can share a level of expertise that a smaller facility might not have. We put a much greater emphasis upon this in the 1970s and early 1980s than we are doing today.

WEEKS:

I haven't mentioned SunHealth yet, but I am sure that many of these things are carried over. Before SunHealth, there was Sun Alliance. I can see this was the nucleus of your partnerships probably. Tell me about Sun Alliance and how it came to be.

LATIMER:

In the early and mid-1970s, we worked primarily in the Carolinas serving all sizes of hospitals. But because of the environment and the mix of facilities in that area, I suppose it was thought that we were concentrating primarily on the smaller and mid-sized facilities. A number of the leaders of larger tertiary referral centers began to think that they might have more in

common. There were a number of other groups that were coming together around the country. In 1978 there was a group in our area, led by Duane Houtz, Jack Skarupa, Tom Howerton, John Laverty, Paul Hofmann and Dan Barker from Emory. They established that the larger tertiary facilities might have something in common, and we sought to create an organization that those hospitals -- in the early days located in the geographic area of the Southeastern Hospital Conference -- could join as a participating network. We determined that a good measure of eligibility might be a hospital of more than 400 beds in a specific service area, usually one of the larger metropolitan areas.

We therefore created an organization that we called the Sun Alliance. It was a partnership. The Sun Alliance had no need for a corporate structure or even a separate set of policies and plan, because it obtained all of its support services through CHHS. CHHS and its staff helped do the planning, do the initial organization work, expanded the group purchasing effort that we had started with just those hospitals within the initial CHHS arena, and added several other services.

We later found that having two organizations was unwieldy -- CHHS on the one hand with its governing board, planning and financial responsibility for the corporation, and then a separate governing board for the Sun Alliance. Sometimes there was overlap, but the Sun Alliance facilities were larger, and they were on the cutting edge of health care. They were anxious to move forward and take more risk. They had more available funds to move into those areas. Management found itself spending too much time in the administration of these programs, determining whose area of authority this particular problem or decision was in. We looked at the alternatives and used an outside consulting group that helped us study our situation and determine that one

organization might meet all of our needs. We adopted a name for that organization that really came from both of the other two. We called the organization SunHealth. Some say that the Sun came from Sun Alliance and the Health came from Carolinas Hospital and Health Services. It was certainly a joining together, a merging if you would, to create one organization, one governing board, and one direction and purpose. It has worked out very well.

Dr. Howard Zuckerman from the University of Michigan led the group that provided the external review and consultation that evolved into SunHealth.

WEEKS:

CHHS was a forerunner of a later corporation called SunHealth, Inc. How did that come about and what happened? We are talking about 1983 now.

LATIMER:

That is correct. Our activities up until the early 1980s probably are best characterized as what was called shared services when we talk about CHHS and perhaps the early activities of the Sun Alliance. I am not sure about this, but I think perhaps that the term we used, Sun Alliance, was the first use of the term alliance to indicate a grouping of hospitals with common purposes that some have called coalitions and other terms. The term alliance was later adopted by the AHA as a generic to indicate a specific type of organization.

At any rate, in the early '80s, the shared services concept seemed to be going very well, but we found that there was a certain overlap of authority and responsibility between the Sun Alliance board and the governing board of CHHS. The study that was undertaken by the group from the University of Michigan, led by Howard Zuckerman, helped us develop a single organization structure, corporate business model, based on ownership of shares of stock.

We subsequently evolved a model that, as far as I know, was not only unique but remains unique today in that it allows all of the shareholders or partner hospitals as we call them to own stock in the same company. There is no first or second class membership or one group dominating the other. We did provide that the larger organizations could own 1,000 shares (we call them four-unit partners) and that the smaller facilities, those less than 400 beds, could own just 250 shares of stock. We call them one-unit partners. But we do provide that the smaller facilities, if they choose, may apply for and own the larger four-unit block.

We formed a structure that did allow all of the participating hospitals to own stock and vote at the parent board level in one single organization and all to participate in the planning and direction of the organization. The purpose was really committed to supporting those partner organizations, to helping those organizations to meet their objectives. There has never been any question about conflict between the development of the central organization or the development of meeting the goals of the individual partner facilities. We have always been very clear about our mission and purpose. We have also elected not to allow individuals to have equity participation. It is our feeling that if individuals have significant equity participation that their decision-making might be influenced. Therefore, we have set up a structure that makes it very clear that our purpose is to meet the needs of those individual partner organizations.

We also made another decision that I think has turned out to be quite sound and that I am quite satisfied with. That is to limit our geographic service area. We concluded that decisions about health care are locally based, that you didn't refer patients from New York to Chicago or from Atlanta

to Los Angeles. Health care decisions are local decisions. Therefore we felt that it was more appropriate to develop concentration of providers within a defined service area than to have multiple participants or members scattered all over the nation. We determined, when we went through the organization restructure, to concentrate on improving health services delivery in a defined geographic service area. It so happened that we were already working in the fifteen states from Maryland to Texas. Our determination was to gain scale and concentration within that area. There is no policy prohibition against enlarging that area, but we have found many advantages: we have been able to develop consensus more quickly, there is a certain cultural bond, economic and regulatory homogeneity, many other things that have facilitated progress within the organization. That decision to limit our geographic service area is something else that has been unique. Sometimes we are referred to as a regional alliance. I'm not sure I know what a regional alliance is. I know that we have size that allows us to gain economies of scale equal to anyone else. And I believe that we have been able to develop consensus and decisions as rapidly, if not more rapidly, than anyone else. I think the decision about the organization structure and giving everyone participation in the same organization and the decision about coverage and concentration within a geographic service area were both very sound decisions that the Michigan team helped us to determine.

Also the structure of our governing board. We have tried to find a way to have the best of both worlds. The "best of both worlds" meaning that every hospital or health care organization that owns stock participates and has at least one board at the parent governing board level. But the business operations of SunHealth are carried on within a subsidiary corporation that we

call SunHealth Enterprises. That governing board has fifteen members plus the CEO position for a total of 16 seats. The fifteen external members are elected for three-year terms, so there are three classes of five in each class, with each person having a three-year term. A director may serve only two full terms. The governing structure also provides that at least seven of the governing board members must be external, that is, not CEOs of shareholder organizations. That assures us that we have the opportunity to select leaders in medicine, business, finance, banking, or other fields. We have executives from large regional banks, the former chairman of the American Medical Association, the chancellor from Vanderbilt -- Ike Robinson -- attorneys -- leading business people who give a business perspective and quality to that governing board that I don't think we would have without them. All of those structural decisions, I think, have been an important influence upon our growth and our ability to meet our partners' needs.

WEEKS:

What has been your position? Have you been CEO of each of these groups as they came about?

LATIMER:

Yes, I've been CEO of every organization we have had under whatever name. Carolinas Hospital & Health Services, CHHS; SunHealth, Inc., and SunHealth Corporation and SunHealth Enterprises. I have been the CEO of every one of these organizations, since 1969.

WEEKS:

When you said that each of these partners was allowed to buy a certain number of shares of stock, what was the price structure of this stock?

LATIMER:

It has varied with time. The hospitals with over 400 beds in the urban areas of the original service area put up a substantial amount of funds for the formation of Sun Alliance and the development activities that it was involved in. I don't remember the exact numbers, but it was well over $100,000 per participating hospital. So when we formed the new corporation, we distributed 1,000 shares in behalf of each one of those organizations in recognition for all of the funds that they had already put in, because all the assets and all the services and programs of CHHS and Sun Alliance were merged together to form SunHealth. So those organizations were each distributed 1,000 shares of stock.

For the new organizations that came in, the larger facilities that bought 1,000 shares paid $100,000 and of course those that bought 250 shares paid $25,000. Today, because the value of the shares has increased and because we have need for additional paid-in capital to do the development and other kinds of refinements and enhancements that have gone forward, the price of stock for 1,000 shares is $150,000 and proportional for those who are one-unit shareholders. I guess we are very proud of the fact that the book value of our stock has appreciated, that we are making a positive margin. As I indicated earlier, we are self-sustaining and going forward based on the services that we have. we don't have to go to anyone for subsidy. At the same time, we don't mandate participation in any of our programs. We earn our way by their very value.

We return to our partners again and again and ask them if they find benefit in our programs and what we can do to adjust the programs so they will be more beneficial to them. We tell them we will return until one of two

things happens: they either use the service or they request a change that we either can't do or that would not be beneficial to the other partners.

That self-sufficiency and that ability to generate a positive margin, I think, are important characteristics of SunHealth and one of the things that gives us our ability to attempt new things.

WEEKS:

What if someone decides to give up the partnership? Do they get a refund? Or haven't you had this happen?

LATIMER:

The provisions say that an organization that doesn't participate, if someone should choose to do so, could come back to the governing board and ask that SunHealth acquire their stock. The governing board can make a determination whether it wants to repurchase and at what price. As I remember, the provisions are that they may pay half the book value or the price paid, whichever is greater. We haven't had to deal with someone who wanted to get out because of non-service. As you know, there are a number of mergers going on in the health care field today. I suppose we are gaining more participants and more converts by way of mergers than are going the other way. There has been one instance, I recall, where a merged hospital elected to participate in another organization. Generally the mergers and acquisitions have been to our gain, and we have had facilities leaving other organizations to join ours.

WEEKS:

This money from the stocks serves as your capital, but you don't pay any dividends, do you?

LATIMER:

We haven't paid any dividends yet although we could have, because there has been enough need for development and enough need for retained equity that our board has not determined that paying out dividends was the appropriate course. That option is certainly there.

WEEKS:

You could do it?

LATIMER:

Absolutely.

WEEKS:

We were talking about the corporate structure before and I was wondering. In this case the stock is held by a subsidiary anyway, isn't it?

LATIMER:

The subsidiary organization is the corporation that houses the service and business divisions. It is the operating arm and it would first generate the margin, but it is wholly owned by SunHealth Corporation and certainly could pay dividends back to the parent. The parent could pay dividends to the individual shareholders.

We are committed to being a service oraganization and don't want our participating partners to look upon us as an investment vehicle designed to return them earnings. We want them to look upon us as a service arm that will bring them benefits to help them fulfill their mission.

WEEKS:

This partnership arrangement of stock is something like the Voluntary Hospitals, isn't it? Don 't they get their capital by the same method?

LATIMER:

There are a number of alliances that use the same stockholder basis for participation. Some of them restrict stock ownership in a variety of ways such as defining eligibility criteria. Each of them has a somewhat different philosophy and structure, but the basic concept of ownership of stock is one that is common to all of the alliance, I suppose.

WEEKS:

There were two or three items or services that I didn't mention before and maybe you could enter a word or two. Vision, is that one of the new SunHealth services?

LATIMER:

That is one of our productivity management services.

WEEKS:

Nursing management?

LATIMER:

That's correct. Vision is our name for a data processing software that provides assistance to nursing in scheduling and staff utilization. Its roots go back to the early management engineering days and development of staffing patterns for nursing based on levels of patient acuity.

WEEKS:

Then I have another one, Productivity Insight.

LATIMER:

Insight is our system for comparing staffing levels and productivity performance by units of output among comparable hospital departments. For example, we compare all of the laboratories in similar hospital departments. The concept of comparing actual performance is quite well established, but the

ability to compare actual to standard between SunHealth Partner A and SunHealth Partner B is beneficial in particular. This lets them know that, using the same standards, one is performing differently vis-avis another, and also helps them to know what the standards of performance are throughout the network. That is our Productivity Insight system.

WEEKS:

Something I don't understand is Computerized Dietary Bidding Services.

LATIMER:

In the early days, or in earlier times, when we were trying to find ways to improve the purchasing practices of hospital dietary departments we developed a protocol or a system in which purveyors of food products submitted at regular intervals pricing schedules that we computerized and fed back to our participating hospitals to allow them to choose vendors and select products in the most efficient and economical fashion. That system evolved into a corporate relationship with a major supplier in the dietary area that covers the entire spectrum of hospital dietary needs, from perishables to canned goods to paper goods to ready-mixed products, etc. We feel as if we pioneered the development of economies of scale and leveraged discounts in the dietary area by identifying one distributor that can serve all of our partners. We have added what we think today are unique features in terms of the size of the orders and in economy at point of use. It is not just how much you pay for the item but how much it costs you to get the item into use. In the case of dietary, how much does it cost you to get an item on the tray of the patient in the room? Our preferred provider has been able to bring our hospitals advantages in the way the products are transported, their readiness for use, how quickly they fit into the menu planning, and how readily they are

to serve. All these are features that our partners tell us make their dietary systems more efficient.

WEEKS:

These are all background information devices, aren't they? When I use the word background I mean something that the whole SunHealth uses as information, but you don't sell individual services? Do you sell individual services in Vision, as an example?

LATIMER:

Yes. The productivity services, the Vision system, Insights, the new Perspective system -- all of these have an in-hospital component and a comparative component. Hospitals pay service fees for the in-hospital component; the comparative component is provided to all network hospitals participating at no additional charge. Establishing yourself as a shareholder also establishes your access to the group purchasing program.

WEEKS:

SIGMA, is that for services outside of the Carolinas?

LATIMER:

Back in the CHHS days when we made the determination to move outside of North and South Carolina, it was kind of difficult to do business in Georgia or Tennessee or Alabama if your first name was Carolinas. We were looking for a different name to provide services to other areas. The name that we used for a few years in states outside the Carolinas was SIGMA. It meant "the sum of" all CHHS services. Folks have asked me as we have adopted the new SunHealth name if there is any geographic significance to it. I tell them there absolutely is -- that we won't do business in any place that the sun doesn't shine. But that is the only limitation to the SunHealth name.

WEEKS:

Like the old British Empire.

LATIMER:

That's correct.

WEEKS:

Sun Alliance was absorbed by the new SunHealth for most purposes. Did we talk about the reason for it going out of business?

LATIMER:

Actually, we merged the activities of Sun Alliance and CHHS. I think we talked about the fact that consolidating the activities of the Sun Alliance (which was composed of the larger tertiary referral centers) with CHHS relate to the overlapping of responsibilities or overlapping of authority in operations and governance. It just made sense to have a single organization with a single purpose, with a single decision-making process. We effected that initially by expanding the Sun Alliance to include hospitals under 400 beds, also, and issuing all the stock by the restructured SunHealth corporation to the alliance of hospitals.

WEEKS:

Is it necessary for a person to become a partner in order to use any of the support services?

LATIMER:

One of the commitments that we make to our owner/partners is to give them competitive edges. Certainly our group purchasing activity and many of our productivity services we think are important benefits that give participants competitive edges. But there are some of our services -- mobile CT scanning is one -- that need a certain volume. Therefore, we offer these to anyone to

make sure that we reach the critical mass. In the managed care area, sometimes you will be dealing with an employer who needs coverage for all of his employees. They may have employees in a location where some facility that is not a part of SunHealth is more convenient or meets their needs, so we will have to include someone else. We always want the decision-making process and the first opportunity for service to be a SunHealth partner, but if a service doesn't provide a competitive edge or if it complements something else that we are doing, we will extend the service beyond those who are network members if there is a business reason to do so.

WEEKS:

Do you want to talk about your organizations size or personnel?

LATIMER:

We are still growing and we are still seeking to add additional partners to the organization. In mid-1988, we have 131 partners. Fifty of those are the larger four-unit or 1,000 share shareholders and eighty-one of those are the one-unit, 250-share holders. Those partners, their facilities, and the hospitals that we manage, number 218 units, or hospitals that are owned, leased or managed by a partner or SunHealth. Those 218 hospitals currently operate 54,403 beds. They represent over 150,000 employees. Combined, their revenue is over $8.2 billion dollars. SunHealth does not have centralized control over all of these revenues. That is part of the premise on which we are built, but if you returned to some of the writings in the industry journals, the Forbes Five Hundred and the Fortune Five Hundred, you would find that together our hospitals are comparable to one of the larger corporations. We would be much larger than Johnson & Johnson. We would be four times larger than the largest investor-owned chain. We do represent substantial leverage

in the marketplace, and we are still growing. We are growing today in terms of numbers of partners in the ten to fifteen percent per year range.

Our growth has been steady going all the way back to 1970. That first year, 1970, our revenue and expenses were less than $150,000 for the entire year. If you trace our revenue performance through today, our average compound growth rate has been in excess of fifteen percent a year. That doesn't allow for inflation, but even if you made allowances for that it is still a strong, stable track record.

WEEKS:

It is amazing what you have done with this in such a few years.

You didn't speak about your corporate headquarters or your own employees, the people who work for you directly. You have something like 300?

LATIMER:

Just under 400 today. I believe the number is 375. The budget that I am reviewing for next year indicates that that number will be substantially over 400.

The corporate headquarters is located in Charlotte. That was the obvious place to begin when we were concentrating on North and South Carolina. Charlotte is the largest city within the two Carolinas and the interstate road system has hubs there with two interstates crossing. As we developed into our broader service area, we were fortunate that the extension of the Charlotte airport accompanied our expansion. Piedmont Airlines, which is now merging into US Air, has its largest single hub there, so we can fly to almost any place in our service area. We are very comfortable in our corporate headquarters. It has room to expand. We feel very fortunate to have the facilities and the linkages to our partner locations that we do.

WEEKS:

I think you did answer the question that SunHealth continued to supply all of the services that CHHS had been.

LATIMER:

Every program and every asset of both CHHS and the Sun Alliance were merged together when we formed SunHealth.

WEEKS:

This is SunHealth, Inc.

LATIMER:

We have made a small distinction there. When we first used the term SunHealth, Inc., we continued to have the Sun Alliance in existence. When we found that total consolidation was necessary, we used the name SunHealth Corporation, which we use today for the parent corporation. So there have been some further refinements as we moved from SunHealth, Inc., which I believe we first adopted in 1983, to SunHealth Corporation, which we adopted in 1985.

WEEKS:

I was wondering about the reason, but it was just a matter of getting minor things straightened out, an organizational plan.

LATIMER:

That's exactly correct. We continually refine the structure as needs change.

WEEKS:

I wondered about the mechanics or logistics of your working between -- you have regional offices and you have what other kind of offices?

LATIMER:

We have the central corporate office in Charlotte and then to better serve our partners, we have network executives in regional offices in a number of locations -- Atlanta, Georgia; Jacksonville, Florida; Richmond, Virginia; Knoxville, Tennessee; Baltimore, Maryland; Austin, Texas; and are in the process of planning for Mississippi and Louisiana. Obviously, also, when we have two or three staff members serving one hospital facility, that is almost like a mini-office in that kind of situation, but that would be located within the corporate hospital itself.

Communications with those regional offices takes the traditional form that the technology of today provides. Sometimes it is electronic communications, sometimes it's FAX services, whatever is the most cost-efficient for the times.

WEEKS:

People in the field report to their regional office? And the regional office in turn is in touch with you in Charlotte?

LATIMER:

That's correct.

WEEKS:

You said that you were planning ahead for Mississippi and Louisiana. What sort of expansion plans do you see for the near future? Maybe this is beside the fact because we have talked about it before, but one question that wasn't answered was how you recruit contract management hospitals? I got the impression that you don't market vigorously, but if there is indication of change in administration or dissatisfaction with administration you might offer your services. Or if something new is starting up you might offer your

services. What is your marketing plan?

LATIMER:

I would hope that we are as vigorous in our marketing and sales of our contract management services as anyone, if not more so, but your point is well made that historically in the industry the times when contract management is most likely to be accepted by governing boards is when there is a CEO turnover or there is a new facility. When those kinds of activities occur, not only SunHealth but other organizations will offer their services. Then there is rather vigorous competition.

WEEKS:

I imagine there are occasions when a board of a hospital approaches you and says they would like to talk to you about contract management.

LATIMER:

Sure. Governing board members -- certainly the voluntary boards -- come into contact with each other in the regular course of their other businesses. They will know of a facility that is doing well and they will ask about their management, so references take place there just as they would in other forms of commerce. You will see leads develop from clients we currently serve or leads develop where there has been a CEO turnover or change, or where a new facility is developing.

WEEKS:

It seems that this is a case of soft approach. Maybe I am not expressing myself very well.

LATIMER:

There have not been very many cases where a voluntary hospital governing board both has been well satisfied with its current management and has elected

to become contract managed and bring that management into the contracting organization. There have been a few such cases, but not many. Consequently, it is better to have what I would characterize as targeted sales and marketing aimed for example at hospitals experiencing CEO turnover. The competition is stiff, so I'm not sure there is anything soft about the competition. It is fairly specific and fairly targeted.

WEEKS:

You talk about your marketing which has to start with a partnership in most cases except the marketing of contract management of hospitals. Contract managed hospitals can or are not partners, is that right?

LATIMER:

The contract managed facilities are not legally prohibited from being partners, but there is really no need for them to be. They have the opportunity to participate in our programs and services, and I would like to think that they are represented by SunHealth management on all the governing boards appropriately. Since they have that access and that representation, there is really no need yet for them to be shareholder/partners. When we get to the point where we are paying dividends and they want to make the investment, that might be reconsidered.

WEEKS:

Another thing, many of the smaller would find $250,000 quite a sum to...

LATIMER:

Remember, the cost of stock for the larger facilities, for the four-unit shareholders is $150,000 and for the smaller it would be $37,500, one-fourth of $150,000. We do have another way that an organization can be a part of the SunHealth network. That we call affiliation. A smaller facility can elect to

affiliate with one of our partners. That partner organization at its discretion can offer an institution in its service area an affiliation. That will allow them access to SunHealth services -- purchasing, productivity, clinical engineering, etc. In addition, the hospital offering the affiliation will add services of its own, perhaps medical education, perhaps interaction between the two medical staffs, perhaps department head support, perhaps management training and education, perhaps emergency room coverage -- all different forms of support for that affiliated organization. That allows a hospital that is smaller in size to develop relationships, to have access to the services, without having to make the investment in stock ownership.

WEEKS:

That is quite versatile then.

LATIMER:

We can't be all things to all people but we do want to respond to as many needs as we can.

WEEKS:

It is certainly impressive.

One question I wanted to ask you was: Somewhere the word hub was used. What is your definition of a hub? Is it a part of your concern, let us say?

LATIMER:

I think that the term hub has two meanings to our organization. First, you hear more and more today about regional clusters, about organizations that are serving a limited or defined geographic service area. I spoke earlier about our early determination that health care decisions were local and regional in nature. The full service organization that is the flagship of that service area is often referred to as the hub. The organization --

sometimes there may be more than one -- that is the primary broad-based provider within that service area is the hub within that cluster. We also use that term in our clinical engineering division. We talk about a central hub, that's in Charlotte, where we can keep parts inventory and do sophisticated repair and things of this nature, then support what we call pods that are geographically disbursed in the region. Pods don't have to have the same depth of parts inventory, the same depth of equipment, machine shop, things of this nature that you have back in the hub. So I use the hub both for the broader organizational context of clusters and specifically on clinical engineering services.

WEEKS:

I have heard another use of the word cluster and that is a central hospital, a hub, plus maybe a psychiatric or maybe a drug abuse hospital, possibly even a women's hospital, any one of the specialty hospitals that are on a campus. I am thinking of Henry Ford Hospital here, as an example.

LATIMER:

For the description that you are giving, certainly hub is an appropriate term. That is a vertically integrated system to me. We have a number of partner organizations that I think are vertically integrated. General Health in Baton Rouge, Louisiana, is a good example. Jacksonville Baptist in Jacksonville, Florida, is another example. The Emory organization with its teaching facility at Emory University and Crawford Long as its acute general care facility and a growing depth of vertical integrated services is another. The emerging Carilion system in Roanoke, Virginia, is another example of vertically integrated organizations that provide home care, outpatient service, emergency room treatment, ambulatory care, acute general primary

care, tertiary sophisticated services, nursing homes, health care for the elderly, addictive disease treatment -- all of those various forms of health care under one umbrella. That is what I think of as a vertically integrated system.

WEEKS:

I am sure that is a good description of that.

How about your relationships with HMOs? Some of your partners must be quite heavily involved with HMOs or may even own -- I'm using HMOs as a generic term.

LATIMER:

I think one of our greatest current challenges is assisting our partners in dealing with managed care -- the joining of financing mechanisms with the provision of care. There are numbers of benefit plans that are being tried today. I don't think that there is any clear winner at this point in time. We think that the way that care is going to be paid for is definitely going to change. We think that physicians have to be involved in developing these new structures also. The HMO, capitation model is certainly one that in certain competitive markets like Detroit or Atlanta, will gain market penetration. Maybe not as great as Minneapolis, but there is going to be penetration. We see more and more movement toward the so-called preferred provider arrangements -- the managed care arrangements where incentives are offered to go to one particular group of physicians and/or one particular hospital site. We are helping our partners structure arrangements with both employers and insurance companies in such preferred provider arrangements. We are showing hospitals that they can attract more volume if they can make certain adjustments to their pricing schedules or offer other incentives. If they can

-- I guess the term is price on the margin -- if they increase the volume then they can make certain considerations in the pricing of their services.

We also are seeing more and more use of utilization management systems. The physician community is very cautious about utilization management systems. Some say that you select the system that is least objectionable since none of them are totally satisfactory to physicians. We have found what we believe is a very good utilization management system that we have developed in an arrangement with an external agency to offer to our partners, and we are providing support services. We, like many of the other alliances and systems, have made investments in the managed care area -- giving consideration to being the sole owner and financial risk-taker of a benefit plan. At this point in time in the environment, with the movement of both the government and employers, we don't see many of our partners thinking that this is the best way to go. They are more interested in letting the insurance company or the employers take the risk and then develop managed care or PPO arrangements that offer incentives for quality, for days' stay, etc. That is the direction we will be moving in.

WEEKS:

Do you get the impression that generally speaking most of these managed care organizations are on thin ice?

LATIMER:

I don't think it is fair to say that they are. Certainly Kaiser has been solvent. There are some that are struggling and there are some that have had to make mid-course corrections. But all of us in alliances and systems, when it comes to managed care and HMOs and PPOs, have had to make mid-course corrections, also. So it is a time for testing several different mechanisms.

There are some who have fallen through the ice. There are some more that will fall through. But I don't think it is fair to say that they all will.

WEEKS:

There will be a lot of mergers, I imagine.

LATIMER:

There will be mergers, shakeout, and redirections.

WEEKS:

As an example, someone made a statement not long ago that in the Ann Arbor area there are four organizations serving Ann Arbor and only one of them is in the black. Now I don't know how far in the red the others are, but the situation seems to indicate that many of these organizations are going to have to raise rates, that they can't afford to operate on the revenue that they are getting now.

LATIMER:

I think adjustments are going to have to be made. They are either going to have to adjust their pricing or rate schedule or adjust their benefits and coverage scale. The price competition that has existed in most of our service areas where HMOs have been introduced has put many of the organizations on thin ice. They are going to have to consolidate, change their pricing structure, change their coverage structure, or some combination of all three.

WEEKS:

That is what I am afraid is going to have to happen or will happen.

We just mentioned the word expansion and I thought that you were talking about maybe two new regional offices for SunHealth. Among your partners is there much of any movement for home health care, as an example?

LATIMER:

I think there continues to be substantial activity among our partners toward diversification, toward ambulatory care, health care for the elderly, toward all of those different forms of and structures for providing care. I think they are all seeking to find stronger ways of relating to their medical staffs and to the physician community. I think that it is going to be really important -- and we are working to help our partners -- to get the hospitals and physicians closer together. As the payment structures change, we can't pit the hospitals and physicians against each other. They are going to have to work together to find the fairest method of payment and reimbursement for the care that they provide. That is an area that is going to offer opportunities for us. It is going to offer opportunities perhaps for us to provide direct services, but also for us to facilitate exchange and referrals and systems of hospitals and physicians working together.

WEEKS:

I was wondering about the care of the elderly, of course, and such things as retirement homes and nursing homes. Do any of your partners have these kinds of facilities?

LATIMER:

Yes. A number of our partners are involved in retirement living facilities and care for the elderly, but it varies with the environment and the situation that various partners find themselves in. We have not been as directly involved with that area of diversification as we have with the activities in the mental health management area or in the home care area, but I think that more of our partners are going to move in that direction. It is a capital intensive area, and that is another reason that we think activities

at the local partner level are more appropriate than at the central unit.

WEEKS:

I have noticed a movement among the proprietaries, or the investor-owned as they call themselves, into special hospitals such as psychiatric and drug abuse and so forth. There must be some money in it.

LATIMER:

I think the reimbursement opportunities are greater in the mental health area, among the specialty areas. I think some are probably short-term opportunities. There are certainly organizations out there that are anxious to capitalize on every short-term opportunity. I think that you will see changes in reimbursement and payment mechanisms to correct any excess profits that are there.

WEEKS:

It seems all hospitals now are looking for new sources of revenue because of the tightness on which they are operating.

In going back, we talked about corporate to corporate relationships. One intrigued me and I have to ask you what it is. PYA/Monarch, Inc.

LATIMER:

PYA/Monarch is our preferred dietary distributor that I described. They provide the distribution of all forms of dietary products and services from the food stuffs to perishables to canned goods to paper products, etc. That corporation is a division of Sara Lee.

WEEKS:

I wondered because when I was a kid Monarch canned goods was an exclusive line, above average in price and quality. If you wanted the best you bought Monarch. But I haven't seen it in years so they have probably gone to the

supplier end of it now.

LATIMER:

They have gone to the commercial end. You will still see the large cans in the institutional food service area where they use the brand name Monarch.

WEEKS:

I remember it had a white label with gold and brown...

LATIMER:

They use a lion as their symbol and logo.

WEEKS:

I have forgotten that. I guess that lion must have been there back then too.

Apparently this Mental Health Management Inc....

LATIMER:

That is one of the premier organizations that provides management and expertise for mental health management and addictive diseases. We have an arrangement with them that allows them to work with our partners on a preferred relationship. They give our partners first opportunity and they provide the special features in their contractual arrangements with SunHealth partners, like some of the other value added arrangements in our other corporate partnerships.

WEEKS:

I am jumping around a little bit, but this is all so interesting I don't know what to leave out.

You were CEO of all of these corporations, weren't you? I have SunHealth and Sun Alliance and SunHealth Enterprises.

LATIMER:

Yes. SunHealth Enterprises Inc. is the operations subsidiary of the parent SunHealth Corporation.

WEEKS:

Is there anything about SunHealth or your organizations or your professional life that we haven't touched upon and you would like to include in here?

LATIMER:

I think it is an appropriate observation that health care alliances are not associations in the historical sense of the word where you spend much time building consensus and you move through a committee structure to the level of the common denominator, or management spends much of its time trying to develop common consensus. Neither are they business organizations that can turn quickly or instantly from one direction to another, as some commercial enterprises can do and do. They are somewhere in the middle. The governance and management responsibility for these organizations requires finding the right balance. I like to characterize management of these organizations by saying that on Monday, Wednesday, and Friday we are an association and it does require consensus and I have to seek the advice and guidance of many of our participants. On Tuesday, Thursday, and Saturday we are a business organization and I can make as many quick decisions as any other CEO can. Part of the necessary skill is to know which day it is. And it is the wrong day, to have the patience to know that the next day will be the one you are looking for. I think that alliances, if they keep the needs of their members or shareholders foremost and concentrate on meeting those needs rather than seeking a place unto themselves, will have a long-term future and a long-term

impact upon health care, both in the cost and the quality and the availability area and hopefully in working with physicians.

WEEKS:

I want to ask you a silly question, and that is do you have a man in Washington?

LATIMER:

We don't. We do not have a lobbying office in Washington. We have a rather strong feeling about the role of alliances vis-a-vis the role of trade associations, that is state hospital associations and the AHA. We believe that hospital associations are the right vehicles for representation. If you look at our leadership, people like Dan Barker who has been chairman of the board of the AHA, you can appreciate that position. Likewise, we don't think state associations or the AHA should be involved in the provision of fee-for-service work, because when they perform that foremost responsibility of representation they need to be able to say they represent all of their membership equally. They need to seek legislation and regulation that meets the needs of all alliances or all systems or all members. If they provide fee-for-service work and only some of their members utilize it, that has an impact upon their revenue and expense statement and that could confuse their representation. We think there is a place for each organization. that there are things that each organization does best, and that alliances are the place to do the fee-for-service and economies of scale work. That state hospitals and the AHA are the organizations to do representation and lobbying.

WEEKS:

AHA has a difficulty in that they can't be all things to all people, so they find themselves in a position, I am sure, many times where they can't

represent one type of hospital or that type of hospital thinks they aren't being represented. It makes a difficult situation, I think. Voluntary Hospitals of America has a Washington office, don't they?

LATIMER:

A few of the alliances do have Washington offices. They, by necessity, spend time coordinating their activities with the AHA, often complementing the AHA. I think at this point in time -- and certainly I will tell you that we are going to watch the environment and respond to it accordingly -- I would be careful not to say that we will never have an office in Washington. At this point in time we feel like we can better represent our positions directly through AHA rather than with a separate office. The amount of resources that you spend communicating and complementing could better be directed elsewhere.

WEEKS:

Jack Owen impressed me with the fact that he has periodic meetings. I don't know whether it is once a month or once every two weeks or whatever it is, but always under the umbrella who have a man in Washington. Probably Owen knows more about what is going on in Washington than the others do so he can keep them up to date and then if they have some common cause they have some chance to talk it over in their little meeting and do something about it together.

LATIMER:

I think Jack Owen and the AHA do a very fine job of communicating with the entire industry. We are not yet convinced that an additional office and additional letterheads adds to the influence. Certainly, we can go directly to our representatives and communicate with them directly when the opportunity requires it, but we, at this point in time, feel like we have excellent

communications directly with AHA and that we would rather put our resources to improving the efficiency and the quality of the service our partners are providing. For now, leave the representation to the AHA and the state hospital associations.

WEEKS:

What about the associations of hospital systems? There is more than one, isn't there? There is the...

LATIMER:

One of the other alliances is made up solely of systems. We have some members of SunHealth who also participate in that alliance, but there is a constituency section of the AHA that is the health care systems constituency section. I have had the responsibility of serving in the chairs of that section's governing council. That provides for a substantial amount of exchange among the systems throughout the country, but our representation with that group is directly through AHA.

WEEKS:

That's as it should be. AHA has many of these different kinds of organizations that are an arm of the AHA.

LATIMER:

That is correct.

WEEKS:

The Associated Hospital Systems, is that the title?

LATIMER:

They are American Healthcare Systems. They are a consolidation of two former alliances -- Associated Healthcare Systems and United Hospitals, I believe. When those two organizations combined they adopted the name American

Healthcare Systems.

WEEKS:

Oh, that's what American Healthcare Systems is. I wasn't sure how they fit together. Do they act like an association, do they act like AHA does?

LATIMER:

No, they are another alliance like several that are around. They limit their shareholders to systems. They provide services like group purchasing, insurance, a variety of services like many of the other alliances.

WEEKS:

You have been active in the American Institute of Industrial Engineering too, haven't you?

LATIMER:

At various times I have. Certainly that was my background and education and I was active in local units and had leadership responsibility in local units. Just as I was in the Hospital Management Systems Society in early days.

WEEKS:

What is the Health Care Executives Society?

LATIMER:

That is a group of health care executives throughout the country who get together once a year to exchange papers and exchange experiences on health care problems and topics of the day. Executives from AHA, from Blue Cross, from hospitals, from many different organizations participate. You're selected as an individual.

WEEKS:

It must be something like we have in this area called University Hospital

Executives' Society or Club. There are only about ten different institutions and the CEO of the institution is the person who goes to the meeting. They meet once or twice a year and discuss problems.

LATIMER:

A number of our mutual friends are selected as individuals in this organization. McMahon, McNerney, McCarthy, Warden, Ludwig, on and on and on.

WEEKS:

There are so many organizations today that sometimes these lists that I have are as long as my arm.

I want to ask you about the Pacific Review Services.

LATIMER:

Pacific Review Services is the organization we have selected as our preferred provider of utilization management services and the number one evaluated utilization management service in the nation. Pacific Review Services is a subsidiary of Pacificare, which as you know is the managed care organization that is owned by Lutheran Hospitals and Homes of Southern California which is in the process of merging with Health West and changing their name to... we'll look it up.

WEEKS:

Is that Tibbitts?

LATIMER:

Yes.

WEEKS:

I haven't talked with him yet. I was interested in what I assume is a preferred executive search company, Tyler and Company.

LATIMER:

We do. Tyler and Company is based in Atlanta. We are particularly pleased about the arrangement that we have developed with Tyler not only because they meet our partners' needs for quality professional search services with preferred pricing, but they have brought value added in terms of their agreements to promote and move professionals within the SunHealth network. They have also done an excellent job of recruiting physicians. They bring continuity and human resources support that I think will stand us well over a long time.

WEEKS:

I was wondering if your partners who probably work together -- in many cities you have more than one partner, don't you?

LATIMER:

In the larger urban areas, Atlanta, Baltimore, Miami, for example, it will require more than one unit to provide total coverage. We want to be able to gain market share so certainly we try to be selective in those that participate, but yes.

WEEKS:

I was wondering if there is any cooperation between partners in the same area such as -- I was originally thinking staff privileges, but that probably would not be the case.

LATIMER:

Quite often partners within the same metropolitan area or that are just contiguous even if they are in less populated areas will come together for an advertising program, for educational opportunities, to share transportation, or to bring in specialized expertise that one of them couldn't do alone.

That's part of the facilitating role. This facilitating activity is difficult because it is not as easy to describe as consulting services or group purchasing, but our partners are telling us that that kind of facilitating and arranging is very important.

WEEKS:

It just seemed that it would be a natural thing for them to try to work together some way.

What is the Virginia Insurance Reciprocal, TVIR?

LATIMER:

It is our group provider of insurance programs. I think that one of the opportunities that we have is to bring both our partner/shareholders and their physicians stronger insurance coverage over which they have some control.

WEEKS:

Is this all kinds of insurance?

LATIMER:

That's correct. We are certainly concentrating on professional liability and malpractice insurance, and we are starting with our shareholder hospitals, but we are going to see that expand to directions and officers, to all forms of benefit insurance. We've got to get better control over insurance and not be at the total mercy of some of the commercial carriers or organizations that might not have the same kind of risk management and quality of service that we think are represented in our program. One of the items that is high on my priority list right now is strengthening the breadth and depth of our insurance program. We think we have a very good one right now. We are pleased with the number of partners that are using our services, but we want even broader and deeper usage as we go forward.

WEEKS:

It seems to me I read that St. Paul was going out of Florida and that they were about the only malpractice insurance outfit there.

LATIMER:

There are a number of states throughout the country, some within our service area, where finding insurance is a real problem. Florida is one of them. Our partners in Florida are exploring the option of forming a separate captive just for themselves. That may be done in some other states also. When you have a number of strong hospitals within the same regulated region, those kinds of opportunities present themselves. But Florida, along with a few other states, does have a troublesome insurance situation.

WEEKS:

One of your competitors, I think, in the Sunbelt area, Seventh Day Adventists -- I talked with Donald Welch...

LATIMER:

Don Welch is a good friend of mine.

WEEKS:

I think he is a first class person too.

LATIMER:

Don Welsh is a fine gentleman. We certainly compete on some things and we work together on some things.

WEEKS:

I was surprised when I talked to him to learn how large Florida Hospital was. So many of the hospitals in the South are small. Another thing I learned, not from Don Welch but from someone else, talking about malpractice insurance learned that it was not such a great problem in Alabama. For some

reason they don't seem to sue very much in Alabama.

LATIMER:

There are also a number of states where the current practices or laws provide caps. I have been being advised for several years that such caps aren't going to last much longer, but they are still available. So long as the awards are small or there is not a lot of litigation we are encouraging those folks to move right along as they are. We've got an alternative ready for them if the environment changes but we don't encourage them to go out and change it.

WEEKS:

It is strange how things differ from one part of the country to another.

I want to ask you about a few of your affiliations. You are a member of the American College.

LATIMER:

Yes.

WEEKS:

Would you talk a bit about your American Hospital Association activities? I have six or seven items listed. I know that you were a delegate in the House of Delegates. Was that in 1981?

LATIMER:

A long time ago.

WEEKS:

I will read you the list and you can react to it. The Assembly of Shared Services Program.

LATIMER:

Some of my first responsibilities for AHA were involved with a group of

shared services organizations back in the CHHS days, the Assembly of Shared Services section that we were a part of. Later on, under Gail Warden and Bob Toomey's active leadership, the AHA formed a multi-hospital systems constituency section. I served on that governing board and then as the chairman of its governing council in 1987. I think that the opportunity to work with people like Gail Warden and Don Wegmiller, Ed Connors, Scott Parker, the opportunity to be associated with and to work with those kinds of leaders in AHA as the multi-hospital systems arrangements were developing has been one of the great opportunities of my life. Each and every one of those leaders, and many I didn't name, have made significant contributions to the structure of health care and to the trial and testing of different organizational forms. I think that I have benefited and I hope the partners that I work for have, in turn, benefited from my experiences within the AHA. Certainly, during the time that I served in the AHA House, prospective pricing and a number of other major challenges faced the industry. The change from Alex McMahon to Dr. McCarthy and the changing structure of AHA from regional advisory boards to policy boards -- all of that structural change and development is an area where I am very pleased that I was on the inside and involved in contributing.

WEEKS:

You have worked with a lot of fine people, there is no question about it.

Was Dr. Crosby still alive when you were there?

LATIMER:

Dr. Crosby was still at the AHA when I came to Charlotte in 1969; my first association with Alex McMahon was when he was still the president of the Blue Cross Plans in North Carolina. Alex was building the Blue Cross building and had his offices located in an old farmhouse that was on the grounds. The

first time that I met Alex McMahon was in his office in that old farmhouse. Alex and I have enjoyed a long, and certainly from my point of view, very positive relationship since that first day. I'm glad he is back in our service area. We have a number of Duke graduates on our staff and I look forward to more. I look forward to continuing the relationship with Alex that we have enjoyed.

WEEKS:

You have heard the story of the selection of Alex, haven't you? McNerney was the shoo-in candidate and then somebody thought that the Blue Cross connection would be wrong and it would be wrong to bring somebody in with a strong Blue Cross connection. To make a long story short, Alex was invited to take the job, but McNerney's original idea, I have been told, was that if he got the job as head of AHA that he then would ask Alex to come and take his old job at BCA. But it just reversed.

LATIMER:

I have heard that story. You probably know more of the people who were players in it than I do.

WEEKS:

I knew some of them, of course.

Is there anything more you want to say about The Duke Endowment before we leave this?

LATIMER:

I can't say enough good about The Duke Endowment. I can't say enough about the influence that the leadership of that organization has had upon SunHealth. I also believe upon health care, not just in the Carolinas but across the country. They have certainly left a most positive mark.

WEEKS:

I get that impression too. The first time I met Billie McCall was at a meeting of CPHA when he was on the board, when Vergil Slee was going through the bad period that he did after the coding book experience. That was kind of bad. I thought his ideas were good, but it didn't work out well.

Do you want to say something about the Hospital Management Systems Society?

LATIMER:

The Hospital Management Systems Society was a personal membership society that I guess we organized outside of AHA and then brought under the AHA umbrella. The early multi-hospital shared services organizations were active in management engineering. Their leadership and management formed the nucleus of the Hospital Management Systems Society. People like Pat Ludwig served as its leadership. I was fortunate enough to be its chairman one year -- 1973, I believe. I think that organization has done a great deal to spread quantitative management, and a substantial number of our consulting staff not only participate but continue to lead that organization and play an active role in its continuing services.

WEEKS:

Wasn't Pat Ludwig a Michigan graduate?

LATIMER:

Sure was.

WEEKS:

I didn't know him well but he was with a group...

LATIMER:

He was with Chi Systems for a while. Pat went to Baltimore with Chi. He

left Baltimore and went to Buffalo, New York, to start a program very similar to ours, prior to ours as a matter of fact. From Buffalo that program spread throughout the whole state of New York. For a time Pat served as the number two person in HANY -- Hospital Association of New York. He went from there to become the state exec in Michigan and then to Kalamazoo.

WEEKS:

What is he doing in Kalamazoo?

LATIMER:

He is the CEO of the Bronson system.

WEEKS:

I looked him up the other day and I didn't see his name. I think maybe the position took place before my list was printed. That Bronson job had a Michigan graduate in there before him too. That is quite a hospital. I have been in it.

LATIMER:

I visit with Pat and Carol once or twice a year but I have never been in his current office.

WEEKS:

My wife had an aunt in there, an elderly woman, and we used to go to see her frequently. I was quite impressed with the operation.

Did we mention Professional Research Consultants did we?

LATIMER:

That is another one of our corporate partners, for opinion research. We are finding more and more need for the decisions that SunHealth makes or the decisions that our partners make to be based on market research, whether it is the diversification that they move into, adjustments they make to the types of

services they provide or the types of services that SunHealth provides. We have developed a preferred relationship with the people at PRC, and we are quite pleased with it.

WEEKS:

It seems to be a logical thing to do.

You have done some teaching at Washington University?

LATIMER:

We have residents from there from time to time so as a part of that residency I become...

WEEKS:

Sort of a preceptorship?

LATIMER:

That is exactly correct.

WEEKS:

This is an interesting situation. In your preceptorship do you organize it? I have been told that in some hospitals, for example, as the resident goes in -- I won't mention the name but one of the most famous hospitals in the United States -- the resident...

LATIMER:

Our internship program for students including their first and second year is organized and structured. We have a philosophy that we want those individuals to do productive work. We don't network for them and we don't want them to spend an inordinate amount of time observing. We allow some of that, of course. We want them to do useful, necessary assignments. We try to match our needs with their interests. We encourage them as they see areas in which work needs to be done and in which they are particularly interested to

approach us or to approach their counselor and ask to work on the project or ask if they can adjust their rotation. We set up organized rotations to many of our functional areas. I think that we give them a very broad-based, diversified experience and perception of what an alliance is like. I sometimes think that maybe we don't develop as many personal relationships, as many one-to-one mentor relationships as some others do. In that I am somewhat disappointed. But there seems to be a trade-off between being able to move through all the departments and really do productive work vis-a-vis the opportunity to spend time with just one individual and develop that mentor relationship. We think those early contacts with leading students are important. We put effort into structuring them and giving them worthwhile assignments.

WEEKS:

I suppose some of them you try to hire.

LATIMER:

We try from the word go to select individuals that we think can be long-term participants of SunHealth. We want their benefit programs to begin from the first day. We look at the end of that first year as a time for decision-making; if for some reason we do not have an opening we ask if they are willing to do something different. But we look to them as part of the new blood that we think will build our organization.

WEEKS:

That sounds good.

Could we talk about your ideas of the future. You have implied that you think there is going to be a change in the reimbursement for health care or there is going to be a change in health care, the position of the hospital in

the future, the position of multis in the future, position of capitation and where that is going in the future. What is going to happen to the physician? Is there an oversupply and will they work for a fee schedule or a salary? If you would like to start talking about what you see for the future, start anywhere and say all that you want. I'll be very happy to listen.

LATIMER:

What was it Yogi Berra said? "It's very hard to make predictions, especially about the future."

I think that SunHealth needs to be spry and prepared to deal with the changes in the environment moreso than to shape it. I don't think that our strength or our long-term edge will be the ability to predict far out. I do think that we have to be able to do some risk-taking and prediction in the short-term. I do think that this is a particularly critical time. Perhaps all times are critical, but this is a particularly critical time because the way in which health care will be paid for is going to change and is changing today. I don't think we will return to the traditional insurance plans of the past. I think we will see managed care characteristics in payment plans, and we will see utilization management. Payors seem to select physicians and hospitals because of the attractiveness of the payment mechanism and the quality of care. I think that consumer preference is going to be important. I think a reputation for quality and a means of measuring quality is coming. We are committing resources today to determining ways to measure quality, and we expect that our partners will not only measure but communicate and compete on the basis of the quality of their services.

If I was going to make a prediction I would predict that systems and alliances and individual units will compete on the basis of quality moreso

than they have in the past.

I would think that there will be a variety of means of paying for health care and that the providers -- the hospitals and physicians -- will become more involved with the financing mechanisms and develop new relationships with the risk takers. Whether they are the equity owners and the risk takers or not, providers will move closer to payors. They will participate in the design of the plans and the benefits. They will participate in determining the incentives. They will actively communicate the measures of quality of their services.

I think that there will continue to be a variety of organizational structures. I think that those alliances who put the needs of their membership, of their shareholders first, will have an impact. I think there will be some shakeout among the alliances. I don't think they will all survive. I just hope that the impact or those who don't survive of their change and/or failure -- doesn't undo the impact of those who are providing positive and useful services.

WEEKS:

I see some problems ahead that probably neither of us know the answer to. One is AIDS. Are your hospital partners going to be able to handle this expected influx of AIDS victims?

LATIMER:

I don't know. Unless something changes -- since we don't today have any partners in California or some of the other areas that have a greater exposure or a greater risk -- we will probably be able to learn from their experiences. We will be watching those areas. I don't know and I worry about AIDS and the impact it could have.

WEEKS:

And where the money is coming from to take care of it, where the facilities, where are the personnel that will want to take care of them, these are big questions.

LATIMER:

AIDS is one of the things that could force some ethical decisions and ethical policies that I think are coming to health care sooner or later. AIDS could make it sooner rather than later.

WEEKS:

Another thing that we can't forget is the increase in the population of the elderly and their demands for services. I don't know how we are going to take care of them. I stop to think of what is happening to Medicare and what is happening to extending HMO protection to Medicare patients which hasn't proved to be very successful, I don't think. I see these as problems, as I see housing for the elderly as a problem. Your group hasn't gotten into nursing homes, has it?

LATIMER:

SunHealth has not gotten involved with nursing homes in a direct sense. Some of our partners are involved in nursing homes, and we do offer some purchasing services, but we haven't become involved in developing or expanding nursing homes or we don't have anywhere near the volume of participation in that area that we do in the acute patient care area. I share your concerns. I guess I feel the burden to do something, to not be a sideline observer. I think that one of the ethical decisions we are going to have to come to grips with is the amount of health care resources that are spent in the final episodes of illness of our population. I am just not sure that we can

indefinitely justify the large expenditures of health care resources spent in those final stages.

WEEKS:

Another point that is related to this is what Jim Hamilton called rising expectations. Many of our people are running to the doctor when they don't need to and, since they are covered by Blue Cross or some other insurance or Medicare, they feel that they are entitled to go. We have a friend who is an x-ray technician. She was telling me that when people come in with insurance the doctor may have ordered one or two x-rays which they provide and the patient will say well the last time I was here I had three. Why don't I have three this time? What do you do about that sort of thing? I don't know what proportion of patients are that way. Maybe that is an exception. Are we expecting too much?

LATIMER:

I think there will be some experimentation. I think we will design incentives to deal with some expensive or unrealistic patient requests. I think a majority of society will respond to incentives that say we can measure the quality of care, we have means of knowing that the depth of the procedures that we are following are appropriate, and excess is going to cost you more. It is going to cost that person. We'll be glad to do the third one, but you have to pay for that third one. Or, if we do that third one, your premium is going to be adjusted at some point.

WEEKS:

What do you think of this? I have seen a couple of indications that make me wonder. If you are a Social Security recipient, if you make $35,000 or more a year total income you pay an income tax on at least part of your Social

Security, a sliding scale. In other words, you are paying an extra income tax on Social Security which up until this time was untouchable. That is one thing. The other thing is, is the time coming when you are going to have to submit your income tax return and be placed in a certain category and if you are making above a certain amount of money a year you will have to pay a certain percentage of your health care? I can see something like that coming, because there is a lot of agitation about the rich who pay more than the poor even though they may have earned enough to get benefits from Social Security they still are being considered as being too wealthy to have it all.

LATIMER:

I think we will have some form of means testing.

WEEKS:

We won't use that word. That is a mean word. I have used that and been corrected too. But we will have something that will be a means test, I am sure.

LATIMER:

I think one of the challenges will be to deal with changing financing mechanisms and the possibility of economic assessments, and still not move to a tiered system of health care. While I believe in certain forms of incentives to select where you go and what services are provided, hopefully we don't ever get to the point that some of our people are getting second class health care. I would much rather make choices about the amount of resources we devote at the end. I would much rather make choices about those who have the ability to pay paying some of their own costs, as opposed to evolution toward a tiered system, or a system tiered by quality.

WEEKS:

I hope so too. I feel that if I have a little bit more income than I actually need that maybe I should pay for some of this that is normally free. From the state of mind of a senior citizen, a senior citizen is more likely to be very conservative because his sources of income are very limited and he isn't likely to be able to go out and pick up a second job if he needs to, so he is threatened.

LATIMER:

That is possibly so but -- it perhaps doesn't directly address the point -- there are going to be more opportunities for senior citizens to earn some outside funds than ever before. As the baby boomers get to the era of needing services, before they get to be elderly, there is going to be a need for services that cannot be met with the same means that they were met with in the fifties and the sixties. That doesn't necessarily address your point. I think to find the wherewithal to provide health care in the way that we have in recent times is going to be very difficult. That is the reason I think it is going to change.

WEEKS:

It is going to have to change. Maybe it is better that we don't know.

LATIMER:

Some of us have got to be involved with it.

WEEKS:

That's right. I can't give up being concerned about things. I haven't had a regular job in quite a few years but I hate to think of not doing anything. Even if I had to work for free, which I am doing on this of course, it is better than doing nothing.

LATIMER:

I think I always want to make a useful contribution to society doing something.

WEEKS:

Sure. I watch retired people. I watched them in the airport today while I was waiting for you and I am amazed at the percentage of people who are of retirement age who are traveling on the airplanes. So they must have some money. We eat dinner out practically every night and it is surprising how many people of our age or older who are eating dinner out. No matter where you go. If you go to an inexpensive restaurant or whether you go to an expensive one or whether you go to the university or whether you go somewhere else, there are always a lot of senior citizens there. Apparently all senior citizens are not hard up.

LATIMER:

I think that is right.

WEEKS:

Is there anything else you would like to add? I have enjoyed being with you and talking with you. I am sure I haven't thought of everything I should have asked you.

Interview with Ben Latimer

Ann Arbor, Michigan

July 6, 1988

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