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BOSTON UNIVERSITY MEDICAL CENTER

The University Hospital

Managing for CHANGE

A Publication for the Managers of the University Hospital February 14, 1989

Managing for Change: A Message from Dr. Abercrombie

Change is the watchword for us these days. We are all in the process of identifying and adapting to new, more cost-effective and efficient ways of getting our jobs done. Through all of this change, I intend to see that the University Hospital continues to be one of the leaders in first-rate patient care—to remain in the vanguard scientifically and technologically. To accomplish this mission while contending with destructive external forces, we must change the way we do things. Change, although unsettling, need not be frightening. Change is challenging: The critical point is to be certain that we manage change, and not have it or other forces manage us.

As long as we hold true to our mission, and to our values of putting the care of patients and respect for fellow employees uppermost, then the changes we make will be wholesome and appropriate, and will prove to have been farsighted.

*This new publication, **Managing for Change**, will help us keep track of the many projects getting under way that involve change. It will inform us of the rationale for changes, and the ways in which we can confront change effectively, for the benefit of the Hospital and its patients. **Managing for Change** will be published twice a month, and will be distributed to all UH administrators, operating managers, chiefs of service and section heads.*

***Managing for Change** will cover those projects that arise out of the operations review; the Length of Stay reduction effort; implementation of the Hospital Information System, and how UH's mission and values play a role in change activities.*

Successful change respects the roles that individuals and groups play in a complex environment. I look forward to your contributions —and I am grateful for them.

J. Scott Abercrombie Jr., M.D.
President

The Operations Review: Where Do We Go From Here?

Today's health-care environment may best be described as "schizophrenic." Increases in costs have combined with decreased payment levels to create an extremely difficult financial position for the University Hospital, as well as for most other Massachusetts hospitals.

Historically, hospitals have responded to such fiscal adversity by making indiscriminate cuts across the board, and reportedly, many hospitals are now doing so. UH, on the other hand, decided not to take any precipitous action, but instead embarked upon a major effort to learn how operating efficiencies could best be attained. Last fall, the Hospital contracted with the international consulting firm of Touche Ross to conduct a thorough review of Hospital operations and report back to an Oversight Committee made up of senior management and clinical leadership (Drs. Abercrombie, Spatz and Levinsky, Mr. Blaszyk, Mses. Dart, Kirby and Hancox).

The fiscal situation

In 1987, the University Hospital achieved a $3.1-million net income based on gross revenues of $115 million. In 1988, UH suffered a $3.7-million net loss based on $144 million in gross revenues. In other words, the Hospital provided more services in 1988, but its bottom line fell by $6.8 million, producing the Hospital's first loss in many years.

How did this come about? Over the past three years, Hospital operating costs have been increasing at an average rate of more than 13 percent per year. Over the same period of time, reimbursement has been getting tighter. For example, Medicare reimbursement, adjusted for cost of living, is approximately 24 percent lower in 1989 than it was three years ago. In addition to losses

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Q&A: Hospital Information Systems

What is the new Hospital Information System (HIS)?

The new HIS will replace the current inpatient and outpatient computer systems, and it will have capabilities for use by clinical staff to order patient-care services. The system will be installed in two phases, with each taking approximately one year, and eventually will involve all Hospital employees who provide or use patient-related information.

What are the phases of the implementation?

The first phase—the "business-office" phase—will replace the procedures and computer systems used to process financially oriented information about inpatients and outpatients. Users of this system will perform most of their work with terminals, and will be able to display or to report system information from their desks when needed. Information entered will also be immediately available for access by other users, with no delays for nightly update processing.

The "Order Entry/Results Reporting" phase will provide computer support for clinical staff to order patient services, review existing orders, and examine the status and results of earlier orders. This phase will eliminate order/charge slips and will greatly reduce the amount of paperwork that typically accumulates in patients' medical records.

Why are we doing this?

The current systems have become outdated. They are not flexible enough to support the demands of today's environment: they do not promote effective or efficient use of Hospital resources.

With the new HIS, users will have access to information that they need, when they need it, regardless of when it was input. Security features will assure that users can access only the data they need to do their jobs.

In short, inpatient and outpatient information will be available from a single source; the system also interfaces with highly specialized computers in some ancillary departments, making much clinical information readily available; and data will be accurate, since errors are identified and corrected during input.

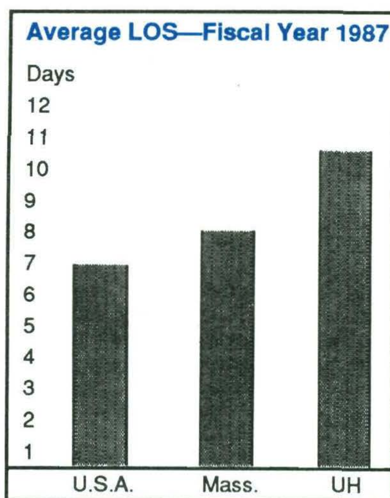
Lynn Crane
Project Manager, HIS

Cutting Length of Stay: Crucial factor

A measure of the stiff challenge facing the Hospital can be seen in how UH lenghs of stay compare with other hospitals of similar case mix. In FY 1987, the University Hospital's average length of stay (ALOS) was 10.6 days, which compared unfavorably with both the national (6.9 days) and the Massachusetts (8.0 days) averages.

Because of the crucial financial implications of having a high ALOS, length of stay reduction is a high priority to UH clinical and administrative staff.

Since the advent of Medicare's diagnosis related groups (DRGs) payment system, and with the growth of managed care systems (HMOs, PPOs, IPAs), payments to hospitals have become even more tightly controlled. The state's own cash flow and revenue problems have exacerbated the Hospital's revenue concerns. Most reimbursement is now based on the number of discharges (adjusted for case mix) that a hospital makes, rather than on how much the hospital itself charges; thus, every unnecessary day, test, or procedure deteriorates a hospital's bottom line. Further, current reimbursement systems generally fail to provide adequately for the longer stays that tertiary patients often need. The reimbursement system is likely to get tighter, rather than better. Therefore, UH, like other hospitals, must streamline its utilization patterns.



To help accomplish this, the Hospital began its Lengh of Stay reduction effort this past fall with a goal of reducing the ALOS by 5 percent over Fiscal Year 1989. Length of stay programs are not new. In fact, they have proven to be quite successful at other institutions throughout the country with similar adjusted case mixes.

The Hospital's LOS reduction program consists of four components:

- **Discharge Planning**—Several committees are involved in evaluating and improving the Hospital's access to post-hospital placement and out-of-hospital care. Specifically, they want to find new ways to improve the discharge of patients into nursing homes, or in accessing post-hospital home care.
- **Model Care Plans**—This component requires creating standard profiles, or protocols, for specific types of patients. Over the next several years, most diagnoses will have their own documented plans reflecting how admitting physicians would expect their patients to progress towards discharge.
- **Hospital Systems**—An encompassing component, this effort will involve the many departments that contribute to the vital flow of patients and information leading to the execution of patient-care related tasks. Departments ranging from Admitting to Radiology to Nursing, among others, are being asked to adjust their operations to remove "bottlenecks" and make smoother the passage of patients through the Hospital.
- **Feedback Reports**—The aim of this component will be to provide physicians with specific data on how their lengths of stay and utilization of tests compare to those of their peers and to the reimbursement-based LOS standards.

At this point, the four components either are being implemented or are in their final planning stages. **Managing for Change** will give periodic updates about the LOS reduction effort.

Michael Paskavitz
Publication Services

Operations Review

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resulting from federal Medicare cuts, UH provided more than $17 million in uncompensated care to patients unable to meet their financial requirements. Meanwhile, the state budget crisis has slowed—nearly stopped—payments from Medicaid.

As a result, current projections indicate that UH will incur more than $9 million in red ink in Fiscal Year 1989, unless the Hospital can improve its efficiency. The freeze on capital spending that was initiated last summer, combined with the December suspension on new hires, has helped curb costs. In fact, with a freeze on such spending, the projected deficit figure for FY 1989 could be reduced to $6 million. The Operations Review is a separate but complementary effort intended to cut costs even further, but on a more logical and rational basis.

The review process

During December and January, the Operations Review team (consisting of representatives from Touche Ross and the Hospital) prepared a "diagnostic snap-shot" of UH operations to highlight areas in which Hospital operations might be improved. This "snap-shot," based on hospital data and on a series of interviews with department managers and selected physicians, provides a comparison of UH with other teaching hospitals with similar adjusted case mixes.

Using this information, the review team has proposed to the Oversight Committee a series of projects for improved efficiency. From the outset, Dr. Abercrombie has made it clear that Touche Ross will only propose actions, but that the Hospital's senior management itself will make the decisions on what actions to take. The Oversight Committee's decisions regarding projects, procedures and priorities for implementation are expected soon.

Potential projects

Resulting from the review will be a series of projects to increase productivity and lower costs. While the actual list of projects is not currently known, the following types of projects have been investigated:

- A new utilization management program to better coordinate the flow of patients through the Hospital, with the aim of reducing lengths of stay and the number of tests and procedures performed on each patient;
- A productivity monitoring system to provide more timely budget information to managers;
- Departmental productivity enhancements, including reorganizations of tasks and staffing patterns, possibly accompanied by some reductions in staff;
- A series of inventory management projects to better control the burgeoning costs of supplies;
- Review of service level contracts to reduce payments to outside service vendors;
- A series of training programs on managing for productivity, coordinated by the Office of Training and Development.

Depending upon senior management's action plan, implementation of the final list of productivity projects will begin in the next several weeks. Some may take days to complete; others may take many months. However, while the most visible efforts of the Operations Review will take place over the next several months, the Hospital is creating processes to make productivity management a routine part of Hospital systems.

David Browne
Planning

Managing for Change is published biweekly by the Office of Publication Services, Department of Marketing Communications & Public Affairs, Donald R. Giller, director. Story suggestions may be addressed to Giller at x8149, or to Owen McNamara, Mike Paskavitz or Paula Gilligan of OPS at x8482. The publication's Advisory Board is made up of David Browne, Planning; Larry Burton, Pastoral Affairs; Trip Folland and John Moran, Environmental Services; Lynn Gaertner and Susan Hancox, Human Resources; Jeff Jenkinson, Financial Planning; Cass Ladd, Rehabilitation Medicine, and Nancy McAward, Nursing.