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Managing for change: October 11, 1989

BOSTON UNIVERSITY MEDICAL CENTER

The University Hospital

Managing for CHANGE

A Publication for the Managers of the University Hospital

October 11, 1989

A Letter to UH Managers

In my view, the University Hospital has had a very successful year. Although it may not be apparent in our year-end bottom line, we have achieved a number of measurable successes—accomplishments that warrant optimism:

- *We have drastically lowered our average length of stay, which indicates that our doctors, nurses and managers are responsive to the call for efficiency and change;*
- *we have maintained our market share of patients and have made strides in positioning ourselves in new, emerging markets;*
- *we have entered into a renewed spirit of cooperation with the School of Medicine;*
- *we have recruited many talented and dedicated managers, physicians and employees;*
- *we are playing an active role among Boston teaching hospitals in bringing about legislative awareness of health-care concerns;*
- *and we have purchased two state-of-the-art information systems that will carry us into the 21st century.*

These positive highlights do not dispell the fact that his year has been one of unprecedented challenge. Hospitals in the Commonwealth, and especially Boston teaching hospitals, have had to band together to respond to the neglect of fiscal reponsibility by the state and federal governments. At the same time, these hospitals have had to become far more competitive with one another.

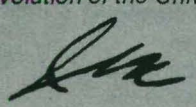
Competition is stressful, but it is good stress. Competition challenges us; it sets high standards and fosters growth and development for those who respond to it boldly, intelligently and decisively. We have chosen to view as an opportunity that which most other hospitals see as a crisis.

The goal of our Change Project is, quite simply, to become more efficient while retaining our commitment to high-quality patient care. Our lack of efficiency has lost the Hospital money in the past—and that is no longer acceptable. But a compromise in quality of patient care will not be tolerated.

In the past decade, many hospitals have placed too much emphasis on marketing to fill beds, without concerning themselves with being efficient in caring for patients. Some of those hospitals are becoming casualties. At UH, we are combining an operations-driven management style with a marketing-driven management style. I believe this approach to be the right one.

There is a tremendous amount of information contained in this newsletter, but it is important information that you need to know. Utilization management, clinical and departmental reorganizations, the TSI and OMEGA systems, marketing, planning and managed care, and legislative initiatives—all are part of the Hospital's strategic positioning for the future. They make up the "Big Picture."

The challenges we've faced this year are the rule, not the exception. Our managers have been, and will continue to be, tested by change. I am pleased with our progress in adjusting to a new way of thinking and working, and I look forward to your involvement in the evolution of the University Hospital.



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

Reorganization is necessary

A large portion of the Hospital's Table of Organization this month has a completely new look, with the number of ancillary and support departments trimmed from 50 to a grouping of just nine, and with 22 clinical departments now grouped under seven major specialty categories. Further, and most importantly, we have a new process which brings much-needed physician input for making decisions about how to use our resources wisely. Let me place the changes into a context that I hope will help you understand the rationale.

Like all hospitals, we are seeing less and less support and cooperation from government, yet we have more and more demands and restrictions put on us by those same governments. This is not likely to change, so we have to deal

continued on page 5

Utilization Management: A key cost-containment program

Not long ago, utilization management was merely a health-care term reserved for top administrators and fiscal and strategic planners. But with the implementation of our Hospital-wide utilization management program, the term will become familiar to all of us.

As part of the Hospital's effort to control its expenses and manage quality through improved operating efficiency, an ad hoc Utilization Management Steering Committee, co-chaired by me and Dr. Mark Moskowitz, and consisting of appropriate UH physicians, nurses and managers, is now working to finalize this resource monitoring program.

Essentially, the program is intended to control the unnecessary use of Hospital resources. Resources are

continued on page 5

AUTOMATION

The Baxter OMEGA system: Changing the way we do business

The Hospital's new information system—the OMEGA system from Baxter Healthcare—will revolutionize the way UH operates each day. For instance, it used to be that an admitting clerk would have to access several systems to get a patient's information—a slow, time-consuming and often inaccurate process. Using the OMEGA system, that clerk will now be able to access up-to-date and thorough patient information, ranging from personal to financial information and medical record data. In essence, OMEGA is a single source of accurate, updated patient information.

The first phase of implementation, currently on schedule, involves patient-related office functions. Phase I will primarily affect clinical support areas, such as Admitting/Registration, Patient Accounting, Medical Records and related areas.

The second phase, known as clinical care "Order Entry/Results Reporting," will primarily affect nursing units and ancillary departments. They will eventually be able to use OMEGA to order and direct patient-care services.

The system's key features: Data is available to all users immediately upon entry into the system; the quality of the information is better than that of the old systems; and security features ensure proper access by users and protection of patient confidentiality.

Clearly, the old systems are unable to meet the demands placed on the Hospital. The new system will be of great importance to the many UH employees who are major users or processors of patient information. Patient Accounts, Medical Records, Admitting and numerous other areas rely on the information contained in the system to smooth the flow of patients through the Hospital. Overall, the system will make users' jobs easier and will allow the Hospital to operate more efficiently.

Because OMEGA will affect how hundreds of UH employees do their work each day, the system has to be tailored to operate within very specific guidelines, since improper or incomplete replacement of current business functions would lead to confusion and inefficiency among users. To guard against this, we have been building the system's information base—shaping departmental policies and procedures—slowly and methodically with the help of representatives from all the major user departments. This core group is helping to mold the system to fit their departments', and the Hospital's, operating patterns.

Once new departmental policies and procedures emerge and all of the necessary information is entered into the system, the project will proceed to the next step: testing the new procedures and the software together to make sure they'll work. In the Spring, we anticipate beginning training users on the system; we are planning for the system to be on-line in April.

The OMEGA system represents a radical change in the way we operate. However, as is the case with all elements of the Change Project, the aim is to promote the timely and efficient use of Hospital resources.

Lynn Crane
Project Manager, OMEGA

Transition I: Managing costs, not budgets

Beginning in October, Hospital managers will be asked to meet with UH financial planning people and analysts from TSI to start the implementation process for the Transition I system. On the surface, TSI looks like a fiscal system for budget reporting and the analysis of case mix, but it also is designed to allow operational managers the ability to project, monitor and manage departmental costs based on detailed clinical information and operational decisions.

The goal of the TSI is to get important data into the hands of certain UH managers, in the form that makes it most usable. UH acquired TSI so that managers could manage costs, rather than budgets. This is a crucial point to understand. By isolating and managing individual costs within your own department, we can provide the entire range of the Hospital's services in the most cost-effective manner.

Ultimately, what TSI will mean to most managers is better access to data from which to make decisions and manage expenses; and, hopefully, this will mean good decision-making. Unfortunately, we cannot simply install a software package and have all the answers at our disposal; there is a lot of necessary legwork involved in implementation.

Like any computer, small or large, the TSI must contain baseline information upon which to build. So the first step, already under way, is creating the links from the "feeder system" (e.g. General Ledger, Payroll, Medical Records, Billing) that will provide TSI with that baseline data.

The next step will be the most difficult—setting "cost standards" and defining "intermediate products" within each department for use in flexible budgeting and cost/profitability projections.

The formation of standard costs and intermediate products will happen simultaneously and in unison. Standard costs are, in effect, detailed budgets of the costs for providing each of a departments' key services, and intermediate products are those defined key services.

Since intermediate products will be the basis for management reports and analyses, it is essential that they be tailored to the way a manager thinks and manages. For example, each hematology blood test could be an intermediate product, but if there is minimal cost difference between two other tests, perhaps those three tests could be combined as one intermediate product for management information purposes.

While intermediate products are being identified, cost standards for each product will be created as a joint effort between department managers and UH financial planners. For example, how much labor cost goes into performing a batch blood test in hematology?

Once it is up and running, TSI will help operational managers make good decisions by providing timely, accurate information in a useful format. TSI provides us the opportunity to improve departmental operations and the Hospital's overall efficiency, but this cannot be achieved without your full cooperation.

David Browne
Project Manager, TSI

Reviewing UH's 'Leading Indicators'

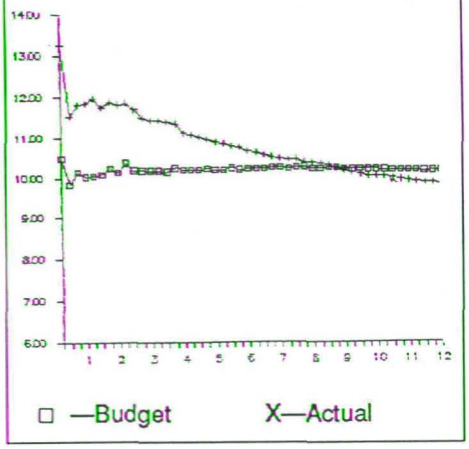
One good way to monitor the Hospital's performance over the past year is to look at the trends of three leading indicators or "vital signs"—Length of Stay, Admissions and Patient Days.

Length of Stay: A new-found strength

What was once a major weakness for UH is fast becoming a strength. Over the past several years, UH's average length of stay (ALOS) has ranged between 10.5 and 11.5 days, but UH's year-end ALOS finished at an unofficial 9.74 days—an outstanding improvement over last year (10.81 days), and the first time this statistic has ever bettered its budget (10.18 for FY89).

Length of stay is an important figure for reimbursement. For example, if a heart patient's DRG (Diagnosis Related Group) says that patient needs to be hospitalized for only 10 days, but he or she stays 13, those three excess days will likely be uncompensated. Thus, the pressure is on to control length of stay while maintaining quality of care.

Length of Stay (through Period 12)

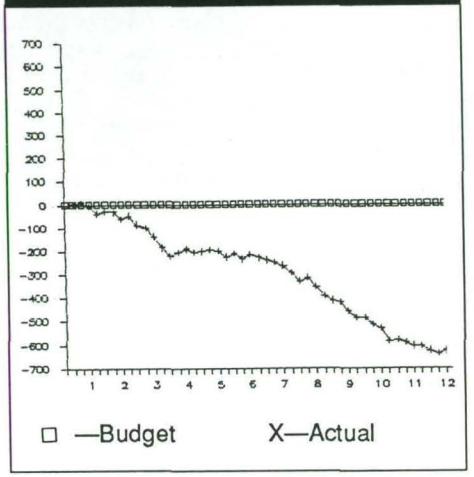


While UH's length of stay is still above the national (6.6 days) and Massachusetts (about 8.0 days) averages, these aggregate figures do not take into account UH's high case-mix and intensity of illness indexes. Nor do they account for the fact that UH has no obstetrics (low LOS), and has two clinical programs with historically high lengths of stay.

The improvement in length of stay performance is directly attributable to the Hospital's Length of Stay Reduction Effort—a program created for FY89 to make the patient-care process more efficient.

How much more can LOS be improved? This is difficult to answer due to the complex nature of the Hospital's patient population. UH is a teaching hospital with expertise in treating patients who are acutely or chronically ill, and thus, who are difficult to manage. It will be UH's objective to continue reducing LOS in FY90.

Admissions (through Period 12)



Admissions: Opportunity for growth

While length of stay tells us how efficient we are at managing patients, in comparison to reimbursement standards, admissions tell us how much inpatient business we're doing. The vast majority of the Hospital's revenue is generated through admissions. On average, each admission translates into approximately $7,000 in net patient-care revenue.

Over FY89, UH did not reach the ambitious level of admissions that had been projected in the budget, but did maintain and perhaps even improve upon FY88 admissions—a claim few Boston hospitals can make. It also should be pointed out that last year's numbers were aided by a strike at Boston City Hospital, which led to an increased number of acquired admissions to UH during that strike.

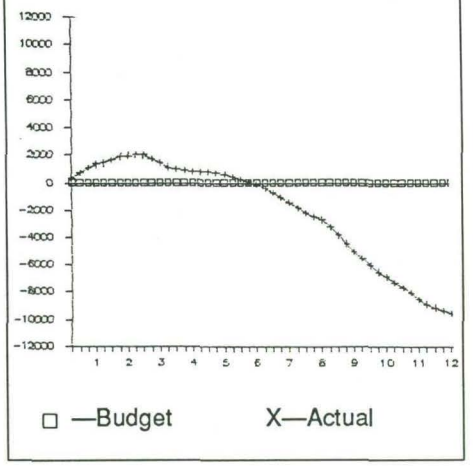
This admissions trend indicates that the Hospital at least maintained its market share over FY89. A strong finish in FY89 admissions, coupled with extensive and strategic marketing and planning efforts for FY90, is cause for optimism that UH will continue to fortify its market share.

Patient Days: A measure of cost

The third leading indicator is patient days, which, as the graph below clearly shows, has taken a dramatic dip during FY89. Patient days are the sum total of the patients' stays in the Hospital, and are an indicator of patient-care expense. A high number of patient days could reflect inefficient length of stay management, which, in turn, raises the cost of caring for patients.

As the LOS drops, so do the number of patient days; that obviously is a good outcome. On the other hand, a low number of patient days means a low occupancy rate. The Hospital's inpatient census has hovered around 75 percent for most of the year (currently it stands at 73.5 percent). UH would prefer to continue lowering LOS, even though it may drive down the patient days and the census. In short, UH would rather be small and efficient than large, inefficient and underutilized.

Patient Days (through Period 12)



For the next fiscal year: On the debit side of the Hospital's ledger, the Length of Stay Reduction Effort and Utilization Management Program are aiming to decrease the number of patient days and control the use of resources, respectively. On the credit side, increased admissions and a higher inpatient census are being achieved by clinical program expansion and aggressive marketing and planning.

Michael Paskavitz
Editor for Clinical Affairs

Marketing and Planning: Targeted strategic activities

This past summer, staff involved in marketing, planning, managed care and business development, and affiliate relations have been laying groundwork for efforts to strengthen physician referral ties and increase the number of admissions to UH.

The approach of this newly configured division is to integrate strategic planning and action with hospital operations and financial planning, assuring maximum involvement of the medical staff. In addition, we are seeking to maximize the potential of existing relationships that have been developed by our physicians, and to achieve a closer strategic relationship between the Hospital and Boston University School of Medicine.

Here is an update on these activities:

Planning Services—Planning Director Miriam Pollack was responsible for the compilation of a Strategic Data Book, which has since been used by Dr. Abercrombie and senior management to outline a new planning process, as well as to support the early planning of a regional outreach program (see below). Steve Friedman, a student in the Health Care Management Program of the BU School of Management, participated in the data compilation. For the first time, Ms. Pollack has been invited to support and participate in departmental planning activities and joint program planning initiatives with affiliated hospitals. Activities have included coordinating our cardiology section's support of three DON applications for community cardiac catherization laboratories, working with nursing department planning, and pursuing a formal definition of existing ties with Boston City Hospital.

Managed Care & Business—Managed Care Director Richard Morse has continued his work in strengthening our existing HMO relationships (see article, page 5). Mr. Morse also chaired a short-term task force that has made recommendations to management on the organization of a coordinated regional outreach program. The program would involve UH and its physicians with physicians and hospitals in a selected region of the Commonwealth.

Affiliate Relations—Health Systems Director Ellen Lutch has taken on the assignment of liaison to institutions affiliated with UH. She meets regularly with representatives of our key affiliates for the purpose of assuring that formal relationships are working smoothly, and to identify opportunites to develop new ties. One byproduct of our efforts to develop new affiliations is our new tie with Charlton Memorial Hospital in Fall River.

Marketing Services—With Marketing Director Virginia Trainor's move to Vose Hall in October, our targeted marketing services programs will be better integrated with our other planning, business development and affiliate relations activities. An early objective will be to assure that UH and BUSM alumni in our region are informed about the Hospital's programs and services. Ms. Trainor also will spearhead development of an outpatient referral form to improve the information patients have on hand when they arrive at the Hospital or the Doctors Office Building.

The way our staff are approaching these tasks takes into account the goals of the clinical and departmental reorganizations announced by Dr. Abercrombie. Specifically, we aim to place the patient and the referral physician in the center of our focus, and to involve our staff physicians and departmental management as we support these new strategic initiatives.

Donald R. Giller
Vice President,
Marketing, Planning,
Business Development

Michael D. Blaszyk
Executive Vice
President, Corporate
Services

Legislative Update

The Commonwealth of Massachusetts, as you know, is in severe financial trouble, and its budget problems show little sign of abating and may, in fact, become worse. The state's bond rating is now among the worst in the country. In short, the state's financial situation is such that there should not be great expectations for the future.

While the FY90 state budget that was passed did not iclude FY90 Medicare shortfall funds, the Governor has promised that hospitals will be compensated, so it is expected that there will be additional appropriations.

A key item is the pending Massachusetts Hospital Association (MHA) law suit against the state. Paramount among the suit's allegations is that the state is purposely delaying, through bureaucratic methods, Medicaid payments to hospitals. The MHA is contending that the state is violating federal statutes in processing applications for reimbursement.

Even worse is the state's requirement that any Medicaid inpatient claim over $10,000 and outpatient claim over $3,000—and there aren't many claims less than that—warrant a manual review, which, of course, further delays payment. This legal case argues for a new payment system and promises to set a very important precedent for reimbursement.

Recent MHA discussions with the Governor may result in manual review being required only for $30,000 inpatient claims and $10,000 outpatient claims, as was the old policy.

On the federal level, the budget reconciliation package, including provisions affecting Medicare reimbursements, has been completed by the House Ways & Means Committee and is currently being considered by the Senate Finance Committee. Of primary concern to UH is the funding for Indirect Medical Education (IME). After a strong educational effort by hospitals—particularly the Boston teaching hospitals, who testified that their losses would total $37 million in 1989 under the Administration's proposed IME cuts—the House Ways & Means Committee left IME adjustment at the current level of 7.7 percent.

The attention is now focused on the Senate Finance Committee, whose members represent more rural states and who are thus expected to be less responsive to teaching hospitals. At this time, we can't predict what their final package will include, but it will undoubtedly be a significant reduction for IME, while a number of the House provisions cutting physician reimbursements will be restored. With both the House and Senate almost certain to include some changes in last year's catastrophic care bill, hospitals will likely be looked to for additional compensatory "savings."

The Boston teaching hospital consortium, including UH, intends to be active and well-represented when the bill reaches the Conference Committee.

Elizabeth Stengel
Director, Government
Relations

Reorganization

continued from page 1

with this from within. We must work to bring our overhead and operating costs, relative to volume, into a more cost-competitive range. We have to find new ways of organizing ourselves in order to get the job done more efficiently, conserve our limited resources, and produce the most effective outcome.

Since the organization of the "modern" UH around 1966, each clinical, ancillary and support department maintained its own identity and leadership and reported directly to administration. As I mentioned in my ***Blue Top***, our current table of organization requires 13 pages to list all departments or sections. A decrease in financial support for hospitals has made it difficult to be efficient and effective under the same structure.

A new institutional structure has been designed that makes things work easier. Formerly, clinical and support departments were separate and distinct, but we have acted from the conviction that the two must be integrated as closely as possible. The new design will yield a more streamlined organization that responds to the following objectives:

- Delivering high-quality services to our patients through improved decision-making and operating efficiency.
- Improving the allocation of resources by involving clinical leadership in directing the usage of resources and in maintaining accountability.
- Providing a structure that will increase physician involvement and promote increased communication at the chief-of-service level.
- Creating a structure that will not conflict with or compromise the existing academic structure at the School of Medicine.
- Increasing the depth of clinical and departmental management to enhance communication, and thus lead to quicker and better decisions.

On the management level, we are working hard to create systems that are simpler and operate more efficiently, and which can respond to every clinical need *expeditiously*.

More than ever, we need to be integrated. It is important that each of us understand that our resources are limited, and that the use of those resources must produce the most effective outcome. In the past, when we were faced with a financial challenge, there was always a way to shift our costs and receive more support and funding, but we simply don't have that luxury anymore. We expect that these new clinical and departmental structures will encourage broader participation in influencing the future direction of the Hospital.

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

Utilization Management

continued from page 1

more than capital; they are labor, services, time, supplies and equipment. The plan's goal is to implement a program defined to ensure the quality of care and services through appropriate and efficient use of resources. The resource-reduction target for fiscal year 1990 is $1.5 million to $3.2 million, to be achieved by a reduction of 10,000 patient days and a 10 percent reduction in ancillary utilization.

The OMEGA and Transition I (TSI) systems ultimately will play a key role in providing timely and necessary utilization management information (see article on Automation, page 3) to physicians, administrators and managers.

The individual elements and intentions of this program are detailed and extensive. However, I'd like to paint some broad strokes by mentioning the means by which the program's goals will be pursued:

1. Screen all admissions for appropriateness, and ask: Is the admission acceptable to the payor?
2. Continue to reduce length of stay, with a special emphasis on eliminating unnecessary pre-op and pre-procedure days, review ICU lengths of stay, and focus on aggressive discharge planning.
3. Establish policies for physician consult turnaround, to reduce unneeded ancillary services, and for O.R. access.
4. Define policies to minimize unnecessary intrahospital and interhospital transfers.
5. Define a case mix/cost management system to monitor resource utilization by case and physician.
6. Evaluate and define model clinical management profiles.

This plan will not be successful without cooperation from those involved and those affected, including managers as well as physicians and nurses.

Jacqueline Dart, Executive Vice President, Operations

Managed Care

The managed care environment—health maintenance organizations (HMOs), preferred provider organizations (PPOs), and managed fee-for-service insurance programs—is growing and changing on a daily basis. Hospitals that don't pay attention to this phenomenon aren't likely to survive.

In 1984, a nationwide study conducted by the Health Insurance Association of America (HIAA) found that 4 percent of this country's insured employees had some form of managed health insurance. In 1988, when the study was repeated, this number had risen to 72 percent. This change in managed care penetration from 4 to 72 percent in only four years represents a shockwave moving through the heath-care industry, which has caused employers, insurors and providers to re-examine their health benefits, plans and contracts, and to negotiate new financial arrangements.

Fortunately, UH is positioning itself in this growing market by strengthening existing relationships, forming new relationships (such as with the new Blue Cross/Blue Shield PPO Master Health Preferred), and improving internal systems to better work with and monitor managed care systems. This process requires that UH develop alternative contracting arrangements and respond with flexibilty to contract offers.

For the Boston teaching hospitals, about half the patients are covered by commercial insurance—HMOs, PPOs, or BC/BS. At UH, this number is approximately 36 percent. Thus, using the formula from the HIAA study, approximately 25 percent of our patients are managed in some way. Of this 25 percent, HMO and PPO contracts made up only 4.1 percent of the Hospital's 1987 admissions and 5.5 percent of the 1988 admissions.

The Department of Managed Care Systems is now focusing its efforts on obtaining a larger share of the market by maintaining and increasing the number of relationships we have. These efforts will help UH retain its flow of inpatients, and hopefully will help increase the number of managed care admissions.

All employees, especially managers, can help with this effort by understanding the policies and procedures associated with each plan, and assisting HMO and PPO patients through their Hospital experience. If you have any questions about managed care, please call me at x8500.

Richard Morse
Director, Managed Care Systems

Financial Report

As reported at the recent OM-DA-GA meeting, UH will incur a net patient-care loss for FY89. On its face, a deficit appears discouraging, but it is important to note that the Hospital actually had a $5,000 gain in Period 12. This is significant because through much of the fiscal year, UH was losing $1 million each month. The numbers during the last several periods, however, have been steadily improving. We credit the recent improvement to better length of stay management—with the subsequent decrease of more than 8,000 patient days from the FY88 total—and to more careful spending of Hospital resources.

It is anticipated that the momentum of these improvements will carry into FY90. This improved performance also should be enhanced as Change Project cost-reduction measures come into effect; the result should be a strong start for UH in FY90.

Other positive financial news includes our early repayment of some borrowed funds and an improvement in our accounts payable status. The Hospital also is exploring the feasibility of an advanced refunding of debt through a new bond issue, since very favorable rates are now available.

Thomas A. Voislow
Senior Director, Finance

Words of Wisdom

Tom Peters, the author of the best-selling book, "In Pursuit of Excellence," is one of America's most respected business consultants and authors. The following passage was excerpted from his column printed in the August 14, 1989, issue of the ***Dallas Business Journal:***

"How do middle managers keep their heads above water in a new 'lean and mean' environment? She or he must be a builder, developer, change initiator and improvement-project creator. She or he will NOT be a guardian of sacred functional turf, hoarder of information, 'coordinator,' or professional meeting attender. If you are good, there's no reason to bet against you."

COMMENTARY

Hospital 'Price-Fixing': The Legal Limits

An article that appeared in the ***Boston Globe's*** business section in August reported that several Bay State health insurors have accused certain hospitals of overcharging as a way to boost revenue and increase cash flow.

It might be helpful to know how the hospital pricing system works in order to understand the issues that brought on this accusation.

Massachusetts hospitals are reimbursed through a payment system that, by law (Chapter 23—the Universal Health Care Law), gives each hospital a revenue cap; that is, a hospital can only generate a certain amount of revenue per fiscal year. A hospital's cap is formulated using a Maximum Allowable Cost (MAC) Report, which is filed annually with the state's Rate Setting Commission.

Once the revenue cap is established, a hospital must meet its revenue cap in order to avoid a financial loss, even if that means boosting its prices.

According to the regulations, a hospital can increase its charges so long as it doesn't exceed its revenue cap. It has been alleged that some hospitals have flagrantly exceeded their caps to increase cash flow. This revenue "fudging" is possible right now only because the Rate Setting Commission is several years behind on auditing hospitals' books.

Such a practice does not occur at UH, however. If a list of hospitals that have exceeded their caps were to be published, we would most certainly be on the bottom of the list, if we were on it at all. The primary reason UH has remained within its cap is our dramatic decrease in length of stay, and the subsequent decrease in actual revenue.

There is an irony to all of this. The government, via Chapter 23, wants hospitals to lower their costs by being more efficient, and thus less expensive. In response, we lower our length of stay, refine our management structure and operating procedures, spend money less frequently and more strategically, and freeze hiring. Yet we still lose money, even though charges are substantially increased, as was the case in this outgoing fiscal year.

It is difficult to work with Chapter 23 because the fact is and remains: The lawmakers who generated this reimbursement system didn't think ahead about any incentives for hospitals who comply, and what problems the system might cause for charge-based payors.

Michael Corcoran
Director, Financial Planning

Effective Managing: Food for Thought

The following are General Electric Chairman Jack Welch's "Six Rules for Managing," which were excerpted from an article on Welch that appeared in the March 27, 1989, issue of ***Fortune*** magazine:

1. Face reality as it is, not as it was or as you wish it were.
2. Be candid with everyone.
3. Don't manage, lead.
4. Change before you have to.
5. If you don't have a competitive advantage, don't compete.
6. Control your own destiny, or someone else will.

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