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BOSTON UNIVERSITY MEDICAL CENTER

The University Hospital

Managing for CHANGE

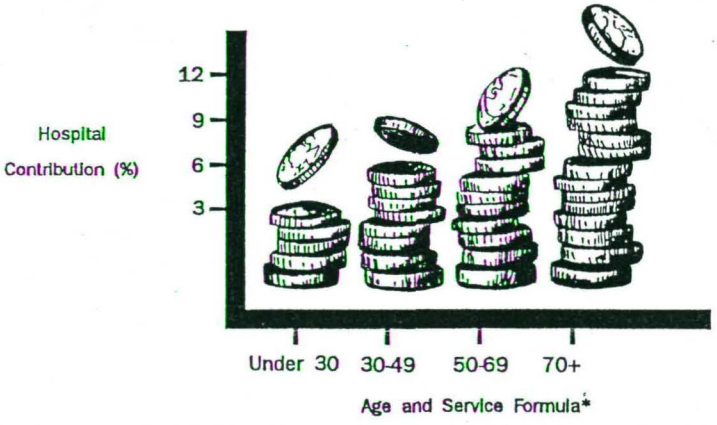
A Publication for the Managers of The University Hospital

April 10, 1991
Volume 2, Number 3

Managers can help promote new pension plan

On May 1, the Hospital will offer a new and vastly improved pension plan to its employees. "I'm told that [this plan] is one of the best offered by any Boston teaching hospital," says UH President J. Scott Abercrombie Jr., M.D. "We expect that the new plan will cost the Hospital about $500,000 more a year, which we consider to be a prudent investment in our employees and a way to attract and retain quality people."

The new plan requires that employees contribute a minimum of 2 percent of their annual salary. In turn, the Hospital will contribute either 3, 6, 9 or 12 percent of the employee's salary, depending upon the employee's combined age and years of service to UH (see chart). For instance, if an employee is 40 years old and has worked at UH for 10 years, he or she has 50 points, for which UH will contribute 9 percent of the employee's salary to the pension account.



(*The above number is derived by adding an employee's age to his or her years of service)

There will be a series of 43 orientation sessions, of which each employee must attend one. "Managers are asked not only to remind their employees about these sessions, but also to encourage them to participate in the plan," says UH Benefits Manager Betty Green.

"Traditionally, the Hospital's pension plan has based its contribution on an employee's age," adds Green. "This new plan combines both age and years of service, indicating that the Hospital really wants to reward both experience and commitment."

The following are a few advantages to this new pension plan:

- The new plan costs employees less than the old plan. Participants contribute only 2 percent of their annual salary. Formerly, employees contributed 3 percent of the first $10,800 of their salary, and 5 percent from pay above $10,800.
- Employees need only one year of service to the Hospital to enroll in the pension plan. The old plan required a minimum of two years of service in order to enroll.

- Employees can make an informed decision about where to invest their money. Plan participants can choose whether to invest their funds in the TIAA-CREF program, in which the Hospital has participated for 21 years, or Fidelity Investments. Investment counselors from both programs will advise employees at the orientation sessions. In addition, the Benefits Office has videotapes from TIAA-CREF and Fidelity available to employees for overnight use—call the office at x8578.
- There is no "vestment" period. In other words, there is no waiting period in which the employee doesn't own his or her pension account.
- Employees own their accounts, even if they should leave UH. However, if an employee does leave, the Hospital discontinues its contributions to that employee's account.
- The money is sheltered from federal taxation until receipt upon retirement. With the stringent federal tax requirements concurrently applied to certain long-term investment programs, this type of pension plan is an attractive option for those seeking retirement security.

"If there is a downside to the plan, if you can even call it a downside, it's that you can't touch your account until retirement," says Green. "Some long-term investments allow you to draw against your account balance for a loan or for emergency relief. With the pension plan, though, you have to put the money away knowing you won't see it until retirement."

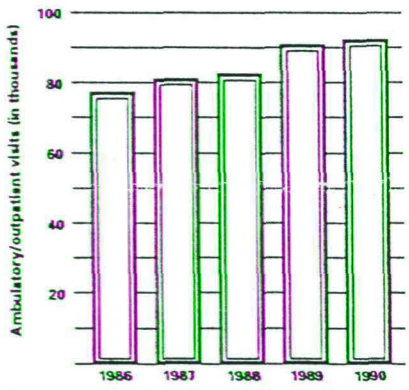
Ambulatory care: Improvements under way at UH

To compete in the 1990s, hospitals must build strong outpatient programs. At UH, ambulatory care accounts for about 16 percent of total revenues, up significantly from previous years and rising. Nationally, outpatient revenue represents almost 20 percent of hospitals' total revenue.

The volume of ambulatory surgical procedures, physicians' office visits, and outpatient therapies and treatments have markedly increased in recent years (see chart). In fact, many people who have high-risk health statuses, and even those who are receiving tertiary services, are seeking ambulatory care.

"Our objectives for ambulatory care at the Hospital are to improve the day-to-day functioning of ambulatory services and to restructure the services to achieve financial stability in today's environment," says Linda A. Burns, vice president for operations. "We're convinced that our systems our services have to make it easier for physicians to see patients conveniently."

UH Ambulatory Visits (FY86-FY90)



At the quarterly Medical-Dental Staff meeting on March 18, Burns and Donna Vignogna, director of the Division of Ambulatory Care, reviewed current initiatives and future plans for ambulatory care at UH.

Burns stressed the efforts by management to improve the flow of ambulatory surgical patients coming to the Hospital for preoperative workups, requiring tight coordination of ancillary services and the anesthesiologist's examination of the patients. She also stressed an inclusive approach to budgeting and planning, working with physicians and other clinicians in addressing problems and opportunities. Burns added that the Hospital's significant investments in new and powerful information systems will produce benefits for ambulatory care, such as improved scheduling of patients and charge processing and billing.

Vignogna recounted several improvements to ambulatory services that already have been implemented:

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- The expansion and redesign of the outpatient laboratory on the fourth floor of the Doctors Office Building. This effort has reduced the waiting time for patients—for entry into the system, registration, and blood and specimen testing and processing—by 66 percent.
- The increase in Admitting and Outpatient Registration staffing, and the redistribution of their work hours, resulting in more registrars greeting and registering patients for early morning surgical cases. These staff also have undergone telephone training and have been provided with better tools, such as telephone headsets, to expedite the processing of admission reservations.
- The expansion of Admitting Lab services, and the addition of another EKG machine to reduce patient waiting time. Functions were reorganized to reduce the number of times patients need to disrobe for tests.
- The opening of the Endoscopy Suite on H-2, and the addition of attending staff as part of an expansion of General Internal Medicine.

Leading indicators: Some good news, some concern

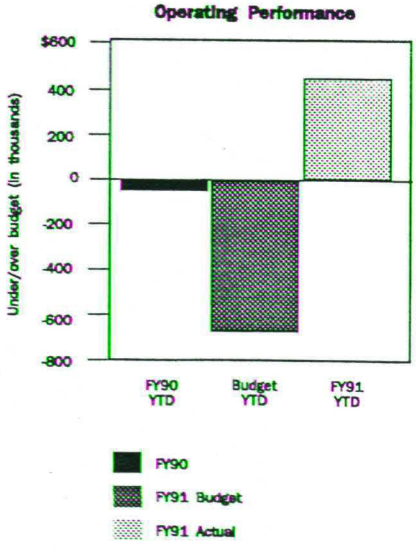
Through Period 5, the Hospital's leading operating and financial indicators are showing mixed results.

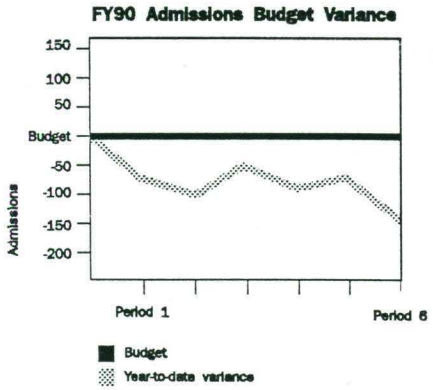
Operating performance—Through Period 5, the Hospital reported a net operating gain of $442,000 from operations—$1.16 million over the FY91 budget and $465,000 ahead of last year at this time (see chart). With below-budget admissions and subsequent below-budget revenue, UH has had to keep expenses—"salary and wages" and "other expenses"—under control, and the Hospital has made far fewer "contractual allowances" for third-party payers than was budgeted for.

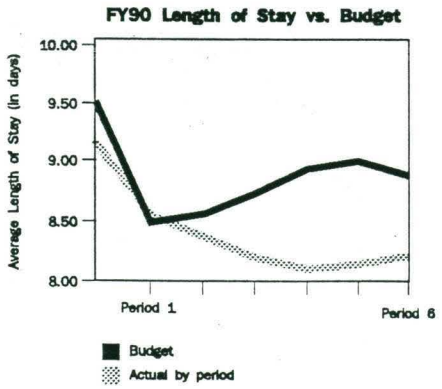
Admissions—This indicator of inpatient activity is inconsistent and troubling. Admissions are about 3 percent (140 admissions) under their aggressive FY91 budget (see chart). One highly speculative reason for this drop, which also is occuring at many other Boston teaching hospitals, is that the receding economy and rising unemployment rate are influencing patients' and referring doctors' decisions for tertiary medical care and elective surgeries.

Ambulatory Care—This indicator of outpatient activity continues to show strength, being about 3.5 percent over budget and 7 percent ahead of last year. The recent opening of the GI Suite and the Mohs dermatologic surgery service in the Ambulatory Care Center on H-2 is expected to further bolster volume.

Length of Stay—It appears as though this indicator of patient care efficiency has leveled off at about 8.2 days (0.6 days ahead of budget) after two years of steady and rapid decline (see chart).







Conflicting reports on Bay State hospital costs spurs heated debate

Two separate reports from prominent authorities on health-care finance and policy have brought the debate about Massachusetts hospital expense to another level of intensity. A study by Boston University School of Public Health researcher Alan Sager, Ph.D., and two colleagues found Massachusetts hospitals to be the most expensive in the nation. Conversely, an Massachusetts Hospital Association (MHA)-sponsored report from Codman Group researcher Philip Caper, M.D., stated that Bay State hospitals are only the twelfth most expensive in the nation, and about mid-range within a group of similar states.

In general, the Sager report stated that 1989 Massachusetts hospital costs were 40 percent above the national average, and that only one-third of that excess was justified by care of out-of-state patients, research and teaching costs, providing hospital-based ambulatory care, undercompensated care for the elderly and high labor costs. This unjustified excess equals nearly one dollar in five spent on hospital care in this state, according to the report.

"The real indicator [of hospital expense], what I think they're both looking for, is price."
—Dr. Abercrombie

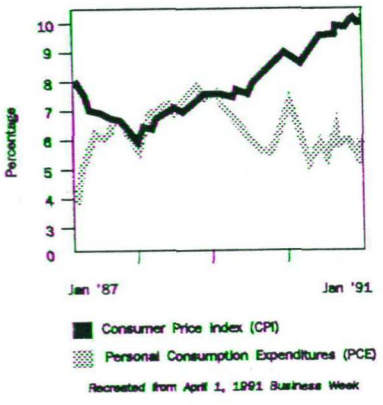
The Codman report asserts that there are three variables that make an across-the-board comparison of hospitals in different states very risky. First, Massachusetts has a higher-than-average elderly population, which inflates its per-capita costs. Second, the Sager report includes outpatient care in its equation, which distorts costs because many acute-care hospitals are not ambulatory sites. And third, the higher-than-average investment Bay State hospitals make in research and teaching also elevates overall costs. Instead, the Codman report bases its data on hospital inpatient charges (the actual amount billed to payers) adjusted for the age and acuity index of the patient population.

"There is no question Massachusetts hospitals are more expensive than most, but the real question is whether this expense is justified," says UH President J. Scott Abercrombie Jr., who feels that the answer lies somewhere in between Sager and Codman's reports. "The Sager study was based on unadjusted hospital 'costs,' and the Codman study was based on per-capita hospital 'charges.' But there's such a wide variance between a hospital's costs and its charges. I think the real indicator, what they're both striving for, is 'price,' and I think the Codman study is a bit closer to that."

Is medical inflation really that high?— Business Week

The April 1 issue of *Business Week* included a report on medical costs that refuted the conventional belief that medical inflation is greatly outpacing general inflation. The cost of medical care services, as reflected in the consumer price index (CPI), is up 9.9 percent in the last year. However, another measure of health-care inflation—personal-consumption expenditures (PCE)—has increased by just 5.9 percent during the same period.

Some experts contend that the PCE is a more accurate measure of medical inflation because it reflects goods and services that are actually consumed, and more importantly, the PCE adjusts to consumer activity patterns, such as a shift to receiving less-expensive outpatient care. The CPI, on the other hand, is based on a fixed basket of medical goods and services.



Recreated from April 1, 1991 Business Week