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Managing for change: July 9, 1991 v. 2, no. 4

BOSTON UNIVERSITY MEDICAL CENTER

The University Hospital

Managing for CHANGE

A Publication for the Managers of The University Hospital

Dear Leader,

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July 9, 1991
Volume 2, Number 4

A Message from Dr. Abercrombie: *With this issue of* ***Managing for Change****, a new format is introduced in which I will address various issues affecting UH. The intent of this new format is for you to know my opinions on some of the key issues and priorities that face us in this increasingly hostile health-care environment.—JSA*

A guide to ambulatory care at UH

As I've said at various Leaders Meetings, ambulatory care is going to play a major role in UH's future. The Ambulatory Surgery Center and Endoscopy Suite on H-2 is making steady progress under the direction of Linda Burns, vice president for operations, and Donna Vignogna, director of the Division of Ambulatory Services. I would like to outline for you the current status and future plans for ambulatory care, and introduce some of the language that describes and defines ambulatory care at UH.

Currently, the Center houses the Endoscopy Suite, the Minor Surgery Suite and the Dermatologic Surgery Service. Patients who use these services are known as **outpatients**, that is, they are persons who are not expected to be hospitalized overnight, such as those undergoing ambulatory surgical procedures, ancillary tests or routine physician's office visits.

These services make up one half of the Center. The other half, not yet functioning, will include four operating suites. We are anticipating an early August opening date for the first ambulatory operating room. The three other ORs will open as ambulatory surgery volume increases.

Patients who come to the ambulatory ORs will be known as **ambulatory surgery patients**. Within a period of 12 hours, these patients will register, be pre-operatively prepped, undergo their procedure, and then will recover postoperatively in the Surgical Short Stay Unit (recently relocated to the Center from Preston 3 [F-3]). The Surgical Short Stay Unit currently accommodates ambulatory surgery patients who are operated on in the Hospital's main operating rooms. Ultimately, the Unit will serve only patients from the Center's four ORs.

The Medical Short Stay Unit will remain on F-3. Its function will be to serve **ambulatory medical outpatients**, such as those undergoing cardiac catheterizations or blood transfusions. These patients will be prepped, treated and released within 12 hours.

I am confident that these initiatives will further improve our ambulatory care programs at UH, from patients' and physicians' perspectives.

NEWS TO USE

Leading indicators: Steady as they go

- **Admissions**—With a downward admitting trend now established at UH and several other Boston teaching hospitals, admissions continue to hold steady at about 4 percent under budget.
- **Average length of stay**—After a strong start to fiscal year 1991, the average length of stay has leveled off at 8.29 days, which is .31 days better than budget.
- **Ambulatory visits**—Currently, ambulatory visits are about 2 percent over budget, a figure that is expected to improve once the Ambulatory Surgery Center and Endoscopy Suite are operating at full capacity.
- **Operating bottom line**—While the admitting decline has meant $10 million less in patient-service revenue than was budgeted, better-than-expected payment from third-party payers (contractual allowances) has made up for almost all of the $10-million revenue shortfall. That, combined with salary and wage expenses coming in below budget, has yielded a $2.293-million operating gain through Period 8.

T-1 update

Now that training for the Transition 1 (T-1) system has been completed for Levels II and III managers, new reports with current data are being produced. However, these reports are based on draft cost standards instead of on the actual standards that ultimately will drive the yearly budget process.

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Business-planning update

The Hospital's business-planning efforts are moving along. Jacqueline Dart, executive vice president and administrator in charge of business planning, tells me that four business plans—comprehensive three-year strategic plans for our clinical services—have been completed and are awaiting implementation. Nine more plans are in process and the last three will be initiated in the next two months. All plans for FY91 are expected to be completed by the end of September.

Business planning is a strict discipline that will be an ongoing process, a way of life, here at UH. When a given plan approaches its three-year expiration date, a new planning process will be undertaken. These efforts are time-consuming and labor-intensive, but they are necessary in today's uncertain health-care environment. I believe the Hospital must be focused and in a state of strategic preparedness in order to remain competitive.

Capital Campaign will require your support

By now, you know that the Hospital's Board of Trustees has approved a five-year, $25-million Capital Campaign for UH, scheduled to begin this fall. This campaign is the most aggressive fundraising effort ever undertaken by the Hospital, and I cannot stress to you enough its importance to our future. Teaching hospitals, such as ours, can no longer expect to receive even adequate support from the federal and state governments; we must rely on ourselves.

This Campaign needs your support. As Hospital leaders, your role will be vital, both as potential donors and as ambassadors for philanthropy. The kickoff event for the Campaign will be the world's largest-ever Jeopardy tournament, to be held on Friday, October 12, at the Marriott Hotel at Copley Place. You should expect more information on the Campaign over the summer.

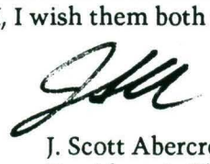
Fighting to retain indirect research support

The Medical Center has been active in Washington, D.C., as of late. Of particular concern to us is an amendment offered by Rep. Bill Dannemeyer (R-California) to the NIH reauthorization bill, which would restrict certain reimbursements for the indirect costs of conducting research. Should this legislation pass, the School of Medicine could lose at least $2 million in overhead support, while UH could lose more than $500,000.

BUSM Dean Aram V. Chobanian, BUMC Government Relations Director Elizabeth Stengel, and I met with the staffs of Massachusetts Reps. Gerry Studds (D-Cohasset) and Edward Markey (D-Malden), both of whom sit on the House Energy and Commerce Committee, which has jurisdiction over the NIH legislation. Since our visit, the House subcommittee on science, space and technology has approved similar restrictions, and similar actions by Appropriations Committees are possible. We will continue to voice our concerns on this important issue.

Higgins and Rich to pursue new challenges

Two of UH's most highly regarded managers—Michael D. Higgins, a vice president for operations, and Darryl S. Rich, Pharm.D., director of pharmacy services—are leaving the Hospital to pursue new challenges. Higgins will assume the post of executive vice president and chief operating officer at University Medical Center in Jacksonville, Fla., and Rich will become national pharmacy director for Critical Care America, Inc. On behalf of UH, I wish them both well.



J. Scott Abercrombie Jr., M.D.
President & Chief Executive Officer

The T-1 time frame is as follows: Cost standards are now being revised with departments. As the standards are revised, training will be conducted and reports will be issued for Level I managers, hopefully by July. In August, the T-1 project team hopes to begin working on cost standards for selected indirect departments. It is anticipated that some revisions to cost standards will be required when the new Computerized Hospital Information Processor (CHIP) comes on line. Managers will be allowed to revise their standards before FY92, when flexible budgets will become the primary expense-monitoring tool.

CHIP training sessions

CHIP training sessions are expected to begin in late July or early August and will continue until sometime in September. Managers should remember that their employees will be required to attend the training sessions, and they should adjust their coverage accordingly. Managers also should remember that these training sessions are vitally important to the Hospital; their employees should not be pulled out of a session. Address questions about CHIP to Training Coordinator Andrea Dawes at x8536.

How UH's operating margin compares to other hospitals

A June 24 *AHA News* article stated that although U.S. hospitals had a slight increase in their operating margins between 1989 and 1990, the increase still is inadequate for building future cash reserves.

According to the report by the Healthcare Financial Management Association (HFMA), U.S. hospitals averaged a 2.6-percent operating margin in 1990, up from 2.2 percent in 1989. Operating margin is a short-term profitability ratio that measures the operating revenue available for a hospital wishing to reinvest in itself.

In 1990, UH's operating margin was 1.56 percent, outperforming its budget of 1.50 percent. This year, however, due to improved expense reduction, the operating margin stands at 2.52 percent through Period 8, compared with its budget of 1.53 percent.