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Boston University Medical Center
The University Hospital

Managing for CHANGE

A Publication for the Managers of Boston University Medical Center/The University Hospital

Dear Leader,

August 11, 1992
Volume 3, Number 5

Managers should lead the Hospital's identity change

Now that the Hospital has modified its identity to be Boston University Medical Center/The University Hospital, we need the help of the entire Hospital community to make this a smooth transition. Realizing that saying our entire new name is a mouthful, feel free to refer to the Hospital in conversation as "Boston University Medical Center Hospital." In writing, however, you and your staff should refer to the full name on first reference and then call us either "the Hospital" or "BUMC/TUH" in subsequent references. We already are printing the new identity on our publications, surgical clothing, envelopes and letterhead. If you have materials bearing the Hospital's old identity, plan to change them soon. However, you should not throw away a large supply of usable materials; wait until the supply is depleted. Please address further questions to Don Giller, vice president of external affairs, at x6900.

Budget and business-planning processes moving forward

I thought it appropriate and opportune to update you on the evolving FY93 budget and planning scenarios.

According to Budget Manager Paula Wyman, cost-center managers worked very cooperatively with the Budget Office in devising this year's budgets. The operating budget requests, which total nearly $170 million, already have been submitted. These requests are now in the hands of vice presidents and division directors, who will evaluate them in the coming weeks. Managers may or may not be asked to reevaluate their budgets. The operating budget represents the amount of money required next year—that is, what managers need—to maintain the Hospital's current level of clinical activity. The Hospital's operating budget will be made final by the start of FY93 on September 27.

A second facet of the budget process, the $1-million new programs budget (which becomes an operating expense) and the $8-10 million capital budget, is moving along fairly swiftly, I am told. Division directors have met recently to reduce the requests to match the total amount that will be available for new programs and capital. Approval of requests is based upon several factors: first, is there a justified need?; second, will the proposed expenditure generate new business or revenue?; and third, how does the expenditure fit into the Hospital's strategic plan?

Simultaneous with the traditional budget process, the strategic business planning process is being conducted by Executive Vice President for Operations Jacqueline Dart, in

NEWS TO USE

Clinical Engineering: A service-oriented resource

The Hospital has under its roof an estimated 4,000 pieces of patient-care equipment, and each piece requires its own safety monitoring, preventive maintenance, service repair, quality-assurance assessment and eventual upgrading. Formerly, such services were performed by vendors, consultants and/or internal personnel for each department that owned or used various equipment—this approach was fragmented, lacked focus and also was costly.

Within the last year, a new entity called the Department of Clinical Engineering was created to take hold of this important management task. Gerald Faunce, manager of Clinical Engineering, and Paul Jeffrey, director of the Division of Pharmacy and Materials Management, have centralized a number of services and functions relating to the management of patient-care equipment within one broad encompassing service called the Department of Clinical Engineering. The department also maintains and manages 500 pieces of equipment through the functions of the Patient Equipment Group. It is anticipated that centralizing will save about $150,000 per year, and that federal FDA and JCAHO requirements will be better met.

Under this new structure, if a new piece of technology is needed or desired, Clinical Engineering can be asked by managers or physicians to identify the best vendors, negotiate a fair price and a responsive service contract, order the equipment, license the equipment with the appropriate agency, conduct

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collaboration with chiefs and clinical leaders. The programs involved in this process generally are of a multidisciplinary nature and have been researched and identified as services for which there are market opportunities. Business planning proposals have been submitted and are being evaluated for such clinical areas as Primary Care, the Emergency Department, the Lung Program, the Cancer Program, the Heart Program, Trauma, Psychiatry, Neurology, Maxillofacial Surgery, Minimal-Access Surgery, the Prostate Center and Gastroenterology. Attached to these services are volume projections that will justify the Hospital's investment. Once the requests for these clinical services are decided upon, they also will become part of the Hospital's overall operating budget.

New budget revision policy exemplifies good communication

Just as we are encouraging physicians to work together to improve patient care, so too are we asking managers to pool their talents and ideas. At the August 5 Council of Directors (C.O.D.) meeting, Jeff Jenkinson, director of Financial Planning, presented a workable compromise to directors' and managers' strong request for periodic budget revisions. The initial request was for managers to receive, as they had in the past, frequent budget revisions to enable important budget adjustments to be made. Mr. Jenkinson made it clear that neither his staff nor that of the Budget Office has the time or resources to produce frequent budget revisions, especially given the complex nature of our budget systems. It was decided, however, that one budget revision can be made during the year, most likely around January (Period 4), in order to reconcile with the Approved Trustees Budget. All departmental budget revisions should be properly approved and documented with an Authorization to Change Table of Organization and Budget Form. After this is done, the T.O. report will be continually adjusted to reflect all position-related changes, and the Quarterly Budget Variance report will be amended to reflect all authorized staffing and expense changes from budget. I was very pleased to hear that C.O.D. chairperson Kathleen Murphy, Ph.D., and her group embraced this proposal. This is an example of how good communication can produce solutions without wasting time or adding expense. Those involved are to be commended.

Boston teaching hospitals support a need

The Council of Boston Teaching Hospitals recently agreed to provide the City of Boston with a one-time allocation of $2 million to help alleviate a severe financial deficit the city was facing. The deficit would have had a particularly devastating impact on Boston City Hospital (BCH) and the city's annual funding of Community Health Centers. The Hospital strongly supported this one-time allocation, and, through the appointment of School of Medicine Dean Aram Chobanian, we will remain actively involved in a mayoral commission that will be looking at issues affecting the future of BCH and the Community Health Centers. Because the viability of BCH obviously is important to the Hospital and the School of Medicine, we will continue to do everything possible to ensure that BCH's building plans go forward and that our mission to form a truly unified medical campus is realized.

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

in-service training and cross-training, manage the contract and provide maintenance. The service contract negotiations alone have already saved the Hospital an estimated $30,000 this year. These are invaluable in-house services that will help eliminate the need for managers to work with outside vendors or consultants, and also will utilize the expertise of the Clinical Engineering staff. The aim is to ensure that the Hospital gets the best value for its dollar.

Faunce and his staff have worked in the last year to inventory every piece of equipment at the Hospital, to create a new database, and to begin reaching out to all departments in need of such a service. This program is functioning at increasing capacity and will become more fully operational during the next year. Centralizing is intended to enhance service to the many users of biomedical equipment and technology. You can contact the department by calling x6060 (a 24-hour on-call technician can be contacted after hours through the deparment's answering machine to respond to emergency situations).

BUMC/TUH a leader in quantifying community benefits

Hospitals are being pressed to demonstrate in a measurable way that they are providing services to their surrounding communities as a means of justifying their tax-exempt status. Joannie Jaxtimer, director of Community Services, is a member of the community benefits steering committee of the Boston Organization of Teaching Hospital Financial Officers, which is concerning itself with this issue. The steering committee is charged with finding universal standards to identify and quantify services that directly or residually benefit the community.

According to Jaxtimer, the steering committee is diverse in nature, made up of representatives from administration, finance, public relations and legislative affairs. BUMC/TUH is an acknowledged leader in creating and quantifying programs that benefit the community. The issue of community benefits will be vitally important to hospitals' ability to maintain a tax-exempt status, to receive Determination of Need approval for expansion and, most importantly, to maintain a good relationship with their surrounding neighbors.