1990

University Hospital at Boston
University Medical Center: Annual Report 1990

University Hospital
University Hospital, Boston University Medical Center

http://hdl.handle.net/2144/20042
Boston University
1990 ANNUAL REPORT

THE UNIVERSITY HOSPITAL AT BOSTON UNIVERSITY MEDICAL CENTER
THE 1990 ANNUAL REPORT of the University Hospital primarily is the story of a severe financial challenge to the Hospital – and a spirited and effective response by its staff and employees.

Our Hospital is like virtually all teaching hospitals in the way that it has been buffeted by change. However, what makes our story different is the manner in which the Hospital dealt with the situation.

In the following pages, you will find discussions of:

- what the financial challenge was;
- what actions we took to meet it, with what results;
- how the Hospital is responding to present and future needs, and
- what values and tools we are using to get there.

Readers of this report, whether they provide health-care services or consume them, will quickly see the main point of all our efforts: Trying to meet the mandate to reduce health-care costs, while maintaining a tradition of quality care. And, as this report will make clear, that high-quality care must always be focused on the patient’s needs and desires.

Hugh Shepley
CHAIRMAN, BOARD OF TRUSTEES

J. Scott Abercrombie Jr., M.D.
PRESIDENT AND CHIEF EXECUTIVE OFFICER
PHILOSOPHERS HAVE OBSERVED for centuries that change is the only constant in life; all else is in flux. Plato dramatically described the perpetual nature of change when he evoked the simple metaphor, “You cannot twice step into the same river.”

There are times when change is smooth, barely noticeable – and times when it is dominant and all-consuming. The strong currents of change that today so dramatically affect the delivery and financing of health care in America cannot be dismissed. Such change has to be dealt with – and the only choices are to fight it, to accept it passively, or to control it.

The University Hospital has chosen the third course: Two years ago, the Hospital faced a major financial crisis brought on by health-care financing changes. Today, the Hospital has attained significant financial strength and is undergoing structural renewal; in the process, UH has discovered that the way to deal with change is continuously to “re-invent” itself.

The University Hospital is a distinctly different institution today than it was even two years ago, because it has welcomed and dealt with major changes over the past two years – in its financial status, in its operations and in its affirmation of mission and values.
AT YEAR'S END in 1988, the University Hospital was facing a troubling financial future. It appeared that by the end of the fiscal year in the following September, the Hospital would lose $9.6 million. The prospect for the following 12 months was even worse: If trends continued, UH stood to lose $23 million in fiscal year 1990. Drastic action was needed.

UH was not alone in facing such fiscal problems. Due in part to the health-care payment and regulatory policies of the federal government and, in a lesser way, to those of the Commonwealth, the Hospital experienced a Catch-22 challenge common to all health-care providers: Finding a way to maintain top-quality care while actually decreasing expenses.

Hospital costs - for better patient care, progressive research and high-quality medical education - are outpacing the resources provided by the government, health insurers and other bill-payers. The largest single cut-back on resources is the federal government's continuing restriction of payments for Medicare. Because health care in Massachusetts has traditionally been more expensive than it has been in most other states, it has now come to the point where caring for each Medicare patient costs the hospital more money than it is paid for giving that care.

Sources of patient-care revenue
When looking at where a hospital's revenue comes from, it is important to remember that each payer reimburses on a different basis. For instance, government payers like Medicare (primarily for the elderly) and Medicaid (for low-income patients) tend to be more restrictive and arbitrary than private insurance companies. Nearly 55 percent of UH patients have their care covered by government payers.
TO CONFRONT THIS situation, Hospital President J. Scott Abercrombie Jr., M.D., challenged the UH family in early 1989 to join in what he called “The Change Project,” a review of operations and productivity that would lay the foundation for improved cost control and efficiency.

SETTING A COURSE FOR CHANGE

The overall goal of the Change Project extended well beyond cost reduction. Dr. Abercrombie invited participation in an effort that would challenge many of the “givens” about operating a teaching hospital in this harsh new financial climate. In meetings with trustees, staff and physicians, he reiterated his theme of meeting change with change: “When change comes, you can fight it, you can passively accept it, or you can embrace it. It is very clear to me that embracing change and attempting to control it will produce the best outcome.”

The Change Project represented a bold cost-reduction tactic. Rather than making across-the-board cuts (the approach taken by many other large hospitals), the University Hospital brought in an international consulting firm, Deloitte & Touche, to assist UH managers in reviewing the entire Hospital operation. Deloitte consultants worked with managers to analyze every department and function throughout the Hospital, and this work resulted in plans to reduce expenditures and increase efficiency. But each proposed change had to clear a major hurdle: Would it preserve the delivery of quality patient care?

At Change Project meetings, Abercrombie reminded administrators and managers of UH priorities. “The key to achieving stability in the current regulatory climate is to increase admissions while reducing length of stay. But our patients remain the number-one priority. The goal of the Change Project is to become more efficient, while retaining our commitment to high-quality patient care. The lack of efficiency has lost the Hospital money in the past – and that is no longer acceptable. But any compromise in the quality of patient care is equally unacceptable.”

THE DEMAND FOR QUALITY, EFFICIENCY

The demand for quality and efficiency placed the greatest challenge upon operations. If UH was to achieve its desired end of providing top-quality care with minimal – or zero – defects, then it had to find ways to make operations as efficient as possible.

A major indicator of a hospital’s efficiency is in its patients’ average length of stay [ALOS]. Because the University Hospital attracts among the most intensely ill patients in New England, its ALOS historically has been high, relative to regional and national averages. As a way to improve the flow of patients through the Hospital without impacting the quality of care, physicians, administrators, nurses and social workers embarked upon an aggressive length-of-stay reduction effort.
THE AVERAGE LENGTH of stay reduction effort produced excellent results: By refining physician practice patterns, expediting discharge planning for patients, and improving communications among staff and employees whose roles impact on patients' hospital stays, the program resulted in a reduction in average length of stay from 10.8 days in 1988 to 9.7 days in 1989 – about a 10-percent drop. Continued emphasis on clinical efficiency pushed that number down another 11 percent in 1990, to 8.66 days.

Another major cost-reduction effort was embodied in a Hospital-wide Utilization Management Program, aimed at reducing expenses related to services, supplies, equipment and time. Based on preliminary indicators, it is clear that the Hospital is able to care for more patients while controlling unnecessary spending.

A dominant challenge to the Hospital throughout this period has been maintaining quality care while reducing costs. Scientifically measuring quality of care is essentially a new and developing skill that is becoming required of care providers by regulatory bodies and bill-payers.

The federal and state governments (Medicare and Medicaid, respectively) have quality-assurance components – called Retrospective Quality Reviews – built into their reimbursement systems. Nearly 55 percent of the University Hospital's patient population is subject to such quality review by Medicare and Medicaid, and UH has adhered to the standards of care set by these groups. Internally, physician and nursing feedback is relied upon to assure that proper, responsible and appropriate care is delivered to patients.
Financial Stability

Within the past five years, the impact of federal and state payment restrictions was felt most harshly at UH in 1988. Since that time, the Hospital, through intensive cost-control efforts, has turned its operating bottom line around by $10 million.

Reduced Costs and Improved Cash Flow

The Hospital's effort to reduce expenses and improve cash flow during this period has resulted in important achievements:

- Of the Hospital's initial $13-million expense-reduction savings goal recommended by Deloitte & Touche, $11 million was realized. The Hospital's 85-percent-of-goal achievement surpasses the 60-percent standard achieved by most hospitals undertaking cost-reduction projects of a similar scope, according to the Deloitte consultants.

- Expense reduction is a continuing focus at UH. In FY90, a nonsalary expense-reduction task force helped the Hospital eliminate yet another $5.4 million in nonsalary expenses, surpassing the goal of $5 million.

- At the beginning of FY90, UH had a gross accounts receivable balance of $48.7 million. That balance has since dropped an impressive $10 million to $38.7 million.

- Average days to be billed - the time it takes the Hospital to get a bill out the door - has decreased from 24 to 10 days, a figure that is still improving.

- Improved accounts receivable has resulted in improved accounts payable. Since October of 1989, the Hospital's days of accounts payable has been reduced from nearly 85 days to its current maximum level of 55 to 60 days.

 Restructured Debt

Refinancing of debt at lower interest rates also figured into the Hospital's cost-reduction program. The Hospital's most valuable physical asset, the eight-story Atrium Pavilion, was refinanced in 1990 at a significant savings to the Hospital. The Atrium Pavilion, a modern patient-care complex that won an international design award when it opened in 1987, had been financed in 1984 by borrowing $78 million through the issuing of Massachusetts Health and Educational Facilities Authority (HEFA) bonds at an interest rate of 10.625 percent.

Since 1984, however, interest rates have fallen considerably. Through the success of the Change Project, the Hospital demonstrated to the financial community an improved ability to manage cash flow, decrease expenses and devise a sound fiscal strategy. The result: UH received an "A" bond rating from two of the most prestigious financial rating services in the country, Standard & Poor's and Moody's, and was able to refinance its debt with the rate set at 7.42 percent for a new issue of HEFA bonds. With this new rate, the Hospital expects to net a minimum annual savings of approximately $700,000 for the life of the bonds.

Administrative Reorganization

As government continued to demonstrate less financial and policy support for hospitals, and with little indication that the situation would soon change, the time came for the University Hospital to rebuild its structural foundation.

In October 1989, the Hospital initiated its new operational structure, which consolidated 50 independent operational depart-
ments into 10 divisions or departments, each related by function and by the delivery of day-to-day services, rather than by medical disciplines. This grouping has allowed clinical and management staff increased access to Hospital services and has helped to ensure that the patient’s hospital stay is managed more efficiently.

A SIGN OF PROGRESS

A public comment that acknowledged the University Hospital’s unique approach to change came in a letter to the editor of Boston magazine in March 1990. The letter, written by a partner of Deloitte & Touche, commented on an earlier article on healthcare issues, called “Future Shock.” The letter’s author praised the University Hospital’s “very innovative and cost-effective changes in the delivery of care,” and said those changes had been brought about “with no apparent loss in recognized medical excellence.” He went on to say it has become common to see large teaching hospitals initiate changes that subsequently have been adopted by others. The type of changes instituted at the University Hospital, he wrote, “may well set the stage for how hospitals will operate in the future.”

That comment, as well as a lengthy analysis of UH’s financial turnaround that was published in late 1990 in the Boston Business Journal, served as confirmation that the Change Project was beginning to produce results, and in a very worthwhile way.
THROUGHOUT THIS PERIOD of change, the University Hospital staff and employees working to bring about those worthwhile changes were guided by a number of principles that have been important to the Hospital's family over the years. This 136-year-old hospital has always had a special character. This year, the Hospital adopted a formal Statement of Mission and Values, which drives all of the Hospital’s decisions and actions.

PATIENT FOCUS:
THE KEY TO QUALITY

Putting the focus on the patient, in both a hospital's mission statement and in its everyday operations, may seem so obvious that it needn’t be stated. But that is not the case, at least in the view of staff and administrators of the University Hospital.

In recent years, reimbursement pressures throughout the nation have been so intense in the direction of “efficiency” that the patient’s wishes and feelings have not had the highest priority in some settings. Clearly, there were inefficiencies and waste in the health-care system, and change indeed was necessary. Federal and private-insurance reimbursement policies were strongly weighted to bring about that change.

At the 136th Annual Meeting of the University Hospital, held in December 1990, Dr. Abercrombie spoke to UH trustees about the need for patient-focused care: “The common quality uniting the nation's high-performing health-care organizations is their increasing emphasis on patient satisfaction—they strive to please patients. It used to be that hospitals would gear their efforts at pleasing only the physicians, but trends in health-care reimbursement have made patients and bill-payers into decision-makers who deserve attention and respect.”

The University Hospital’s constant attention to “patient focus” is a continuing reminder to avoid an impersonal approach to patient care. The UH credo is simple: Deliver excellent care, and do it in the most efficient manner, and most importantly, keep the patient’s desires uppermost.
OUR MISSION AND VALUES

WE BELIEVE it is important for the University Hospital to acknowledge its reason for being, and the values it respects in achieving that mission. This is a statement of mission and values that describes the University Hospital at Boston University Medical Center.

OUR MISSION
The mission of the University Hospital is to provide patient-focused, scientifically and technologically advanced health care. As the principal tertiary teaching and research hospital associated with Boston University, the University Hospital provides leadership and joins with others in delivering care, advancing clinical knowledge and educating health professionals. The Hospital serves the general health and well-being of a broad community and accomplishes its programs and services with respect for sound management and financial principles and concern for ethical standards.

OUR VALUES
Our core beliefs that drive decisions and actions are as follows:

QUALITY PATIENT CARE
We strive for the best in care and services for the individual patient by:
• encouraging innovation in the approach to clinical practices;
• developing and utilizing supportive new technologies;
• supporting opportunities for significant research whose results may lead to improvements in patient care and clinical outcomes.

We believe that by supporting compassionate, as well as expert, care, we are best able to provide quality patient care.

RESPECT FOR OTHERS
We hold precious the dignity of those whom we serve and with whom we work. We value a supportive, personal environment for patients and their families, and for employees and all other health professionals, whether or not employed by our organization, who share in the responsibility and recognition for the care that we provide.

COLLABORATION AND COOPERATION
We affirm our commitment to reach out and work together with our institutional partners and neighbors within and adjoining Boston University Medical Center in developing coordinated approaches to shared challenges. We offer support to and seek the support of our community neighbors in working to improve the life of our community.

RESPONSIBILITY FOR THE FUTURE
We value and support the education and training of future generations of health professionals.

MANAGING FOR CHANGE
We constantly seek new approaches to improve the efficient management of our resources so that we can assure the effectiveness of our programs and services.

The Family of Employees, Staff, Managers and Trustees of the University Hospital.
BUILDING A SOUND STRUCTURE

To ensure that UH will be able to carry out its mission amidst a turbulent fiscal climate, the Board of Trustees’ Finance Committee approved a group of financial “leading indicators” to monitor the Hospital’s fiscal performance.

Certain financial ratios will serve as the Hospital’s fiscal guideposts in carrying out the UH strategic plan. The benefit of using ratios to complement traditional periodic financial reports is that the ratios can be computed with concurrent data, which will allow the Hospital to notice financial target variances early, and then correct them. Essentially, these ratios will permit the Hospital to proceed with long-term strategic initiatives despite short-term concerns.

Such mechanisms are useless without comparative analysis. Thus, the Hospital will measure its ratio performance against its own budget targets, the performance of other Massachusetts hospitals, certain Standard & Poor’s A-plus-rated hospitals, and other teaching hospitals of similar size and case mix.

As a way to ensure that fiscal responsibility is maintained, the Hospital acquired a state-of-the-art cost-management system. This sophisticated software package will allow managers to manage their costs rather than their budgets, by looking with great accuracy and precision at costs that in the past may have been hidden or seemed insignificant. This system can provide managers with information vital for flexible budgeting and for financial planning projections.

THE ROLE OF RESEARCH

The University Hospital is a key research and teaching affiliate of Boston University School of Medicine (BUSM) and the University's Goldman School of Graduate Dentistry (GSGD). As such, this teaching hospital provides the ideal environment not only for patient care, but also for clinical research and medical education. Members of the University Hospital's Medical and Dental staff also are on the faculty of either BUSM or GSGD. The chiefs of the Hospital's clinical departments are professors and chairpersons of the corresponding academic departments of the schools. A number of UH physician-researchers also are involved as faculty members in BUSM research projects with funding from the federal government, private foundations and corporations.

The Hospital's Evans Memorial Department of Clinical Research and Preventive Medicine was founded in 1912, and was one of the first such facilities in the nation. The intent of the Evans Department's founder – to intertwine laboratory research with the clinical care of patients – remains a major characteristic of the University Hospital today. The Hospital's Division of Surgery benefits from a similar endowment, the Smithwick Foundation.

Research funding at UH supports a diversity of investigations, ranging from hypertension to cancer research, from blood pressure control in the elderly to fatty acids in the offspring of the Framingham Heart Study participants.
PHILANTHROPIC SUPPORT

In fiscal year 1990, friends and employees of the Hospital displayed increasing confidence in the institution and its mission. Nearly $1.4 million in restricted and unrestricted donations were committed - a marked improvement over the past two years.

Of particular note were an extraordinary pledge of $250,000 and two commitments of $100,000 each, all from Hospital trustees. Other gifts supported specific programs, including medical oncology, hematology, cardiology, the Elders Living At Home program, the Grasberger Residents' Resource Center and the Alzheimer's and Parkinson's research funds.

Grateful patients continue to be the largest single source of Annual Fund contributions, with donations from this group totalling almost $300,000. Members of the Hospital family, corporate sponsors and unrestricted bequests added another $136,000 to the Annual Fund; the participation rate of 39 percent of the active members of the Medical-Dental Staff is among the highest rates of Boston teaching hospitals.

Such generosity is made more meaningful by the fact that the Commonwealth's economy continues to struggle. But the realities of this climate require that all hospitals place a greater emphasis on philanthropy to insulate themselves from the swings in the federal and local economies. Plans are under way at the University Hospital for expanded development programs to complement the careful allocation of capital resources through the next decade. These plans include a formal capital campaign for current and deferred gifts to support construction, endowment, new program development and the steady growth of the Annual Fund.
As it sets its future course, the Hospital is encouraging the development of clinical programs that are of a broad, multispecialty nature and of services that have been shown to be strong performers in more targeted markets. The special emphasis on interdisciplinary care is part of UH's philosophy of bringing a tertiary care teaching hospital's vast clinical expertise to bear on pervasive health problems. Through that means, the most effective, cost-efficient and expedient care can be provided for both the patient and his or her referring physician.

The following are some of the innovative clinical programs that are serving increasing numbers of patients at UH:

- As testimony to its proficiency in cardiothoracic surgery and cardiology, UH recently was designated by the federal government's Health Care Financing Administration as one of four national centers to perform Medicare-funded coronary artery bypass grafts. UH's cardiac surgeons also recently acquired the capability to surgically correct cardiac arrhythmias, which further broadens the Hospital's arsenal of cardiac-surgery techniques.

- The incidence of fungal illness in patients with suppressed immune systems, such as those with AIDS, has skyrocketed in recent years. Because of the gravity of this health problem, the National Institutes of Health, despite federal cuts in research funding, has created its second national Mycology Research Unit by awarding a $2.2-million grant to the University Hospital's Infectious Disease Section, allowing UH physicians to study the host defense mechanisms of a variety of fungal illnesses.

- The Hospital's new Breast Health Center offers a thorough, same-day service that reduces into one day the consultations, tests and waiting for results that can involve weeks. Female physicians from the Hospital's Women's Health Unit, surgical and medical oncology sections, and radiology and pathology departments team up to provide prompt, coordinated and expert care.

- As testimony to its proficiency in cardiothoracic surgery and cardiology, UH recently was designated by the federal government's Health Care Financing Administration as one of four national centers to perform Medicare-funded coronary artery bypass grafts. UH's cardiac surgeons also recently acquired the capability to surgically correct cardiac arrhythmias, which further broadens the Hospital's arsenal of cardiac-surgery techniques.

- The 1989 opening of the University Hospital's Biomolecular Medicine Research Laboratory coincided with the laboratory's involvement in clinical trials of a promising new drug that has been genetically engineered to treat certain cancers. The IL-2 toxin—a hybrid of two naturally occurring proteins known as interleukin-2 and diphtheria toxin—was created to locate, attack and kill adult T-cell leukemia and chronic lymphocytic leukemia cells without harming healthy cells. This research not only holds promise in the treatment of cancer, but also may have applications to other conditions, such as diabetes, rheumatoid arthritis, multiple sclerosis, acute graft rejection and myasthenia gravis.

- The Photopheresis Program has shown promising results in patients with Sezary's syndrome, a rare but fatal form of leukemia. In photopheresis, light-induced blood therapy is used to treat certain illnesses. The program, one of only two in New England, has been so successful that it is being expanded to investigate potential use in treating sarcoma, a cancer that invades the body's connective tissues, and rheumatoid arthritis.
By employing a pioneering skin-grafting technique known as cultured epidermal allografting, University Hospital dermatologists can offer patients complete wound healing of 90 to 100 percent of superficial ulcers and about 65 percent of chronic ulcers. UH is the only hospital in the nation that routinely performs this technique.

The emergence of laparoscopic cholecystectomy as an option for removing the gallbladder has given momentum to an international trend in surgery: Performing surgery through the smallest possible opening in the human body. Such "minimal-access" surgeries offer patients less pain, a briefer hospital stay, a quicker recovery and lower costs than the traditional "open" surgery. To remain in the vanguard of surgical innovation, the Hospital recently created a unique Center for Minimal Access Surgery. With support from the Division of Surgery's Minimal Access Surgery Research Laboratory, UH surgeons can advance the field by working with private industry to test new approaches to traditional surgeries and to train UH surgeons and residents in minimal-access techniques.

As recently as five years ago, the only way to help patients with renal or biliary stones was through painful surgery and long recovery. Today, Boston University Medical Center's Stone Center offers patients a variety of state-of-the-art options that involve minimal invasiveness and maximum comfort. With the use of such technologies as the Sonolith 3000 extracorporeal shock wave lithotripter (ESWL) and a pulsed-dye laser for percutaneous laser lithotripsy, the Hospital's specialists can effectively treat stones without the need for open surgery.

Since its inception as an airborne intensive-care unit five years ago, Boston MedFlight has airlifted more than 3,100 critically ill and critically injured patients over 100,000 miles to Boston's Level I trauma centers. MedFlight, which was proposed and developed by UH and is operated by a consortium of Boston teaching hospitals, celebrated its fifth anniversary in June 1990.

By arthroscopically replacing a damaged ligament with an artificial knee ligament - the ligament augmentation device (LAD) - grafted to a transplanted tendon, UH orthopedic surgeons have helped more than 250 athletes get back in action 50 percent more quickly, with optimal strength, and with no incidence of infection or rejection. The success of the LAD, which was tested clinically for the first time in New England at UH, has prompted research on the efficacy of a similar device for a torn posterior cruciate ligament.

The adverse health effects of obesity, combined with the mounting social pressure to stay healthy and fit, has prompted some 20 million Americans to embrace liquid diets. While most liquid diets promote fast weight loss, the results often don't last, and the diets can pose serious health risks if they are misused or unsupervised. The Hospital's newly expanded Evans Nutrition Clinic offers the choice of balanced, protein-sparing or liquid diets that are clinically supervised, safe and optimally effective over the long term.
MARKING A DECADE

of change, progress and creativity, University Hospital
President J. Scott Abercrombie Jr., M.D., celebrated his 10th year as
the Hospital’s chief executive
officer and his 20th year as a
member of the Hospital’s
Department of Laboratory
Medicine.

Hugh Shepley, a 10-year member
of the UH Board of Trustees,
became chairman of the Board in
December 1989. Shepley, who
had served as vice chairman since
1983, assumed the role from John
F. Cogan Jr., who served UH with
distinction as Board chairman for
17 years. Shepley is committed to
supporting the development of the Hospital during a period of
dramatic change. As an architect,
Shepley brings to the board a keen
perspective in planning, which has allowed him to gain a broad
viewpoint of the Hospital and to plan for its future. Shepley’s two
areas of focus are strategic planning and philanthropy.

Following a national search,
Dorothy O’Sullivan, R.N.,
M.B.A., joined the Hospital in
October 1990 as vice president for
nursing, succeeding Karen K.
Kirby, R.N., M.S.N., who left UH
after seven years of distinguished
service. O’Sullivan came to UH
from her most recent post as the
center nursing executive at the
Columbia Presbyterian Medical
Center in New York City.

Leonard S. Gotthieb, M.D.,
M.P.H., chief of pathology, was
elected president of the American
Physicians Fellowship, Inc., for
Medicine in Israel. One of
Gotthieb’s first tasks in this role
was to work in conjunction with
the surgeon general of the Israeli
Defense Forces’ Medical Corps to
educate Israeli and American
physicians in emergency and
trauma medicine.

A member of the Department of
Surgery, Barry M. Manuel, M.D.,
took office in 1990 as president of
the Massachusetts Medical
Society (MMS).

Thomas J. Ryan, M.D., chief of
the Section of Cardiology, took a
sabbatical at Oxford University to
conduct cardiovascular research.
Ryan’s research was supported by
a fellowship awarded by the John
E. Fogarty International Center of
the National Institutes of Health
[NIH]. An international leader in
cardiology, Ryan shared his broad
experience in clinical trials of
thrombolytic therapy with his
British counterparts. Another
intention of the endeavor was to
improve clinical-trial methodology for cardiovascular disease.

Robert F. Meenan, M.D., chief of
the Hospital’s Arthritis Section,
was installed as the 55th president of the American College of
Rheumatology.

Robert E. Leach, M.D., chief of
the Department of Orthopedic
Surgery, was appointed editor of
the American Journal of Sports
Medicine.

Two members of the Nursing
Department last spring earned
canational and statewide recogni
tion. Julie Bonenfant, R.N.,
C.C.R.N (critical care registered
nurse) was selected from a
national field of candidates to
serve as a spokesperson for
Nurses of America, an organiza
whose efforts are aimed at
enhancing the nursing image and
recruiting more staff to the
profession. Bonenfant’s colleague,
surgical oncology nurse Patricia
Doran-Wong, R.N., was named
the Massachusetts winner of the
Search for Excellence Award by
the American Nurses Association,
a prestigious title that is bestowed
upon only one nurse in each of
the 50 states.
WITH STRONG clinical program development and dedicated staff and employees, the University Hospital will continue to deal with change by continuing to “re-invent” itself. Delivering quality patient-focused care in a hostile cost environment will remain the Hospital’s continuing challenge.

But patient-focused care recognizes that the Hospital is willing to be measured by the patient and his or her family. UH President Abercrombie recently remarked to his physician colleagues, “I believe that while patients initially come to a hospital because of the reputation of the doctors and the institution itself, they return because they had an excellent overall experience there. Competition is at the point where one referral does not guarantee continued referrals.

“We must constantly prove ourselves to the patient, his or her family and the referring physician. We have to emphasize patient-focused care—care that is expert, efficient, kind, courteous and respectful—in all that we do,” concluded Abercrombie.
<table>
<thead>
<tr>
<th>NET OPERATING INCOME</th>
<th>1989 ($139,717)</th>
<th>1990 ($144,403)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other operating revenue</td>
<td>3,168</td>
<td>3,360</td>
</tr>
<tr>
<td>Research support from grants and contracts</td>
<td>7,400</td>
<td>7,787</td>
</tr>
<tr>
<td><strong>Total Operating Income</strong></td>
<td>150,285</td>
<td>155,550</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPERATING EXPENSES</th>
<th>1989 ($133,878)</th>
<th>1990 ($136,519)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research expenses</td>
<td>7,715</td>
<td>8,102</td>
</tr>
<tr>
<td>Uncompensated care</td>
<td>12,630</td>
<td>9,335</td>
</tr>
<tr>
<td><strong>Total Operating Expenses</strong></td>
<td>154,223</td>
<td>153,956</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXCESS (DEFICIENCY) OF OPERATING REVENUES OVER EXPENSES</th>
<th>1989 ($3,938)</th>
<th>1990 ($1,594)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonoperating revenue</td>
<td>6,997</td>
<td>6,103</td>
</tr>
<tr>
<td>Extraordinary loss on advance refunding</td>
<td>0</td>
<td>[7,441]</td>
</tr>
<tr>
<td><strong>Excess (deficiency) of revenues over expenses</strong></td>
<td>3,059</td>
<td>256</td>
</tr>
</tbody>
</table>

*With an increase in inpatient and outpatient volume, the Hospital's operating revenue increased by nearly $5 million.*

*While expenses increased, the average cost per Hospital stay for patients decreased.*

*Through increases in revenue and control of expenses, the Hospital's operating bottom line improved by more than $5.5 million.*

*This line shows the one-time loss incurred by the Hospital for financing activities to decrease interest expense. There is no effect on cash.*
## CONSOLIDATED BALANCE SHEET

For fiscal years ended September 29, 1990 (52 weeks) and September 30, 1989 (53 weeks) (in thousands)

<table>
<thead>
<tr>
<th>Account Description</th>
<th>1989</th>
<th>1990</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash and other investments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>$6,376</td>
<td>$29,801</td>
</tr>
<tr>
<td>Held by trustees</td>
<td>13,807</td>
<td>31,530</td>
</tr>
<tr>
<td>Restricted</td>
<td>57,407</td>
<td>59,165</td>
</tr>
<tr>
<td>Patient accounts receivable</td>
<td>31,684</td>
<td>23,569</td>
</tr>
<tr>
<td>Grants, pledges and other accounts receivable</td>
<td>8,507</td>
<td>8,787</td>
</tr>
<tr>
<td>Property, plant and equipment – net</td>
<td>118,841</td>
<td>119,609</td>
</tr>
<tr>
<td>Other assets</td>
<td>10,894</td>
<td>13,383</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>247,516</td>
<td>285,844</td>
</tr>
<tr>
<td>Accounts payable and accrued expenses</td>
<td>21,529</td>
<td>19,514</td>
</tr>
<tr>
<td>Estimated final settlements to third-party payers</td>
<td>18,425</td>
<td>24,916</td>
</tr>
<tr>
<td>Debt</td>
<td>81,001</td>
<td>114,511</td>
</tr>
<tr>
<td>Fund balances:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>51,584</td>
<td>50,596</td>
</tr>
<tr>
<td>Specific purpose</td>
<td>49,144</td>
<td>50,187</td>
</tr>
<tr>
<td>Endowment</td>
<td>25,833</td>
<td>26,120</td>
</tr>
<tr>
<td><strong>Total liabilities and fund balances</strong></td>
<td>247,516</td>
<td>285,844</td>
</tr>
</tbody>
</table>

This increase in unrestricted funds resulted from stronger operating results, improved accounts receivable and third-party payment.

This increase in Trustee-held funds represents a result of financing activity during the year.

Through aggressive efforts to improve accounts receivable, the Hospital was able to improve its cash flow by $8 million.

This increase in debt represents the effects of financing activity to support new-program development and to finance new technologies.
Officers of the Board of Trustees
Hugh Shepley, Chairman
Eugene M. Tangney, Vice Chairman and Treasurer
Edward J. Christiansen Jr., Secretary
Richard H. Egdaahl, M.D., Vice Chairman
J. Scott Abercrombie Jr., M.D., President and Chief Executive Officer

Board of Trustees
J. Scott Abercrombie Jr., M.D.
Herbert A. Abramson
Haig Agababian
Richard K. Babayan, M.D.
George S. Bissell
Aram V. Chobanian, M.D.
John F. Cogan Jr.
Martin J. Curry
John K. Dineen
Dexter A. Dodge
Richard H. Egdaahl, M.D.
Robert D. Fanger
William E.R. Greer, M.D.
Edward F. Hines Jr.
James S. Hoyte
Mary Jane Kemper, R.N.
David H. Knight
William E. Lee
Norman G. Levinsky, M.D.
George D. Levy
Joseph C. Maher Jr.
Joseph C. McNay
Marqueterie A. Piret
Jerome Preston Jr.
Louis W. Roberts
Thomas A. Rosse
Roger H. Samet
Melvin I. Shapiro
Hugh Shepley
Susan Siroky
George E. Slye
Alan D. Solomont
Edward L. Spatz, M.D.
Frederick H. Stephens Jr.
Marvin A. Stolberg, Ph.D.
Eugene M. Tangney
Betty Taymor
Stokley P. Towles
John H. Valentine Jr.
Stephen L. Wald
Alfred M. Zeien

Trustee Emeriti
James F. Hunnewell
Rhodes G. Lockwood
Stephen Paine Sr.
Jerome Preston Sr.
Mrs. George Sherman

Corporators*
David Acker, M.D.
Francis P. Allen Jr.
Joel P. Alpert, M.D.
Gaspar W. Anastasi, M.D.
Isaac Asimov, Ph.D.
Anthony S. Athanas
Julia Livingston Bell
Herbert L. Berman
Lawrence Bianchi
Donald F. Booth, D.M.D.
Standish Bradford Jr.
Henry Burkhardt III
Ismael Dudhia
Sanford D. Elsas
Robert G. Feldman, M.D.
Robert P. Fitzgerald
Spencer N. Frankl, D.D.S.
Murray M. Freed, M.D.
Odis Gates
Barbara A. Gilchrest, M.D.
Rev. Francis J. Gilday, S.J.
Wilfred Godfrey
Lee Goldman, R.N.
Leonard S. Gottlieb, M.D.
John L. Grandin Jr.
Clare Helman Hayes
Roger C. Heiser
Ann M. Hershfang
J. Wade Howard
Philip R. Jackson
Dorothy C. Keefer
David I. Kosowsky, Sc.D.
Robert J. Krane, M.D.
Stanley W. Krygowski
Robert E. Leach, M.D.
Howard M. Leibowitz, M.D.
Hans F. Loeser
James Lowell II
Kenneth T. Lyons
L. Anthony Magliozzi
John S. Perkins
Rev. Dr. Leicester R. Potter Jr.
Gerard Regard
Fernando Requena
Daniel Rose
David T. Rubin
Robert Sage
R. Penelope Scheerer
Amy B. Schoening
Bruce Seddon
Jerome Shapiro, M.D.
Samuel Shapiro
Richard J. Shemin, M.D.
Sidney Shuman
John R. Silber, Ph.D.
R. Knight Steel, M.D.
Frederick I. Thacher
Louis Vachon, M.D.
Ralph B. Webber Jr.
David L. Weltman
Marcelle M. Willock, M.D.

Medical-Dental Staff
Richard K. Babayan, M.D., president

Massachusetts Memorial Hospitals School of Nursing Alumni Association
Lee Goldman, R.N., president

The University Hospital Auxiliary
Susan Siroky, president

* Members of the Board of Trustees are also Corporators.

This list is inclusive through January 1, 1991.

Memberships and Affiliations

Memberships
American Hospital Association
Association of American Medical Colleges
Boston MedFlight
Boston University Medical Center
Conference of Boston Teaching Hospitals
Council of Teaching Hospitals
Greater Boston Chamber of Commerce
Massachusetts Hospital Association
Metropolitan Boston Hospital Council Association
Newmarket Business Association
Regional Emergency Medical System Advisory Committee

Managed Care Affiliates
Bay State Health Care
John Hancock Preferred Health Care
Blue Cross/Blue Shield's Master Health Preferred
Met-Select PPO
Neighborhood Health Plan
Pilgrim Health Care
U.S. Healthcare

Licensed and Accredited by
American Association of Blood Banks
American College of Surgeons
Commission on Cancer
College of American Pathologists for Laboratory Facilities
Joint Commission on Accreditation of Healthcare Organizations
Massachusetts Department of Public Health
Residency Review Committee on Graduate Medical Education
This annual report was produced for
The University Hospital's Office of Development
by the Department of Public Relations at
Boston University Medical Center.

J. Scott Abercrombie Jr., M.D.
President and Chief Executive Officer
The University Hospital

Bonnie R. Clendenning
Vice President, Development
The University Hospital

Donald R. Giller
Vice President, Marketing/Planning/Public Affairs
The University Hospital

Editor
Owen J. McNamara

Managing Editor
Paula A. Gilligan

Writers
Cynthia L. Lepore
Michael R. Paskavitz

Design
Corey McPherson Nash

Illustrations
Fred Lynch

Photography
Greg Nikas
Steve Dunwell
The University Hospital

at Boston University

Medical Center

88 East Newton Street

Boston, MA 02118-2393

For further information,
call the Office of Development at (617) 638-8990

Bonnie R. Clendenning, Vice President