The Cambridge Hospital

1493 Cambridge Street, Cambridge, Massachusetts 02139 (617) 498-1000

CITY COUNCIL SUB-COMMITTEE ON HEALTH AND HOSPITALS

AGENDA

JUNE 6, 1995 8:00 am

1. Key Trends
2. Implications for Public Hospitals
3. Update on Building Project
4. Update on Network Re-Organization and Finances
5. Update on Discussions with Other Providers
6. Update on Neville Manor Strategic Plan

KEY TRENDS

→Dramatic Changes in Type and Locus of Care

→Significant Change in Number and Configuration of Hospitals

→Emphasis on Seamless, Multi-Provider Network

→Reshaping of Physician Practice and Relationships

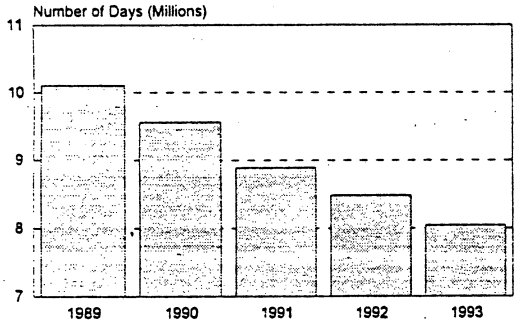
→Cost Control through Different Payment Incentives and Structures

→Environmental, Demographic Factors Increasingly Important

→Dramatic Growth in Managed Care

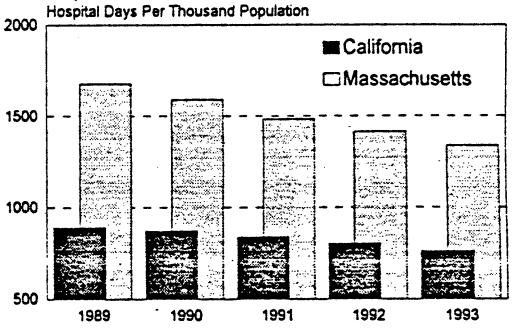
HOSPITAL UTILIZATION IS DECLINING.....

Mass. Patient Days



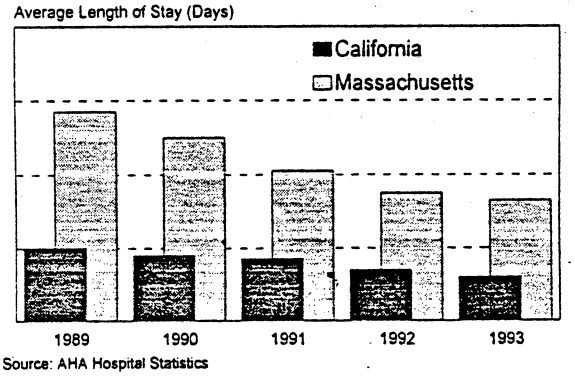
Source: AHA Hospital Statistics

Hospital Days



Source: AHA Hospital Statistics

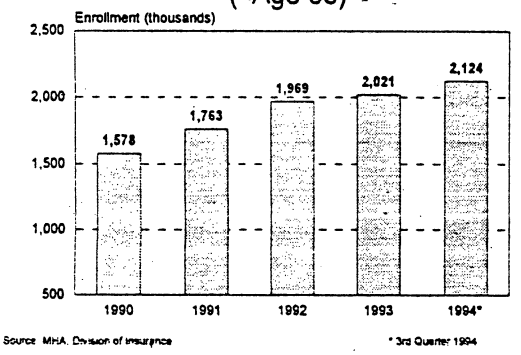
Length of Hospital Stay



Source: AHA Hospital Statistics

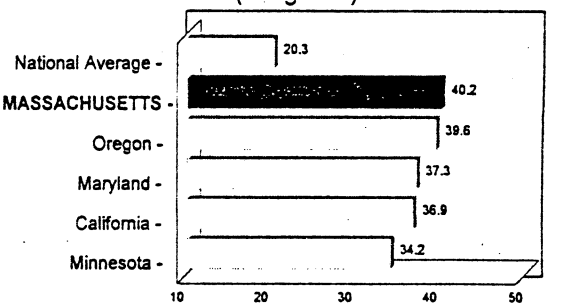
WHILE MANAGED CARE IS GROWING.....

Mass. HMO Enrollment
(<Age 65)



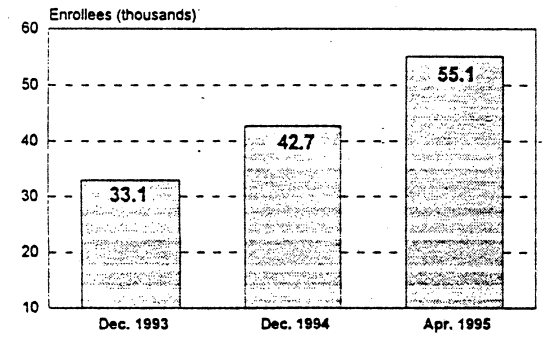
Source: MHA, Division of Insurance * 3rd Quarter 1994

National HMO Market Penetration*
(< Age 65)



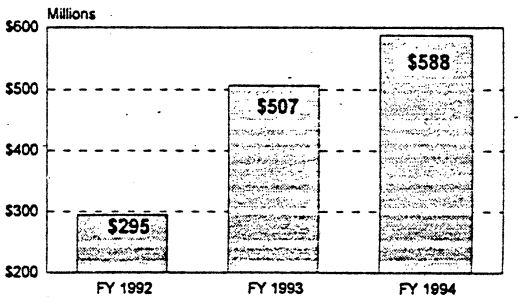
Source: Marion Merrell Dow
* As of June, 1994

Mass. Medicare HMOs:
Enrollment in Risk Contract Products



Source: HCFA Monthy Report

Net Worth of Area HMOs*

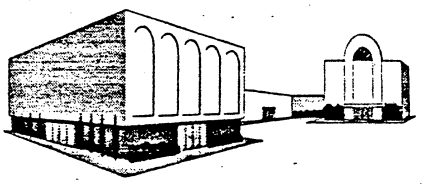


Source: MHA HMO Quarterly Report, Division of Insurance (HMO DoI Filings)

*HMOs: BAY STATE; CHP; CIGNA; CMHC; FALLON; HCHP & AFFILIATES; HEALTHSOURCE; HMO BLUE; HNE; KAISER; MATTHEW THORNTON; METLIFE; NHP; PILGRIM; TUFTS; UNITED; USHC

MASSACHUSETTS HOSPITALS ARE CLOSING, CONVERTING AND MERGING.....

Between 1986 - 1994



- **34** hospitals closed
- **18 of 34** hospitals that closed were converted to specialty and other services
- **15** hospitals merged

UNRESOLVED PUBLIC POLICY ISSUES THAT THREATEN TRADITIONAL HEALTH CARE MISSION

→Who will pay for the uninsured?

→Who will pay for medical education?

→Who will pay for research?

→Who will pay for community benefit programs?

→What governance structures are necessary to maintain local accountability?

PUBLIC HOSPITAL TRENDS

→Increase in Uninsured/Underinsured

→Welfare and Medicaid Block Grants

→Medicare and Medicaid Deficit Reductions

→Attack on Disproportionate Share Hospitals

→State Level Reforms

→Increased Competition for Medicaid Patients

→Medical Education Payments and Policies

→Other Public Health Programs

→Local Budget Pressures

SOURCE: National Association of Public Hospitals, Executive Committee Retreat, April 1995

Remaining Acute Public Hospitals: 1990-1995

Hunt (Danvers): closed; reopened as private outpatient - 1990

Worcester City: closed; reopened as private substance abuse - 1991

J.B. Thomas (Peabody): closed; reopened private subacute - 1992

Amesbury Hospital: sold; now private outpatient - 1993

Glover Memorial (Needham): sold; now private hospital - 1993

Hale (Haverhill): publicly opened - privately managed

Quincy Hospital: publicly opened - privately managed

Boston City Hospital: pursuing merger with private hospital (UH)

The Cambridge Hospital: publicly owned and managed

PUBLIC HOSPITAL OBSTACLES TO SURVIVAL

→Inability to compete effectively for patients with choice

→Inadequate community linkage and primary care capacity

→Inability to merge and consolidate with other public and private entities

→Lack of bottom-line incentives for efficiency, productivity and revenue generation

→Motivation of staff

→Image

→Budget process

PUBLIC HOSPITAL OBSTACLES TO SURVIVAL (continued)

→Control over revenues and expenditures

→Personnel

→Access to capital

→Adequacy of governance

→Ability to make decisions

→Ability to partner

→Other legal restrictions

SOURCE: National Association of Public Hospitals, Executive Committee Retreat, April 1995

UPDATE ON BUILDING PROJECT

Payette Associates Contract: July, 1993
Gilbane Construction Management: July, 1994
Schematic Design Complete: October, 1994
Traffic and Parking Study: October, 1994
Parking Management District Committee: October, 1994
Perimeter Oversight Committee: October, 1994
Amendment to Memorandum of Understanding: April, 1995
Mid-Cambridge Neighborhood Conservation District Committee: June, 1995
Interim Parking Control Commission: June, 1995
Design Development Complete: July, 1995
Birth Center Open: January, 1996
Groundbreaking: April, 1996

City of Cambridge

The Health and Hospital Committee held a public meeting on June 6, 1995 beginning at 8:15 a.m. in the Macht Auditorium, Cambridge Hospital for the purpose of reviewing hospital building plans and reimbursement changes.

Present at the meeting were Councillor Timothy J. Toomey, Jr., Chair of the Committee, Councillor Francis H. Duehay, Vice Mayor Sheila T. Russell, and City Clerk D. Margaret Drury. Also present were Robert W. Healy, City Manager and John O'Brien, Commissioner of Health and Hospitals, and several board and staff members.

Councillor Toomey convened the hearing and explained the purpose. He requested that those present introduce themselves. Thereafter Councillor Toomey invited John O'Brien to make a presentation to the Committee.

John O'Brien provided an overview of the agenda of the meeting, and distributed a summary. Mr. O'Brien stated that he has been involved in many discussions with other area hospitals.

Councillor Duehay stated that he is interested in the entire concept of public health as it relates to this issue and that he would like more information about what has just happened in Boston.

Mr. O'Brien then discussed key trends in health care. Inpatient care is declining. There has been a significant decrease in the number of acute care hospitals. Before the end of the century, there will be only 65 - 70 in Massachusetts. There has been continued vertical and horizontal integration of health care. Insurance now takes 20% of the health care dollar, and there are systems that are seeking to eliminate insurers in the middle. Primary care physicians will become the drivers of the system. There is excess capacity in the area of specialty physicians.

Mr. O'Brien noted that Cambridge Hospital last July 1 established a PSO (Physician Services Organization) with 45 physicians, as a partner of the hospital. He is the president. One-half the hospitals in Massachusetts have PSO's. He also explained that this helps the physicians to be loyal to the hospital.

Councillor Duehay asked whether the PSO is like an HMO. John O'Brien said that there are some similarities, but the PSO has neither the capital nor the management information systems needed for truly managed care. This is a seedling.

The Commissioner then discussed the increasing importance of environmental, demographic features and noted the dramatic growth in managed care. Patient days are dropping.

Mr. O'Brien continued by saying that even with closures and conversions there is still 30-50 % more bed capacity than will be utilized in coming years. Mr. O'Brien also discussed the danger of large for-profit hospital associations, which have meant changes for the worse in the areas in which they operate.

John O'Brien stated that medicare is the hot market right now because there has been so much waste in the fee-for-services payment system. Secure Horizons are attempting to enroll the healthy elderly and are making big profits. Mr. O'Brien continued by saying that Attorney General Scott Harshbarger has just announced voluntary guidelines for HMO's because there are many issues. They pay no attention to the uninsured and are making huge profits. HMO's are exhibiting a huge influence on health care.

John O'Brien then noted the unresolved public policy issues that threaten the traditional health care mission.

-Who will pay for the uninsured? The projections are for 50 million uninsured by the end of the century.
-Who will pay for research?
-Who will pay for community benefit programs? Hospitals are retrenching in these programs.
-What governance structures are necessary to maintain local accountability? For example, Nashoba Hospital in Ayer is now Deaconess-Nashoba. Local decision-making power is diluted.

Mr. O'Brien then discussed public hospital trends. Public hospitals are closing. Proposed medicare and welfare block grant cuts at the federal level are very large. There is an attack on disproportionate share funds. There is increased competition for medical funds. Beth Israel and Massachusetts General Hospital are investing heavily in Chelsea. Across the country, public health programs are being decimated as local municipalities no longer have the funds to support them.

Mr. O'Brien continued to say that in 1990 there were only nine public hospitals in Cambridge. Now there are four. Of these, Hale and Quincy are privately managed. Boston City Hospital and University Hospital are merging. Public health will stay as a part of the city. This raises some concerns as to whether the municipality will have enough money over time to adequately support public health.

Dr. David Bor agreed with the gravity of the financial concerns expressed by Mr. O'Brien.

Councillor Duehay suggested that the tax money that went to the public hospital could go to public health. Mr. O'Brien noted the issues of trying to keep close collaboration when the ownership is separate.

John O'Brien then summarized the obstacles to public hospital survival. He noted that the enterprise fund has been very helpful to the survival of Cambridge Hospital, and gave the example of frail elderly care, which does not presently bring in revenue but will in the future. Obstacles include control over revenues and expenditure, personnel, access to capital, adequacy of governance, inability to compete efficiency, budget process, staff motivation.

John O'Brien noted that the Hospital would like to be exempt from Massachusetts General Laws, Chapter 149 prior to starting any major construction. Intensive planning is going into this area. There is also renewed consideration of the idea of becoming an authority to deal with the stringent controls on municipalities in areas like purchasing, which make it hard to be competitive.

Robert W. Healy described the enormous changes in the thinking about the structures necessary to survival of health care. There have to be changes in personnel and purchasing. There will be collective bargaining impacts. Neville Manor is very expensive because of wages and benefits. Many more meetings will be required to truly consider the complexities required for the delivery of health care.

Councillor Duehay noted the need for more information in writing and many more meetings. For example, he has not seen a written description of the public health community network. The City Council must have the information to be able to respond to taxpayer's concerns and fears.

Richard DeFilippi, Chair, Cambridge Hospital Governing Board, agreed with the City Manager's description of the necessity of being sensitive to the competitive nature of the environment while providing the information needed for the understanding necessary to make decisions.

Linda Chin, Director of Planning and Marketing, provided a brief update on the building projects. She viewed the history of the building project. After completion of the traffic and parking study, a Parking Management District Committee and Perimeter Oversight Committee were instituted. Both have community members. Ms. Chin stated that next week there are public hearings before the Mid-Cambridge Neighborhood Conservation District Committee and Interim Parking Control Commission. The process is proceeding a schedule with a groundbreaking currently projected for April, 1996.

Councillor Toomey asked about discussions with other hospitals. Mr. O'Brien replied that due to the enormous and rapid changes in the health care environment, there are serious questions about Cambridge Hospital's ability to survive as a free-standing institution. He has engaged in some very preliminary discussions with various local hospitals, including Somerville and Mt. Auburn Hospitals about the possibilities of mutually beneficial arrangements, Discussions have been very preliminary, and the competitive nature of the industry requires confidentiality at early stages.

Robert W. Healy said that with regard to the building project, it is clear that parking and ambulatory care construction must be done, no matter what agreements might be made with other facilities.

Councillor Toomey noted that this is critical point in terms of the time frame because of the impending building project.

Rick DeFilippi noted that the Hospital has a good position vis a vis its balance sheet from which to consider these changes.

Councillor Duehay noted the difficulty of achieving the goals without the public discussion that will persuade the parties who need to make the decision. Councillor Duehay requested more one and two page summaries of what is going on, that need not disclose confidential discussions with other hospital's trustees.

Robert W. Healy said that he has encouraged John O'Brien to go back to the Governing Board for further discussions of what structures of the governance system would have to change to allow arrangements with other hospitals to succeed.

John O'Brien then introduced Dr. Jim Schlosser, Chief of Clinical Services. Dr. Schlosser described the reorganization of the Cambridge Hospital staff structure. He said that before last year, physicians were not a part of the hospital's organizational chart. There was a need for a more collaborative structure, and an integration of care.

Councillor Duehay asked whether all the public health programs are involved.

Dr. Schlosser said that the reorganization was into three service levels: primary and family health, mental health and addictions, end specialty services. There is an expection that there will be integrated health care in each area, which would involve the public health programs.

Councillor Duehay asked if there is a written description.

Dr. Schlosser said that the process is in its formative stages. Leadership teams have been identified in each area. A vision exists. Dr. Schlosser described the vision:

1. Improve Community Health
2. Meet the needs of patients.
3. Be efficient and cost competitive.
4. Be a flexible and adaptable organization.

John O'Brien said that there are several memos which outline the thinking behind this which will be supplied to the City Council.

John O'Brien gave a quick update of Cambridge Hospital's finances. He said that the Hospital expects to break even prior to the tax transfer.

Paul Hollings, Administrator of Neville Manor, then gave an update on Neville Manor. In general, public longterm care entities face threats similar to those of the Cambridge Hospital.

Mr. Hollings said that an evaluation of Neville Manor was performed by Lanzikos and McDonough. Neville Manor's evaluation showed strengths in longterm care but needs for more short-term and respite care, and needs for IV skills. These issues are being addressed. Short-term and respite care is being provided. Half of the admissions are short-term, three months or less. Because of this change, Neville Manor is getting more patients from Cambridge Hospital.

Councillor Toomey asked if there is still a waiting list for longterm care. Mr. Hollings said that the only people on waiting lists are those who want to transfer from other nursing homes. Waiting lists are no longer an issue. Vice Mayor Sheila T. Russell asked about transfers from Mt. Auburn, which is where West Cambridge residents often go.

Paul Hollings said that there are a few, but Mt. Auburn moves fast, and often makes another placement before Neville Manor can even respond. He said that Neville Manor has kept its favorable state medicaid rate, but this is projected to end after 1996, and if it does, it will require a much larger subsidy from the City. The evaluation also recommended looking at the physical site. There are bathrooms without sinks, only two elevators, not much common area, many three and four bed rooms.They are working with an architect on an architectural feasibility study that should be completed in a month. The price for renovationsplus addition would be six or seven million dollars. The price of a new facility would be nine or ten million.

After looking at the options, they came down to renovations/replacements or closing.

Councillor Duehay asked whether Neville Manor is really needed in light of other health care developments. John O'Brien said that best case is a $1.4 million yearly deficit which city taxes would have to cover. He added that may be some capacity to provide some present services at other existing hospital facilities.

Robert W. Healy noted that Neville Manor is a major employer. He also noted that its function has changed dramatically. It is no longer the place that aged relatives go to spend the last years of their lives.

Councillor Toomey thanked John O'Brien and his staff for their presentations and emphasized the importance of regular updates. He noted that this is the first of many meetings on this issue.

The meeting adjourned at 10:10 A.M.

For the Committee

Timothy J. Toomey, Jr.
Chair

Committee Report #1 61 214

Communication was received from D. Margaret Drury, City Clerk transmitting a report from Councillor Timothy J. Toomey, Jr., Chair of the Health and Hospital Committee for a public meeting held on June 6, 1995 for the purpose of reviewing hospital building plans and reimbursement changees.

In City Council June 12, 1995

Report accepted
Placed on file