To: City Councillors
From: Francis H. Duehay, Chair, Committee on Health and Hospitals
Date: January 23, 1992
Re: Summary of Cambridge Hospital Strategic and Facilities Master Planning

Enclosed is a summary of strategic and facilities master planning efforts at The Cambridge Hospital. In my capacity as Chairperson of the Health and Hospitals subcommittee of the City Council, I convened a meeting on December 19, 1991 to discuss the hospital's progress year-to-date. My recommendation to Dr. Melvin Chalfen and John O'Brien was that they meet with each of you to provide updates and to answer any questions you may have. My sense is that a more in- depth understanding of the efforts made in the past year will give you a fuller understanding of the growth the hospital has experienced, the collective vision of the Hospital's Governing Board and staff of the healthcare needs of our community, and their recommendations on how to proceed in meeting these needs.

cc: Health Policy Board

OK
F Duehay

The Cambridge Hospital

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

SUMMARY OF STRATEGIC AND FACILITIES MASTER PLANNING AT THE CAMBRIDGE HOSPITAL - 1991

The strategic plan developed by The Cambridge Hospital in 1987-1988 provided a review of the institution's strengths and weaknesses, identified areas of programmatic growth, and helped clarify its vision. Many aspects of the original plan have since been implemented, with the ob/gyn and nurse midwifery service, increased primary care physician presence in the neighborhood health centers, and the closer integration of Neville Manor's long-term beds with the hospital's acute care capacity being direct outgrowths of planning efforts. The goals and objectives have been updated annually in concert with the budget process, and have yielded improvements in the hospital's operations and more patient-focused healthcare delivery as well as new programmatic initiatives developed in response to community need.

Equally important to the strategic plan itself, the process nurtured a collaborative relationship, and shared sense of commitment by the Governing Board, medical staff, and administration which have provided the momentum behind the hospital's string of successful efforts. These include the following: a glowing review from the Joint Commission on Accreditation of Healthcare Organizations, selection as a national demonstration site for the Hospital Community Benefits Standards Program, development of model programs in the areas of adolescent health, community-based primary care, AIDS, mental health, and geriatrics, increased penetration in the managed care marketplace, and weathering storms on legislative fronts which have threatened the fiscal solvency of many hospitals throughout the state.

Paralleling the strategic planning efforts of the past five years have been dramatic increases in ambulatory volumes at the hospital and the neighborhood health centers (from 100,000 visits in FY1987 to 170,000 in FY1992) and steady increases in inpatient utilization. The Cambridge Hospital is clearly emerging as a principal participant in local community partnerships, a leading force in the State's public health, mental health, and Medicaid systems, and a nationally recognized community service institution. This has translated into greater high quality service to residents of Cambridge, and reduced dependence upon local tax support.

From a facilities standpoint, the hospital is in need of updating and expansion. The hospital has completed several construction projects in the past few years, including the Teen Health Center, North Cambridge Health Center, Child Assessment Unit, and Addictions Treatment Units, has relocated fiscal and other administrative services off-site, recently broke ground for a new Riverside Health Center on Western Avenue, and is undergoing renovations to its Cahill Building for inpatient adult psychiatry units. However much of the growth in activity, particularly in ambulatory visits, has taken place within the same physical space with little or minor renovations. Ambulatory functions are dispersed throughout the hospital campus, and do not adequately meet patients' desires for convenience and accessibility. Parking capacity is not sufficient to meet patient and staff needs, and is particularly not conducive to the high turnover required for outpatient visits.

To identify future health care needs and corresponding facilities solutions for the hospital and neighborhood health centers in a comprehensive fashion, the hospital has begun a Facilities Master Planning Process. Specific goals of the planning process are as follows:

o upgrade existing medical and support facilities, to support the health care delivery and education needs of staff and patients, improve functional relationships between departments and services, provide additional space where needed, increase parking capacity, enhance efficiency of operations, and to stay abreast of technical advancements in health care delivery;

o identify directions and opportunities for future growth, and allow flexibility for change and new program development;

o develop a new ambulatory care building which is convenient, efficient, and accessible, to accommodate anticipated growth in service volumes, to provide care more cost-effectively, and to provide up-to-date facilities which enables the hospital to compete for patients and physicians.

o develop a facilities plan which addresses community needs and concerns and is consistent with the long-term plans of the City of Cambridge.

City management, hospital administrative and medical staff and Governing Board members are actively participating in the development of a facilities master plan for The Cambridge Hospital. Reminiscent of the strategic planning process, which allowed for input from many parties to foster ownership of the plan, a steering committee and four working subcommittees have been formed to provide direction and carry out the range of specialized responsibilities.

The subcommittees include the following:

o the *strategy and program subcommittee*, which is primarily responsible for making volume projections and developing a functional and space program for each department and service in the hospital;

o the *finance subcommittee*, which is responsible for all aspects of financial planning related to facilities development, including feasibility analyses, financing options, revenue projections, and reimbursement implications;

o the *building subcommittee*, which provides expertise and oversight for bring the building projects from conception through implementation, including site development, massing, review of program and design, and project management, oversees the work of outside consultants, and ensures interface with zoning, traffic, construction, and licensure requirements, and;

o the *external relations subcommittee*, which is responsible for interface with neighborhood groups, regulatory bodies, and hospital staff about the facilities planning process, and which will assist in launching the capital campaign.

To provide for community participation and feedback, the City Manager will be appointing a *Community Advisory Committee for the Hospital Facilities Plan* (CACHFP). Residents from Mid-Cambridge neighborhood, Line Street (Somerville), and respresentatives of the local business community will be encouraged to participate to communicate their concerns.

Participants from the steering committee and four working subcommittees involved in the development of the facilities master plan will convene together at a full-day retreat in March 1992. The group will review work accomplished to date, evaluate preliminary facilities solutions, and will establish a facilities direction which is in the best interest of the hospital's and community's needs.

The development of a Facilities Master Plan at The Cambridge Hospital, with upgrade of inpatient space and construction of a new ambulatory care building, is consistent not only with trends in patient care delivery but external forces vis-a-vis hospital financing and reimbursement.

The new *hospital financing legislation* emphasizes service volume growth to ensure financial stability, and fosters competition among hospitals for survival. Since hospitals compete on the basis of facilities as well as the quality of services and staff, an up-to-date physical plant is essential. Our service volume growth strategies include developing new programs and pursuing new geographic markets as well as continuing to increase our market share in Cambridge. Increased ambulatory activity is in itself an important contributor to total revenues; also, a larger ambulatory patient base generates more referrals, ancillary usage and hospital admissions.

Another financing trend which has influenced our facilities directions is increased *contracting with third party payors*, as more of the Massachusetts population becomes enrolled in managed care programs. The hospital's successful efforts in this arena, evidenced by our recent contracts with the Blue Cross HMO Blue and Medicaid's MassHealth/Managed care program, underscore the importance of an ambulatory care focus. Managed care programs provide more care in the outpatient setting to drive down the costs of expensive hospital days, making the development of efficient ambulatory care space essential. Also, The Cambridge Hospital's participation as part of preferred provider networks throughout the State will channel patients towards our institution and indicates that we will likely draw our patients from a broader geographic base than the immediate community.

Our facilities development plans are critical to our ongoing efforts to improve access to care. As patients who have no insurance coverage and cannot afford to pay for care represent a large proportion of our service population, many of our administrative efforts have been directed towards *maximizing our reimbursement* from the Federal Medicare and State payment systems. The Cambridge Hospital is presently qualified to receive payments from the State's uncompensated care pool (UCP) and Medicare and Medicaid disproportionate share hospital (DSH) programs. Eligibility and payment levels for each program are driven by complex formulas, and for us the payments we receive under these programs are equivalent to the rates from many third party insurers.

The hospital's ability to finance the costs associated with the development of a Facilities Master Plan will in large measure be predicated upon our ability to protect UCP and DSH payments from the State and Federal government. In FY1991, these combined payments represented about $17 million in net revenue, and in FY1992 they are expected to be in excess of $20 million in total revenue. Top priority is given by hospital staff to protecting these monies and to understanding how the individual payment formulas for each DSH/UCP program are inextricably interwoven with the Medicare and Medicaid payment systems, and rely upon a myriad of hospital operating and financial data. Because of this, small changes in variables which drive the payments for these programs tend to have a substantial impact on revenues owed. It is also not surprising that this complexity contributes to often precipitous changes in UCP/DSH receipts from one year to the next. Furthermore, financial incentives often vary widely from one payment source to the next. An example of this is a problem that has surfaced, as increased patient volumes and corresponding UCP/DSH payments have enabled the hospital to reduce its tax dependence by the City by $1.8 million in the last two years.

Tax support by the City is an important component unfortunately of the formula by which we qualify for these payments, so as the City's tax support is reduced, our ability to qualify for these payments is threatened, thereby creating an unusual dichotomy. On one hand, we are successfully meeting established financial goals but in so doing may reduce USP/DSH payments which in turn will then lead to a need for greater tax support in the future. It does appear, however, that due to the preferential tratment provided to DSH hospitals under the new healthcare financing bill, which was achieved in large part because of the advocacy of the Speaker of the House of Representatives Charles Flaherty and the Cambridge delegation, our revenues will be more predictable in future years. Clearly, a critical portion of the facilities master planning effort is the financial feasibility of such an undertaking.

In conclusion, our mission, facilities directions, service volume expansion strategies, and their financial and reimbursement ramifications go hand-in-hand. Increasing the numbers of people we serve, including those from outside the City of Cambridge and including those without ability to pay, may not have the negative financial effect we once may have feared, but can actually contribute to the hospital's financial solvency, and to the City's primary goal of continuing to provide care to its own residents. Closely monitoring the hospital operating and financial data, revenues from the DSH and UCP, and financial variables in the payment formulas to maximize our overall payments will remain a high priority. And, reducing our dependence on city subsidy continues to be our goal, though ironically, local tax support is a variable in the DSH payment formulas on which our eligibility and favorable level of reimbursement is dependent.

COMMITTEE REPORT

Health and Hospitals Committee Report fora hearing held on December 19, 1991 relative to summary of the Cambridge Hospital Strategic and Facilities Master Planning.

In City Council,

January 27, 1992

Report accepted.
Placed on file