PREPARE/21
Participation
Responsibility
Education
Productivity
Accountability
Recognition
Excellence

...for the 21st Century

An Innovative Program in Hospital Operation and Management to Improve Productivity, Reduce Costs, Strengthen the Working Environment, and Enhance the Quality of Patient Care, Teaching, and Research at Boston's Beth Israel Hospital.

March 1, 1989
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The economic and regulatory environments in which hospitals function are going through dramatic changes. What is emerging is a new world in which teaching hospitals, in particular, face growing challenges to their ability to provide quality patient care, excellent teaching, and leading-edge research. At Boston's Beth Israel, with its reputation for these qualities and for the warm, personal manner in which our care is provided, we must take the initiative to find ways of managing change so that we may continue to fulfill the hospital's mission.

A resolution adopted by Beth Israel's Board of Trustees in 1983 states:

The major mission of Beth Israel Hospital is to deliver patient care of the highest quality, in both scientific and human terms. This mission is to be carried out within a framework of financially responsible management which is sensitive to the requirements both to deliver health care which is efficient and cost-effective and to be considerate of the overall health needs of the populations of concern to the hospital.

Patient care at Beth Israel Hospital is to be provided in a context of clinical teaching, through the participation and teamwork of clinicians, teachers, research scientists, and others who are also the sources of innovation and progress for future improvement in care capabilities. The strength of Beth Israel is partly attributed to its role as a major teaching hospital affiliated with Harvard Medical School; to maintain and strengthen that role, the hospital will continue to exercise leadership through excellence in teaching and research activities as well as in its clinical services.

In 1986, the hospital's senior management, in order to find ways of linking more closely the talents of our employees to furthering our overall mission in the face of changing times, began exploring organizational approaches to "participative management." One process that had been dramatically successful in a number of organizations over a period of several decades was based on principles outlined by a management innovator named Joseph Scanlon. The so-called "Scanlon Plan" successfully fosters "ownership" by employees of quality, productivity, and efficiency. Such a plan is developed by the employees themselves, through elected representatives, and with the approval of senior management and trustees.
In the months that followed, a planning committee of 75 employees elected from throughout the hospital developed a Beth Israel Scanlon-type plan that is called P R E P A R E / 2 1 (for Participation, Responsibility, Education, Productivity, Accountability, Recognition, and Excellence for the 21st Century).

The document that follows was prepared by the P R E P A R E / 2 1 Planning Committee, and submitted to senior management and to the Board of Trustees for their review and participation in the process of developing the plan.

It is important to note that the compelling need for change that is evident today may evolve in the months and years to come. The trustees and senior management of the hospital may determine at any time that our environment has been changed sufficiently to require a renewed examination of the Plan. The Plan, as is stated in its pages, is a “living document,” and is subject to renewal and revision to meet new needs of changing times. Indeed, that very vitality and flexibility are among its greatest strengths.

Finally, it is recognized that one of the most important aspects of the hospital’s work — the quality of its service — is, by its nature, difficult to measure. It must be a goal of the hospital and its employees to develop acceptable standards of measuring quality that will help shape various portions of the plan, including the gains-haring aspects.
About This Document

The PREPARE/21 Plan is divided into three sections: Identity, Participation, and Equity.

Key points of the Plan:

Identity

- To participate effectively in improving performance and thus succeed in achieving the hospital’s mission, employees need to understand that mission, the history and values that support it, and the environment in which it is pursued. The PREPARE/21 Plan ensures that the appropriate information will be made available to all.

- When the hospital succeeds, each of us succeeds. All employees share in the opportunity to understand, to influence, to act, and to share in gains.

- Change is inevitable, and we must learn to manage it individually and together in order to grow and improve.

Participation

- PREPARE/21 reflects Beth Israel’s commitment to an environment within the hospital in which the competence and diversity of its employees provide a means to work together to achieve the hospital’s goals.

- The work team is the cornerstone of PREPARE/21. Every employee belongs to at least one, and can participate in others. The success of PREPARE/21 will depend on work teams individually and collectively developing solutions to problems, and generating ideas for improvement. Work teams will develop means of measuring departmental performance.

- Employees will be informed regularly about the hospital’s progress in meeting its performance goals, and about actions that will be required to improve that performance.
Equity

- “Equity” refers to the investment that our patients, community, and employees have in the hospital’s successful performance, and the expectation of fair rather than equal return on those investments.

- Equity for employees means fair, personal, and professional return for investment of time, talent, and ideas; the opportunity to participate in enhancing the hospital’s performance; and a share in any gains derived from that participation. The PREPARE/21 Plan defines a specific formula to calculate on a period basis whether the hospital has generated a financial gain.

- Continuing improvement in performance is required to produce gains. The best way to achieve better performance is to focus on the quality of our individual and collective efforts.

Reading the Plan

The PREPARE/21 Plan document is presented in two levels — the full text of the plan in the wide, left-hand column, and a running summary in the narrow right-hand column headed “In Brief....” The document can be read quickly, in its essentials, through the “In Brief...” column, or in greater detail in the main body of the text. The “In Brief...” column also acts as a running reference index to the main text.

Among the Plan’s appendices are the hospital’s extended Mission Statement (Appendix A); the Mandate (Appendix B), written by David Dolins, executive vice president and director; and the statement on the Rights, Responsibilities, and Opportunities of Employees and Staff (Appendix C), written by Dr. Mitchell T. Rabkin, president.

The Plan was written by the PREPARE/21 planning committee, an elected group of individuals representing all areas of the hospital. It was approved and signed by the committee on 4 November, 1988.
We, the members of Beth Israel Hospital's Prepare 21 Planning Committee, are convinced that the Hospital must and can change in order to meet the challenges and opportunities of the future. We have developed a Plan to enable all of us to make these changes.

We feel it encourages, recognizes, and rewards employees' participation in improving the highest quality of patient care, teaching, and research. The Plan is an evolving document, subject to renewal and revision in the future to meet new needs of changing times.

We are pleased to present the Prepare 21 Plan and recommend it for your approval.

Beth Israel Hospital Prepare 21 Planning Committee

4 November 1988

[Signatures]
Who We Are
Employees of Beth Israel Hospital are people of many backgrounds, skills, and interests who share a desire to provide the best possible care for people who are sick or injured; to train the caregivers who will have that responsibility in the future; and to conduct and support scientific research that will give those caregivers the tools they need in preventing, treating, and curing disorders of the body and mind.

We are linked to the purpose of Beth Israel Hospital, as expressed in the hospital's bylaws: "...to provide medical and hospital services for the sick and disabled of any race, creed, color, or nationality, and to carry on such educational, philanthropic, and scientific activities and functions as are a part of efficient, modern hospital service."

In 1983, the hospital's Board of Trustees defined Beth Israel's "major mission" as the delivery of "patient care of the highest quality, in both scientific and human terms. This mission is to be carried out within a framework of financially responsible management which is sensitive to the requirements both to deliver health care that is efficient and cost-effective and to be considerate of the overall health needs of the populations of concern to the hospital...." (For the full mission statement, see Appendix A.)

We subscribe to that mission whether we are directly responsible for patient care, teaching, or research, or whether we support those who are in such roles.

Values and Beliefs
As employees, we are bearers of a set of values originally expressed by the founders of Beth Israel Hospital in the early 1900s, and we intend to enhance those values and to pass them on to those who follow.

In Brief...

We at Beth Israel are a group of people with various disciplines and talents who provide the best possible care to patients, train future caregivers, and study medical problems to find cures and treatments.

Our work is linked to Beth Israel’s mission: High-quality medical services to all, in scientific and human terms, in a framework of financially responsible management.
We subscribe to the values fostered by the hospital: commitment, warmth, compassion, respect, initiative, diversity, dignity, trust, fairness, recognition, and professional excellence.

We believe that we should be held accountable for our actions, and that we have the opportunity and the responsibility to influence the future of the hospital and everyone in it.

Change from the world in which we live, and from within our own hospital, is an inevitable part of our professional lives; furthermore, it is an opportunity to learn and improve. We believe that in order to live in a changing world, we ourselves must be prepared to change. One of our major challenges is to find ways of managing change so that it is constructive, rather than allowing the forces of change to control us.

Constructive change must come from within ourselves both individually and as an organization. We believe that our individual capacity and desire for change is a powerful resource that must become part of the fabric of our work lives.

The potential of Beth Israel Hospital is much more than the sum of our individual potentials, and our major challenge — and opportunity — is to find ways of tapping this energy. We recognize and honor aspiration.

**Our Identity**

As individuals, we identify with Beth Israel and with those who work with us. At our hospital, it might be said that we “wear” our jobs rather than just “hold” them.

The hospital’s mission is also that of its employees. To the extent that the hospital fails short of achieving its mission, collectively and individually we fall short; to the extent the hospital succeeds, we succeed. We are the hospital, in both its excellence and in its shortcomings; in its achievements and its failures; in its progress and its lapses; in its gains and its losses; in its challenges met and its opportunities lost.

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Any failure diminishes us all, as any success advances us. To identify Beth Israel is to identify its people.

Our Challenge
Our challenge is to understand the changes taking place in the world of health care and the economic environment in which it exists, and to learn how to turn those changes into opportunities. Each of us has responsibility for finding ways to manage change, to influence and to be influenced for the good, and to be willing to be held accountable for the implementation and success of proposals that address change.

Beth Israel has met this challenge before. Our history is one of taking on challenges, identifying the opportunities within them, and prevailing by summoning the collective talent and shared concern of our people. Change is one side of a process on which we embarked long ago; the other side is preservation of those qualities that define us at our best, and should not be changed.

This is Beth Israel
Beth Israel is in the "big league" of health care — a major general teaching hospital affiliated with Harvard Medical School. We admit more than 27,000 patients each year, and have more than 192,000 outpatient visits. There are more than 38,000 visits to our emergency unit, through which nearly half of our inpatients come to the hospital. Thousands of people rely on us.

We train more than 250 house officers and fellows annually in medicine, surgery, orthopedics, neurology, obstetrics/gynecology, pathology, psychiatry, radiology, dermatology, and anesthesiology. Our teaching programs prepare social workers, nurses, respiratory therapists, laboratory technologists, pharmacists, nutritionists, physical and occupational therapists, and other patient-care workers for service here and in other health centers around the world. Among US independent teaching hospitals, we are the seventh-largest recipient of biomedical research funding from the National Institutes of Health.
The patient population at Beth Israel forms a cross-section of our society — from newborns to young adults to the elderly; an across-the-board range of ethnic backgrounds, races, religions, and economic levels; a rich blend of languages and accents; a medical dictionary of symptoms, illnesses, injuries, and general states of health. Our patients are identical only in the quality of care they receive, and in the fact that each is a human being whom we treat with dignity and respect.

Beth Israel employees, staff, and volunteers are likewise a cultural and societal cross-section. We bring with us a diversity of ethnic, racial, and cultural backgrounds and interests; the languages of the world; a wealth of specialized training, skills, and experience. We are identical only in the quality of care we deliver and support, in the pride we take in doing so, and in the fact that all of us, too, are human beings who treat each other with dignity and respect.

Beth Israel enjoys international stature as a major teaching hospital. It has managed consistently to provide quality patient care, administer an outstanding teaching program, and conduct leading research while at the same time achieving prominence for introducing innovations in the management of care.

The same hospital in which the cardiac pacemaker was developed is the hospital that first published a formal Statement on the Rights of Patients. The hospital that led the way in establishing conservative management of breast cancer as the preferred approach was the first major medical center to implement, hospital-wide, the revolutionary professional practice model of primary nursing care. Beth Israel is also a leader in:
  • developing administration of insulin via nasal spray
  • pioneering the use of magnetic resonance imaging for early detection of cancer
  • promoting family-centered maternity care
  • opening up a world of understanding about the "architecture" of the brain
  • advancing procedures for treating heart disease

Our hospital cares for patients from all ethnic backgrounds, races, religions, and economic levels, all with a wide range of illnesses and injuries.

Beth Israel employees, staff, and volunteers also come from many ethnic, racial, and cultural backgrounds, and bring specialized training, skills, and experience. We take pride in delivering and supporting high-quality care, and in treating both our patients and each other with dignity and respect.
In addition, Beth Israel
- was the first hospital to introduce a systematic health-assessment and well-being activity program as an employee benefit [LIVE FOR LIFE®]
- is the first to embark on an employee-based participative management program designed to provide channels of influence and expertise linking all employees in setting standards and goals and in sharing collective gains [P R E P A R E / 2 1]

Beth Israel’s Beginnings
In the early 1900s, waves of immigrants who had fled oppression and economic hardship in various parts of Europe came to the United States. Among them were many Jews, particularly from Eastern Europe and Russia; thousands of families and individuals found their way to Boston. Few had received adequate medical care in their lives; few spoke English; many observed cultural and religious practices unknown to most non-Jewish Americans. They came homeless, frequently in poor health, and often bewildered by a society that was insensitive to their needs. Health care, of course, was a primary concern, and the Jewish community that already existed in the Boston area took it upon itself to find some means of providing for basic health needs. The existing system of hospitals with very few Jewish doctors, medical schools that allowed few Jewish medical students, and built-in language and cultural barriers formed a major obstacle. The Jewish community, particularly its women, undertook the task of raising money to establish a medical facility that would not only provide good health care, but would also be able to accommodate the cultural and language needs of this growing segment of the population. That medical facility would come to be Beth Israel Hospital.

Turning Points
In 1901, the Mount Sinai Hospital Association was incorporated to establish a Jewish-sponsored hospital "...to give all Jews and non-Jews, all races, creeds, and colors...the benefit of our institution." In 1902, Boston’s first Jewish outpatient facility opened its doors. A year after its

In the early 1900s, waves of immigrants arrived from Europe. Many came to Boston — most homeless, ill, and confused by cultural, language, and religious barriers. Boston’s Jewish community — particularly its women — took on the task of raising funds to establish a medical facility that respected the cultural and language needs of this new population.

In 1902, the Mount Sinai Association opened an outpatient clinic in Boston’s old West End. In 1915, the Beth Israel Association was...
founding, Mount Sinai moved to larger quarters, where it continued to serve the community until 1915, when the Commonwealth of Massachusetts issued a certificate of incorporation to the newly organized Beth Israel Hospital Association, and the dream of an inpatient hospital facility was finally realized. In large measure, it was the women of the community who raised the funds for what was to be Beth Israel ("House of Israel"), and its certificate of organization offered "... medical and surgical aid and nursing to sick or disabled persons of any creed or nationality."

Organized out of a need to care for those who often felt unwelcome at other facilities, the hospital made as its first official act a declaration to open its doors to all. The fundraising efforts yielded the then-considerable sum of $8,000 towards the purchase of an estate building on Townsend Street in Roxbury — then the center of Boston's Jewish community. The 45-bed facility (less than one-tenth the size of today's Beth Israel) was dedicated in October, 1916, and opened for patients the following February. A year later, a second building was purchased and remodeled. A school of nursing was opened with an initial enrollment of 10 students (and graduated 1,300 nurses until its closing in 1967).

By 1921, daily admissions had risen, and the need for further expansion was evident. A possible relationship with Harvard Medical School took shape as a dream; the Harvard system needed teaching beds, and Beth Israel's trustees recognized that the highest excellence in clinical service could not be achieved without a major academic affiliation.

It was a pivotal point for the young hospital. The trustees faced a decision of whether to expand the Townsend Street property at a relatively low cost or relocate nearer to the medical school with the hope of forging a relationship there. A leading authority consulting with Beth Israel strongly advised against a move. "I cannot perceive any advantage to the Fenway site," he sniffed. The trustees had the courage and foresight — then as at other critical

Beth Israel's first official act was a declaration to open its doors to all.

A 45-bed hospital opened in Roxbury in February, 1917.

By 1921 the need for further expansion was evident, and a relationship with Harvard Medical School was sought.
junctures — to weigh the expert opinion against their own instinct and intelligence, and to follow what they felt was right.

Beth Israel purchased property on Brookline Avenue near Harvard Medical School (in what was then regarded as a somewhat wild Boston outskirt accessible only by a long streetcar ride). The fundraising expertise of the community and its resourceful women succeeded in making possible both the property acquisition and the building of a 200-bed institution including the North (now Gryzmish) Building, Kirstein Hall (then the BI nursing school), and the Rose Outpatient Building, all dedicated in 1928. Beth Israel joined Massachusetts General Hospital, Peter Bent Brigham Hospital (now part of Brigham and Women's Hospital), and Boston City Hospital as a Harvard teaching center. Other Harvard medical institutions already in or to come to the “Longwood Medical Area” included The Children's Hospital, the New England Deaconess Hospital, the Dana-Farber Cancer Institute, the Harvard School of Public Health, the Harvard School of Dental Medicine, and the Joslin Diabetes Foundation. Non-Harvard educational institutions in what has since become a pre-eminent “professional neighborhood” of Boston include Simmons College, Emmanuel College, the Winsor School, the Massachusetts College of Pharmacy, Wheelock College, Massachusetts College of Art, Boston Latin School, and Boston English High School.

The strength of the Harvard affiliation was developed largely under the guidance of Dr. Monroe Schlesinger, pathologist-in-chief, Dr. Harry Linenthal, physician-in-chief, and Dr. Hermann L. Blumgart, director of medical research and later physician-in-chief. (There are now 15 professorial Harvard Chairs at the hospital, and today all Beth Israel chiefs of service and virtually all staff physicians hold joint appointments at the hospital and on the faculty of the medical school.) In 1974, when Boston City Hospital ceased to be a Harvard teaching affiliate, its prestigious Harvard Medical Unit and the Harvard-Thorndike Research Laboratory were moved to Beth Israel.
Building For the Future...
In 1948, the Yamins Building was constructed to bring all of the hospital’s research programs under one roof. That function was later expanded with the addition of the George and Beatrice Sherman Clinical Research Building, the Slosberg-Landy Research Building and, above it, the Charles A. Dana Research Building. The latest research additions are “Research West,” above the Sherman Building, and “Research East,” leased from neighboring Emmanuel College.

In the 1950s, the Service Building expanded the operating rooms, kitchen, and cafeteria. The Stoneman (South) Building made possible the creation of an obstetrics service that delivers more than 5,500 babies annually. In the 1960s, the Rabb Building greatly expanded outpatient facilities. The BI pediatrics service that had existed since the Townsend Street days was discontinued in the early 1970s, its role appropriately taken over by nearby Children’s Hospital.

Modern Times
In the 1970s, the state-of-the-art Feldberg Building for inpatient care was completed, the Libby Building was purchased from Emmanuel College, and an ambitious building and renovation program called The Project expanded inpatient facilities; provided high-technology medical and surgical intensive-care units and a special-care nursery; modernized older areas of the Stoneman Building (bringing all inpatient rooms to modern standards); built the Reisman Building for in-patient care; created the new Berenson Emergency Unit (as Beth Israel became a formally designated Trauma Center, joined with Brigham and Women’s and Children’s); completed the Dana Research Building; and created new patient care and clinical laboratory areas in the Finard Building. The most recent addition is the Ansin Building to house a magnetic resonance imaging (MRI) unit next to the diagnostic radiology area.

Turning points in modern times — those beyond which the hospital would never be the same — have included the dramatic move from a relatively little-known hospital to an internationally
internationally regarded academic medical center. The transition built on the accomplishments of earlier leaders and developed with the appointments of Dr. David G. Freiman as pathologist-in-chief, Dr. Howard H. Hiatt as physician-in-chief, Dr. William Silen as surgeon-in-chief, and Dr. Mitchell T. Rabkin as chief executive. Milestones that followed included the development of primary nursing care under Joyce C. Clifford, RN, MSN, in the mid-1970s; the increasing emphasis on hospital-based outpatient care culminating in the establishment of BIAC (Beth Israel Ambulatory Care) and subsequently Beth Israel Healthcare Associates; and the consolidation of the departments of medicine at Beth Israel and at Brigham and Women's Hospitals under Dr. Eugene Braunwald in 1980. These major moves were carried out under a sequence of trustee chairmen from Samuel L. Slosberg, Irving W. Rabb, Sidney Stoneman, Bernard D. Grossman, Stanley H. Feldberg, Norman B. Leventhal, Eliot Snider, Phillip J. Nexon, to Edward H. Linde.

Economically, major waves of change have profoundly affected the hospital. They include the enactment of Medicare and Medicaid legislation at the federal and state levels in the mid-1960s and, more recently, enactment in Massachusetts of the Universal Health Care and Hospital Financing Law, whose long-range effect is as yet unclear.

The World in Which We Live
Beth Israel functions within a highly progressive, technologically volatile, and unpredictable environment influenced by scientific, social, economic and political forces — over which we have little control and, sometimes, poor capacity to anticipate. Furthermore, as patients become better educated about the world of health (a process towards which the hospital contributes through public education and responsiveness), and more involved in payment, expectations are heightened and more information is demanded.

The cost of the trained personnel and the technology to meet increasingly sophisticated expectations is high and growing rapidly, yet it must be provided in an atmosphere of

Economically, Medicare and Medicaid legislation in the mid-1960s, and more recently, Massachusetts’ Universal Health Care Law, have had, and continue to have, profound effects on the hospital.

Our world is highly progressive, technologically volatile, and unpredictable. We face increasing demands and heightened expectations from our patients.

With cost increases, hospital regulation tightens. These regulations and limitations on

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increasingly tight regulation and a generally bleak fiscal environment. Chapter 23, the Universal Health Care law signed by Gov. Michael Dukakis on April 21, 1986, not only guarantees health insurance for all state citizens, but also regulates hospital charges over the next four years. In addition, major third-party payers (Medicare, Medicaid, Blue Cross, and health-maintenance organizations such as the Harvard Community Health Plan) continue in their own competitive environments to try to reduce payment levels for services provided by hospitals. Meanwhile, the actual costs that hospitals must pay to provide those services — medical supplies and equipment; wages and benefits; plant operation expense — are rising faster than are these levels of payment by third-parties.

Within the regulatory environment, hospitals must find their way through a forest of laws and regulations. While these include federal, state, and local regulations governing everything from safety codes to building permits, many are peculiar to (or peculiarly restrictive to) health care providers, including virtually unilateral decisions by payers on what they will pay for and how much they will pay. Because the philosophy of Beth Israel is not to deny care to an ill patient for reasons of payment problems, the hospital becomes increasingly disadvantaged in today's economically restrictive environment.

The Competitive Environment
During the first half of the century, the health-care environment was relatively noncompetitive. Payment systems introduced in mid-century tended to cover all requested services, and were defined as "cost-reimbursement." In general, medical practice was characterized by the solo practitioner. Organizational medicine became more a fact of life in the 1960s; as costs and technological sophistication grew, the focus of medical care began to shift from the individual practitioner who cared primarily for those already sick towards health-care institutions or systems that offered outpatient care and acute care, that began investigating preventive care, and in many cases also conducted research and performed teaching. With the advent of Medicare and Medicaid, the large amount of federal support in the 1960s brought medical services to more people than ever before. Hospitals were reimbursed for almost all costs of caring for patients.

Despite these pressures, Beth Israel remains firm in its philosophy to provide care of high quality to any ill patient regardless of the source of payment.
of funding infused into the US health-care system increased accessibility of medical services to a broader segment of the general population.

The recent change to payment through diagnosis-related groups (DRGs), with its incentives for shortening lengths of stay and increasing the numbers of admissions, has increased pressures for hospitals to become oriented towards "capturing" and enlarging shares of patient markets. The result is a much more competitive environment than ever before among hospitals, especially those whose occupancy levels have been low. Among Boston teaching hospitals, occupancy is relatively high — in the mid-80 to low-90 per cent range with Beth Israel among the highest — but many community hospitals have considerably lower occupancy. Because staffed empty beds must still be maintained, they cost the system (and ultimately the payer) money, so there is a major incentive to keep beds filled. Aggressive marketing has become a fact of life in health care and will continue with mounting economic pressures directed towards hospitals. Increasingly, hospitals will be competing in terms of both quality and price.

Hospitals do not compete only for patients, of course. They must also strive to attract the best house officers, staff physicians, nurses, and employees in all roles. Competition for financial resources — research grants and charitable giving — is also keen.

And the Future . . .
When we think about our future, we think not just about change but about opportunity as well. We, Beth Israel, have sought excellence throughout our history, and must continue to learn, change, and innovate to achieve excellence in a future where the stakes are higher, the challenges more demanding, and the competition keener. Our focus will remain on the highest-quality patient care, service and scholarship, and on managing our changing world to achieve the qualities that have been foremost since the early years of the century.

The recent change to diagnosis-related groups (DRGs) created incentives for shortening hospital lengths of stay and increasing numbers of patients. The result is a more competitive environment among hospitals. Aggressive marketing is now commonplace, and will continue.

Hospitals compete for patients, and for the best employees in all roles. Competition for research grants and philanthropy is also keen.

The future will bring both challenge and opportunity. Our focus will remain on excellence in patient care, service, and scholarship.
We will continue to progress towards our goals by summoning the talent, intelligence, and good will of our people, the Beth Israel "family." We must maintain the collective sense of identity that sets us apart from others, giving us the competitive edge and the determination to keep that edge; and we must understand that success for any of us is success for all of us.

To this end, we have embarked on a process of ongoing involvement through education, participation, and the maintenance of an equity that will allow us to identify strengths and weaknesses, seize opportunities, overcome obstacles, accept challenges.

The process is called PREPARE/21, to prepare Beth Israel for the 21st Century, and it invites participation, responsibility, education, productivity, accountability, recognition, and excellence, from all of us at Beth Israel today — the inheritors of yesterday, the builders of tomorrow.
Participation

Beth Israel’s Mandate and the Rights and Responsibilities and Opportunities of Employees and Staff (Appendix B, Appendix C) form the foundation of the PREPARE/21 structure and process.

PREPARE/21 reflects Beth Israel’s commitment to foster a working environment that benefits from the diversity and competence of its employees and provides a way to work together to achieve the hospital’s goals of excellence in patient care, teaching, and research.

The cornerstone of this process is the work team. Every employee is a member of at least one work team. PREPARE/21’s success will depend on the ability of work teams to understand their own goals and the goals of Beth Israel and to recognize the ability of employees to work effectively on their own team as well as with other teams to reach or exceed team goals and to solve problems and generate ideas for improvements. Employees will have the opportunity to influence, within their areas of competence, how work can be done more efficiently, appropriately, productively, or less expensively, while maintaining or improving our standards of quality.

Participation in this process is defined as “the opportunity and the responsibility to influence the decision-making process within one’s area of competence.” Participation is both the right and the responsibility of every employee.

Employees’ ideas will be evaluated and responded to. Action will be taken to implement ideas that contribute to the hospital’s commitment to improve quality of care and overall performance. The process must be understandable, visible, and capable of being influenced, but management will still be accountable for decision-making.

Finally, all employees will be informed regularly on how well we are achieving our performance goals and what actions will be needed to continue to improve and achieve success.

In Brief...

Beth Israel’s Mandate and the Rights, Responsibilities, and Opportunities of Employees and Staff are the foundation of PREPARE/21. The process recognizes the potential of every employee and provides a way for employees to work together to achieve the hospital’s goal of quality patient care, teaching, and research. Work teams will solve problems and propose improvements. Employees can influence how work can be done more efficiently, appropriately, or productively, or less expensively, while maintaining quality.

Participation is the right and responsibility of every employee.

Ideas will be evaluated and timely responses will be made.

Employees will know how well we are meeting our goals.
Because Beth Israel is a large and diverse organization, each area will have the opportunity to adapt this process to fit its own function and structure.

The ultimate objective of PREPARE/21 is to continue to improve and sustain the hospital's performance and competitive position in delivering high-quality, cost-effective services. Every employee has an integral part in meeting that challenge.

**Purpose**
The participation process provides all employees the opportunity:

- to know, understand, and accept as their own, the competitive realities of Beth Israel’s environment, performance, and plans on an ongoing basis
- to take responsibility to influence the decision-making process through ideas and suggestions for improvements
- to identify with the organization’s accountability to respond to those ideas
- to identify with and commit to the hospital’s goals and mission

The participation process will not review personal complaints or personal problems about an employee’s job — these should be directed to the individual’s supervisor or the Employee Relations Specialist for advice and assistance.

**What are the roles of various members of the Beth Israel family?**
**The President**, working with the Board of Trustees, is responsible and accountable for the direction of the hospital through its *Mission Statement* (Appendix A) and its *Mandate* (Appendix B).

**Senior management:** The President and Executive Vice President are responsible and accountable for working with each Vice President and Chief of Service to establish goals for each division and service.
Management is responsible and accountable for leading the organization in meeting and exceeding its established performance goals.

Work teams are the focal point of how work gets done at the hospital. There are two kinds of work teams to which employees may belong — their Departmental Work Team and one or more Functional Work Teams. In addition, an employee may be asked to serve on an Ad Hoc Work Team or task force from time to time.

Work team leaders are individuals who have employees formally reporting to them (for example: work team leaders do employee performance reviews).

Department managers are responsible for establishing Departmental and Functional Work Teams, ensuring that each employee knows which team or teams he or she belongs to, and who is the work team leader.

Department managers will regularly evaluate the structure of existing work teams and determine whether new teams need to be established.

Departmental Work Teams are made up of a work team leader and the staff that he or she supervises. Every employee is a member of a Departmental Work Team. Departments may have a number of work teams. A Departmental Work Team is an employee’s primary source for receiving information and reports about the performance of both the hospital and his or her division or service in achieving established goals. As a result the team meets at least 13 times a year — once each fiscal period.

For many employees, the Departmental Work Team is also the group with whom they interact regularly to accomplish their work. As a result, team goals should be established and the team’s progress in meeting these goals should be monitored. The team is expected to encourage and review employee ideas on how to solve problems and how to

The Departmental Work Team is an employee’s primary source for receiving information about the hospital’s performance. The Departmental Work Team meets each fiscal period.
improve the way the team's work gets done, not only within the work team but also in relation to other areas or functions in the hospital with which the work team interacts.

**A Functional Work Team** is made up of employees from several Departmental Work Teams. These employees have some work mission in common and, as a result, interact regularly to deliver services or complete tasks jointly. These teams often cut across departments or disciplines.

Functional Work Teams will establish mutually agreed-upon goals that may be broader than those of their individual division or service. They should review their progress regularly in meeting these broad goals. There may or may not be a designated work team leader.

The team will encourage employee ideas on how to solve problems and improve the way the team's work gets done.

An **Ad Hoc Work Team** is a task force brought together to resolve a specific issue or to review a new idea for its feasibility of implementation. An Ad Hoc Work Team has a specific responsibility to bring its conclusion or finding back to the individual(s) who appointed it. Such teams will disband once the task is completed.

**A PREPARE/21 Council** is a committee that facilitates the review of ideas within divisions or services. Councils also ensure that the idea review process is understood and used by employees.

The Council is chaired by the division Vice President or Chief of Service or designate. It consists both of individuals who are appointed by the Vice President or Chief to provide the appropriate expertise on the Council, and of elected members. The elected members will represent the types of competence needed in the particular division or service, such as:

- Administrative office support
- Clinical support (non-nursing and non-physician)
- House officers

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*Functionality Work Teams include employees from several Departmental Work Teams who share a common work mission. Work teams should establish goals and review progress toward meeting them, and are expected to encourage and review employee ideas on how to solve problems and improve the way work gets done.*

*Ad Hoc Work Teams will be brought together to resolve a specific issue or review a specific idea.*

*PREPARE/21 Councils will facilitate the review of ideas within divisions and services.*

*Participation, page 16*
Nonclinical support
Nursing
Research staff
Staff physicians
Members may be either management or nonmanagement employees.

The 20 PREPARE/21 Councils are:

Division Councils
Clinical and Support Services
Development
Facilities Planning and Engineering
Financial Planning and Issues Management
Fiscal
Human Resources
Public Affairs
Research

Service Councils
Anesthesia
Dermatology
Medicine
Neurology
Nursing
Obstetrics/Gynecology
Orthopedics
Pathology
Psychiatry
Radiation Therapy
Radiology
Surgery

The chairperson of each Council is responsible for setting the agenda for Council meetings. Agendas will typically include:
- new ideas submitted
- status of ideas under review
- ideas implemented since last meeting
- savings achieved through implemented ideas
- ideas declined
- previously declined ideas submitted for reconsideration

Beth Israel will have 20 PREPARE/21 Councils, where chairpeople set agendas, lead regular meetings, and report activity to the PREPARE/21 Coordinator.
Each chairperson will report activity and results of the idea review process to the PREPARE/21 Coordinator at the end of each fiscal period. Each Council will meet at least once every fiscal period.

The PREPARE/21 Screening Committee facilitates the review of ideas that affect work teams outside an employee's own division or service. The chairperson is appointed by the President and Executive Vice President, and other members will be appointed who have expertise in the areas listed below. [There need not be one individual for each area of expertise. In fact, it is desirable to seek out employees with competence in several areas in order to keep the committee small.]

Clinical Support
Facilities Management
Fiscal
Human Resources
Nonclinical support
Nursing
Physicians
Public Affairs
Research
Information Systems
Teaching

The committee will have at least one elected member from each of the following employee categories. These individuals may be either management or nonmanagement employees:

Administrative office support
Clinical support
House officers
Nonclinical support
Nursing
Research staff
Staff physicians

The PREPARE/21 Screening Committee will review ideas that affect work teams outside an employee's division or service, and its members will be appointed for expertise or elected from certain areas.
The Screening Committee chairperson is responsible for setting the agenda, which will typically include:

- new ideas submitted for referral
- status of ideas under review
- ideas implemented since last meeting
- savings achieved through implemented ideas
- ideas declined
- previously declined ideas submitted for reconsideration

The committee will meet at least once each fiscal period.

The categories of employees are defined broadly to give chairpersons optimum flexibility in establishing each Council and the Screening Committee. Once the Councils and the Screening Committee have been formed, the membership of each will be reviewed by the President and/or Executive Vice President to ensure that appropriate balance has been achieved.

The PREPARE/21 Coordinator will occupy a full-time position and that individual, selected by the President and Executive Vice President, has the following responsibilities:

- Coordinates the day-to-day functioning of the PREPARE/21 process:
  - participates in the orientation program for all new employees to provide an overview of the PREPARE/21 process
  - provides training for work team leaders and elected members
  - maintains a roster of PREPARE/21 committees and members
  - acts as liaison between and among PREPARE/21 committees
  - assists committee chairpeople and members in establishing their committees and in performing their functions
  - serves as staff on the PREPARE/21 Screening Committee
Communication

The purpose of the communication process is to ensure that employees have the information necessary to understand the competitive realities of Beth Israel's environment, performance, and plans on an ongoing basis and to enlist employee participation in achieving the hospital's performance goals.

After the end of each fiscal period, the President, Executive Vice President, and senior management will review the hospital's operating and financial performance in meeting budgetary goals, whether and why a gain has or has not been realized, the achievements of the Idea Review Process, external and internal factors that are affecting or may affect the hospital's performance or its competitive position, and other pertinent information relating to the hospital's performance and direction.

After that review a written summary report will be prepared for distribution and presentation to all work team leaders, and then to all employees.

Within the following week, senior management will discuss the hospital's performance with all work team leaders, based on the written summary report. It will include the results of the period's financial performance and the PREPARE/21 gain calculation, if any.

The communication process will ensure that employees have the information to understand the hospital's environment, and enlist participation in achieving its goals.

After each fiscal period, senior management will review the hospital's performance and PREPARE/21 gain calculation and prepare a written report, to be shared with employees.

Within the following week, senior management will review the hospital's performance and the PREPARE/21 gain calculation with work team leaders.
Each period there will be several meetings for work team leaders to ensure that all day, evening, and night work team leaders or their designates are able to attend and participate.

Each work team leader will then discuss this report with all employees on his or her Departmental Work Team within a reasonable amount of time, ideally within 48 hours. The work team leader will be responsible for answering or finding answers for whatever questions employees may have.

In addition to the overall hospital report, work team leaders and their employees will also receive reports from their division and department managers on:

- success in meeting their own performance goals
- how that performance contributed to the achievement of the hospital's budgetary goals
- what the focus needs to be in future fiscal periods

**Idea Review Process**

**What is the purpose of the Idea Review Process?**

The purpose is to provide an opportunity for every employee at BI to contribute ideas that will improve the hospital's overall performance.

Employees are encouraged to initiate ideas, identify and solve problems in their areas of competence as part of their everyday interaction with their own work teams and with other work teams.

The Idea Review Process (Appendix D) will ensure that employees receive responses to their ideas, understand why ideas are either implemented or not, and receive recognition for ideas that are implemented.

**What kinds of ideas are sought?**

The best ideas are those that identify ways to improve quality of patient care, teaching, and research, quality of services, productivity, efficiency, quality of work life, to increase hospital revenue, reduce current costs, avoid new costs, or eliminate waste or that which is not necessary.

Employees will receive responses to their ideas, understand why they are or are not implemented, and be recognized for successful ideas.

Ideas will be sought to improve quality or efficiency, increase revenue, or reduce or avoid costs.

Each work team leader will communicate this information to all employees on his or her work team.

Division and department managers will also prepare and discuss individual, divisional, or departmental reports for employees.

The Idea Review Process will provide an opportunity for every employee to contribute ideas.
What will not be reviewed through this process?
The process will not review employee complaints or problems of a personal nature such as:

- difficulties in one's job, and other related personal matters
- relationships with supervisors or peers, pay or benefits
- problems regarding the employee's performance or that of another employee

Such issues should be directed to the individual's manager, or to the Employee Relations Specialist in human resources for advice and assistance.

What is the first thing an employee should do with an idea?
The first step is to obtain an Idea Guide (Appendix D-1), which is readily available to assist in defining the idea. The idea should then be discussed with the work team leader, or if preferable, an elected P R E P A R E / 2 1 Council or Screening Committee member to make sure the idea is clearly developed. The P R E P A R E / 2 1 Coordinator is also available to provide assistance.

What should an employee do if the idea affects only that person's work team?
When an employee's work team is the only team affected, the employee should bring the idea directly to that work team for review and then for support and acceptance. If accepted by the work team leader, the idea can be implemented. An Idea Form (Appendix E) should be completed and submitted to the employee's P R E P A R E / 2 1 Council for recognition and record keeping.

What if other work teams are affected by the idea?
If other work teams are affected, the employee's work team leader assists in determining the most expedient way to have the idea reviewed: that is, whether to work directly with other affected work teams, or to submit the idea to the employee's P R E P A R E / 2 1 Council or to the P R E P A R E / 2 1 Screening Committee using the Idea Form.

An Idea Guide is available to help employees define and process ideas.

Ideas that affect only your work team should be brought to the work team for review, support, and acceptance.

An idea that affects other work teams should be discussed with your work team leader to determine the best route for its review and consideration.
When is the review of an idea best facilitated by the employee's PREPARE/21 Council?

In general, the Council reviews ideas that affect only work teams within the employee's division or service.

For example:
- when the idea affects work teams other than the employee's own
- when the affected work teams have been unable to reach a decision about whether to implement an idea
- when an employee seeks a review after an idea is declined. In this instance, the Idea Form should include the reasons the idea was declined
- when the employee wishes to submit an idea confidentially, a completed Idea Form may be sent or given to one of the elected Council members to present at the Council meeting

What will the PREPARE/21 Council do with an idea?

When an idea affects only work teams in the division or service, these guidelines will be followed:
- When an idea has already been reviewed by the appropriate work teams but no decision is made, or the idea has been declined and the employee wishes another review, the Council will take one of the following actions:
  - review the idea as a Council and reach a decision with the chairperson, or
  - appoint an Ad Hoc Work Team to review the idea, or
  - serve in an advisory capacity to the Vice President or Chief, making a recommendation on whether to implement the idea

If an idea is submitted to a PREPARE/21 Council that affects work teams outside that division or service, it may be referred to the Screening Committee.
What happens when the Council reviews an idea and members disagree with the chairperson?
The Vice President of the Division or the Chief of Service will decide. (This is still true even if the chairperson is the Vice President.)

May an employee seek another review if the Council declines an idea?
Yes, in cases where the Council chairperson is not the Vice President or Chief of Service, an employee may submit the Idea Form and the reasons why the Council declined the idea to the Vice President or Chief of Service for the final decision.

When would the review of an idea be facilitated by the PREPARE/21 Screening Committee?
The review of an idea would be facilitated in the following instances:

- when an idea has not yet been reviewed, and it affects work teams in the employee's division or service and in at least one other division or service, or impacts work teams outside his or her division or service
- when an idea has been reviewed that impacts more than one division or service, and no decision is reached
- when an employee seeks a review of an idea that has been declined that affects work team(s) outside his or her division or service. This review requires both a completed Idea Form and written reasons for which the idea was declined

When the employee wishes to submit an idea confidentially, a completed Idea Form may be sent or given to one of the elected Screening Committee members to present at the Screening Committee meeting, or may be sent or given to the PREPARE/21 Coordinator.
What action will the Screening Committee take with an idea?
The Screening Committee will generally use the following guidelines to determine the most appropriate action:
- when an idea affects only one work team, the idea is referred directly to that work team leader
- when an idea affects two or more work teams in separate divisions or services, the Screening Committee chairperson will seek the assistance of the appropriate P R E P A R E / 2 1 Council chairpeople to determine the best process for its review
- when an idea was reviewed and no decision was made, the chairperson of the Screening Committee will refer the idea and the supporting background information to the Executive Vice President for resolution
- when an employee seeks review of an idea that has been declined, the Screening Committee chairperson will facilitate a review of the idea and supporting background information by the Executive Vice President who may confer with the President as appropriate. This will be the final review

Employees are encouraged to discuss their ideas with their work team leaders, an elected or appointed Screening Committee member, or the P R E P A R E / 2 1 Coordinator before submitting an idea directly to the Screening Committee.

What factors are considered in determining whether to implement an idea?
The individuals reviewing an idea should consider the following:
- has the employee had an opportunity to explain the idea?
- will the idea improve quality of work life, quality of patient care or services, teaching, research, productivity, efficiency, morale?
- will the idea increase revenues, reduce costs, avoid costs, eliminate waste?

The Screening Committee will follow established guidelines to determine the most appropriate action for each idea.
- will the idea increase costs?
- what will the idea cost to implement?
- whose expertise is needed to evaluate the idea?
- which work team or teams will be affected and therefore should have input in the review of the idea?
- do those affected teams support the idea; if not, why not?
- what priority should be given to the idea in light of other priorities?
- who will be accountable for its implementation?
- how will the idea be implemented?
- how will the idea, once implemented, be evaluated to determine whether or not it has achieved its objective?

How will an employee be notified about what happens to an idea?
The P R E P A R E / 2 1 Council or Screening Committee will acknowledge receipt of the idea, thank the employee, and inform the employee of the date of the committee meeting at which the idea will be reviewed.

The idea will be forwarded to the assigned decision-makers following the committee meeting. Within 10 work days of the committee meeting, the decision-makers will determine their timetable to make a decision and will notify the Council or Screening Committee and the employee of that timetable. Once the decision is made, a written response will be sent to both the employee and the Council or Screening Committee.

How will an employee be recognized for his or her idea?
If an idea is implemented, the employee will receive written congratulations from his or her Council or the Screening Committee.

At least quarterly, but monthly if possible, the names and departments of employees who had ideas implemented through the Idea Review Process will be published in the P R E P A R E / 2 1 section of the Beth Israel Examiner along with a brief description of their idea.

Employees will receive acknowledgment for ideas and be kept informed of progress and dates of review.

Employees will be notified of the decision in writing.

Employees will be recognized publicly for ideas that are implemented.
In addition, a number of implemented ideas will be highlighted that exemplify a significant contribution to improving quality, achieving cost savings, or increasing revenue.

As many ways as possible should be sought to recognize employees for their participation in this process.

**How does an employee submit an idea anonymously?**
If an employee chooses to submit an Idea Form anonymously, it should be directed to the PREPARE/21 Coordinator.

However, employees are strongly encouraged to submit their ideas openly so that there can be an opportunity to obtain additional information, clarify the idea, and give the employee a response and recognition.

**Election Process**

**How are Screening Committee members and Council members elected?**
Elected members are determined through a nomination process. Employees in each of the following categories may nominate themselves and/or other employees to serve on Councils or the Screening Committee. Employees will then vote on the nominees in their own category.

- Administrative office support
- Clinical support
- House officers
- Nonclinical support
- Nursing
- Research staff
- Staff physicians

The Screening Committee will have at least one elected member from each of these categories. But for each Council, this will not always be the case since members will be elected from those categories of employees who apply to that division or service Council. For example, the Public Participation, page 27
Affairs Council would not have an elected member from clinical support, house officers, staff physicians, nursing, or research. At the same time the Council could have more than one elected member from the administrative office support and nonclinical support categories to achieve the best overall Council composition.

The Screening Committee should have at least one elected member from each category and they may be either management or nonmanagement employees.

The highest vote-getter will serve as the elected member for that category, but only one member may serve from any one division or service. This will provide the broadest representation possible.

Management and nonmanagement employees are eligible.

The highest vote-getter will win, but only one employee from any division or service may serve on the Screening Committee.

Who is eligible to be elected?
Any employee who has been employed at Beth Israel or by a BI Foundation for one year or more is eligible to be elected to his or her PREPACRE/21 Council or to the PREPACRE/21 Screening Committee.

Anyone who has been employed by the hospital for at least one year is eligible for election to his or her Council or the Screening Committee.

Who will conduct the elections?

Councils
Once the chairperson and the appointed members of the Council have been named and announced to that division or service, the Council elections will be conducted. The election will be overseen by the Chief, Vice President, or Council chairperson. Elections will be conducted with the assistance of managers and supervisors.

A broadly representative election process will create membership in the Councils and Screening Committees.

Ballots will be prepared by the Council chairpeople or their designates. After the election, ballots will be tallied by the Council chairperson or designate. Only the highest vote-getters will be published. Each nominee may request information as to his or her placement.
Screening Committee
Once the chairperson and the appointed members have been named and announced to all employees, elections will be conducted by the Committee chairperson and the PREPARE/21 Coordinator with the assistance of managers and supervisors.

In general, elections will be held three months before membership is to begin, to allow time for the training and orientation of newly elected members. New members will then be able to go to meetings as observers for the two months preceding the time they assume office. (For the first elections this process may be modified.)

Members of the PREPARE/21 Planning Committee may be asked to assist in running the first election, unless they are running for elected member positions. In future years elected members may be asked to help with the election process (distribution of ballots, collection of ballots, dispersing information) unless they are running for second terms.

How long will the term of membership be for an elected member?
The term of membership will be one year with a two-year maximum for consecutive terms served. Employees may run for a different membership following their two terms or may run again following at least a year's hiatus.

If an elected member cannot complete his or her term, the person who had the next highest number of votes will complete the term. When the employee ran unopposed, a special election will be held.

Who is eligible to vote?
Every Beth Israel and Foundation employee employed on election day is eligible to vote. Absentee ballots will be permitted for employees on vacation and for those on a leave of absence for three months or less on election day.
What are the desired attributes of elected members?
The desired attributes of elected members should include:
- leadership skills
- ability to communicate effectively
- accessibility
- objective and fair-minded, and perceived as such
- nonparochial, that is willing and able to consider the overall good of the hospital

How many elected members serve on a Council or the Screening Committee?
The number of elected members will be the same or greater than the number of appointed members on the Screening Committee and each Council. The total number will be determined by the division Vice President or Chief of Service in conjunction with the designated chairperson.

What are the elected members' responsibilities?
- to become knowledgeable about the hospital's mission, mandate, goals, gain formula, and divisional goals
- to become knowledgeable about the PREPARE/21 process, its objectives, and how it operates
- to attend meetings of the committee to which they were elected
- to ensure that employees receive information necessary for their active participation in the PREPARE/21 process
- to present ideas on behalf of employees who submit them confidentially
- to communicate back to employees who submitted ideas confidentially on their review status and then the results of the review
- to serve as a resource to employees in their division or service to explain how the idea review process works and how to submit ideas

Participation, page 30
What will the training requirements be for elected members for both the Screening Committee and the Councils?

An orientation session will be conducted for elected members to learn about the importance of participation and what it means, including:

- effective communication techniques
- good listening techniques
- group dynamics — how to work in a group
- how to use the Idea Guide and Idea Form
- the equity formula and Period Financial Report
- Beth Israel's organizational structure

New members will also attend meetings with incumbent elected members as observers before assuming office.

How and when will the PREPARE/21 process be evaluated?

Within a year, an Ad Hoc Work Team will be designated by the President and Executive Vice President to determine if the PREPARE/21 process has met its objectives and to make recommendations for changes. The Ad Hoc Work Team will include appointed and elected members from the Councils and the Screening Committee as well as other employees who have not served in either an elected or appointed capacity.

This evaluation process will be performed annually, and the results will be shared with employees and the Board of Trustees.

The PREPARE/21 process will be evaluated each year by an Ad Hoc Work Team designated by the President and Executive Vice President.
Equity

The cornerstone of the equity plan is quality of performance in patient care, teaching, research, and support services.

The term "Equity" has two meanings for us.

The first is "that which is fair and just," and refers to our belief that all Beth Israel employees help to shape the quality of the hospital's overall performance. It is fair and just, then, that they share in the benefits that may result.

The second meaning has to do with the sense of ownership we feel when we invest in something. It could be investing money in anything from a house or car to stocks and bonds; it could be investing time and effort and talent in anything from making a piece of furniture or fixing something broken, to working to help elect someone to office. In each case, we feel some sense of ownership arising from our investment, and we expect to benefit in some way from the result.

At Beth Israel, our patients make an investment by choosing this hospital for care. Our community invests because its members rely on Beth Israel to be capable and available when needed. And our employees and medical staff invest by committing a major part of their waking day to their jobs and to Beth Israel's mission.

For our Patients' Equity, there are the benefits of the highest quality medical care, teaching, and research within a humanistic and ethical framework.

For the Community's Equity, there is the hospital's continuing existence, with constant improvement of the resources necessary to deliver the highest quality patient care, teaching, and research.

For our Employees' Equity, the return on their investment includes enhanced job security; better and safer work conditions; fair personal treatment; professional growth and opportunity for investing time, talent, and ideas; the ability to participate in and influence decisions within an individual's area of competence; the opportunity to help provide care for the ill; the opportunity to improve overall hospital performance; and the opportunity to share in various kinds of benefits from participation in PREPARE 21.

Our continual seeking of quality means that all employees will know what is expected of them in their jobs; will have the

In Brief...

The cornerstone of the equity plan is performance.

Equity means that which is fair and just. It also refers to our sense of ownership when we invest in something.

Our patients, community, and employees and staff all have a return on their investment in the hospital. That is their equity.
qualifications to perform these tasks; and will attempt to meet these expectations on time and get them right the first time with optimal use of time and resources.

Consistently achieved improvement in performance and productivity will result in continued improvement in quality, in overall reduction in operating costs, and therefore in gains to be shared by employees and the hospital.

**Ethical Concerns**
Recognizing an obligation to balance the actual institutional bottom line, the equity plan affirms a commitment to Beth Israel's mission: the provision of humanistic, ethical patient care within a practice of academic medicine of high quality. The equity plan therefore must not only ensure but also enhance these values. (While the concept of quality implicitly affirms such values, concern for and commitment to them should be explicit.)

It is important to acknowledge a potential for ethical conflict between the necessity of cost-savings and the responsibility of properly meeting professional obligations to patients, colleagues, students, trainees, research, and institutional support activities.

Thus, the equity plan must be implemented in a manner that will not conflict with the employee's fulfillment of professional and ethical responsibilities or quality of work. The plan should confirm and reinforce professional commitment. Should conflicts arise, a mechanism will be found to preserve the values at risk. Concern for these values must pervade all decision-making, both on an individual and work team level.

**The Gain-Sharing Program**
The equity plan identifies three major groups whose interests must be considered in a fair and balanced manner — Patients, Community, and Employees. Employee equity mandates that for their investment of time, expertise, effort, and commitment, employees should share in any monetary gains thereby achieved, and a gain-sharing formula will be implemented to accomplish this goal. The following sections describe the sources of this formula and how employees will participate.

**Sources of Monetary Benefits from Our Equity**
Monetary benefits arising from the implementation of PREPARE/21 will be realized:
1. from the value of ideas that are...

Improvement in performance and productivity will result in reduced operating costs and gains that will be shared by employees and the hospital.

The equity plan affirms a commitment to Beth Israel's mission.

The equity plan will not conflict with an employee's professional or ethical responsibilities or with the quality of his or her work.

Employee equity mandates that for an investment of time, expertise, and commitment, employees should share in any gains thereby achieved.

Gains will be provided from budgeted improvements,
accepted through the PREPARE/21 participation process

2. from successful efforts to purchase and consume less

3. from increasing the hospital's volume of patients served

These improvements will generate the dollar gains which, in turn, will yield the monetary returns on our equity.

**Measuring Gains**

Gains will be measured at the overall hospital level, and there will be three sources:

1. The difference between budgeted expenses and actual expenses (costs). If actual expenses are less than budgeted, there will be a gain. But if actual expenses are greater than budgeted, there will be no gain from this source.

2. The difference between budgeted inpatient admissions and outpatient visits and actual admissions and visits. Again, if volume exceeds the budget, there will be a gain and, conversely, if volume is less than budget there will be no gain.

3. The dollars actually saved from the Idea Review Process explained in the participation section, once ideas are implemented.

Only those costs associated with activities, operations, and responsibilities that employees can influence through individual and participatory effort will be included. For the purposes of the equity plan, depreciation, interest, and pension expenses will be excluded from the calculation of gain because employees do not influence them. How every employee influences and manages costs will determine, collectively, whether there is a gain. The best way to influence costs will be to strive for improved quality of the work we do for each other and for patients, to offer suggestions for cost reduction, and to participate in work team efforts to improve operations.

The method of distributing gains will be determined by a gain-sharing formula. The formula will govern gain-sharing for a fiscal year; therefore, no gains or losses will be brought forward to a new fiscal year. The basis of the formula is as follows:

*Gains will be measured at the overall hospital level, coming from the difference between budgeted and actual expenses, budgeted and actual admissions and outpatient visits, and savings from ideas.*

*Only those costs that employees can influence will be included in the gain calculation.*

*Gains will be determined by a gain-sharing formula.*

*Equity, page 34*
1. Board of Trustee approval of the hospital's annual operating budget must be obtained, as in the past. It is possible that circumstances will require the Board of Trustees to modify the annual operating budget, as also in the past. In such a case, the revised operating budget will serve for purposes of calculating the gains.

2. The budgeted amount of depreciation, interest, and pension expense will be excluded from total Board-approved budgeted expenses for this calculation. Similarly, nonoperating income (interest earned, charitable contributions to the hospital, etc.) will not be included.

3. With each approved operating budget, the dollar value of each admission and outpatient visit will be established by the Vice President, Finance. The dollar value will be set at an amount that approximates the net revenue less variable costs of each item.

4. At the completion of each four-week fiscal period, the accounting department will prepare a Period Financial Report (Appendix F, Appendix G).

5. The difference between actual and budgeted volumes and expenses (excluding the actual amounts of depreciation, interest, and pension expense) will be obtained from these statements and placed on the Gain Sheet (Appendix G).

6. The sum of the actual dollar savings of all ideas accepted for implementation by the PREPARE/21 process during the preceding 12 months will be divided by 13 to arrive at the period's amount of savings. This amount will be placed on the Gain Sheet. The dollar amount of any savings idea will have deducted from it the amount of the annual depreciation expense associated with any capital (equipment or renovation) investment necessary to implement the idea.

7. The sum of the dollar value from patient volumes (Gain Sheet, Appendix G, line 11), actual versus budgeted expenses (line 14), and ideas (line 15) will be the total dollar amount of gain for the period.

8. Twenty-five per cent of a period's total gain will be held in reserve and not paid out at that time.

Each fiscal period a financial report will be prepared and distributed to employees.
At the end of each fiscal year any balance in the reserve fund will be released for payment by the second week in December. The reserve fund is necessary to handle unusual swings in either expenses or volumes and to handle any year-end adjustments to expenses.

9. Fifty per cent of the resulting net gain will be allocated to the gain-sharing pool for distribution to employees with the hospital retaining fifty per cent for furthering Patient and Community Equity.

10. The total amount in the gain-sharing account will be converted to a percentage of eligible salaries. Therefore, an employee's period gross wages will be multiplied by this percentage to yield a gain payment for a period. Wages earned will include all components of an employee's pay, including overtime, shift differential, and earned time (excluding Earned Time cash-ins and on-call pay) up to a limit of $3,846 per period. (This upper limit is $50,000 per year, the figure that the Internal Revenue Service uses to define highly paid individuals.) The percentage calculation used to distribute the gain payment will be the same for all employees, a methodology that meets requirements of the Fair Labor Standards Act. This upper limit will be increased at the start of each year by the average increase in wages for the budget year as established by the Vice President of Human Resources. Any gain payment received by an employee will not affect the employee's fringe benefits, i.e., no impact on pension, life insurance, etc. However, gain payments must be included in an employee's taxable income and therefore appropriate taxes must be withheld on a period basis, according to tax law.

11. To be eligible to receive a payment the following criteria will be met:

All employees (including those on grant funds), except as noted below, who have completed three months of employment will qualify for the payment. This will include full-time and part-time employees, regardless of the number of hours worked.

Those in a training (student) status will not qualify, except for house staff (interns, residents) and fellows.

Net gain will be distributed 50/50 between the hospital and employees.

The gain will be based on a percentage of period gross wages. Appropriate taxes will be withheld. The maximum amount of annual wages on which the gain will be based will be $50,000.

Full- and part-time employees of more than three months will be eligible for gain payments.

Except for house staff and fellows, employees in training (students) will not qualify for
Employees will not qualify for the gain payment (including any reserve payment) unless they are on the payroll on the date that the gain is paid.

Gains to physicians (excluding interns, residents, and fellows) will be paid only for administrative and teaching services. No gain will be paid on physician income derived from direct patient care. All physicians on the hospital payroll will be eligible for a gain payment, although the gain will not be calculated on their actual salary. Instead, an equivalent salary amount will be established to cover the services for teaching and administration.

12. A minimum gain of 1/2 of 1 per cent (0.5%) must be exceeded for a gain to be paid. Any unpaid gain will be added to future period gains and paid when the combined gains exceed the minimum.

13. If the sum of the three sources of gain is negative, there will be no gain for that period. Also, before a gain is paid, the sum of the positive results must exceed the amount of any negatives, as calculated on a cumulative “year-to-date” basis.

14. Each PREPARE/21 gain payment will be made on a separate PREPARE/21 check.

15. All PREPARE/21 gain checks will be paid on the last Thursday of a period for the results of the prior period. In addition to the check, the employee will receive a copy of the Gain Sheet.

16. An equity calculation committee will be formed to review the calculations prepared by fiscal services.

Measurement of Performance Improvement
Under PREPARE/21, benefits will arise from improvement in performance in patient care, teaching, research and research overhead, and operations, which will be measured by methods developed by employees participating in work teams. The purpose of the measurement is to quantify and track performance of individual departments over time.

Improved performance is critical in order to produce gains. The plan will involve all employees and will focus on improving the quality of patient care, teaching, research,
and institutional support services. The fundamental activity will be to ask the questions “How can I (we) improve what I am (we are) doing?” “Is there a better way?”

Each unit of the hospital will identify tasks, procedures, activities, methodologies, functions, etc., fully or partially within its domain that can improve one or more aspects of its operations. Next, established work teams should work to devise relevant indices of their own performance that can be defined, easily understood, and quantified. Next, work teams should develop ways to measure, follow, and report this performance, then work to generate improvement. In addition, each unit will set time goals for accomplishing planned improvements and report improvements to all employees.

**PREPARE/21 Period Financial Report**

A major goal of PREPARE/21 is to help employees become more knowledgeable about the hospital's environment, a significant component of which is financial. Understanding the finances of the hospital is essential if one is to understand how and why certain decisions are made.

To start this education process, the equity subcommittee has designed a report (called the Period Financial Report) which will be distributed each fiscal period to every employee. It contains both statistical and financial information. The statistical information documents the number of patients receiving care at the hospital and how that number compares with expectations. The financial information is a condensed statement of revenues and expenses for the hospital for the fiscal period and on a year-to-date basis.

The information contained in the Period Financial Report is in addition to the specific information that will be distributed relating to the gain calculation each period. This report will be distributed at the same time as the gain calculation.
Expanded Mission Statement
Adopted by the Beth Israel Board of Trustees
November 1983

The major mission of the Beth Israel Hospital is to deliver patient care of the highest quality, in both scientific and human terms. This mission is to be carried out within a framework of financially responsible management which is sensitive to the requirements both to deliver health care which is efficient and cost-effective and to be considerate of the overall health needs of the population of concern to the hospital.

Patient care at Beth Israel Hospital is to be provided in a context of clinical teaching, through the participation and teamwork of clinicians, teachers, research scientists, and others who are also the sources of innovation and progress for future improvement in care capabilities. The strength of Beth Israel is partly attributable to its role as a major teaching hospital affiliated with Harvard Medical School; to maintain and strengthen that role, the hospital will continue to exercise leadership through excellence in teaching and research activities as well as in its clinical services.

The strength of Beth Israel is also attributable to its mix of physicians — those whose primary activities are directed toward the broad practice of clinical medicine and those whose activities focus primarily upon teaching, research, and more delineated clinical practice. While it is recognized that either group partakes of some of the activities of the other, it is understood that both are essential to the future of Beth Israel Hospital. The continuing productive and complementary relationship of each with the other shall be fostered, within the limits of available resources, in support of the hospital's overall mission.

Although the strong humanist tradition that characterizes Beth Israel Hospital arises in part out of its Jewish community origins, Beth Israel has been viewed from its inception as a non-sectarian organization evolving out of the founding and continuing effort of its Jewish community for the benefit of the community at large. The hospital will continue to promote actively the utilization of its facilities and services by practitioners and patients of every faith, race, and nationality, and to provide equality of opportunity in its employment practices. At the same time, the hospital will maintain its special and close relationship to the Greater Boston Jewish community, with particular view toward providing a leadership role in assessing the health-care needs of that community and in planning for those needs to be met.
The Beth Israel Hospital Mandate

As our health-delivery system experiences significant pressure from government and business to reduce costs and improve the outcome of patient care, Beth Israel Hospital can remain competitive, if we take full advantage of our successes of the past. All aspects of patient care — diagnosis, treatment, and caring — must continue to be superior. Our professional standards must be the most rigorous, and our medical education and research programs must sustain and enrich their long traditions of excellence.

In the past, it was enough to be identified with quality and effectiveness by our patients and those who collaborate with us in research and education. This will not suffice for the future. Our reputation as Boston’s best, in patient care and scholarship, must extend beyond those who know us first-hand to include the public at large.

To remain current with important diagnostic and treatment discoveries, Beth Israel must annually generate surplus income for reinvestment in our future. This demand for continuous renewal will require that we become even more competent as individuals and as an institution in delivering the highest quality patient care at an ever-decreasing cost per unit of service.

We must all be responsible for finding ways to cope with the new requirements of our environment, and be willing to be held accountable for the implementation and success of our proposals. Rather than compromise our traditional standards, the Beth Israel response will be to pursue new opportunities generated by the ingenuity and involvement of informed and committed employees and medical staff who consider the hospital’s problems their problems.

We will constantly strive to create an institutional climate in which each of us feels that Beth Israel is a good place to be — an organization which highly values its most important resource, its people, and an organization which provides each of us an equitable return on our investment of time and talent.

David Dolins
Executive Vice President and Director
January 1987
Rights, Responsibilities, and Opportunities of Employees and Staff at Beth Israel Hospital

Boston's Beth Israel was the first hospital to issue a statement on the rights of patients. Published in 1972, the document arose out of the hospital's concern that changes in technologies and economics could erode the warmth and personalization we felt to be essential to excellence in medical diagnosis and treatment. Our Statement on the Rights of Patients fostered growing responsiveness to the human concerns of caring at Beth Israel and, subsequently, elsewhere.

Because economic and societal pressures influence both work life in hospitals and the care of patients, and because the nature of that work life and the quality of patient care are intertwined, Beth Israel Hospital issues the following statement of Rights, Responsibilities, and Opportunities of Employees and Staff. We believe the policies, intentions, and actions backing up this statement will enable the hospital and its employees and staff to strengthen the value of working at Beth Israel, and by enhancing the quality of work life, to make even more outstanding the excellence of our patient care.

Over the years, Boston's Beth Israel Hospital has grown in capability and performance through the efforts of its employees and its staff, and its volunteers and donors, from a small community hospital to one of the nation's leading institutions for patient care, teaching, and research. Today, external pressures to reduce health-care costs pose a growing challenge to the fulfillment of our traditional mission:

The provision of medical care of technical excellence delivered to the patient with warm personalization and convenience, at competitive costs and with assured value greater than that of our competitors, in a manner which also helps fulfill our related responsibilities for excellence in teaching and research.

It is the intention of Beth Israel Hospital to master these environmental challenges as they arise, and to become stronger and more capable year by year. To do so requires the considerate, intelligent, and outstanding performance of every employee and staff member, and their careful selection, effective use, and efficient management of the hospital's buildings, equipment, supplies, utilities, and other resources. Because the hospital values its people as its most important resource, the following rights,
responsibilities, and opportunities of employees and staff are put forth as basic components of working at Beth Israel:

- To be informed about the realities we face.
- To help shape the directions the Hospital will take to sustain and strengthen its excellence.
- To understand how the achievement of that excellence requires ongoing investment of new resources in the Hospital's future.
- To understand and become committed to the long-term profitability required in order to generate those resources.
- To participate in forging the economies and increasing the productivity which must serve as the basis of the hospital's profitability, and therefore of its continuing excellence.
- To participate in setting one's own work-specific goals in order to make these achievements possible, because to define improved productivity and superior service, no one knows his or her job better than the individual doing it.
- To be held accountable for meeting those goals, because long-term operating profitability calls not only for the education of informed employees and staff but also their "ownership" of Beth Israel Hospital's problems as their problems and its solutions as their solutions.
- To be committed to achieve such goals, and be recognized as these goals are achieved and again as they may be exceeded.
- To participate in a challenging but rational, humanized, and fair working environment where employees and staff are valued and respected as individuals.
- To enjoy the potential for increasing personal and professional returns on individual investment of time and effort.

Committed to these rights and accepting the responsibilities and opportunities which accompany them, Beth Israel employees and staff will work to develop and manage new ways to sustain and improve our patient care, research, and teaching, and to carry out all the other activities appropriate to our role as a leader among hospitals.

Mitchell T. Rabkin, MD
President
January 1987
Idea Review Process

Listen, I was just thinking...

Whom does it affect?
- Just your work team
- Other work teams in your division
- Work teams outside of your division

Who reviews or decides who will review the idea?
- Your work team leader and work team
- Leaders of affected work teams or Council
- Leaders of affected work teams or Screening Committee

Who decides, after review, if the idea should be accepted?
- Leaders of affected work teams and appropriate management

What do they do?
- They let you and all those who reviewed the idea know if it was accepted or not and why
- If accepted
- If not accepted

What is the result?
- Implementation and recognition

If you have an idea:
1. Read the idea guide
2. Review the idea with your work team leader

Where your idea is sent for review depends on the following factors:

→ Idea → Review → Action!
Have you ever looked at the way work gets done either by you or by those around you and thought, "There might be a better way to do this," or "I could improve the way I do my work but it might really affect someone else's job."

Your ideas about how to improve the way work gets done can make a difference. Turn your thought into an idea, an idea into a plan, and your plan into action.

**STEP 1**

**HOW DO YOU DEFINE YOUR IDEA?**

Writing down your ideas helps you to think them through.

Once you have formulated your idea, ask yourself, "Rather than being an idea, is this really a complaint, or a problem that concerns my job, my relationship with my supervisor or peers, an issue of pay, benefits, my performance, or another employee’s performance?" If the answer is yes, please talk with your supervisor or the Employee Relations Specialist so they can assist you in addressing this issue.

The following questions may help you clarify your idea. If you do not understand the questions — or feel unsure of your answers — ask for help from your work team leader, your elected member, or the P R E P A R E / 21 coordinator.

- **What do you think needs to change?**
  For example, is it how a job is performed or how a service is provided? Is this a new service or a problem with something already done?

- **Why do you think change is needed?**
  For example, will your idea improve quality of patient care, quality of service, productivity, efficiency, quality of work life, or will it increase hospital revenue, reduce costs, avoid new costs, eliminate waste, or avoid foreseeable problems?

- **How would you change it?**
  What would you do differently? Be specific.

Now you have an idea!

**STEP 2**

**HOW DO YOU DETERMINE WHO SHOULD REVIEW YOUR IDEA?**

A new idea may affect others and may require changes in the way we work. Change is most effective if the right people are involved in the planning. Step 2 will help you decide where to bring your new idea for review.
Whom would this change affect?
- Does it affect your work team alone, other work teams, another department, another discipline, the whole hospital?
- Whose approval and cooperation appears to be a "must" to go forward with this change?
- Who would be needed to make this change?
- Does this change involve your job alone, your work team alone, or other work teams or departments?
- Who would know best how to make this change?
- What expertise does this idea require to determine if it will be feasible — yours, another discipline's, another co-worker's, an administrator's?
- Who would be responsible for implementing the idea?
- Who would have the authority to make this change, determine whether money will be saved (or more will be spent), and look at the effect of this change on the overall goals for the work teams and departments involved?

You can now turn your idea into action. You have an idea, you know who it affects, and you understand who can make the change!

STEP 3

HOW DOES YOUR IDEA GET REVIEWED?
There are two ways to have your idea reviewed and, if accepted, implemented:
1. Review your idea with your work team leader.

The following chart will help you decide where to go with your idea.

<table>
<thead>
<tr>
<th>Whom does the idea affect?</th>
<th>To whom do you talk?</th>
<th>Who reviews it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your job alone</td>
<td>Discuss your idea</td>
<td>Your work team leader</td>
</tr>
<tr>
<td></td>
<td>with your work team leader and/or team members to be sure it only affects your job</td>
<td></td>
</tr>
<tr>
<td>Your work team alone</td>
<td>Discuss the idea</td>
<td>Your work team leader</td>
</tr>
<tr>
<td></td>
<td>with other team members to be sure it affects only your team and to get their support and input</td>
<td></td>
</tr>
<tr>
<td>Your work team and other work teams</td>
<td>Discuss the idea with your work team and work team leader. Suggest that other work teams discuss the idea</td>
<td>Your work team leader and other affected work team leaders</td>
</tr>
</tbody>
</table>

The second way to have an idea reviewed is through the P R E P A R E / 2 1 Idea Review Process.
THE PREPARE/21 IDEA REVIEW PROCESS
To have an idea reviewed through this process, you will need to fill out an Idea Form, which is readily available. Ask your work team leader, your elected council member, or PREPARE/21 Coordinator if you cannot readily locate an Idea Form. In any event, you should talk with your work team leader or, if you prefer, a Council member or PREPARE/21 Coordinator to develop an idea and ensure it gets directed appropriately.

Use your answers to the questions in Steps 1 and 2 to write down your idea. Your idea may be submitted to your PREPARE/21 Councils:

**When**...
- Your idea affects other work teams within your division or service and could not easily be implemented by your work team alone
- Your idea was declined by your work team or other work teams within your division or service and you want another review
- Your idea does not involve your work team but does involve other work teams in your division or service

**To whom should you talk?**
- Talk with your work team leader on how to get the idea reviewed
- Talk with your work team leader. Find out why your idea was declined. Include this information on the Idea Form
- Talk with your work team leader to determine the best way to get your idea reviewed

Your idea may be submitted to the PREPARE/21 Screening Committee

**When**...
- Your idea impacts other work teams outside your division or service altogether
- Your idea involves other work teams outside your division or service and would be difficult to review or implement
- Your idea was declined by other work teams outside your division or service and you want another review

**To whom should you talk?**
- Talk with your work team leader about how to get the idea reviewed
- Talk with your work team leader
- Talk with your work team leader. Include the reasons why the idea was declined on your Idea Form
HOW DOES AN EMPLOYEE SUBMIT AN IDEA CONFIDENTIALLY?
Employees will always be encouraged to submit an idea openly through the Idea Review Process so that there may be an opportunity to obtain additional information, clarify the idea, and give the employee a response and recognition directly. However, if an employee wishes to submit an idea confidentially, an Idea Form may be sent to an elected Council member or the PREPARE / 21 Coordinator.

HOW DOES AN EMPLOYEE SUBMIT AN IDEA ANONYMOUSLY?
If an employee chooses to submit an Idea Form anonymously, it should be directed to the PREPARE / 21 Coordinator.
# Idea Form

**Beth Israel Hospital**

**PREPARE / 21 Idea Form**

**Submitted By:**

<table>
<thead>
<tr>
<th>Department</th>
<th>Ext./Page</th>
<th>Work Team leader</th>
<th>Date</th>
</tr>
</thead>
</table>

**My/Our Idea is:** (attach additional pages if needed)

---

**Received by:**

<table>
<thead>
<tr>
<th>Work Team</th>
<th>Council</th>
<th>Screening Committee</th>
<th>Date</th>
</tr>
</thead>
</table>

**Referred to decision-making group:**

- PREPARE/21 Council chair (s)
- Work Team Leader
- Ad Hoc Team

<table>
<thead>
<tr>
<th>Anticipated Date for Decision</th>
<th>Notification sent</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Response:**

- [ ] Accepted
- [ ] Declined

---

**Date to be Implemented**

<table>
<thead>
<tr>
<th>Respondent's Signature</th>
</tr>
</thead>
</table>

**Date received by PREPARE / 21 Coordinator**

**Have cost-savings been calculated?**

<table>
<thead>
<tr>
<th>Amount</th>
</tr>
</thead>
</table>

**Has the budget been adjusted?**

- [ ] Yes
- [ ] No, adjustment to budget is planned

**Date of Budget Adjustment**

---
Description of Period Financial Report

The hospital operates on a fiscal year that ends on the last Saturday in September. Therefore, most of our fiscal years have exactly 52 weeks or 364 days. Since the calendar has 365 days in a year, every few years the hospital has the equivalent of a "leap year" in order to catch up. Our leap years have an extra week in them.

Because our fiscal year normally has 52 weeks, we split it into 13 fiscal periods, each of which has 28 days, four Saturdays and four Sundays. It is much easier to compare equal periods than to compare months, which have different numbers of days and may include either four or five weekends.

Every four weeks, the hospital's accounting department closes the books and issues financial statements for the period. These statements tell how the hospital is doing from a financial standpoint for those four weeks and for the fiscal year up to that point. The financial statements compare what we have done in relation to our budget, which is our financial plan for the year. It is important to understand why there are differences (called "variances") between what we actually did and what we planned to do. If the differences are good (what we call "favorable" variances), perhaps we can try to do more of the same or apply a similar idea in another area so that we can do even better. If the differences are bad ("unfavorable" variances), we might be able to take action to change the situation that is producing bad news.

Part of the PREPARE/21 process requires all employees to understand better the financial results of the hospital, in order to understand the reasoning behind many of the hospital's decisions. The Equity Subcommittee of the PREPARE/21 Planning Committee has designed a special financial report for all employees that summarizes the hospital's financial results. You will receive this report from your supervisor or work team leader shortly after the end of each fiscal period.

The report is divided into two major sections. The top half of the report gives you some information about the number of patients for whom we have been caring. The lower half shows a condensed statement of revenues and expenses. Both sections are important in order to understand what is going on in the hospital.

The statistical section tracks three indicators of our patient volume. The first is OCCUPANCY. Occupancy tells you what percentage of our beds are filled ON AVERAGE in any given period. If all our beds were filled every day, our occupancy would be 100 per cent. Beth Israel has been averaging about 90 per cent occupancy over the past few years. By comparison, the average hospital occupancy in Massachusetts in fiscal year 1988 (October 1987 to September 1988) is 65 per cent.
The chart is set up so that you can see the occupancy each period during the fiscal year. At the right end of the chart is the average occupancy for the fiscal year so far. You might notice that occupancy falls off in Periods 3 and 4. This is a well-established historical pattern due to a fall-off in patients over the Chanukah/Christmas/New Year’s holiday period.

Occupancy may go up for two reasons. The first is that we are taking care of more patients. The second is that our patients are staying in the hospital longer. Generally, taking care of more patients is good for the hospital financially. Having our patients stay longer is not good financially. So, if you want to know whether the change in our occupancy is good or bad, you need to look at adult admissions, which is the second indicator on the report.

Adult admissions tells you how many patients came into the hospital as inpatients for the period. It includes all patients except newborn babies. This information is presented in a graph format. For each fiscal period, the graph has two bars. The bar with lines in it represents the budget and tells you how many admissions we thought we would have for the period. The solid black bar represents our actual admissions for the period.

If the solid bar is taller than the bar with lines, we had more admissions than we planned. Generally, this is good for the hospital financially. If the solid bar is shorter than the bar with lines, we had fewer admissions than planned, which is not good. At the bottom of the graph are the year-to-date figures for admissions. In most years, we budget an increase in admissions from the year before. Even if we are slightly under the current year’s budget, we are often treating more inpatients than we did the previous year.

The third indicator is total outpatient visits. A significant portion of the hospital's business comes from patients who do not stay in the hospital overnight. They come in for routine visits or treatments at one of our specialty units or the emergency unit and then go home. Many patients visiting Stoneman 1 have minor surgery and go home afterwards. Such outpatients are illustrated in a graph of this indicator. Included in total outpatient visits are patient visits to Healthcare Associates, psychiatry, the dental unit, all of our specialty units, Stoneman 1 outpatient, the emergency room, and the medical walk-in center.

The graph for total outpatient visits is set up the same way as the graph for adult admissions. The bar with lines represents our budget and tells you how many outpatient visits we thought we would have. The solid line represents actual visits. In terms of hospital finances, it is good if we have more outpatient visits than we budgeted and it is bad if we have fewer visits than planned.
These three indicators provide a clear idea of how many patients pass through the hospital each period and how busy we are as a result. There are other factors as well, such as the complexity of illness of our patients and the extent of effort they may require from us as a result of that complexity. When we devise appropriate measures of these factors, they may be included as well in reports to employees.

The lower half of the report shows a condensed statement of revenues and expenses. This statement shows how we are doing financially for both the period (on the left side) and for the year-to-date (on the right side). Each side has three columns: Actual, Budget, and Variance. As in the graphs, the budget represents what we thought would happen and the actual column shows what really happened. The variance column is the difference between the actual and the budget.

It is important to remember that there are both "good" (positive or favorable) and "bad" (negative or unfavorable) variances. For example, if admissions or outpatient visits exceed what we had planned, the result is a "good" or favorable variance; if expenses exceed what we planned, the result is a "bad" or unfavorable variance.

Net Operating Revenue is the first line on the statement. Over 90 per cent of this is the revenue the hospital receives for taking care of patients. Of the remainder, about half is the money that some of our research grants pay us for use of the hospital and its facilities. This is called Research Overhead Recovery. The rest is revenue from places like the parking garage and the cafeteria. Research overhead pays some of the "rental" costs — space, utilities, environmental services, etc. — for research activities; it does not represent a net profit. Similarly, garage and cafeteria revenues pay the costs of these activities.

Salaries and Wages (S & W) are the direct payments made by the hospital to its employees. Salaries and wages by themselves amount to about half of our expenses. When you add payroll-related expenses such as the cost of fringe benefits and payroll taxes, which are included in the supplies and expenses line, the total "cost of people" is around 60 per cent of the hospital's expenses.

Supplies and Expenses (S & E) are all the other costs of running the hospital except for S & W, the direct payments to employees. This category includes such items as supplies used by us in taking care of our patients, utilities, office supplies, fringe benefits, insurance, and much of our operating equipment. Supplies and expenses represent a major opportunity for all of us to be more efficient, by managing these resources prudently but without sacrificing quality, while at the same time increasing our professional and management competence.
APPENDIX F

Operating surplus or deficit is how much net revenue the hospital has left after it pays all of its expenses. Net revenue represents what we actually get paid, and not our listed "charges." If the hospital has more net revenue than expenses, that is called a surplus. A regular business would call it a profit. If the hospital has more expenses than revenue, that is called a deficit, which a regular business would call a loss. If we have a deficit in either the actual or budget columns, we put it in parentheses so it is easy to identify.

Looking at our budget by period, note that in some periods we have budgeted a surplus, and in others a deficit. As noted previously, we always experience a reduction in patient volume over the holiday period in December and January. Therefore, our revenue goes down then, but our expenses do not go down to match. If revenue goes down, but expenses stay the same, we will run a deficit.

Also, as the fiscal year goes on, expenses go up. This is because of inflation in the cost of our supplies and because, as our employees receive any merit increases, the cost of salaries and wages goes up as well. Our revenues do not go up because of these factors. Therefore, we tend to move towards deficits in those periods at the end of the fiscal year as well.

If we have a smaller deficit than we budgeted, that will show as a favorable variance because we lost less money than we thought we would. We also can have a surplus for a period and still have an unfavorable variance because we didn’t make as much money as we planned.
Admissions for the year were slightly under budget. We had more Obstetrics admissions than planned but not as many Medical/Surgical admissions.

Outpatient visits for the year were slightly under budget also. This was because we did not have as many visits to the Walk-In Unit as planned.

Revenue for the year was $1,622,000 better than budgeted. However, expenses were $1,689,000 worse than budgeted. Therefore, our operating deficit was worse than we had planned by $67,000.
I. PREPARE / 21 Volume Factor

1. Admissions:  
   - Budget: 9,384  
   - Actual: 9,400  

2.  

3. Variance Favorable (Unfavorable)  
   - 16  

4. Value Per Admission  
   - $2,794  

5. Inpatient Volume Factor (lines 3 x 4)  
   - 44,704  

6. Outpatient Visits:  
   - Budget: 45,276  
   - Actual: 44,832  

7.  

8. Variance Favorable (Unfavorable)  
   - (444)  

9. Value Per Visit  
   - $83  

10. Outpatient Volume Factor (lines 8 x 9)  
    - $(36,852)  

11. Total PREPARE / 21 Volume Factor  
    (line 5 + line 10)  
    - $7,852  

II. PREPARE / 21 Savings Factor

12. Budget Expenses  
    - $36,577,000  

13. Actual Expenses  
    - $36,500,000  

14. Total PREPARE / 21 Savings Factor  
    (line 12 - line 13)  
    - $77,000  

III. PREPARE / 21 Ideas Factor

15. This Period's PREPARE / 21 Ideas Factor  
    (see appendix G-1)  
    - 101,148  

16. Total Gain so far This Year (lines 11 + 14 + 15)  
    - 186,000  

17. Less: Part of Gain Held in Reserve (25%)  
    - 46,500  

18. Gain to be Shared (line 16 - line 17)  
    - 139,500  

19. Less: Gain Previously Shared  
    - 0  

20. Available for Distribution This Period  
    - 139,500  

21. Employees' Share (50% = 1/2 line 20)  
    - 69,750  

22. Eligible Salaries This Period  
    - 6,925,000  

23. Percentage to be Paid (line 21/line 22)  
    - 1.00%
<table>
<thead>
<tr>
<th>The Idea</th>
<th>Department(s) Affected</th>
<th>Period Implemented</th>
<th>Dollar Value Per Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the type of paper that certain patient bills will use</td>
<td>Ambulatory Accounts</td>
<td>X</td>
<td>$1,000</td>
</tr>
<tr>
<td>Change the type of paper cups stocked in the hospital</td>
<td>All</td>
<td>X</td>
<td>2,000</td>
</tr>
<tr>
<td>Reduce security guard duty at 109 Brookline Ave.</td>
<td>Security</td>
<td>X</td>
<td>3,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>95,148</td>
</tr>
<tr>
<td>All other ideas accepted</td>
<td></td>
<td></td>
<td>101,148</td>
</tr>
</tbody>
</table>

Total year to date

To Gain Sheet (line 13)