University of Pennsylvania Health System

Driving Down Operating Costs

Keith A. Kasper
SVP & Chief Financial Officer

New York Presbyterian
October 28, 2011
TRUSTEES OF THE UNIVERSITY OF PENNSYLVANIA

PENN Medicine Board

President of the University

University EVP/SOM Dean

School of Medicine

Clinical Practices of the University of Pennsylvania (CPUP)

Hospital of the University of PA (HUP)

PENN Presbyterian Medical Center (PPMC)

Pennsylvania Hospital (PAH)

Clinical Care Associates (CCA)

Penn Home Care and Hospice Services (PHC&HS)

Health System
Focus on high intensity activity growth in combination and cost control has enhanced our financial position and allowed for increased investments across all missions.
Quality Improvement and Cost Focus are Compatible

MORTALITY
INFECTIONS
LENGTH OF STAY
READMISSIONS

PATIENT & STAFF SATISFACTION
REFERRALS TO POST-ACUTE CARE
P4P IS ON TRACK
Labor and benefit costs represent 55% of total operating expenses and are managed to activity levels. FTEs/AOB levels have declined 4% over the last four years while the CMI has increased 7%.
Constant Focus on Appropriate Staffing Levels and Benefit Costs

Our primary time, attendance and scheduling system is Kronos. We supplement this system with entity based Labor Dashboards that provide trending of key metrics: FTE/AOB, nursing hrs/pd, overtime, contract labor, SWB % NPR.

Physician clinical department productivity metrics included:
   • Salary Coverage (all revenue sources)
     • Tenure 104%, Research 95%, Acad. Clinician 157%, HSC 162%
   • Clinical productivity RVU’s versus benchmark (65% of UHC)
   • Departmental overhead % of revenue
     • Hospital based 43%, Medicare 68%, Surgical 66%
   • Room Utilization (visits/room/day)

Recent benefit plan modifications include:
  • Pharmacy benefit change (employer purchasing coalition, Rx mail order, dispense as written, hospital retail pharmacy utilization incentive. ($3.8M)
  • Co-pay differential for non domestic utilization. ($1.2)
  • New hires to 403b effective 7/1/11, Defined benefit participants given one time choice to move to 403b. Provides retirement cost stability over time.
UPHS: Supply Costs per Adjusted Admission

Volume adjusted supply costs across the Health System have grown 1% over the last 4 years. Variability across entities is reflective of service mix.
Clinical Leadership is a Partner in Supply Chain

UPHS unit pricing is very competitive through a combination of group purchasing (UHC/VHA) and direct contacting.

Entity based Supply Chain Committees evaluate new technology requests in addition to savings opportunities identified by Value Analysis Staff. Issues spanning the Health System are evaluated by the Corporate Supply Chain Committee.

Both quality and financial impacts are part of all reviews.

Clinical leadership is often a key element in capturing savings or avoiding costly, limited value new technologies. In cases where extraordinary clinical efforts are required savings are often shared.

Recent successes include:
- Reduction of spine implant costs across all vendors.
- Reduction of orthopedic implant costs across all vendors.
- Restricted utilization of MRI ready implant
- Structured evaluation of surgical site preparation.
Quality and Finance Partnership

UPHS Invested in bringing the clinical strategy to the frontline by establishing “local leadership” on each hospital unit.

Physician Leader and Nurse Leader are paired at the hospital unit level — with a Project Manager for Quality who brings data and project management skills.

We call these trios “UBCLs,” for “Unit Based Clinical Leadership.”
## Quality Strategies for UPHS

The CMOs and CNOs identified targets directly aligned to the UPHS Blueprint for Quality and Patient Safety, which is UPHS’ framework for clinical strategy.

### Transitions in Care

<table>
<thead>
<tr>
<th>All Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase use of homecare</td>
</tr>
<tr>
<td>• Med reconciliation on admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Selected Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HUP only: 25% reduction in preventable readmits for CHF, Diabetes &amp; Anticoagulation for patients from HCHS</td>
</tr>
<tr>
<td>• Increase appropriate use of hospice</td>
</tr>
<tr>
<td>• Core measures — heart failure discharge instructions</td>
</tr>
<tr>
<td>• Unplanned readmission to ICU</td>
</tr>
</tbody>
</table>

### Reduce Variations in Practice

<table>
<thead>
<tr>
<th>All Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce CR bloodstream infections</td>
</tr>
<tr>
<td>• Reduce urinary tract infections</td>
</tr>
<tr>
<td>• Time to admin of STAT antibiotics</td>
</tr>
<tr>
<td>• Decrease rate of DVTs &amp; PEs</td>
</tr>
<tr>
<td>• Decrease falls with injury</td>
</tr>
<tr>
<td>• Decrease pressure ulcers</td>
</tr>
<tr>
<td>• Adherence to hand hygiene</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Selected Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ventilator-associated pneumonia</td>
</tr>
<tr>
<td>• SCIP (Surgical Care Improvement Program)</td>
</tr>
<tr>
<td>• Process improvements for high risk patient populations</td>
</tr>
</tbody>
</table>
Quality investments are vetted by the senior leadership as part of the annual budget planning process.

Both quality and financial expected outcomes are incorporated into entity operating budgets and incentive compensation plans.

Recent successes include:

- Reduction of blood stream infections reduced by 75% resulting in >$10M of drug cost savings and increased capacity through lower LOS.

- Increased reporting and focus on appropriate use of hospice care resulting in improved patient/family satisfaction, reduced MICU length of stay, and freed critical care capacity.