

POWELL HALL FOR USE BY
AMBULATORY PATIENTS AND FAMILIES

We are happy to announce that a new service for patients and their families has been instituted and is effective immediately. The 3000 corridor in Powell Hall is now a motel-type accommodation for outpatients and their families, as well as the families of inpatients. As yet no priorities have been set, but it is planned primarily for county authorized outpatients here for clinic appointments and those who can't afford commercial facilities. Although there is no allotted length of time a guest may occupy a room, it is hoped that visitors planning a rather lengthy stay here will find other accommodations so that the Powell facility may serve as many patients as possible. There is a great need for sleeping facilities for other patients too, but because of the shortage of space in Powell Hall we must accommodate those with the greatest need first. We will be studying its usage to help us determine the amount of expansion that appears desirable in the future. At the present time there are both double and single rooms, totaling 22 beds. Cots are available, as are cribs for infants. There is also a sitting room with a television for the guest's use.

Before sending a patient directly over to Powell Hall, please call the receptionist at hospital extension 2691 to ascertain the availability of rooms, giving the patient's name, and county, if he is a county patient. Then direct the patient to Powell Hall, advising him to go directly to the receptionist who is located to the left of the main entrance on the third floor. There they will be given their key and can make arrangements for payment. The price is \$4.00 per person per night in a single room, and \$3.00 per person per night when sharing a double room.

Although there is no cafeteria in Powell Hall, visitors are welcome in the hospital cafeteria for breakfast which is served from 6:30 a.m. until 8:00 a.m., and for the evening meal which is served from 5:00 p.m. until 7:00 p.m. Because of the crowded conditions in the cafeteria at noontime, attendance is limited to hospital personnel, however, the coffee shop serves light lunches.

County patients may pick up meal tickets at the Outpatient Information Desk located on the second floor of the hospital, near the Outpatient entrance. There they will be given three meal tickets daily for which the county will be billed. For the morning and evening meals the patient and his family can go to the cafeteria giving his ticket to the cashier at the end of the line. At noontime the same procedure will be followed, but in the coffee shop, rather than in the cafeteria.

If Powell Hall is full at anytime, there are several rooming houses and two motels all located within walking distance of the Hospitals.

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If you have any questions about either Powell Hall or the meal tickets, please call the Outpatient Information Desk, extension 2120 or Mrs. Eldredge at extension 2975. Thank you.

NOTE: Under NO CIRCUMSTANCES are patients requiring any assistance to be sent to Powell Hall. It is not equipped nor staffed to handle patients needing special treatment. Such patients should be accompanied or referred to a nursing home for the night. For assistance in placing the patient in a nursing home, please call Social Service at extension 2641.

P R O P O S A L

FOR A

SIMULATED AMBULATORY CARE UNIT
UNIVERSITY OF MINNESOTA HOSPITAL

I. Reason for Proposal

A. Changing Patterns of Medical Care

The rapidly rising costs of health care have been of deep concern to H.E.W. The major factor in the rise of costs of medical care is the rapid increase in costs of traditional hospital care. For this reason, both H.E.W. and A.A.M.C. have urged the medical schools to experiment with new methods of providing health care. Particular emphasis has been placed on teaching in an ambulatory care setting.

It is likely that patterns of medical care demonstrated in medical schools and in graduate training tend to be perpetuated in the practice of medicine in the community. For this reason the methods of health care delivery demonstrated to students is of great importance in terms of the total national cost of health care.

It would seem logical to carry out a demonstration of new methods of health care in the outpatient department. Unfortunately, there are several barriers to this in the present setting. First, the medical outpatient department has very limited physical space.

Secondly, the facilities of the outpatient department are heavily used by the specialty clinics.

Thirdly, the patients referred to the hospital are usually from outside the Twin Cities and require overnight lodging and rapid completion of the workup.

For these reasons it was thought that a unit could be established in the hospital which would provide for rapid workup of ambulatory patients and which would simulate the facilities of an ideal outpatient department. This unit would serve for both graduate and undergraduate teaching. It is planned that this unit be very closely linked with the ambulatory care service in the outpatient department. Ultimately it may be possible to develop an outpatient department unit which effectively serves this purpose. But this will probably will await the new construction. Even under these circumstances there will probably be a place for minimal care unit in the hospital.

Emphasis in the unit will be placed on cost monitoring and an attempt will be made to deliberately keep costs at a minimum. New methods of data retrieval will be used. One of the major problems hindering rapid patient workup at the present time is the inability to retrieve x-rays and laboratory work. New methods will be developed for accomplishing this. Experimentation

with new medical records will also be carried out.

Finally, the unit will be utilized to study the most effective use of various types of health personnel.

II. Operation of the Unit

The unit will receive only ambulatory patients. While these patients may have, and usually will have, serious underlying disease they will be able to participate in the program designed for the unit. Patients with serious physical or mental disabilities will not be admitted to the unit.

Emphasis will be placed on self-care. The atmosphere will be more like that of a hotel rather than a hospital. The patient will take his own medication, the drugs being obtained by the patient from the pharmacy. Nursing consultation will be available but it will not be expected that ordinary nursing care be provided. If the patient requires nursing care or observation following a procedure he will be transferred temporarily to a different unit.

CONCLUSION

A minimal care unit is proposed which will serve as a laboratory for the Department of Medicine in studying new methods of health care. Particular emphasis will be placed on self-care, on newer methods of using health professionals, and on modern methods of retrieval of data. This unit will be used both for

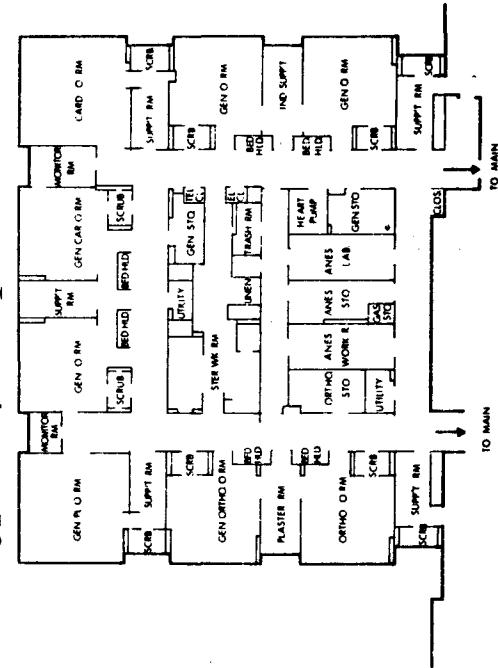
Embroidery Care Unit in N Residence
Doris Peterson visited

This architectural plan illustrates a building's layout. A vertical dashed line serves as a central axis. To the left of this axis, there is a section labeled "south addition". This addition features a large rectangular room at the base, topped by a smaller square room. Above these, a taller section contains a square room on the left and a rectangular room on the right. The entire "south addition" is shaded with a diagonal hatching pattern. To the right of the central axis, there is a larger, more complex section of the building. This section includes several rooms of varying sizes, some with their own internal subdivisions. A single room in this section is filled with horizontal lines, indicating it might be a storage area or a specific type of room. The overall plan shows a mix of original building sections and the added "south addition".

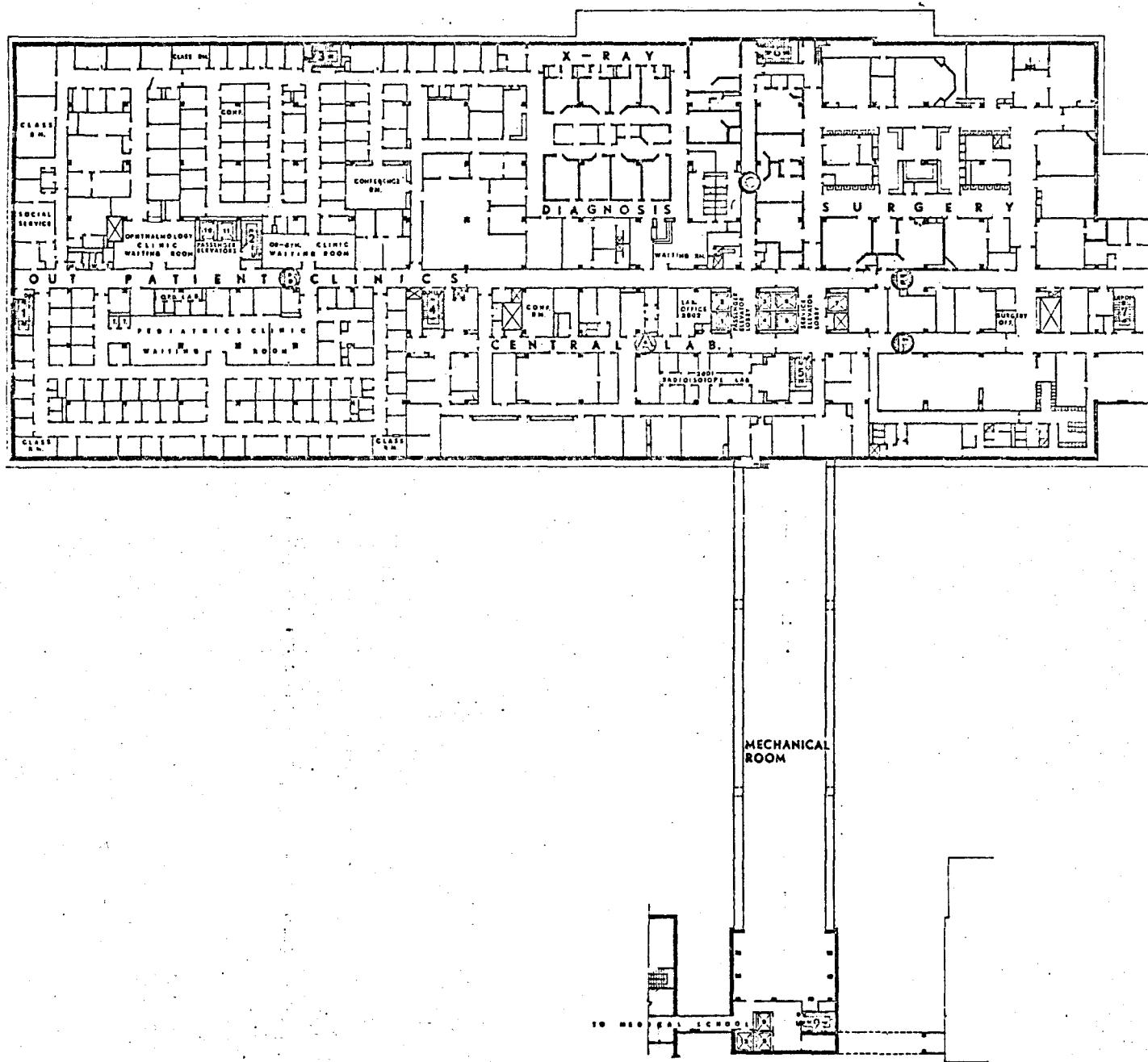
The diagram shows a cross-section of a building's interior. A vertical dashed line divides the space. To the left of this line, a room is filled with diagonal hatching, labeled "north addition". To the right, there are several rectangular rooms of varying sizes, some with internal divisions. A central vertical corridor or staircase is visible, with a small square opening near the top. The entire drawing is composed of black lines on a white background.

Looking at the new facility typical floor plan

typical floor plan

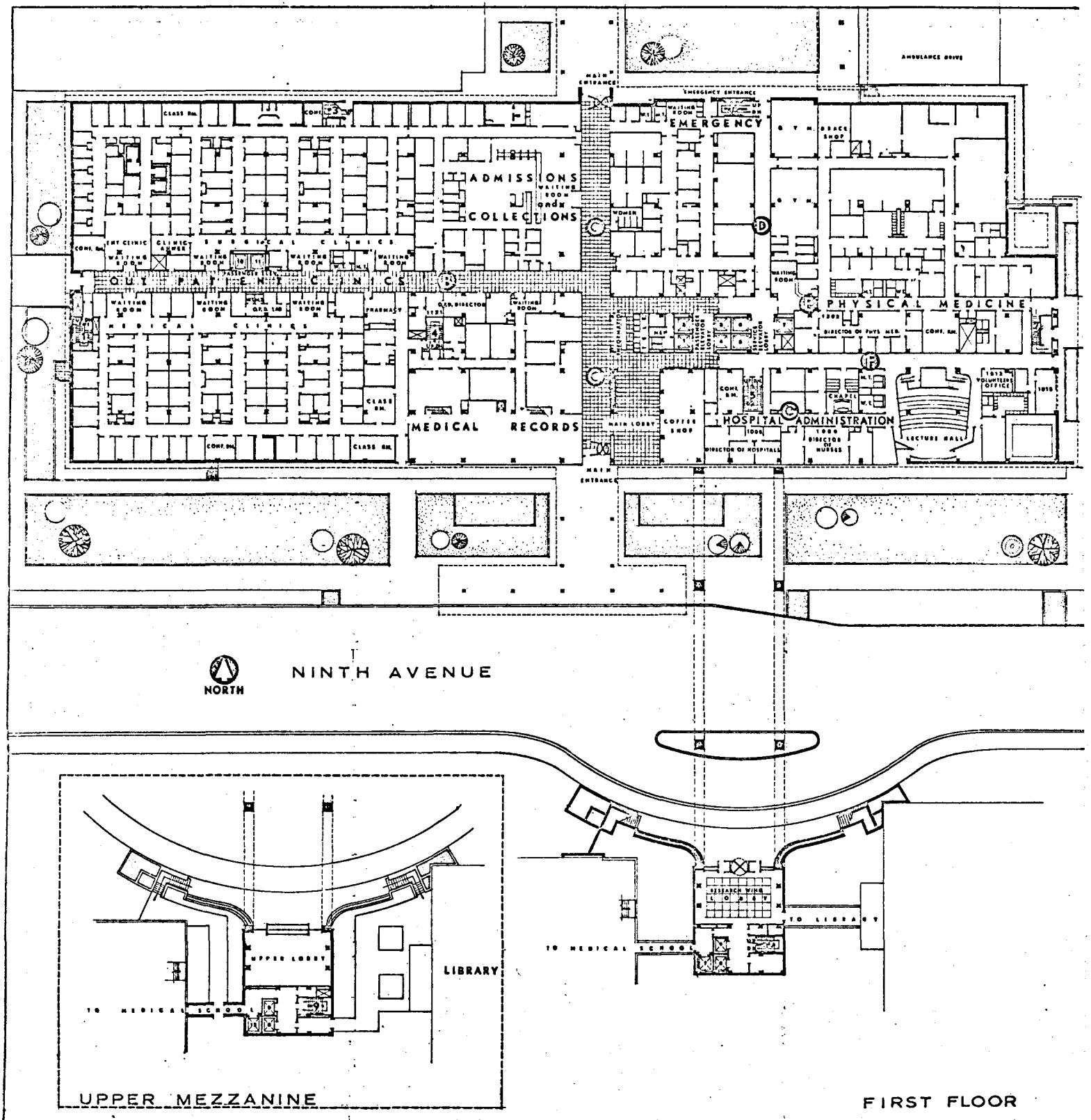


Colorado General



SECOND FLOOR

Colorado General



TRENDS IN AMBULATORY CARE

By

William H. Stewart, M. D.
Assistant to Special Assistant to the Secretary
(Health and Medical Affairs)

U. S. Department of Health, Education, and Welfare
Washington, D. C.

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In the not too distant past, the traditional symbol of medical care was the kindly old family doctor with his big heart and little black bag. Today this has been replaced by the picture of the young, cold, intense surgeon, in mask and gown, surrounded by the gleaming intricate machinery of the operating room. From Dr. Gillespie to Dr. Ben Casey in one generation reflects the changes which have really occurred in medical practice.

The scientific advance of medicine has resulted in a new and enlarged technology--in equipment, institutional facilities, technical procedures, medical and paramedical relationships--which is steadily transforming a highly individualized profession into a vast and intricately interdependent industry.

It is the impact of the rapidly advancing science and technology of medicine which must be appreciated and understood if one hopes to describe the trends in ambulatory care. For it is the results of the present scientific revolution which are creating the forces that are shaping and driving the trends in ambulatory care.

In order to better understand these trends, I propose that we look at four results. The first of these is specialization.

Specialization is an aspect of increasing knowledge and the resulting variety of skills in a profession. It is the inevitable shadow of science. The divisions of labor, which have characterized virtually all other aspects of modern life were inevitable in the medical field. Each new discovery produced smaller and smaller fields of concentration and progressively more refined disciplines.

* For presentation at Seminar at the University of Minnesota, University of Minnesota Hospitals, Comprehensive Clinic Program, Minneapolis, Minnesota, Friday, January 8, 1965

The 1963 American Medical Directory lists 35 distinct specialties and 19 separate examining boards. Adding the more common subspecialties there are over fifty types of physicians.

The ratio of full-time specialists to all physicians has expanded from 11 percent in 1923 to 61 percent in 1963, while the general practitioners fell from 89 percent to 39 percent.

Specialization has come as a necessary concomitant to technological advance. It is essential for high quality modern medicine. Yet it has raised many disturbing problems concerning our ability to provide adequate and efficient physician services.

Recently, the Surgeon General described the situation like this: "Let us go back to 1930 and look at ten young men newly graduated from medical school. --If they followed the usual pattern for that time, all of them entered hospitals for one year of internship. At the end of one year, most of them were in practice. After two or three years, eight of the ten were in private practice--six of them general practitioners, one a specialist in internal medicine, and one a surgeon. In effect, seven of the ten--the six general practitioners and the one specialist in internal medicine--were in practice as family physicians.

"Now let us look at ten typical graduates today. All of them will serve a one year internship. Most of them will continue residency training in a hospital for an average of three years. Many of them will serve for two years in one of the uniformed services. About five to six years after graduation we will find seven of them in private practice--of whom two will be general practitioners, two will be in internal medicine or pediatrics, one or two in surgery, and one or two in other specialties.

"Thus we find that two significant changes have taken place. First, after the completion of medical school it now takes about five or six years, rather than one or two, for most physicians to enter practice. Second, in 1930 seven out of ten physicians became family practitioners: today, the rate is about four out of ten."

Specialization has complicated the problem of providing physicians' services to the people. For not only is it important to have a physician available, but it must be the right kind of physician with the right kind of training to give the particular service needed.

Specialization of physicians has been supplemented if not overwhelmed by the growth of a multiplicity of paramedical professions. To provide modern medicine, it is a necessity that the services of the physician be

supplemented by dozens of other health professions and occupations. In place of the one-to-one relationship between doctor and patient, optimum medical care has become a complicated, and necessarily expensive, undertaking involving many different disciplines and institutions.

This extensive complex, known to the Census Bureau as the "Health Services Industry," is now one of the Nation's largest and fastest growing. In 1964, it cost the Nation approximately \$37 billion.

In 1960, 2.6 million persons were employed in the health services industry. This represented four percent of all employed persons. Between 1950 and 1960, there was a 54 percent increase in employment in health services compared to a 12 percent increase in total employment.

In 1900, about three of five professional health workers were physicians; in 1960, about one in five. And finally, a fact that is seldom discussed but extremely important is that seventy percent of all workers in the health services industry are female. Between 1950 and 1960, the number of female employees increased by 67 percent compared to a 32 percent increase for male workers.

From this rather extensive discussion of specialization you can see I believe it is one of the major forces affecting the provision of ambulatory care.

Another result of the advance of science and technology has been the disappearance of many diseases, the control of others, and the emergence of the chronic diseases including the mental diseases, as the predominant diseases which threaten each and everyone of us today.

The chronic diseases are characterized by an indeterminant time of onset, are progressive over a long period of time, and result in varying degrees of deviation from socially accepted norms of physical or mental behavior, often with dependency on others as a result of these disabilities.

By the very nature of the chronic diseases, persons so afflicted need access to a wide variety of these specialized services, each as it is needed, and so linked over time as to provide continuity of care during the progression of the disease.

In addition, the very characteristics of the chronic diseases require a shift in the traditional life-saving goal of medicine to one of preserving the highest quality of life that can be lived with the condition. This is easy to say but represents quite a change. Specific curative therapies are rare

indeed, and prevention of the resultant disabilities and rehabilitation have become the central core of case management. It is clear, I believe, that preserving the highest quality of life in spite of disease calls for not only medical skills but those skills needed to fit the chronically ill person into his family and community.

Where, in our present ambulatory care, can one now go and receive the kind of case management I have just described? There are few places, and as a result, I believe that the emergence of the chronic diseases--heart disease, cancer, stroke, arthritis, diabetes, mental illness, congenital defects, etc. --as the diseases which the public is most concerned serves as a major force affecting the provision of ambulatory care.

Another result of the advance of science and technology but not so clearly tied to it as the two results we have just examined is the rising demand of the people for medical services.

Medicine has much more to offer today. The people are more aware of this fact and have the means to realize their demand.

It is only recently that medical care has graduated from the status of a "private luxury" or "public charity" to the status of a necessity and "civic right."

The increased demand and rising expectations are rapidly being translated into a greater volume of medical care.

A larger part of the Nation's income and the average family budget is going for health than ever before. The Nation's total health and medical bill-public and private--rose from \$3.6 billion in 1929 to \$37 billion in 1964, a ten-fold increase. This represents an increase of about 60 percent in the relative portion of our gross national product devoted to health and medical care--from 3.6 percent in 1929 to 6.0 percent in 1964. Private expenditures alone advanced from \$3.1 billion to \$27 billion. Aside from the expenditure--derived data already discussed, the more direct measures, admissions and total hospital-days per year--also indicate a significant rate of increase. Between 1931 and 1962, the annual rate of admissions to general hospitals per 1,000 population went up steadily from 56 to 139, nearly 2.5 times. Owing to a continuous decline in the average length of stay, however, the total days per year per 1,000 population moved up at a much slower rate, from 860 to 1269.

Adding together general, mental, and tuberculosis institutions, Americans average 2.9 days per person per year in some type of hospital.

The reasons for the movement to hospital are many and complex. The greater hospital use is at the core of the expansion in almost all forms of medical care, including physicians' services, drugs, nursing, and the use of all sorts of paramedical personnel.

In 1928-31 an annual average of 2.6 out-of-hospital physician visits was reported for white persons in this country. Today, the average for the entire population has risen to 5.3.

Physician visits by age groups show a sharp drop from early childhood to youth, and then a steady rise into old age. It is the two extremes of the age spectrum of our population, the very young and the aged that use the most physicians' services. And these are the very population groups which have shown the greatest growth over the last two decades.

The increasing demand for medical care and the rising expectations of the people toward medical care has led to increased use of medical services as reflected in expenditure figures and utilization data. In the course of the increasing demand, more and more service and a greater share of the medical care dollar have come to be centered in the hospital. This movement toward the hospital and the rising demand for health services certainly are forces which have a profound effect on ambulatory care.

Thus far we have discussed three results of the onslaught of modern scientific medicine which affect ambulatory care:

1. specialization,
2. the prominence of the chronic diseases, and
3. the rising demand for and use of medical services.

Each of these forces can be visualized as a vector, so to speak, and the resultant vector can be pictured as the pressure toward organization of services. When it is viewed in this light, it becomes apparent, I believe, that the major trend in ambulatory care is toward some form of organization.

As the Somers have stated in their book, Doctors, Patients, and Health Insurance, "More science and more knowledge mean increased specialization which, in turn, brings subdivision of labor and interdependence of personnel. Complex mechanical equipment means dependence on paramedical personnel as well as institutional arrangements for feasible economic use of such equipment. Today it is no longer possible, in terms of either know-

ledge or cost, for a single doctor to deliver a total medical product. Medical practice is inescapably an organizational process."

This organizational process in the area of ambulatory care does not at this time, in my opinion, show any one pattern which one can point to and say, "this is it." You have observed, I am sure, that individual doctors are practicing more and more in association with one or more other doctors. And these associations range all the way from loose arrangements to cover during the absence of one of the doctors to highly structured group practices.

In Bethesda Maryland, where I live, I have noticed two movements which I am sure are happening elsewhere in the country. First, the physicians are clustering their offices within close proximity of the community hospital. They would probably move right into the hospital if space were available and they thought they could get away with it. And second, doctors buildings are being constructed in which are contained certain shared central services such as laboratory services.

I do not want to spend time on these organizational movements in medical practice now but rather I want to spend the rest of my time on the outpatient clinic of hospitals and particularly those that are part of teaching hospitals because I believe you are more interested in that area. And then I particularly want to dwell on what I think is beginning to happen in medical school-based outpatient departments and some of the implications of it.

Dr. John Knowles, General Director of the Massachusetts General Hospital, had this to say about the ambulatory clinic recently.

"All hospitals are social instruments which face the community and, if functioning properly, reflect its wants and needs. Our urban hospitals in their necessary preoccupation with acute, curative medicine, practiced on inpatients, have neglected one or all of their several doors to the community -- the emergency ward, the ambulatory clinic and the social service department."

Dr. Knowles goes on to say, "Emergency wards have been slow to develop in some urban hospitals, but most have found it necessary to support what seems to be endless growth. They have become the immediate sanctuary for the community in times of all kinds of disease, much what the Church must have been in the Middle Ages. -- Both doctor and patient meet in the emergency ward now and seldom in the house or office when

acute illness strikes. The massive technology is readily available as are teams of specialists, expert in the care of every nook and cranny, every appendage, orifice, and organ of the body.--"

But when Dr. Knowles turns to the outpatient department he says, "we find the step child of the institution. Traditionally this has been the least popular area in which to work and, as a result, few advances in medical care and teaching have been harvested here for the benefit of the community. -- Heads of departments and professors have never toiled in these vineyards, preferring the prostrate inpatient with florid disease and the convenience of multiple test results for obvious reasons: the situation was easier to grasp, diagnosis and treatment were simpler, and all the not-so-easy-to-settle social and mental diseases were screened out or not admitted." And Dr. Knowles goes on and on.

Few would deny that the present clinic system of our urban hospitals is second-rate and that many of the current social and economic issues of medical care could be studied and remedied best in the environment of ambulatory care.

There have been several attempts in the last decade or so to improve the care of ambulatory patients and to improve the educational value of such service. Cornell, University of Colorado, Temple University, and the University of North Carolina, all have programs which are designed to experiment with different forms of organization of ambulatory clinics and their use in medical education. You are probably aware of these and many others. You are also probably aware of the review the Association of American Medical Colleges made of some of these programs a few years ago. I read the report of the review with the feeling that while each approach has contributed to our meager knowledge of "how to" in regard to ambulatory care, no one has reached the millennium yet.

We have discussed many of the issues which revolve around ambulatory care, and as usual, in a talk such as this, no answers have been given. Dr. Knowles has raised two interesting questions in regard to these issues:

- "1. Is it--too much to hope that the issues raised will in time become a part of the medical curriculum, so that the medical profession can broaden its horizons in medical schools and assume leadership in these broad areas of social welfare?"
- "2. Will the schools recognize the two major health problems of our era--mental disease and chronic illness--problems which are compounded by specialism, rising costs, and our present

disorganization of health services--and bend the students' interest and knowledge in this direction?"

Recently, and by coincidence in relationship to this talk, there have been a series of informal meetings in my office--bull sessions is perhaps the more proper term--in which the role of university medical centers in ambulatory care was discussed. This happens to be three medical centers that we were talking about, the way they see ambulatory care, both in the provision of service and in teaching, and some of the problems they have run into or visualize in implementing their plans.

I have a blackboard in my office and during the discussions, a diagram developed which I think describes the development of our present medical centers and the present day developments in ambulatory care. So I copied the diagram off the blackboard, cleaned it up a bit, and I have it here to be distributed to you since I was not sure there would be a blackboard here on which I could develop the theme.

The center portion of the diagram outlined by the double line represents the classical medical school consisting of the basic sciences and the clinical sciences. This is the kind of medical school I went to and I imagine many of you went to also.

The lines drawn vertically in the clinical sciences and horizontally in the basic sciences represent departmentalization.

This classical medical school represents the development of medical education after the Flexner report in 1910. This development was more or less completed by the beginning of World War II.

Points "A" and "B" on the diagram represent, for the most part, post-war developments which are still under way."A" represents the extension of the basic sciences of the medical school into graduate education, either as part of the medical school or part of the graduate school of the university. This was a necessary concomitant to the development of science during the war and after it and reflects the growth of public support of research and research training during the 50's and 60's. Point "B" represents the extension of the clinical sciences of the medical school into the teaching hospital which I believe is reflected in the accelerated development of the medical school owned or affiliated hospital during the last 20 years and the great growth of intern and resident programs during this same time. As you are probably aware, there is considerable talk now going on that the medical schools should assume responsibility for all intern and resident training.

The teaching hospital outpatient clinic is illustrated as attached to the hospital. It has sort of followed along with all the other developments and has essentially developed as an extension of the departmentalization of the inpatient services.

You will also note that the lines which denote departmentalization are simply extended into these areas which have developed since World War II.

The concentration on bits and pieces of the horizontal patient which has followed the growth of hospital centered teaching and specialization has bothered many medical educators.

Point "C" represents the attempts which have been made by many medical schools to teach the "whole man." Comprehensive clinics, family clinics, screening clinics, general practice clinics are a few of the attempts.

But all of these have had to be accommodated into the usual departmentalized and specialized environment. They are overwhelmed and as a consequence become responsive to the needs of the medical school or hospital and not to the people they are serving.

Point "D" illustrates what I detect as the new development in ambulatory care. This is the extension of the outpatient department into the community with a shift of the orientation of the outpatient department away from its present ties to the inpatient and clinical science departments to the community.

Now, if we make the assumption that this is so--and I can cite you a couple of places that are seriously considering doing this--what seem to be the requirements that are necessary to bring about this new look in ambulatory care? So far I have listed five. I am not sure the list is correct or complete but it will give us something to discuss when I finish.

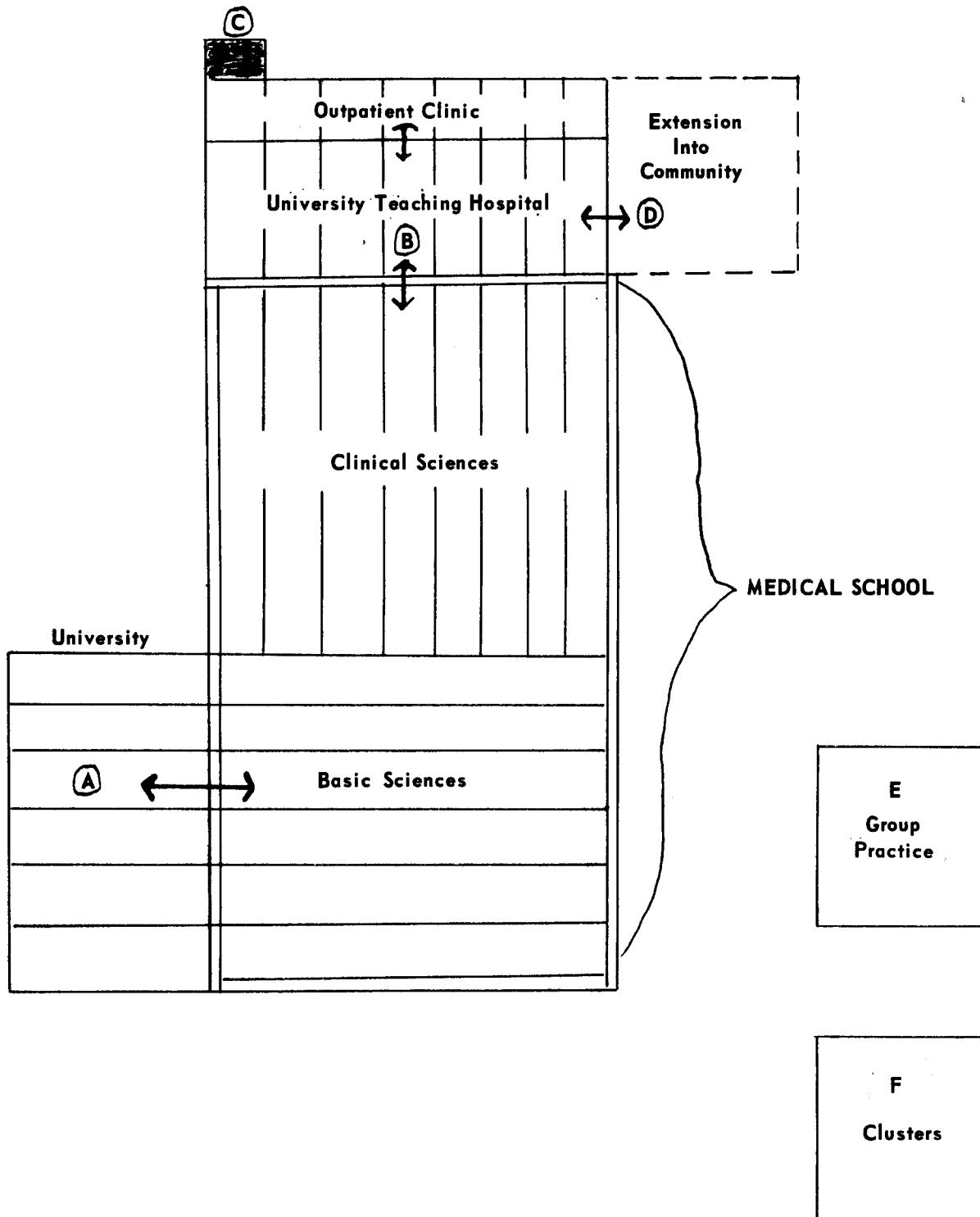
1. The first requirement appears to be a new faculty. At the present time, the university medical centers consist of two faculties; one oriented toward the graduate student and school, the other oriented to the intern and resident and the hospital. I do not believe the community orientation of the outpatient clinic can be brought about by using these faculties on a sort of ad hoc basis. I think a new faculty will be necessary.

2. It will require a different kind of organization since it is designed to serve a population in the community rather than designed to serve the hospital and medical school.
3. It will require a different method of financing than is presently the case for ambulatory care--a little more organized and let us hope better than that which now exists.
4. It will require a defined population that will be served since this is a requirement for orderly staffing and financing.
5. And finally, it will require an intimate interrelationship of the clinic with the other services in the community.

I don't know how these requirements can be brought about but perhaps we can explore that later.

Returning now to my diagram, I have yet to mention "E" which represents group practice and "F" which represents these clusters of doctors around common services. I have not related them to the medical center but put them there because it is possible they could become affiliated in such a way as to meet some of the requirements listed above and because they are forms of organization of ambulatory care which are occurring. I do know of one medical center that toyed with affiliation with a group practice but they were unable to decide who would be responsible for the patient (which faculty so to speak) when hospitalization was required.

This, then, is the way I see trends in ambulatory care. I believe there are forces in our society which will inevitably lead to the organization of ambulatory care. I do not think any one dominant type of organization has emerged, as yet, and there are many social and economic problems which act as impediments to the process.



AMBULATORY
1.0

QUESTIONS

July 21, 1967

Dr. Barr: Are you using ambulatory care to mean outpatient?

Mr. Stephan: Outpatient and some home care as well.

Dr. Barr: Look back in history, we had an ambulatory ward in the basement of the hospital.

Dr. Fifer: You speak of ambulatory bed facilities. I equate ambulatory with walking. Does this include people who come to the family care unit?

Mr. Stephan: People who come for diagnostic studies and who are ambulatory would use this, as well as those who have had hospital care, are still getting treatment before they go home. They could go to the cafeteria for meals. This requires a different type of staffing.

Dr. Fifer: Convalescent and diagnostic patients together?

Mr. Stephan: Yes, possibly.

Dr. Barr: have you given any thought to using Pioneer Hall for an ambulatory care unit; so that ambulatory patients would have a place to stay and go to the outpatient department?

Mr. Stephan: I don't know if they have given thought to it. The University is short of dormitory space. We are hanging on to Powell Hall hoping to set up a trial motel unit.

Dr. Barr: No matter what you do you get criticized; why not go ahead.

Mr. Stephan: We found out we cannot move that fast.

Mr. Kaye: There are two areas people talk about: the second medical school and the children's hospital. Does this planning envision these?

Mr. Stephan: I don't think either is rules out. Regarding the children's hospital, we are concerned with our pediatrics facilities. There is need for a unit for teaching and research. We are talking about 90 beds in terms of pediatrics facilities. If children's hospital would be relocated on this site, the University would make some shifts and let them put it up. If children's hospital is built in Minneapolis, this will be used by the University for teaching. It would depend upon how the children's hospital board looks at staffing privileges.

The second medical school could possibly come in; whether it will or not depends on many factors over which the University has no control. It is a costly venture for someone else...

Dr. Barr: The Hill planning report said the second medical school should be under government maintenance, affiliated with the Board of Regents. Recall Time magazine telling how the private schools are having difficulty financing their way.

University, with the Board of Regents, should put in some of this into the picture because reports would indicate that even with 200 students ~~w~~ this will not meet present needs in the northwest area. There should be some way to strengthen the University relationship with other medical centers, developed in the Twin City area. It is the fellows and interns who settle to practice here, not the medical students. The University has not been realistic in this kind of relationship in developing strengths in the Twin Cities in training; also in working with the North Dakota and South Dakota two year schools.

Dr. Barr: In your planning, you are planning for outpatient services in the new building. Have you got adequate space?

Mr. Stephan: I would never say anything is adequate; we think there is a balance involved. We think it is adequate in net square feet for the program we now envision...Clinic Directors made a detailed study, estimated and tried to relate this to square feet... I don't know if it's adequate, but we think it is...

Dr. Barr: I asked because St. Paul Ramsey's outpatient is by no means adequate to take care of the load.

Secondly, we are ~~are~~ seeing the development of outpatient facilities in hospital centers and in the state which will grow more and more. Patients will go where the facilities can handle them.

You'd better take a hard look at clinical waiting rooms at Mayo before you start putting up little square waiting rooms. How much is going to be used? If it isn't good, they won't use it. How much should you provide to meet the need. This will be a strong point in teaching in the future. Student needs good experience in outpatient to be able to practice in an office.

There is another study at General Hospital. Some of the other hospitals see the people that train at General Hospital and they don't get them. If they ~~ya~~ could get rid of General Hospital, they think they'd get them; but that's not true. They would go somewhere else. If they could develop programs, they will get them. It is the responsibility of the University to help to secure good working relationships to see that this is done.

AMBULATORY CARE

UNIVERSITY OF Minnesota

MEDICAL SCHOOL • DEPARTMENT OF MEDICINE
DIVISION OF INTERNAL MEDICINE • MINNEAPOLIS, MINNESOTA 55455

November 30, 1967

Mr. John Westerman
Director,
University of Minnesota Hospitals
Box 1

Dear John:

At our departmental meeting today, there was a discussion of the need for a new type of teaching unit. This unit would be designed for study of patients who were referred for diagnosis but who are not sufficiently ill to require nursing care. Many of our patients fall into this category. The unit would consist of motel-type facilities with a clerk who would be responsible for appointments to X-Ray, laboratory, etc. The patient would be interviewed and examined in his room and teaching rounds would be carried out. Nursing care would not be provided. The patient would be fully dressed most of the time and he would eat in a restaurant or cafeteria.

The group was enthusiastic about this plan and recommended that consideration be given to such a facility in the new construction. Dr. Kennedy pointed out that such a facility already exists at Dartmouth. It was the general consensus that with the rising costs of hospitalization, that our present mode of caring for this type of patient is no longer practical.

I hope these suggestions may be helpful to you.

Yours sincerely,

Dick
Richard V. Ebert, M.D.

RVE:nh

University of Minnesota Hospitals
Minneapolis, Minnesota 55455

October 31, 1968

TO: Clinical Chiefs
Chief Residents
Outpatient Committee
Outpatient Clinics (for posting)
Nursing Stations
Administrative Staff
Hospital Department Heads

FROM: Peter H. Sammond

SUBJECT: Ambulatory Care Facilities

As most of you are aware, the Hospitals has been developing a program for the overnight accommodation of ambulatory patients and families of inpatients. The attached announcement represents the first step in this program. We hope that this facility is of help to our patients.

PHS/pd
Enclosure

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UNIVERSITY OF Minnesota

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

October 16, 1969

TO: Mr. Tom Smith
FROM: Peter H. Sammond *JHS*
SUBJECT: Ambulatory Patient Traffic

In response to your recent request for information regarding ambulatory patient traffic for use by the elevator consultants, I would say that under present circumstances we average 420 patient visits a day on Tuesdays, Wednesdays and Thursdays and approximately 390 visits on Mondays and Fridays. The bulk of patients are here between the hours of 9:30 a.m. and 2:30 p.m. As you know we are anticipating approximately a 50 percent increase in patient visits during the 1970's. I would guess that better scheduling may even out the usage pattern some, but the above pattern will remain proportionately.

I attach a summary of emergency room visits sampled during the past year for this purpose. As you can see, the difference in average patients seen on weekdays and weekends is not great. Furthermore, they are pretty well evenly spread between the hours of 7:00 a.m. and 11:00 p.m. with 90 percent of the patients being seen during that period. Here again we are anticipating more than 100 percent increase in patient visits, and if our emergency population changes appreciably, as is likely, the usage pattern may change in favor of heavier weekend and night use.

If any further information would be useful to you, please let me know.

PHS/lmc

cc/Karen Levin



HEALTH SCIENCES CENTER

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OCTOBER 2, 1969

AVERAGE NUMBER OF PATIENTS SEEN IN THE EMERGENCY ROOM

WEEK OF JANUARY 12, 1969

DAY	19.3	AVERAGE PER WEEK	43.6
RELIEF	15.6	AVERAGE PER WEEK DAY	45.1
NIGHT	6.4	AVERAGE PER WEEKEND	38.1

WEEK OF MARCH 9, 1969

DAY	19.5	AVERAGE PER WEEK	43.3
RELIEF	18.0	AVERAGE PER WEEK DAY	40.2
NIGHT	5.4	AVERAGE PER WEEKEND	51.1

WEEK OF JUNE 8, 1969

DAY	23.0	AVERAGE PER WEEK	47.6
RELIEF	19.0	AVERAGE PER WEEK DAY	50.6
NIGHT	5.85	AVERAGE PER WEEKEND	41.0

December 1, 1969

TO: Mr. David Preston

FROM: C. Thomas Smith, Jr.

SUBJECT: Response to Proposal for Simulated Ambulatory Care Unit

- 1) On page two of the proposal, it states that the Ambulatory Care Unit would "simulate the facilities of an ideal outpatient department" and further would "be very closely linked with the ambulatory care service in the outpatient department". In reference to the first part of this statement, I would ask how an inpatient service would simulate an outpatient unit. It would seem more readily comparable to create an atmosphere in a true outpatient environment to simulate outpatient conditions rather than try to have a makeshift outpatient service on what will no doubt remain an in-patient ward. In reference to the second portion of the quotation, there was no explanation as to how this close fusion of ambulatory and outpatient service would be made. This needs to be defined more precisely.
- 2) What is the basis for establishing the unit as an eleven bed unit? Is there any documentation that confirms that particular size, or is that a figure which is subject to negotiation?
- 3) The continual pressure which the Bed Allocation Committee gets for more acute beds argues strongly against taking acute beds out of service for any use. It would seem more logical that if internal medicine does not need eleven acute beds that these beds would be made available to all services which are requesting them from the Bed Allocation Committee on a demonstrated need basis.
- 4) Alternative locations should be considered for this unit, although I realize Dr. Ebert's strong objection to placing it anywhere except on Station 31. Some of the alternatives which might be considered would include:
 - A) Powell Hall
 - B) Pioneer Hall (assuming the University would make it available to us)
 - C) Third Floor OB-Surgery clinic. Since this designated clinic space will no longer be used by OB-GYN, perhaps consideration should be given to setting a portion of the unit aside for ambulatory unit purposes. In light of the strong case that is made that this is an outpatient-type function, this would be a much more suitable location for it.
 - D) Student Health Service Addition. This would be an obvious location for this kind of service and perhaps initiation of it could be delayed until this facility is available.
- 5) What will be the financial impact of this change in use? The 1968-69 financial report reveals that Station 31 had 25 beds, 44% of which would be taken for the proposed ambulatory unit. Further, Station 31 produced \$849,904.00 in charges for the Hospital, 44% of which is \$373,958.00. In other words, approxi-

mately \$374,000.00 or \$115.00 per patient day was generated by the beds which are proposed to be taken out of service for the ambulatory care unit. Has there been any analysis to indicate that the expenses will be reduced sufficiently to cover the reduction in income that would arise from this change in use?

- 6) One of the strong arguments for engaging in this type of experiment is to reduce the cost of services to the patient. If we are seriously interested in reducing the cost to the patient and if this indeed is an outpatient-type of activity, then it would seem logical to handle this patient in a true outpatient setting rather than in a quasi-inpatient-outpatient setting. If we can assume that the tests one would receive as an outpatient and an inpatient would be the same then the only difference in cost to the individual would be the difference in the charge for utilizing the outpatient facility and the charge for utilizing an inpatient facility. This proposal implies still charging the patient on an inpatient basis although somewhat less than the present rate. A more drastic change could be effected by going totally to an outpatient status.
- 7) There was no mention made in the proposal of the provision of dietary services for patients in the proposed unit. Further, your memo was not distributed to the Nutrition Department; therefore, I am concluding that no nutrition services are expected to be provided to any of these patients other than those normally provided in the present outpatient setting. For her information, however, I have forwarded a copy of the proposal to Mrs. Coulter. As you know, the Nutrition Department has development plans in mind which would include a satellite kitchen in this same area of the Hospital. The Nutrition Department is reviewing its ideas with a dietary consultant and will obviously not proceed until a decision is made on the proposed ambulatory care unit.

cc: Thomas Jones

UNIVERSITY OF Minnesota

file
HS EXP
Hosp.

July 16, 1970

UNIVERSITY HOSPITALS • MINNEAPOLIS, MINNESOTA 55455

TO: Mr. Ken Taylor
FROM: Peter H. Sammond *P.H.S.*
SUBJECT: Ambulatory Care Program - Unit C

On Tuesday, July 14th a small group met to give definition to what has previously been programmed as the Ambulatory Care Unit in the planning and which has recently been proposed for the top of Unit C. This group operated under the assumption that a commercial motel would be available in the area to provide space for relatives and secondly that insurance companies would pay for motel costs for outpatients in the future. Therefore, the Ambulatory Care Unit was characterized to be for a patient who needs more extensive observation or treatment than would be available in a motel but less than that typically on a general care ward.

The unit was deemed similar to the present use of Station 30. Therefore, for a statement of philosophy on this unit, I enclose a copy of a proposal for Station 30 developed earlier by the Department of Medicine. Obviously, the Ambulatory Care Unit, about which we are speaking, would serve others in addition to Medicine. In fact, our small group felt that there may be a demand for additional facilities in the present hospital being converted to this type of care as services learn how to adapt to it.

The following factors emerge to outline the Ambulatory Care Program in Phase I for Unit C:

1. Nursing coverage would be limited to 8 hours a day, although it would probably be necessary to have "desk clerk" type staffing on a full time basis.
2. Patients admitted to the unit would be there because of the necessity of some on-going type of service or observation by nursing or the physician staff which could not be carried out easily in the clinics which are planned for high turn-over use of rooms.
3. The facility would serve as a training adjunct of the clinics in that it would allow patients needing such care a less expensive option to hospitalization, but allow them services greater than those that would be available in the clinics.

4. The rooms should be of a size to take two people, one a patient and the other a relative or friend to assist. Perhaps some sort of day bed in addition to the regular bed would be appropriate allowing use of a room size less than that of a typical double.
5. A unit of 20 to 22 rooms was thought to be appropriate for one nurse. If the space were available to provide an additional 20 rooms, this would be recommended.
6. Patients would use facilities outside the station for eating, pharmacy, laboratory, X-ray, etc.
7. In addition to the patient rooms, space should be provided for:
 - a) a consultation office for the head nurse
 - b) nursing storage
 - c) a small treatment room
 - d) a small conference room
 - e) a small doctor's work and recording space
 - f) all kinds of maintenance and housekeeping facilities

Please direct any questions or suggestions regarding this program to me at your earliest convenience.

PHS/lml

cc/Mr. Tom Smith
Dr. Donlin Long
Dr. Richard Ebert
Dr. Leon Satran
Mrs. Jane Felder
Mrs. Pat Robertson
Miss Rosie Acton
Mrs. Kathy Roberts

P R O P O S A L

FOR A

SIMULATED AMBULATORY CARE UNIT
UNIVERSITY OF MINNESOTA HOSPITALI. Reason for Proposal

A. Changing Patterns of Medical Care

The rapidly rising costs of health care have been of deep concern to H.E.W. The major factor in the rise of costs of medical care is the rapid increase in costs of traditional hospital care. For this reason, both H.E.W. and A.A.M.C. have urged the medical schools to experiment with new methods of providing health care. Particular emphasis has been placed on teaching in an ambulatory care setting. It is likely that patterns of medical care demonstrated in medical schools and in graduate training tend to be perpetuated in the practice of medicine in the community. For this reason the methods of health care delivery demonstrated to students is of great importance in terms of the total national cost of health care.

It would seem logical to carry out a demonstration of new methods of health care in the outpatient department. Unfortunately, there are several barriers to this in the present setting. First, the medical outpatient department has very limited physical space.

Secondly, the facilities of the outpatient department are heavily used by the specialty clinics.

Thirdly, the patients referred to the hospital are usually from outside the Twin Cities and require overnight lodging and rapid completion of the workup.

For these reasons it was thought that a unit could be established in the hospital which would provide for rapid workup of ambulatory patients and which would simulate the facilities of an ideal outpatient department. This unit would serve for both graduate and undergraduate teaching. It is planned that this unit be very closely linked with the ambulatory care service in the outpatient department. Ultimately it may be possible to develop an outpatient department unit which effectively serves this purpose. But this will probably will await the new construction. Even under these circumstances there will probably be a place for minimal care unit in the hospital.

Emphasis in the unit will be placed on cost monitoring and an attempt will be made to deliberately keep costs at a minimum. New methods of data retrieval will be used. One of the major problems hindering rapid patient workup at the present time is the inability to retrieve x-rays and laboratory work. New methods will be developed for accomplishing this. Experimentation

with new medical records will also be carried out.

Finally, the unit will be utilized to study the most effective use of various types of health personnel.

II. Operation of the Unit

The unit will receive only ambulatory patients. While these patients may have, and usually will have, serious underlying disease they will be able to participate in the program designed for the unit. Patients with serious physical or mental disabilities will not be admitted to the unit.

Emphasis will be placed on self-care. The atmosphere will be more like that of a hotel rather than a hospital. The patient will take his own medication, the drugs being obtained by the patient from the pharmacy.

Nursing consultation will be available but it will not be expected that ordinary nursing care be provided.

If the patient requires nursing care or observation following a procedure he will be transferred temporarily to a different unit.

CONCLUSION

A minimal care unit is proposed which will serve as a laboratory for the Department of Medicine in studying new methods of health care. Particular emphasis will be placed on self-care, on newer methods of using health professionals, and on modern methods of retrieval of data. This unit will be used both for

AMBULATORY CARE UNIT

Minutes for Meeting 21 July 1970

PRESENT: Richard Ebert, Leon Satran, Pat Robertson, Kathy Roberts, Rosie Acton, Peter Sammond

PATIENT NEED

The Committee described the Ambulatory Care Unit in terms of patient needs: a bed area where patients could receive 8 hour-type treatments by a nurse, without having to pay for a hospital bed plus a night's fee at a hotel. The type of bed service described for the ACU is like that which often is needed by outpatient clinic patients, but which could be provided remotely on the 15th floor, rather than individually in the clinics. The major drawback cited by the committee involved the psychological adjustment for the preoperative patient for example, of not being worked up by the same staff who would care for him post-operatively. In general, however, it is felt that this kind of staff follow-through is not feasible.

DESCRIPTION

- A. 8,780 Sq. Ft.
- B. Double rooms
- C. 20 patients
- D. Staffing
 - a. one nurse 8 hours
 - b. student attendant 24 hours
- E. Other facilities
 - a. telephone
 - b. nursing and medical staff consult office with storage space
 - c. treatment space
 - d. conference teaching
 - e. doctor's space

LEARNING CENTER

The Committee discussed the Learning Center proposal. At present plans include only the retrieval aspect consisting possibly of carrels in Diehl Hall. The question was forwarded of including "patient learning" in the Learning Center Program.

AMBULATORY CARE UNIT

Minutes of Meeting August 26, 1970

Present: Ms. Hokanson, Dr. Ebert, Mrs. Robertson, Mr. Dingmann, Dr. Satran
Mr. Sammond

Topics of discussion:

A. Treatment Room - An open area for performing treatment room functions should be available in the ACU. Although the spaces specifically required may not be very large, it is felt that partitioning at this time is not wise. Even temporary partitions have a way of becoming permanent.

B. Showers - It is felt that some baths should be provided in addition to showers, because some patients will not be able to take showers (remain standing long enough, etc.) Furthermore children's bathrooms with facilities for taking urine specimens should be available.

C. Children's Playroom - It is felt that a children's playroom should be designed into the area.

D. Lounge - A specific lounge area where patients can watch TV, play cards and talk should be designed separate from teaching areas. In this way patients will not be displaced by conferences and classes of students.

E. Scheduling for Students - Some thought must be given to scheduling ambulatory care unit patients in the Outpatient Clinics at times when the students can learn from talking to and observing them.

F. Funding - It was decided that there is no longer any question whether an Ambulatory Care Unit is an appropriate facility. The question is rather what is the best way of funding a larger facility. The possibility was discussed of tripling the Unit without NIH money, through private funds.

THE ARCHITECTS COLLABORATIVE, INC.

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION

MEETING NOTES

DATE:

LOCATION: Powell 4107

PRESENT: Dr. Howe, Ron Robertson, Miss Prosnick, Jim Solverson
Ken Taylor

JOB: B-C, #70046

SUBJECT: Review of Ambulatory Care Unit, Floor 15

BY: Ken Taylor

The plans were reviewed and in general no alterations were suggested. Questions were raised about communication systems for the patient in the case of an emergency in the middle of the night when nursing staff isn't available, questions of the use of medical records on this floor if teaching and examination is going to be done here, and the provision of dictating facilities. None of these three main questions has serious design implications at this point. Dr. Howe and Miss Prosnick suggested that the plans should be reviewed with Kitty Breitenbau, who is the nurse on Station 30, which is a similar facility.

KT/bb
8 February 1971

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DATE:	
H. G. S. P.	
P. P. & D.	
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H. J. S. A.	
LENCH	
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THE ARCHITECTS COLLABORATIVE INC.



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JEAN B. FLETCHER
1945 — 1965
NORMAN FLETCHER
WALTER GROPIUS
1945 — 1969
JOHN C. HARKNESS
SARAH P. HARKNESS
LOUIS A. MCMILLEN

9 February 1971

Mr. Peter H. Sammond
Associate Director
University Hospital
Minneapolis, Minnesota 55455

RICHARD BROOKER
ALEX CVIJANOVIC
HERBERT GALLAGHER
WILLIAM J. GEEDIS
ROLAND KLUVER
PETER W. MORTON
H. MORSE PAYNE, JR.
ERNEST L. BIRDSALL
TREASURER

Re: University of Minnesota
Health Sciences Expansion
TAC Job No. 70046

Dear Peter:

Within the next six weeks it will be necessary for us to review the design development plans for Unit B-C, with both the local and state code officials and the regional office of N.I.H. in Chicago. A question which will most certainly be raised is the proposed use of the Ambulatory Care facility on the fifteenth floor of Unit B-C. A letter from you which describes the intended use and nature of that facility would be useful in demonstrating to these code officials that the facility is not for inpatients, and that it can be treated like a hotel or a motel with respect to its occupancy classification. We will point out that the facility is not being designed for inpatient use, that we will not provide eight foot wide corridors, that we will not provide four foot wide doors or other design factors provided in inpatient areas. Your assurance that these facilities will only be used for ambulatory patients will help us establish the proper code classification for this area. If you have any further questions regarding the contents of the letter, please call.

Yours very truly,

THE ARCHITECTS COLLABORATIVE, INC.

Kenneth Taylor

KT/bb

cc: Paul Maupin
Hugh G. S. Peacock
HSAE

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A.C. 10

THE ARCHITECTS COLLABORATIVE, Inc.

UNIVERSITY OF MINNESOTA
HEALTH SCIENCES EXPANSION

MEETING NOTES

DATE: 21 May 1971

PLACE: Powell Hall 4112

TAC JOB: Unit B C, #70046

PRESENT: Dr. Van Bergen, Dr. Buckley, George Michaelson, Ken Taylor,
Jim Block

SUBJECT: Ambulatory Surgery

The emphasis of the meeting centered around maintaining staff and patient control in the operating room area. This meant a clean corridor would be maintained in the operating room area which could only be entered after going through control points.

The staff control points consist of locker rooms, a toilet and a scrub area. The patient area consists of a dressing area with lockers and a toilet.

To meet fire codes and also allow a litter access directly from the elevators to the ambulatory surgery suite, a third direct route must be maintained.

A sketch plan which resolved all of these problems but eliminated one of the minor OR's was considered unacceptable. The main objection being the elimination of the third OR. It was agreed that every attempt should be made to maintain three minor OR's even if the third minor OR was only 14 feet square.

A new plan will be developed which resolves the problems listed above for discussion at the next meeting.

JB:pci

U. OF MINN.	
DATE:	
H. G. S. P.	
P. P. & D.	
H. S. - COOD.	X
H. S. A. E.	X
H. J. S. A.	
LERCH	
MAIN	
FLYNN	
C. D. M.	
Van Bergen	X
MICHAELSON	X
SUMMERS	X

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Van Bergen	X
MICHAELSON	X
SUMMERS	X