UNIVERSITY HOSPITALS AND CLINICS

ANNUAL PLAN FOR 1976

Submitted to the Board of Governors
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INDEX

FORWARD

In the forward to the 1975 plan, some emphasis was given to describing the characteristics of a university hospital and clinics as part of an academic health center. The roles of serving as a general state hospital and of providing a clinical base for the other health sciences units were stressed.

The key to accountable performance is the development of a crisp, responsive health delivery decision making process. Creation of the Board of Governors and the development of new medical staff by-laws were major steps in enabling University Hospitals and Clinics to achieve an effective delivery decision process. Now we must focus on both what goes into the process and the outcomes from the process which the patients perceive as benefits.

Increased accountability is reflected in increased external controls and requirements. There is growing concern that the multitude of external requirements add undue costs without a commensurate benefit in organizational performance. The reasons for increased accountability are numerous, but the sheer magnitude of total expenditures on health explains a large part of the external interest. Consider the following figures in billions of dollars:

	1974	1975	Increase
Total Expenditures	$104	$118.5	13.9%
Public Expenditures	$ 40.8	$ 49.9	22.2%
Private Expenditures	$ 63.2	$ 68.6	8.6%
Per Person	$484.00	$547.00	12.0%

Health expeditures now contribute 8.3% to the Gross National Product. Hospital care is the largest category of expenditures, $46.6 in 1975 or 39% of the total. Physician services accounted for $22.1 or 19% of the total.

It should come as no surprise that increasingly detailed information will be required from those whom society licenses as providers. Perhaps there is a great deal of truth in the assumptions relating to compliance cost and questionable value of compliance. However, it is unlikely that those assumptions will stem the

tide of new laws and regulations designed to influence organizational behavior, particularly the efficiency of health services delivery.

What is it that society's regulators would have us do? There seems to be several objectives:

(a) A better developed primary care system with greater ease of access by the consumer.
(b) An improved system for distribution of manpower resources.
(c) A more rationale method of linking provider capabilites into an organized network.
(d) More involvement by the consumer in their own health management, including an understanding of useful preventive measures.

To achieve these objectives, closer cooperation among providers will be required. Perhaps this can be achieved through the organization of large consortia offering more diversified health care services. Examples of shared services, corporate mergers, diversification of service programs and innovative uses of health manpower are growing. The Health Sciences Center is an active participant in many of these activities. The board will need to consider how the hospital can participate further to serve the needs of the State.

As you review the new programs relating to patients, personnel and their environment, we should give some thought to the larger organizational framework in which the University operates. The system is complicated and one is wary of yielding to the temptation to introduce cosmetic changes to satisfy the most immediate concerns. And yet, change is ever present. There exists an uneasy sense that more of the same will not achieve our objectives. Consideration of some reorganization of the hospitals and clinics seem to be appropriate.

A recent report from an American Hospitals Association study group discussed health care in 1986: What should hospitals do today? A problem list of 63 items was reduced to the following seven priority areas:

1) Failure to identify priority health care issues at national, state, and local levels and to allocate or reallocate sufficient resources to them.
2) Inadequate emphasis on preventive care and health education.
3) Lack of effective controls for quality assurance in health care institutions.
4) The wane of local initiatives in problem solving.
5) Lack of effective management systems in hospitals.
6) Continuing maldistribution of physicians and other health care professionals.
7) Lack of rational regionalization of special services.

We have reported on various local activities in each of these areas. As the annual plan is implemented, there will be an attempt to relate the programs to the broader issues involved.

STATEMENT OF MISSION AND GOALS OF UNIVERSITY HOSPITALS & CLINICS

A. MISSION

. To provide a broad range of quality health delivery programs.
These include the necessary facilities, resources, and programs for health care services to the people of Minnesota and the Upper Midwest. Programs include specialty referral care services, comprehensive health delivery models which include outreach clinics and other primary care models, home care programs, emergency care and other health care services as statewide and local need analysis suggests.

. To provide, through its multiple service programs, opportunities for clinical education in the health sciences for Health Sciences students, staff and practitioners. These programs offer interdisciplinary training experiences and promote a continuum of education through undergraduate and graduate education to continuing education opportunites for health care practitioners, plus health education of the patients and the public.

. To maintain an environment for advancement of biomedical research, health promotion, disease prevention and research in the delivery of medical care and health services.

. University Hospitals and Clinics has a role in the advancement of health services management. As a result of this role, University Hospitals and Clinics serve as a resource for management in the health delivery system.

B. GOALS

I. Health Delivery Goals

A. To make high quality health services available to people of Minnesota and the Upper Midwest through a well-functioning referral and out-

reach service.

B. To develop a well-organized specialized ambulatory care capability that provides diagnostic services and treatment alternatives to the patient and his referring physician.

C. To develop and participate in primary care model programs that will create an educational environment for health sciences professionals and other students and will assist in the improvement of the primary care health delivery system.

D. To continually evaluate and modify delivery programs to assure the lowest possible program costs consistent with the quality assurance objectives.

E. To develop all aspects of our delivery programs in conjunction with the existing delivery system emphasizing education/delivery/cost considerations.

F. To maintain an effective professional staff organization which assures high quality of health care.

II. Education Goals

A. To particpate in and develop exemplary delivery programs in the context of educational objectives of the Health Sciences Units.

B. To develop programs of continuing education which complement existing programs. These programs include both education within University Hospitals and programs for health professionals throughout the State.

C. To involve hospital patients as active participants in improving their personal health by offering programs of patient education within the hospital.

D. To promote improvement of the level of personal health status by developing programs of health education throughout the State.

III. Research Goals

A. To participate in the development and evaluation of health care delivery models and to test delivery hypotheses.

B. To promote and participate in health care delivery system research with emphasis on state and local health care needs.

C. To assure an environment for biomedical research consistent with the educational objectives of the Health Sciences Units and delivery system/cost considerations.

IV. Leadership Goal

A. In pursuit of the highest program quality -- to develop and recruit a staff capable of developing model programs which can be shared with health care institutions throughout the state.

Introduction to the Annual Plan
University Hospitals and Clinics

The following areas of concentration have been identified for University Hospitals and Clinics in 1976. Specifically excluded from this report are programs which have already been initiated or are a part of on-going hospital operations. No ranking has been assigned to these programs, but the projects have been categorized into programs which relate to Patients, Personnel and their Environment.

Reflected in this report is an emphasis on the more personal aspects of health care delivery. Programs planned for 1976 indicate the strong interest which University Hospitals and Clinics has in addressing the individual personal needs and concerns of its Patients and its Personnel. Importance is placed on this theme now as the institution, already of considerable size and magnitude, looks toward future expansion of its services. In its growth, University Hospitals and Clinics wishes to maintain and monitor its ability to personally serve those who come to this hospital for care and those who come to provide care.

With respect to the environment in which these parties interrelate, University Hospitals and Clinics hopes to provide physical facilities which will most efficiently, effectively, safely and comfortably meet the needs of all the people who come here.

A. PATIENTS

1. Patient Sensitivity

   Patients deserve to be treated well, medically and personally. Although patients of University Hospitals receive excellent medical care, it is difficult to determine the amount of personal attention they receive. Because patients often equate quality medical care with individual attention, warmth, and personal service, providers of health care must be aware of these important elements of care, especially in an institution of this size. Emphasis must be given to an awareness of patients as people who

command respect, courtesy and concern.

To examine the situation of patient treatment at University Hospitals, a Patient Sensitivity Task Force was formed. The Task Force has developed an information gathering plan to determine the level of sensitivity University Hospitals has toward its patients' personal needs and in what ways we can become more sensitive. It is planned that by March of 1976, sufficient data will have been gathered for a study committee to examine and evaluate the findings. The study committee will then be able to prepare a report of recommended programs specifically directed toward enhancing the care University Hospitals provides its patients.

2. Senior Patients

The Senior Citizens of this country are increasing in numbers. They have organized to influence responses to their concerns. One such concern frequently cited is that of health care. They speak of the difficulties involved with availability and accessibility to health services and to the complexities and confusion it often causes the Senior Citizen.

University Hospitals wishes to learn more about the aging individual's health care needs and concerns. Commencing in December of 1975, all patients in University Hospitals will be receiving a questionnaire upon discharge. The questionnaire is an element of the Patient Sensitivity information gathering plan and thus, its purpose is to obtain from patients their impressions of the care they received while in University Hospitals. Among other facts about the patients, the questionnaire will identify the patient's age. Through this mechanism the additional benefit of learning of the unique problems which elderly individuals experience as patients in a hospital will be achieved. Once identified, University Hospitals is committed to do what is required to alleviate any problems which confront Senior Citizens.

This project is seen as a starting point from which further investigation will evolve to assist Senior Citizens as they enter and make their way through

the health care system.

3. Patient Discharge Information

In recent years there has been a move to provide patients with more information about prevention and treatment of illness. While patients are hospitalized they are informed about their illness, and about the therapies provided. However, upon discharge, patients are infrequently provided a written record relating to their hospitalization. Thus, the patient may have a difficult time recalling the details of these events at a later time.

It is felt that such a written record, provided to the patient upon discharge or shortly thereafter, would be valuable. This record might contain easily understood information relating to the patient's diagnosis, operative procedures, summary of laboratory results, the drugs prescribed for use after discharge, number of days the patient was hospitalized, and the name of the attending physicians.

During 1976, guidelines will be developed for the informational content of a discharge document and the means of providing it to the patient.

4. Comprehensive Epilepsy Program

A contract for a Comprehensive Epilepsy Program in Minnesota was awarded to the University of Minnesota and the Mayo Foundation on June 30, 1975 by the National Institutes of Neurological and Communicative Disorders and Stroke. The primary objective of the program is to utilize existing resources for applied clinical research.

For those individuals who have been unable to attain control of their epileptic seizures through conventional therapies, a Diagnostic, Treatment, and Rehabilitation Unit is to be developed at University Hospitals. Intensive medical diagnosis and treatment as well as concomitant social, psychological and vocational evaluation and treatment will be available to the patient in this unit. Following the in-hospital stay, patients will be discharged to

appropriate living situations where their progress will be followed by the Epilepsy Program Staff.

An active outreach program including the dissemination of information to professionals, patients, and the public will be carried out in cooperation with the Minnesota Epilepsy League. Information on services available to persons with epilepsy will be available as well as help in obtaining needed services not readily available through existing programs. Educational services will be available to persons with epilepsy as well as their families and the professionals who serve them.

It is the intent of this program to build on existing resources and not duplicate them. It is also the intent of the Comprehensive Epilepsy Program to see that services are delivered in a satisfactory manner.

5. Chemical Dependency

Various components within the Health Sciences Center are actively involved in the area of chemical dependency. Several educational programs have been developed to acquaint students with this growing social problem and instruct them in dealing with patients who may be chemically dependent. Programs of an interdisciplinary nature are being considered to facilitate the team approach in working with such patients. Future possibilities in this field also include the formation of specialty groups involved in the treatment of chemical dependency.

Activity in this area of chemical dependency has not been restricted to education alone. Extensive research on the subject is being conducted within the Health Sciences Center. Nationally, researchers of the University of Minnesota are known as forerunners in their investigations of the causes, effects, and treatment of chemical dependency.

University Hospitals has no service unit for the chemically dependent. Students and researchers go outside the Health Sciences Center to study this

problem in a clinical setting. Although a number of treatment programs do exist in the Twin Cities area for those with chemical addiction, there does not appear to be a surplus of inpatient units. With the increasing occurrence of this disease, the majority of these units have waiting lists for admission. To accommodate education and research in this important field, University Hospitals needs to consider the possibility of developing a chemical dependency clinical research model.

An interdisciplinary study committee will be formed to investigate the need for and benefits of such a model. A report of its findings and recommendations will provide the bases for further consideration of this concept.

6. Outreach

Concern for patients reaches beyond the Health Sciences campus. Present involvement with the Metropolitan Health Board and the Northwest Human Services Council is directed toward the development of an outreach health program in Northwest Hennepin County. The goal of this project is to develop an innovative health program which will be coordinated with existing services in the area. The intent of the program is to respond to the health needs perceived by that community; that it be a model capable of duplication; and that it serve as a training site for students in the health sciences.

The University Hospitals and Health Sciences team has been working closely with the concerned residents and providers of the Northwest area. A number of open meetings have been conducted with providers of health care, community agencies, local schools, elected officials, and consumers to document their concerns, hopes, and ideas on the nature of health needs.

Early in January of 1976, the University team and the Northwest Human Services Council will jointly appoint a Program Planning Task Force of local residents and University representatives. The Task Force will gather additional data on need, will consider program planning in the area of health

promotion and the prevention of disease, and will begin to focus on such implementation considerations as site selection, funding mechanisms and the selection of an Advisory/Policy Board for the program. Commencement of the program is contingent on the success of the Task Force's efforts. However, final implementation is anticipated for the Fall of 1976. In addition to this outreach project, other possible involvements to be pursued in 1976 include activities with Senior Citizen high rises and rural outreach.

B. PERSONNEL

1. Personnel Management

A number of projects are planned for 1976 within the Hospital Personnel Department. A sub-committee of the Personnel Advisory Committee has recently been formed to discuss improvements in the performance evaluation system. The goal is to develop a system which would be meaningful and equitable for all employees. Coinciding with this, the University is planning a thorough review of the pay for performance system. The Hospital Personnel Department will be actively participating in this review. Further, the Hospital Personnel Department has developed a proposal for an employee assistance-counseling program. It is felt that such a program would be of great benefit to employees who wish an alternative source of counsel.

Within the area of human resource management, many activities are ready for implementation. Workshops and conferences have been organized to discuss such topics as the effective utilization of time, union regulations, the employee selection process, management techniques, communication skills, and methods of interviewing. Topics are planned for both supervisory and non-supervisory personnel. The Hospital Personnel Department is also most interested in listening to what employees have to say. Employee opinion surveys have been used and will be utilized to an increasing extent in 1976, with the objective of increasing employee commitment and lowering

turnover. Importance is placed on proper follow-up of employee comments and concerns.

2. Departmental Interaction Program

There are a large number of separate departments within the hospital which interrelate daily in the performance of their functions. Communications among hospital departments is the key to the efficient functioning for delivering health care. Ease of communication and co-ordination can result in significant benefits.

A Departmental Interaction Program for 1976 will be developed to achieve this objective. The program will involve the periodic formation of study committees which brings groups of three departments together so that key managers, the responsible administrators, Personnel Department consultant staff, and involved Medical Staff members can discuss such issues as departmental responsibilities and objectives, interdepartmental co-ordination of services, and staff development.

3. Communication Leader Program

As noted above, communication is the key to the proper functioning of an institution. Because of the size of the hospital, emphasis must be placed on co-ordinating communication to assure that it is channeled to reach all necessary parties. The Communication Leader Program planned for 1976 calls for the dissemination of important information of general interest from various departments to all supervisors and employees in the hospital. This will provide a means for everyone to know what vital things are happening throughout the hospital and Health Scinces Center. Another aspect of the Communication Program is the formalized submitting of problems and complaints by employees to supervisors and department heads for their attention and response.

This Communication Program requires the selection of twenty individuals from a group of approximately 300 supervisors in the hospital to serve as

communication leaders. These leaders will meet separately each month with a group of approximately 15 supervisors with whom they will deal specifically in the reporting of information. The appropriate information will be provided to the communication leader by means of a newsletter or Supervisory Scene Sheet as prepared by the Hospital Personnel Department staff. All supervisors will then be responsible for seeing that employees within their departments are provided access to this information.

Items which might be covered in the exchange of information include such issues as parking, the reorganization of the Nutrition Department, the Hospital's Affirmative Action Program, developments in union contract negotiations, changes in Hospital policies, etc. In cases where employees submit complaints or problems, records will be kept within the Hospital Personnel Department of responses to such concerns. This will serve as a mechanism to monitor appropriate follow-up. The objective is to provide more information to personnel and to receive information from personnel for appropriate response.

4. Guided Management Project

The Guided Management Project is an invitation to provide hospital supervisors with the opportunity to improve their own performance as departmental managers while working together to increase the effectiveness of the departments. Supervisors will take part in this program with other members of their own departments so the project can be directed to the needs and goals of their specific area. The emphasis of the project is to turn management ideas into successful action.

The Guided Management Project involves approximately ten supervisors from a particular hospital department working with a management development project leader for approximately 15 weeks. The project will deal with two core content areas. The first area will examine supervisory self-concepts to assist supervisors in developing a strong self-image of themselves as managers. The second area of concentration will be that of

the goal setting and action planning for departmental projects. This element is included to provide practice and guidance in utilizing new management skills and methods to increase the supervisors' success as leaders and professional managers, plus assisting them in achieving improvements in their department. The project will be conducted through individual work sessions and group conferences under the guidance of organizational development specialists.

5. Decision Making Study

Effective interaction between the Department Head Group and the Administrative Staff of the hospital is essential. Because of recent changes in the governance structure and the organized Medical Staff, a re-evaluation of the supporting organizational structure is appropriate. A study has been proposed to examine the responsibilities and the composition of various hospital committees within the corporate and Medical Staff organization. Such a study would include reviewing each committee's effectiveness in terms of its ability to function effectively within the changed circumstances. The examination of the quality and quantitity of committee work will also be an element of the study. The study will result in recommendations of change when and where appropriate.

6. Personnel Resources Management

The cost of health care continues to escalate at rates in excess of the Consumer Price Index. Several years ago, when the percentage of the Gross National Product spent for health was less than 7%, few people felt that the country could tolerate a figure in excess of 7%. Today the rate is in excess of 8% and every health care institution must increase its efforts to improve productivity.

To assist in this process University Hospitals will continue implementation of a system for reporting productivity by responsibility center. The system is based on the establishment of standards and compares actual hours worked to hours required. The system will assist all levels of management to monitor and evaluate productivity within each area.

7. Malpractice and Liability Insurance Program

The hospital as a unit of the University operates within the context of the State of Minnesota Constitution which names the Board of Regents as the sole governing authority for the University. In the past, the legal status of the hospital was such that it had the right to invoke the defense of sovereign immunity i.e., it was immune from legal suit in civil actions. The Legislative Claims Committee was established to hear and decide claims for which an equitable judgement could result in a payment for damages. However, because of a recent Minnesota Supreme Court decision, the defense of sovereign immunity will not be allowed after August 1 of 1976.

Therefore, the hospital, in cooperation with the Health Sciences Center, the University and others is actively considering the issues related to development of an appropriate risk management program which is consistant with hospital needs, sound business practices, and appropriate public policy. This insurance program will be defined and made operational by August, 1976.

C. ENVIRONMENT

1. Planning and Physical Development

Phase I of the master plan for the Health Sciences Center is nearing completion. Buildings A and K/E are occupied. Building B/C, a classroom, office, research, and outpatient clinic building, is now under construction and scheduled for occupancy in 1977. Building F, a joint educational facility to house programs of the College of Pharmacy and the School of Nursing will be constructed shortly. Pedestrian walkways, service tunnels, parking structures and modification of major utility services will also be completed.

Phase II of the Master Plan will address clinical inpatient facilities' needs. Program task forces are presently exploring the feasibility of meeting high

priority pediatric, surgical intensive care, and post-anesthesia recovery requirements by constructing additional floors on Health Sciences Unit K/E.

A more refined definition is required for the remaining elements of the Phase II plan which include Units H and J. Unit J, originally planned for the Powell Hall site, will accommodate new nursing care units to replace old, obsolete, and non-functional units now located in the Mayo Complex. Selected support departments which have a close functional inpatient service relationship will also be incorporated into this building. Expanded operating room space and a hospital entry concourse extending along Union Street were elements of the Unit H Master Plan concept. Plans for these two buildings will be updated and refined, including both site and program reviews.

Unit D, to be located underground and adjacent to the south end of Masonic Hospital, will accommodate new facilites for the Radiation Therapy service and additional support space for Health Sciences oncology programs. Program planning and architectural drawings, including a study of relationships to existing and proposed buildings, must be completed. Analysis of funding alternatives will proceed concurrently. In terms of renovation of the Mayo Complex, vacated areas will be remodeled to provide additional and more functional space for several clinical support departments. Space requirements, functional relationships, and block schematics, must be identified.

The goal for 1976 is to complete block schematic drawings for all elements of the Phase II plan and to develop initial cost estimates. These plans and costs estimates should then lead to a major clinical facilites capital development effort. A construction fund acquisition plan is essential to establish final program parameters and to assure completion of the building program within a time frame consistent with program needs for University Hospitals and Health Sciences.

2. Ambulatory Care

The scope of activity in Ambulatory Care for 1976 will expand as the institution continues to pursue and operationalize the reorganization of ambulatory care as proposed in the Medical Staff Ambulatory Care Reorganization Report. This activity will coincide with the construction of Unit B/C and its completion according to schedule. The areas of involvement along which ambulatory care activity will proceed are as follows:

Ambulatory Care Reorganization, in the context of this program, refers to activities necessary to bring about a reconfiguration of the decisionmaking and policy formulation processes at the highest levels of institutional management. In accord with, but apart from, the Ambulatory Care Reorganization activities, a vast amount of revamping and reorientation of present administrative and financial systems is required over the next several years. These activities are necessary to assure that Unit B/C can be optimally functional.

B/C Construction includes all matters related to capital facility development, equipment, budgeting and related supervision. B/C Operations encompasses the necessary activity related to functioning within the facility upon its completion. It should be noted that B/C activities are closely interlinked with and dependent on both Ambulatory Care Reorganization and Ambulatory Care Operations and Systems Activity, yet steps must be taken to make Unit B/C functionally satisfactory no matter what the outcome may be in other work program areas.

All plans for Unit B/C assume a construction completion date no later than December of 1977. University Hospitals looks forward to providing its patients and personnel with the newest in out-patient facilities operated with an innovative and efficient ambulatory care organizational structure.

3. Infection Control Program

The Infection Committee of University Hospitals has a difficult mission to accomplish within an institution which presently has such serious structural

deficiencies. The Infection Committee has been charged with the development of policies which can ensure the delivery of quality medical care by providing the safest environment with respect to the control of infectious substances. As new policies are established to safeguard functions of patient care and ancillary support services for patient care, continuous checks must be made to see that these policies are being carried out. Another aspect of the work of the hospital's Infection Committee is that of providing a physical planning reference for future development.

Because of the complexities of the infection control process and because of the rapid medical-technological advances and innovations, it is felt that the Infection Committee must acquire an individual with special expertise and time to devote to infection control. The hiring of a full-time consultant is a major step which will be considered in 1976. Such a consultant could provide assistance in the problem identification and solutions to infection control, as well as play an integral part in guiding decisions in terms of future planning.

4. Biomedical Engineering

University Hospitals utilizes many complex electrical devices in the delivery of health services. The medical/legal responsiblities of the hospital increase markedly with the acquisition of more electronic equipment and the need to ensure safe operations. Many factors are involved with the use of such equipment including the difficulties encountered when engineers and medical representatives attempt to interact in the purchasing, installation, operation and maintenance of technical devices. During the past few years, a new engineering specialty called clinical or biomedical engineering has emerged which provides a means to solve some of the technologically-based problems associated with health care delivery. Clinical engineers are primarily involved with the evaluation, acquisition and maintenance of complex equipment used to monitor the status of patients and to temporarily provide life support to critically ill patients.

The functions of a biomedical engineer include preventive maintenance and

electrical safety programs, equipment maintenance, specifications for purchase, evaluation of equipment, research support and consultation, equipment fabrication, and the development of training and educational programs.

In 1976 University Hospitals will examine the possiblity of developing a biomedical engineering capability for the hospital and will decide what form such a program should take. Biomedical engineering is an endeavor which will provide additional protection for patients and personnel who utilize the hospitals' sophisticated equipment. Further, it is envisioned that in time a regional advisory service and continuing education program could be provided for other hospitals as well.

5. Paging Communications

In order that University Hospitals may be able to ensure the availability of medical care to its patients, the hospital must be able to contact those providers of health care either when they are within or outside of the institution. The development of a shared services proposal among the affiliated teaching hospitals and other private hospitals within the metropolitan area is planned for 1976, with the installation of a "medical community" radiopaging and information-availability computerized switch. The system being pursued is designed to accomplish a communications linkage among the metropolitan hospitals to optimize the availability of medical care providers at all times throughout the Twin Cities for all hospitals

Such a paging communications system would allow for the common control of the radio-paging frequencies available for Emergency Medical Services per the State of Minnesota Communications Plan. This would then improve the quality and integrity of these communications both internally and externally for medical and key administrative support personnel. Further, because this project is being pursued on a shared services basis, reduction of unit costs to all participants will be an important result.

6. Environmental Investigations

University Hospitals is participating in a number of studies designed to provide a better understanding of the environment in which we operate.

Regulations and Disclosure

The Department of Health Services Administration is working with the Minnesota Hospital Association and the Minnesota Health Department on a study of the impact of current regulatory practices and a definition of the data required for public policy decisions. It is our working hypothesis that multiple agencies require excessive information at a substantial cost to the institution. However, there is no good uniform data base within the state to capture meaningful information about the institutional sector of the health delivery system. Thus the current system satisfies none of the participants. Therefore it would appear that this is an appropriate time to reconcile public expectations with reasonable provider disclosure.

Mergers and Larger Systems

Gradually the country is moving from 5600 general or acute hospital corporations to a considerably smaller number. This reduction is coming about through consolidations and mergers. The local community is well advanced in merging hospitals with diversified programs that include a broad range of health care services. The marketing implications for the emerging large scale health organizations are just beginning to be explored. What is the future for a free-standing hospital in this environment? Already the metropolitan area has six delivery organizations that are larger than the University. What have other academic health centers done in the area of building a comprehensive delivery system? The outcomes of this investigation should serve as the base of future board discussions.

Trustee Education

With the increased emphasis on trustee accountability, greater attention has been given to the subject of trustee education. Many of the organized educational programs will be of interest to our board members. There

remains a need, however, for special programs designed for hospitals and clinics that are part of an academic health center. Discussions have been held with representatives of Yale, Rochester (New York), and Wisconsin about the feasibility of joint seminars for board members. As the board completes its orientation phase it is anticipated that there will be greater emphasis on special need programs.