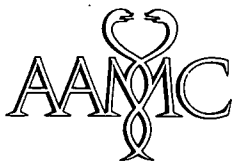


ASSOCIATION OF AMERICAN MEDICAL COLLEGES

STRATEGIC PLANS

COTH ADMINISTRATIVE BOARD

June 1991

STRATEGIC PLANS FOR:

FACILITY MISSION STATEMENT

Audie L. Murphy Memorial Veterans Hospital
San Antonio, Texas

A. MAJOR FUNCTIONS AND LEVELS OF CARE:

The Audie L. Murphy Memorial Veterans Hospital is a 674-bed acute care facility which provides primary, secondary, and tertiary health care in medicine (246 beds), surgery (218 beds), neuropsychiatry (180 beds), rehabilitation medicine (30 beds), and a 120-bed nursing home. A 30-bed spinal cord injury unit is presently under construction and should become operational August 1991. Inpatient services include a recently expanded alcohol treatment unit and a PTSD clinical team.

An active ambulatory care program provides primary level services in 50 specialty clinics to eligible veterans throughout south Texas at the hospital and through the largest network of satellite outpatient clinics in the Veterans Health Services and Research Administration. Satellite Outpatient Clinics in San Antonio, Corpus Christi, McAllen, Victoria and Laredo provide comprehensive ambulatory care to an estimated veteran population of 300,000 in South, Central, and West Texas. Together, these outpatient facilities see almost 100,000 outpatient visits each fiscal year. In addition, the San Antonio Outpatient Clinic serves as a clinic of jurisdiction for the fee basis program and compensation and pension exams.

Special needs of the Vietnam Era veterans are met with Veteran Outreach Centers (Vet Centers) located in Laredo, McAllen, Corpus Christi and San Antonio. Additionally, administrative support of the Ft. Sam Houston National Veterans Cemetery in San Antonio is a responsibility of this medical center.

This hospital's primary objective is to provide comprehensive health care services of the highest quality in a compassionate and timely manner for eligible veterans through a full range of inpatient ambulatory care, and rehabilitation services. Toward this end this facility has initiated a wide range of ambulatory care programs and complex sharing agreements and joint procurements unique in the Veterans Health Services and Research Administration. Programs such as adult day health care, hospital based home care, day treatment center, day hospital, and homeless chronically mentally ill are among the many aimed at preventing and limiting costly hospitalization. Under the sponsorship of a hospital based geriatric evaluation unit, special needs of the elderly veterans are met through an effective community residential care program and outreach services. Significant among the wide range of sharing agreements is a highly successful Bone Marrow Transplant Program initiated between this facility and Bexar County Hospital District in 1985. A recent joint procurement involving this hospital, the University of Texas Health Science Center at San Antonio, and Wilford Hall U. S. Air Force Medical Center in San Antonio, resulted in the acquisition of a PET Scanner/Cyclotron scheduled to be operational in 1991.

B. CLIENTELE:

The hospital is a tertiary care facility which is affiliated with the University of Texas Health Science Center at San Antonio. Situated in the tenth largest metropolitan area in the United States, with a population of 1,060,000, the hospital was built in 1973 as an integral component of the South Texas Medical Center. The facility and its clinics in Corpus Christi, McAllen, San Antonio, Victoria and Laredo serve the 41 counties in the primary service area. This hospital and the Kerrville VA Medical Center constitute a "cluster" establishing cooperative arrangements for inter-hospital referrals and sharing of selected patient services. A steady population growth through 1995 will result in a veteran population approaching 300,000 for the 41 south Texas counties served by the San Antonio Veterans Hospital. Socio-economic conditions of the clientele served range from the relative affluence of veterans in the immediate San Antonio area to the widespread poverty and unemployment of the largely Hispanic population in the Rio Grande Valley. The economic and social diversity of the region and the projected aging of eligible veterans will lead to a significant upturn in the need for health care intervention.

C. CHARACTERISTICS:

The Audie L. Murphy Memorial Veterans Hospital is located in San Antonio, Texas, a growing metropolitan area of over one million. Situated on a campus approximately six (6) miles from downtown, the hospital is an integral component of the South Texas Medical Center, a confederation of eight (8) major hospitals and attendant support services bound together by the San Antonio Medical Foundation. The hospital adjoins and is connected by an enclosed crosswalk to the University of Texas Health Science Center at San Antonio and the Medical Center Hospital of the Bexar County Hospital District.

The attraction of the rolling hill country just north of San Antonio, the Rio Grande Valley to the south, and the Texas Gulf Coast combine to contribute to the rapid growth of this sun-belt area. In addition to the sustained growth experienced in San Antonio and nearby Austin, vast expanses of thinly populated rural areas are found within the 41-county primary service area. The distance of the satellite outpatient clinics from the hospital in San Antonio (Victoria 116 miles, Corpus Christi 144 miles, McAllen 237 miles, Laredo 153 miles) present logistical challenges to the safe and efficient transportation of patients, supplies and services.

D. SHARING AGREEMENTS:

This hospital is committed to the precepts of sharing of medical resources and enjoys a peer relationship with the most advanced health care providers in the South Texas Medical Center. Presently,

we are involved in several agreements which result in an estimated two million dollar cost savings/avoidance. A unique Clinical Diagnostic and Treatment Center, operated jointly by this hospital and the University of Texas Health Science Center (UTHSC), supported by a grant from the National Institutes of Health, provides benefits of the most current applications of medical science to veteran patients and to patients from the Medical Center Hospital. Joint ventures for procurement of Magnetic Resonance Imaging (MRI) and Linear Accelerator have been accomplished.

In Fiscal Year 1989, a Positron Emission Tomography (PET) System and Cyclotron were jointly procured by the VA and DOD. Equipment will be housed in the University of Texas Health Science Center's new Clinical Research Imaging Building currently under construction. The system will be operational in summer 1991. Other agreements with DOD are currently being negotiated with Wilford Hall USAF Medical Center for liver transplants and for lung transplants with the Bexar County Hospital District (BCHD). A Heart Transplant Sharing Agreement between VA and BCHD was recently approved. Other agreements include arrangements with UTHSC for sharing a cell sorter, research animal boarding, electron microscope and computer support. Agreements with BCHD include bone marrow process, ultraviolet procedures, electrophysiology and the highly successful Interleukin-2 program. Sharing radiation therapy and the use of linear accelerator with the Cancer Treatment Research Center places this facility in the forefront of cancer treatment and research. Agreements with the U. S. Navy in Corpus Christi for laboratory support, physical therapy and pharmacy back-up expands sharing to satellite outpatient clinics. Finally, sharing with Brooks Air Force Base for hyperbaric treatments and Brooke Army Medical Center for burn treatment attracts patients from all over the world.

E. INTERRELATIONSHIPS:

The Audie L. Murphy Memorial Veterans Hospital actively seeks out opportunities with other organizations/facilities in the area to improve patient care and to expand and enhance the role the hospital plays in the medical community. Among the notable interrelationships are blood services with Wilford Hall USAF Medical Center. Wilford Hall has provided blood services to this hospital for approximately ten (10) years. In return Audie L. Murphy provides half the personnel (10 FTEE) and uses one-third (1/3) of the blood products. We purchase outpatient hyperbaric treatment from the School of Aerospace Medicine at Brooks AFB. They welcome our patients because they do not have enough patients for their clinical research and, in turn, we avoid the high cost of obtaining the resource. We purchase Lithotripsy capability from Wilford Hall USAF Medical Center and in return we provide a limited number of MRI Scans. We purchase GYN procedures from Wilford Hall USAF Medical Center when they are not readily available at the Medical Center Hospital. The Navy makes

available back-up medical laboratory service and physical therapy support to the VA satellite clinic in Corpus Christi. A major interrelationship is the responsibility we have for veteran patients treated at Brooke Army Medical Center's Burn Center. The joint purchase of a Positron Emission Tomography (PET) System between the VA, the Air Force, and the University of Texas Health Science Center at San Antonio is illustrative of a commitment to community sharing. We are in joint operation with the Bexar County Hospital District for MRI's. The Cancer Therapy and Research Center has been providing radiation therapy for our patients for the past ten (10) years. A Linear Accelerator was jointly procured in FY 1987 and is currently being managed by the Cancer Therapy and Research Center. We process and store bone marrow from the Bexar County Hospital District and Methodist Hospital in San Antonio. We provide laboratory support, MRI's and EEG's for patients of nearby VAMC, Kerrville, Texas. A multidisciplinary Sleep Lab has been established with the Bexar County Hospital District and the University of Texas Health Science Center. The study of the anti-cancer agent Interleukin-2 is conducted under a grant from the National Cancer Institutes. A unique program in VA, this service is available to both veteran and non-veteran patients. We now have the capability to do heart transplants under a sharing agreement with Bexar County Hospital District.

F. ACADEMIC AFFILIATIONS:

The Audie L. Murphy Memorial Veterans Hospital is primarily affiliated with the University of Texas Health Science Center at San Antonio (UTHSC/SA). Each year approximately 400 medical and dental residents rotate through 130 programs in all five schools (Medicine, Dentistry, Nursing, Allied Health and Graduate Biomedical Sciences). Sub-specialties include Allergy-Immunology, Cardiology, Digestive Diseases, Gastroenterology, Geriatric Medicine, Hematology, Infectious Disease, Internal Medicine, Nephrology, Oncology, Pulmonary Medicine and Rheumatology; Radiology with sub-specialties in Nuclear Medicine, Diagnostic and Therapeutic Radiology; General Surgery with sub-specialties in Gynecology, Neurosurgery, Orthopedic, Otolaryngology, Plastic, Thoracic, Urology, and Vascular; Anesthesiology; Dermatology; Family Medicine; Neurology; Ophthalmology; Pathology; and Physical Medicine and Rehabilitation. In addition to Medicine and Dentistry, other fully accredited Health Profession Education Programs include Nursing, Medical Laboratory Technology, Social Work, Podiatry, Psychology, Medical Records Administration and Health Care Administration.

The affiliation is expanding to underserved rural areas of south Texas under a collaborative effort between this hospital and UTHSC/SA involving use of VA outpatient clinics for clinical training.

G. RESEARCH:

Ranked among the outstanding Research and Development Services in the Department of Veterans Affairs, the Audie L. Murphy Research Service dedicates 28,000 square feet of space to medical investigations. Currently over 150 investigators pursue nearly 500 separate studies in such diverse areas as cardiovascular disease, bone marrow transplantation, aging, drug metabolism, hypertension, stroke, intestinal growth and fungal infection. Our Research Service is also renown for its part in the nationwide Interleukin-2 Cancer Study; the only VA Hospital selected. Last year more than 700 publications resulted from the data obtained by the Research Service. Recently, researchers from Audie L. Murphy were recognized by the national media for their work in effects of aspirin and frailty among the elderly. Research Service's operating budget includes over three million from other federal and state agencies, private firms and interested charities and individuals. The Biomedical Research Foundation of South Texas was created in 1989 with the specific intent of supporting the research mission of this hospital.

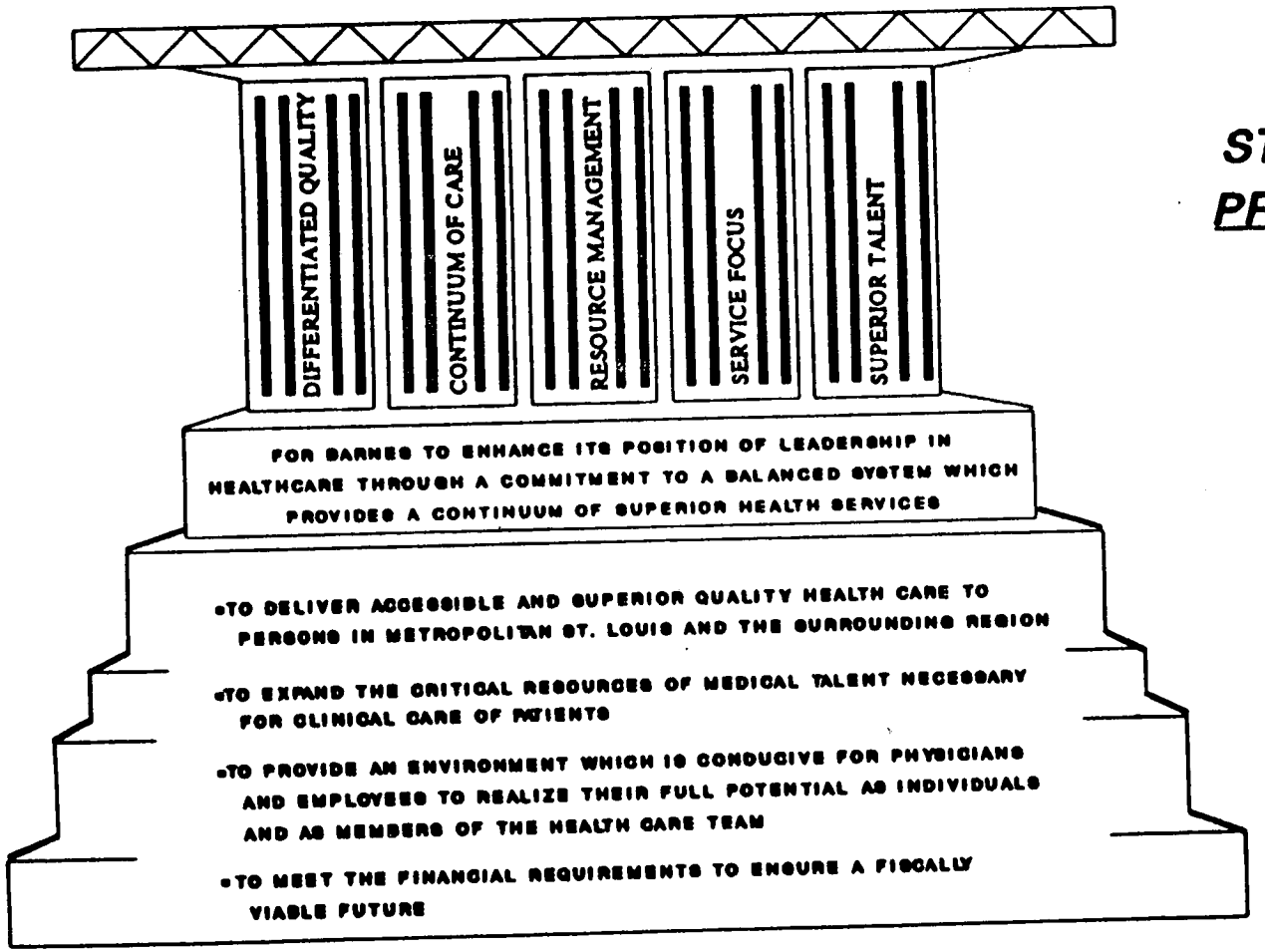
BARNES HEALTH CARE SYSTEM

In July of 1987 the Barnes Hospital Board of Directors committed to a new direction for Barnes Hospital. With a vision for Barnes as a balanced health care system a commitment was made to expand the leadership and talent at Barnes Hospital into new areas of service both at the hospital and within an approximate 150 mile radius. Our focus for the 1990-94 planning horizon is to maximize the return from our existing relationships while continuing to monitor our environment for attractive vertical and horizontal expansion opportunities.

BARNES HEALTH CARE SYSTEM DEVELOPMENTS

- Arch Area Helicopter - 1987
- Expansion of Barnes/Sutter Health care - 1988
- Purchase of St. Peter's Hospital - 1988
- Joint Venture Abbott Ambulance - 1988
- Lung Transplants - 1988
- Home IV/HME - 1988
- Acquired Independence Center Day Hospital - 1988
- Relationships with hospitals in Keokuk, IA, Salem, IL - 1988, 1989
- Purchase of Barnes West County Hospital - 1989
- Barnes College offers a BS in Nursing - 1989
- Private Duty Nursing - 1989
- Gallstone Laparoscopy - 1990
- Relationships with hospitals in Poplar Bluff, MO, West Plains, MO - 1990
- Purchase of St. Louis Health Center - 1990
- Purchase of technical components of Barnard Cancer Center - 1990
- Opening of Barnes Extended Care, Clayton - 1990

BARNES HEALTHCARE SYSTEM



STRATEGIC PRINCIPLES

VISION

MISSION

BARNES HEALTH CARE SYSTEM

In 1990, after a thorough examination of our environment, we reconfirmed our mission, vision and strategic principles. Our mission statement for the health care system still serves as the foundation for all System entities and the development of future services. Our vision, "for Barnes to enhance its position of leadership in health care through a commitment to a balanced system which provides a continuum of superior health services" still accurately focuses the accomplishment of our mission, even in these turbulent times. The five strategic principles, Differentiated Quality, Continuum of Care, Service Focus, Resource Management and Superior Talent, flow directly from our vision and describe the "critical success factors" which will allow Barnes to maintain its dominance by achieving excellence in health care.

ENVIRONMENT

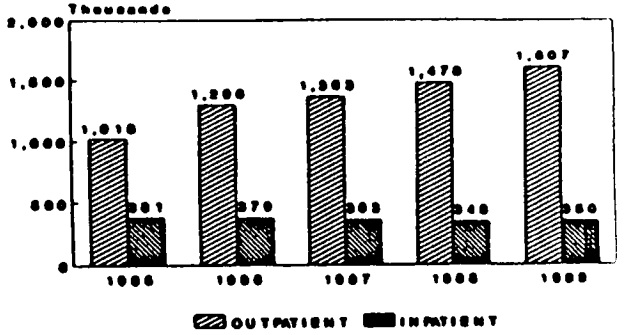
Patient Utilization

- Shift from Inpatient to Outpatient Services (Inpatient Discharges: Down 8.2% in 1989 compared to 1985; Outpatient Visits: Up 57.7% in 1989 compared to 1985.
- Increase in amount spent on Home Health services and products (expected growth 75% from 1989 to 1993) Source: Frost & Sullivan
- Increase in Nursing Home use (nursing home population expected to grow 30% from 1990 to 2000) Source: AHA

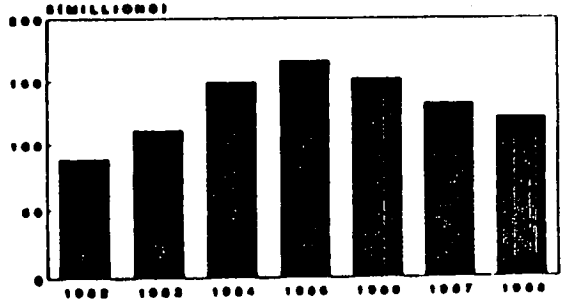
Profitability Pressures

- Total hospital industry profits remain healthy (1988: $121,000,000) but continue to decline since 1985 ($166,000,000) in the St. Louis area. Source: Business Health Coalition
- Continued growth in managed care plans (short-term expected annual growth rate in enrollment: 10%)
- Growth of cost of unsponsored care (growth from 1980 to 1986: 150%)
- Growth of uncompensated care (5% of total costs in 1980 to 7% in 1990)
- Pressure to reduce ALOS (8.3 days in 1988 to 8.1 days in 1989 and 7.9 days in 1990) (St. Louis area) Source: HAMSTL
- Growth of Medicare and Medicaid discharges as a % of total discharges (Medicare: 34.6% in 1988, 35.4% in 1989, and 36.4% in 1990 & Medicaid: 11.2% in 1989 to 12.4% in 1990 in the St. Louis area) in conjunction with projected declines in Medicare and Medicaid reimbursement Source: HAMSTL

SHIFT FROM INPATIENT TO OUTPATIEN
(HAMSTL: O.P. VISITS / I.P. DISCHARGES)

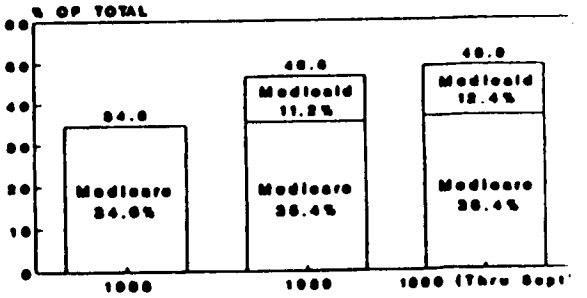


HOSPITAL INDUSTRY PROFIT - ST LOUIS ARE/
(EXCESS OF REVENUES OVER EXPENSES)



Source: Business Health Coalition

MEDICARE & MEDICAID AS % OF TOTAL
(BASED ON HAMSTL DISCHARGES)

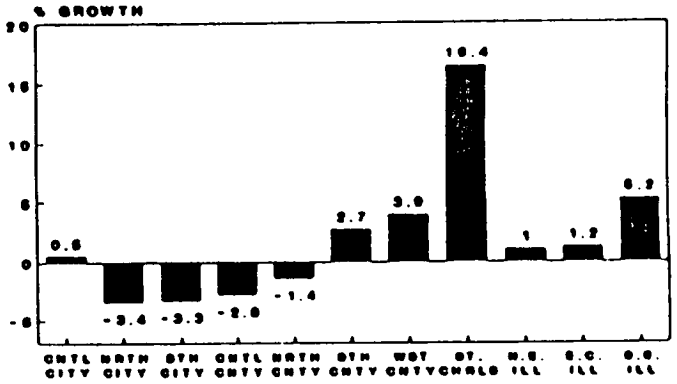


Note: Medicaid data unavailable for 1988

Shifting Demographics in Primary Market

- Fastest growing population through 1994: St. Charles County (+16.4%), Southeast Illinois (+5.2%), West County (+3.9%)
- Largest declining population through 1994: North City (-3.4%), South City (-3.3%), Central County (-2.8%)
- Largest percentage of its households with $50,000 or more income in 1994: West County (65.4%), St. Charles County (44.6%), and South County (43.5%)
- Largest growth in 55+ age group through 1994: West County (+3.1%), South County (+1.7%)
- Largest decline in 55+ age group through 1994: South City (-1.4%)

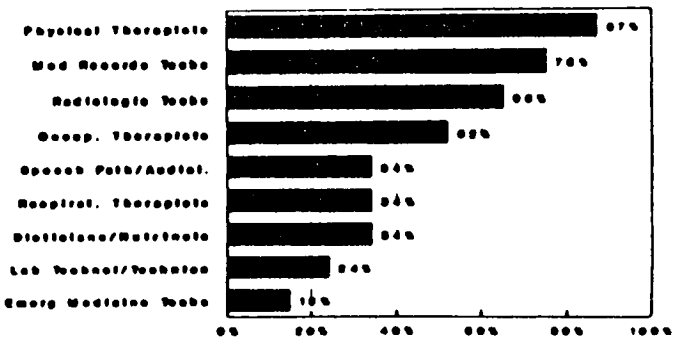
POPULATION GROWTH 1989-1994
ST. LOUIS PRIMARY MARKET



Technology

- Growth of laser, laparoscopy & other non-invasive treatment has resulted in large increase of outpatient surgeries.
- Genetic Engineering Technologies (drugs, birth defects)
- Bionic Technologies (digital limb replacement, computerized neurological implants)

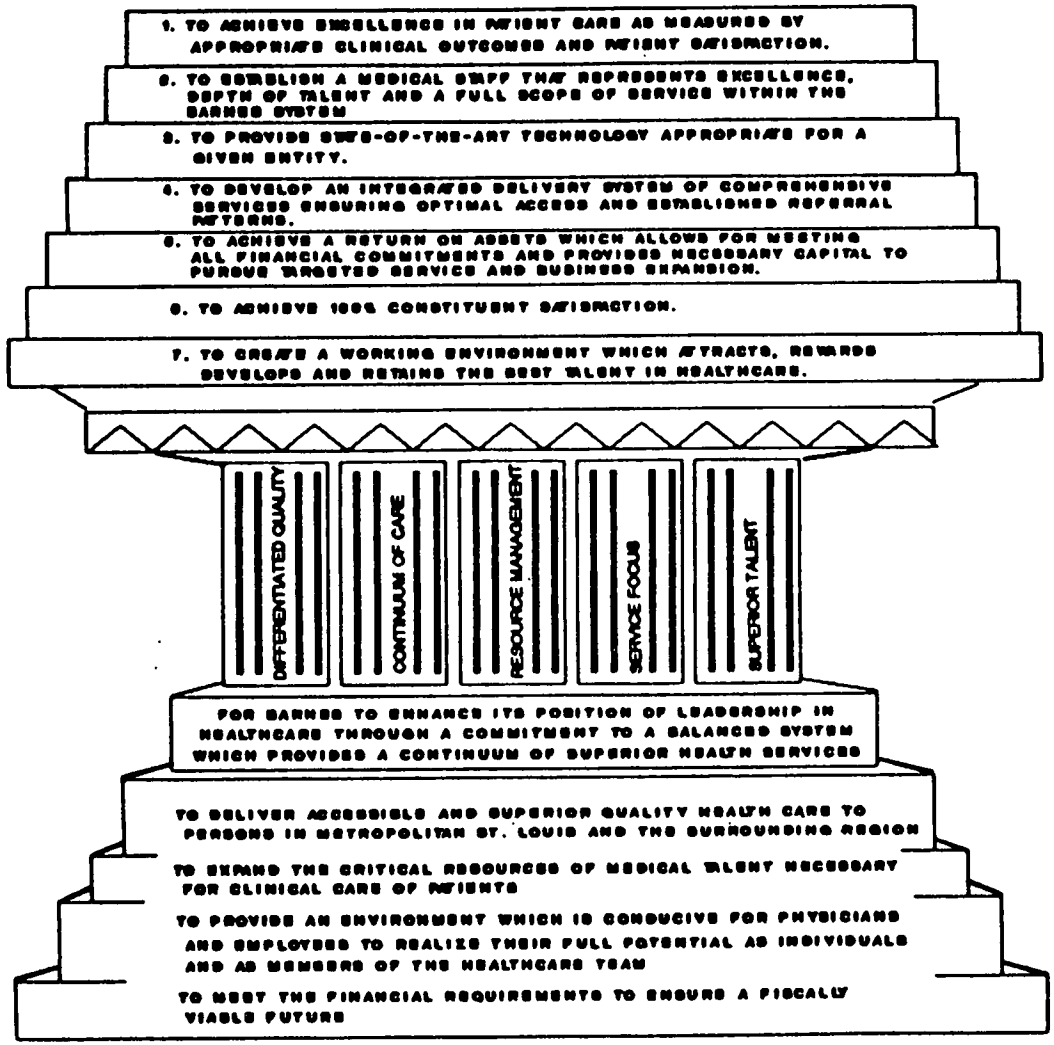
DEMAND FOR ALLIED HEALTH PROFESSIONALS
PROJECTED GROWTH RATE (%) 1986-2000



Changing Labor Market

- Nursing shortage (Demand: increase of 44% for registered nurses from 1986 to 2000 vs. Supply: expected decrease by 17% of nursing program graduates from 1986 to 2000) Source: AHA
- Demand for Allied Health Professionals (Highest projected growth from 1986 to 2000: PT's 87%, Medical Records Techs 75%, Radiological Techs 65%, OT's 52%)
- Growth and demand for female MD's in U.S. (# of female MD's expected to grow 91.9% from 1986 to 2000 vs. male 9.2%)

BARNES HEALTHCARE SYSTEM



LONG RANGE OBJECTIVES

STRATEGIC PRINCIPLES

VISION

MISSION

STRATEGIC PLANNING

Over the past several years, the health care environment has changed. Introduction of an all payor case payment system in New York State has provided incentives for reductions in length of inpatient stays and increased patient discharge options. The inpatient needs of persons with AIDS and substance abuse problems have increased. Nearly all New York area hospitals are facing a shortage of space in which to develop new and expand existing patient care and administrative programs. In addition, hospitals continue to compete to attract physicians and the patients they admit. To address these issues, the Medical Center has undertaken the following actions to maintain its financial and competitive position:

- The establishment of a multispecialty group practice (New York HealthCare) in midtown Manhattan;
- The establishment of an affiliation with Doctors Hospital located on the Upper East Side of Manhattan;
- Establishment of a nursing home (245 beds located in White Plains, N.Y.);
- The opening of inpatient units to serve terminally ill and AIDS patients.

The Medical Center has established a multispecialty group practice, known as New York HealthCare, staffed by Beth Israel-affiliated physicians. The group practice operates in a Medical Center owned 50,000 square foot building located one-half block from the Empire State Building. The practice is currently generating over $4,800,000 in gross revenue on an annual basis and has resulted in over $400,000 in revenue from inpatient admissions to the Medical Center during 1989. In addition, a private ambulatory radiology suite (with CT scanner) performed over 15,000 studies in 1989.

During early 1990, a Japanese medical practice was established which generated $500,000 of revenue in the first six months of operation.

In 1987, the Medical Center established a corporate relationship with Doctors Hospital, a voluntary not for profit facility located at 170 East End Avenue in Manhattan. The Medical Center's parent corporation is the parent of Manhattan East Community Services, Inc., which is the parent corporation of Doctors Hospital. The affiliation with Doctors Hospital creates visibility on the upper east side of Manhattan for the Medical Center and helps to address space constraints confronting the Medical Center. The Medical Center's high occupancy rate and the associated demand for operating room time has created a backlog in admitting elective patients. The high utilization of the Medical

Center's emergency services department emphasized the need for additional patient care space. Doctors Hospital, which completed a total modernization program in 1986, offers the Medical Center State of the art operating rooms, quality ancillary services, such as radiology, and attractive patient rooms. The Medical Center has transferred the physical location of its Stuyvesant Square Treatment Program to Doctors Hospital. This move, while utilizing vacant space at Doctors Hospital, has permitted the Medical Center the opportunity to expand its Drug Detoxification Program. The affiliation also allows for the consolidation of various departments, thus bringing economies of scale to both institutions.

The Medical Center leases and operates a 245-bed nursing home, known as the Beth Israel Nursing Homes, Inc., Westchester Division, in White Plains, New York. Access to nursing home beds has helped relocate patients not requiring acute care who continue to occupy acute care beds at the Medical Center while awaiting nursing home placement, thus permitting the Medical Center to admit additional acute care patients. The replacement of long term care with acute care patients should continue to provide additional revenue to the Medical Center since hospitals generally receive lower reimbursement for long term care patients.

The Medical Center was designated an AIDS Center by the New York State Department of Health in 1986. A 12 bed inpatient unit and a separate outpatient program care for the complex medical and social needs of these patients. Designation as a State AIDS Center has enabled the Medical Center to receive enhanced reimbursement for both inpatient and outpatient AIDS services.

The Medical Center created and is the sole member of the Jacob Perlow Hospice. The Hospice is an integrated inpatient/home care program that also maintains an eight bed inpatient unit at the Medical Center. New York City has a critical shortage of beds available for treatment of terminally ill patients. The Hospice has received contributions in excess of #3.4 million in support of its operation.

DRAFT

HENRY FORD HEALTH SYSTEM

Futures Committee

Strategic Plan 1990-2000

September 18, 1990

HENRY FORD HEALTH SYSTEM
FUTURES COMMITTEE

STRATEGIC PLAN
1990 - 2000

TABLE OF CONTENTS

WORKING PAPERS (Not included in the report.)

A. Issue Papers

1. Demographic Changes In The U.S. And Michigan: Trends And Implications.
2. A shift In Focus: From Treating Acute Care Episodes To Managing Chronic Diseases.
3. Health And Human Resource Services.
4. Employer Perspectives In Health Care.
5. Prospects For Universal Health Insurance.
6. Technological, Social And Economic focus: Their Impact On The Structure And Future Of The Health Care Industry.

B. Situation Analysis

1. Industry Trends
2. Southeast Michigan Environment
3. Competitor Trends
4. Henry Ford Health System Market Summary

EXECUTIVE SUMMARY

In the last 18 months the Futures Committee has vigorously pursued the assignment to develop a framework for Henry Ford Health System (HFHS) over the next decade. The focus of the Committee has been to look beyond short term considerations and annual plans and to develop a strategic vision for HFHS for the year 2000. Throughout the process the Committee has recognized that it must consider the industry environment, competitor assessments, the health care delivery and insurance markets in the region, and the difficult trade offs in capital investments and programs that are necessary for the sake of financial viability and continuous quality improvement.

A key component of the Future Committee's deliberations was the development of the following mission statement for Henry Ford Health System:

> **Henry Ford Health System is dedicated to developing and providing the highest quality, compassionate health care to serve the needs of the southeastern Michigan community. The System's services will be the most comprehensive, efficient, and clinically effective in the region, supported by nationally recognized Henry Ford education and research programs.**

Related to the mission statement was the articulation of a vision for Henry Ford Health System, as well as a quality definition, corporate values statement and quality guidelines.

Based upon the environmental and competitor assessments, as well as an analysis of current System strengths and weaknesses, the Futures Committee next identified six key System requirements to meet community needs. These are:

- **Pursue an organizational focus that combines advanced clinical care and excellence in teaching and research with emphasis on health care delivery through managed care.**

- **Develop a cohesive, vertically integrated health care system that demonstrates a commitment to excellence and the process of continuous quality improvement.**

- **Continue to grow to serve a broad range of people in the region, achieving the benefits of scale for all Henry Ford Health System's constituencies.**

- **Strengthen Henry Ford Health System's position in health care insurance by providing a range of desired products that meet the needs of employers and consumers.**

- **Provide the necessary funds to support a) the Henry Ford Health Sciences Center, b) continuous quality improvement throughout the System, and c) continued growth.**

- **Effectively communicate Henry Ford Health System's vision to all constituencies--health care users, medical staff, other employees, the national health care community, governments, regulators, the financial community, and philanthropists.**

For each of these System requirements, key System objectives and strategies are identified.

This report, the result of wide spread participation by Trustees and staff, represents a blueprint for the future evolution of Henry Ford Health System.

I. INTRODUCTION

The Futures Committee was appointed in January, 1989, with a specific charge to develop a framework for Henry Ford Health System (HFHS) development over the next decade. The focus of the Committee was to look beyond short term considerations and annual plans and to develop a strategic vision for HFHS for the year 2000.

The Committee followed the strategic planning process shown in Figure 1 to develop the strategic plan. As a first step the Corporate Planning staff prepared a series of six papers. These papers identified key issues facing the health care industry including such issues as changes in the focus of health care from acute care to chronic care, human resource shortages, prospects of universal health insurance and the employer perspectives. These papers were circulated to the members of the Futures Committee as background reading.

The first two meetings of the Futures Committee were held with a guest moderator, Jeff C. Goldsmith, Ph.D, who is a nationally known health care futurist. Dr. Goldsmith summarized key trends in the health care industry and his vision of the future, which the Committee discussed in depth.

For the third meeting of the Committee a detailed situation analysis was prepared by the staff. The Committee discussed environmental and competitor assessments and HFHS's market position. At this meeting some System needs were identified for future discussion. The Futures Committee also developed a glossary of strategic planning terms.

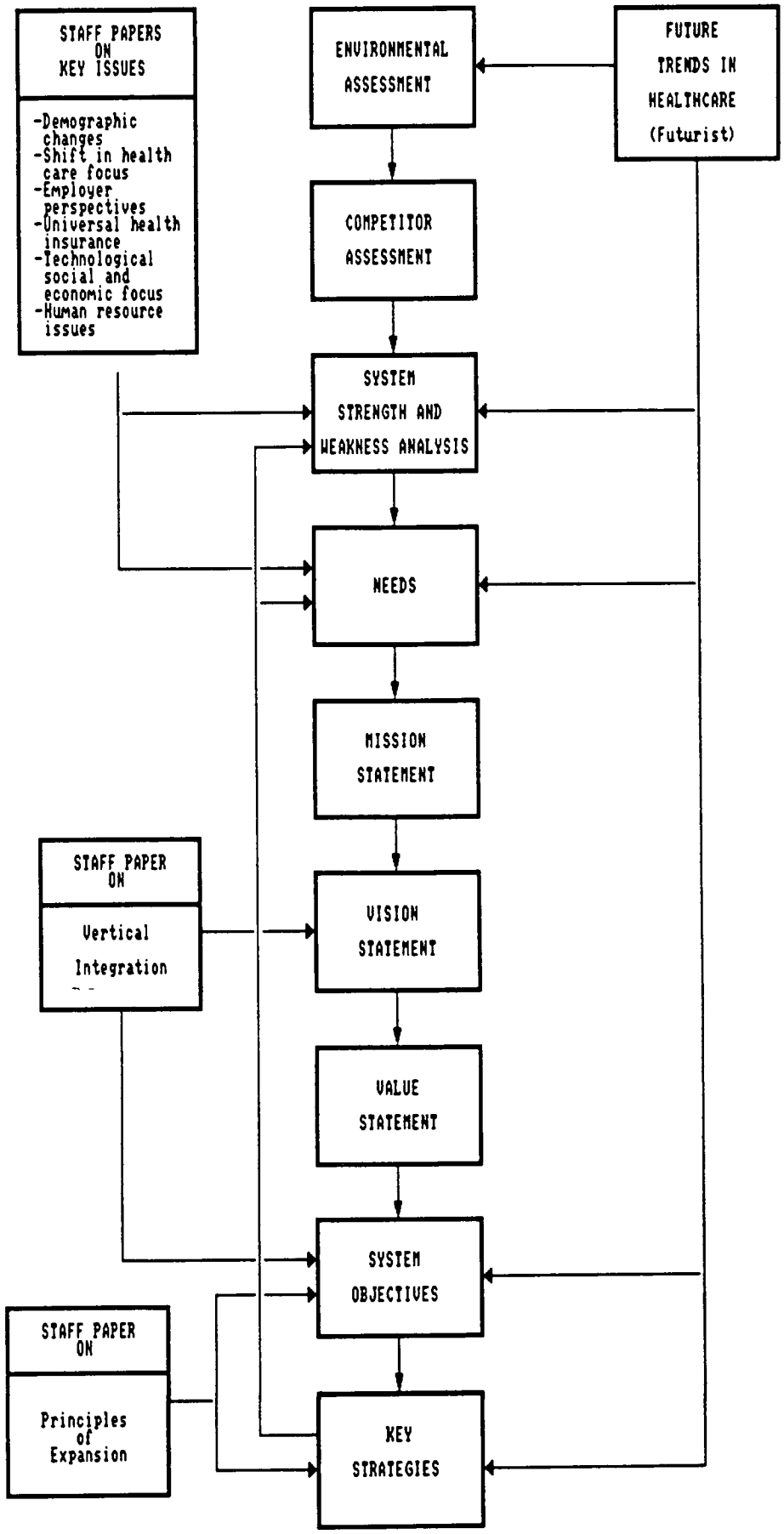
For the fourth Futures Committee meeting, the staff prepared a strength and weakness analysis, a paper on advantages of vertical integration in health care delivery organizations, principles and guidelines for future expansion, and mission, vision and value statements. The Futures Committee discussed each of these papers at length and further identified needs facing HFHS and some key objectives. At this meeting, Gail L. Warden presented for discussion key strategies to accomplish the objectives for the year 2000.

The fifth meeting of the Futures Committee was held on May 17, 1990. At this meeting the committee reviewed objectives and key strategies, as well as a draft of the strategic planning document.

A progress report was presented to HFHS Board of Trustees on May 31, 1990. HFHS Board members gave their input to the Futures Committee at Trustee Forums held on July 9 and 27. In addition, several Board members gave valuable written and oral comments to the committee. The feedback received was discussed at length at the Futures Committee meeting on September 5, 1990. This final report is being prepared and circulated to the members of the Futures Committee prior to the submission to the Henry Ford Health System Board of Trustees.

FIGURE 1

STRATEGIC PLANNING PROCESS



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II. MISSION, VISION AND QUALITY DEFINITION

Mission

Henry Ford Health System is dedicated to developing and providing the highest quality, compassionate health care to serve the needs of the southeastern Michigan community. The System's services will be the most comprehensive, efficient, and clinically effective in the region, supported by nationally recognized Henry Ford education and research programs.

Vision

Henry Ford Health System will:

- Evolve into the highest quality, most comprehensive and integrated health system in the region.
- Develop a Center for Health Sciences which will be engaged in leading edge tertiary care, research and teaching.
- Provide virtually all of the health care needs of the population served, from primary care to highly specialized tertiary care.
- Offer a range of health insurance and managed care programs that meet the diverse needs of the population and payors.
- Think of itself as an entity to which the users of its services belong. Administrative systems will emphasize the ease and convenience of use by the members.
- Be a responsible member of the community and will take leadership in developing sound health care policies at the local, state and national level.

Quality Definition

Quality is continuous improvement in patient care and service, education and research, and all other activities in which we are involved, in order to make the System a leading standard of excellence within the health care industry.

III. Corporate Values and Quality Guidelines

Henry Ford Health System embraces these basic values and quality guidelines and recognizes their role in its continued success.

1. *Customer Focus*

- Quality of patient care and service is a key principle for HFHS.
- HFHS is committed to continuously improving the quality of services to both our internal and external customers, and to giving priority attention to their concerns.
- Communication with customers is key to better understanding their needs and expectations, continuously improving processes, and building their trust.

2. *Management and Clinical Leadership*

- Leadership demonstrates commitment and behaves in a manner consistent with quality management concepts; including team work, continuous improvement, process focus, and statistical thinking.
- Leadership accepts the principal responsibility for creating an environment that encourages the involvement of all System employees and medical staff in continuous quality improvement.

3. *Employee Focus*

- HFHS employees are an important asset and resource, and will be treated fairly, with dignity, and respect.
- Employees will be given an opportunity to develop their potential through education and training, including the use of tools and techniques of quality improvement.
- Communication with all employees about mission, strategy, plans and objectives of the organization is key to building their understanding and trust.
- Employees are an important source of knowledge about the current processes and ideas for improvement.
- Employees at every level will be active members of quality improvement teams.

4. *Measurement*

- All work units within the system are committed to using customer and process knowledge as an input to identify key quality indicators.

- All work units will develop quality reports using the key quality indicators to monitor progress and to identify areas for improvement.

- The System is committed to the process of competitive benchmarking as a means of improving its services.

5. *Community Focus*

- HFHS will continue to improve the health status of the population it serves.

- HFHS will volunteer its expertise, time and facilities to meet civic and professional needs; participate in advocacy for health care; and being a responsible corporate citizen and neighbor.

6. *Systemness*

- To deliver quality products and services to our customers, all components of our System must collaborate and work in concert and harmony. The achievement of Systemness is essential for consistent quality and service in meeting both internal and external customer expectations.

7. *Recognition and Reward*

- HFHS leadership will create an environment that encourages people to practice, participate and teach the principles of quality improvement. Groups and individuals will be recognized for quality improvement practices.

IV. KEY SYSTEM REQUIREMENTS TO MEET COMMUNITY NEEDS

As indicated by its mission and vision, Henry Ford Health System is dedicated to continuous improvement in meeting the health care needs of those it serves. In analyzing the current health care environment and System strengths and weaknesses, the Futures Committee developed six basic requirements that must be met if Henry Ford Health System is to successfully pursue its mission and fulfill its role as a leading provider of health care services.

- Pursue an organizational focus that combines advanced clinical care and excellence in teaching and research with emphasis on health care delivery through managed care.

- Develop a cohesive, vertically integrated health care system that demonstrates a commitment to excellence and the process of continuous quality improvement.

- Continue to grow to serve a broad range of people in the region, achieving the benefits of scale for all Henry Ford Health System's constituencies.

- Strengthen Henry Ford Health System's position in health care insurance by providing a range of desired products that meet the needs of employers and consumers.

- Provide the necessary funds to support a) the Henry Ford Health Sciences Center, b) continuous quality improvement throughout the System, and c) continued growth.

- Effectively communicate Henry Ford Health System's vision to all constituencies--health care users, medical staff, other employees, the national health care community, governments, regulators, the financial community, and philanthropists.

In the following section of this report, the rationale for each of the six key System requirements is discussed.

1. **Pursue an organizational focus that combines advanced clinical care and excellence in teaching and research with emphasis on health care delivery through managed care.**

Rationale

The community will be best served by organizations that provide high quality care in an effective and efficient manner. Henry Ford Health System is in an ideal position to respond to the needs of the community due to the long tradition of Henry Ford Hospital as a center of tertiary care and academic excellence, combined with the System's experience as a provider of managed care under pre-paid or capitated funding mechanisms. Specific advantages of emphasizing both managed care and the development of a Center for Health Sciences include:

- Tertiary care excellence will result in Henry Ford Health System being able to continually enhance quality by disseminating the latest clinical techniques and knowledge to practitioners throughout the System.

- An academic orientation, including both teaching and research, is crucial to tertiary care excellence, as well as to recruiting and retaining medical leadership and staff physicians.

- Tertiary care excellence and continuous improvement in health knowledge and service are key features which can distinguish Henry Ford Health System from other developing systems, thereby improving the attractiveness of the System to the population served, including subscribers of Health Alliance Plan.

- All payors are placing increasing emphasis on the efficient and effective *management* of health care resources. Henry Ford Health System needs to be at the forefront of this movement in order to best serve a broad population throughout the region.

2. **Develop a cohesive, vertically integrated health care system that demonstrates a commitment to excellence and the process of continuous quality improvement.**

Rationale

The development of a vertically integrated health care system creates the appropriate institutional framework to meet community expectations for high quality care delivered in an effective and efficient manner. By integrating various types of health care services and settings, the System can assure that the patient receives the *right* level of care, in the *right* setting, at the *right* time:

- Whereas the traditional orientation of providers has been on specific services, the focus is increasingly on the total course of illness or injury, involving a longitudinal relationship with the patient. An integrated health care system offers the best response to such a change by emphasizing a coordinated continuum of care.

- The focus on uniform high quality encompasses the full range of customer encounters with the System. Whether in highly technical medical services or routine "hotel" services, Henry Ford Health System should represent high quality, accessible, compassionate care which is responsive to patient and customer needs.

- For the *Henry Ford Health System* "brand" to become valuable, it must represent uniform high quality, regardless of the component of the System.

- System integration results in greater influence over a full range of entry channels to services (i.e., how patients access various types of health care). To take full advantage of the System's potential, Henry Ford Health System should look and act like a unified system to patients, purchasers, medical staff, and employees.

- Having an integrated system allows Henry Ford Health System to adopt a long range, flexible planning horizon, adjusting different components of the System to respond to demographic, scientific and practice style changes.

3. **Continue to grow to serve a broad range of people in the region, achieving the benefits of scale for all Henry Ford Health System's constituencies.**

Rationale

To provide high quality, effective and efficient care throughout the region, Henry Ford Health System needs to continue a pattern of balanced growth. While continuously improving quality, growth allows the System to achieve economies of scale, as well as create the infra-structure to directly meet a wide range of customer needs and expectations:

- Henry Ford Health System must be large enough to assure convenient access to primary and secondary care through a broad based distribution system, including service to uninsured and underinsured populations in the region it serves.

- The primary and secondary base of Henry Ford Health System needs to be large enough to generate sufficient volume to support its initiatives as a regional referral center for clinical excellence and tertiary care, a center for medical research, and a major center for graduate medical education.

- A large base of primary and secondary care also enhances quality. At the tertiary care level, high volume tends to be associated with higher quality (e.g., the most successful heart surgery programs tend to be those that do a large number of cases, also efficiently organizing and utilizing resources).

- A large system allows economies of scale to be achieved in such areas as purchasing, planning, marketing, financial management, corporate development, legal affairs, insurance and administration.

- Expanding the size and the breadth of the delivery system in the suburbs can contribute to off-setting losses associated with care to the uninsured and underinsured in the city. In addition, economies of scale and innovative methods of delivering care (e.g. urban initiative) will be crucial to managing the cost of providing services within the city.

- Size and the variety of organizational settings can give the System an added advantage in recruiting and retaining highly qualified professionals.

4. **Strengthen Henry Ford Health System's position in health care insurance by providing a range of desired products that meet the needs of employers and consumers.**

Rationale

Henry Ford Health System needs to develop and participate in a range of health care insurance products that meet the varying needs of the population and area employers. By so doing, the System assures a continued flow of patients for its products and services. In addition, customers are better served when the System assumes responsibility for the cost of care, placing increasing emphasis on health maintenance and innovative approaches towards managing episodes of illness:

- Health care insurance vehicles such as Health Alliance Plan allow Henry Ford Health System to assure utilization of its health care services by dealing directly with employers.

- Many employers are shifting their health care benefits strategy from guaranteed benefits to funding fixed contributions toward health care benefits. Employees will increasingly be required to pay the difference between the actual premium cost and the subsidy paid by the employer. Therefore, there will be increased market demand for less costly, reduced benefit packages.

- Major insurance companies across the country are recognizing the vulnerability of regional HMO's and insurance products in comparison to national insurance plans and will be offering leading edge alternatives to capture market share. Such moves could result in the diversion of existing patients to other delivery systems and reduce the population being served by Henry Ford Health System.

5. **Provide the necessary funds to support a) the Henry Ford Health Sciences Center, b) continuous quality improvement throughout the System, and c) continued growth.**

Rationale

To maintain its commitment to academic excellence, continuous improvement, and balanced growth, Henry Ford Health System needs to increase the amount of capital available for acquisition of new technology, upgrading and expanding the delivery system infra-structure, and funding the development of leading edge programs:

- Significant capital is required to achieve the System's vision, including funds for tertiary care and leading edge technology, as well as for expansion of the primary and secondary delivery system in the suburbs.

- Despite the significant need for capital, Henry Ford Health System margins are low relative to suburban hospital competitors. Ramifications of this include inability to pay adequate compensation to physicians as well as meet the capital spending needs of the organizations. Failure to be competitive in these areas can lead to a less competitive product, which in turn can lead to a loss of revenue, a lower margin and a downward spiral.

- The current gap between capital needs and the margin generated even by efficient providers such as Henry Ford Health System is contributed to by national policies governing reimbursement for medical care. Although those policies are implicitly designed to shake out inefficient providers, they also cause wide spread short term dislocations and capital shortages. These inadequate reimbursement policies are expected to continue over the next five years.

- Care for the medically indigent will continue to be a major burden for Henry Ford Health System. There is little likelihood of achieving adequate funding for services for the uninsured and underinsured in the near horizon.

- The level of capital need, combined with pressures on operating margins, will result in a greater reliance on philanthropy as a source of funds.

6. **Effectively communicate Henry Ford Health System's vision to all constituencies--health care users, medical staff, other employees, the national health care community, governments, regulators, the financial community, and philanthropists.**

Rationale

The development of an integrated health care system has the greatest potential to improve the provision of health care to the communities served by Henry Ford Health System. Like any innovation, its success is related to the level of understanding of those affected.

- As Henry Ford Health System grows and evolves as a integrated system, it needs to forge a common culture among its diverse entities. The entire work force needs to understand the meaning of "systemness" and work towards maximizing system synergies.

- For communities and individuals to support Henry Ford Health System there needs to be a clear understanding of the System's vision and the advantages of the model being forged by the System.

- The health care industry is perceived by major employers and governmental entities as having failed to adequately control the costs of care. At the same time, significant segments of the population have insufficient access to care or are unable to pay for care. As a result, there is considerable pressure to impose changes on the health care industry. It is crucial that Henry Ford Health System be a party to offering a vision, shaping such changes, and to assuring that resulting policies support the delivery of high quality, effective and efficient care.

THE
MEDICAL COLLEGE OF GEORGIA

The Health Sciences University of the State of Georgia

HOSPITAL & CLINICS

FIVE YEAR PLAN
1990 - 1995

AUGUST 1990

MEDICAL COLLEGE OF GEORGIA
HOSPITAL AND CLINICS

FIVE YEAR PLAN, 1990 - 1995

AUGUST 24, 1990

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS

FIVE YEAR PLAN, 1990 - 1995

CONTENTS

I. INTRODUCTION

OPENING STATEMENT

The Medical College of Georgia Hospital and Clinics Five Year Plan, 1990 - 1995, was prepared upon the request of President Francis J. Tedesco. At the Medical College of Georgia Executive Council Retreat in January, 1990, he announced that each school and the hospital should develop a plan from which a detailed institutional plan would be developed for submission to the Chancellor in January, 1991. He stressed that the goals of the Hospital and Clinics must contribute to the successful achievement of the mission of the Medical College of Georgia.

It is with this general direction that the Hospital and Clinics Five Year Plan was developed.

METHODOLOGY

The administrative and functional organization of the Medical College of Georgia Hospital and Clinics forms the basis for the planning organization and assignments shown in Exhibits 1 and 2. The Director's Council Planning Group (DCPG) was the core planning group with the Executive Director serving as chairman. The plan was divided into seven key topic areas. Committees were established for each area; membership reflected broad participation by hospital administration, faculty and staff (Exhibit 3). One or more members of the DCPG were appointed as facilitators for each committee. Committees worked independently to develop goals for specified topic areas.

Selected resource documents were provided to assist in planning. Among these were summaries of the Hospital and Clinics Management Plan (1982); Master Plan/Facilities Master Plan (Hamilton/KSA, 1985); Functional Space Program (Douglass Group, 1988); Children's Medical Center Master Plan (Douglass Group, 1988); Medical College of Georgia Master Plan - 1985-95; and the report from the January, 1990, Medical College of Georgia Executive Council Retreat. These documents reflected amazing unanimity in purpose, clarity of Hospital and Clinics' mission, and included the necessary components required to accomplish this mission. They formed a sound basis for the development of this 1990-1995 Plan.

Initial drafts of committee reports were reviewed by the DCPG. Comments and suggestions were then returned to each committee for further consideration. Final goals in this Plan represent agreement by both the committees and the DCPG.

A new Mission Statement was developed to describe the organization's reason to exist and to convey a consistent, clear, and strong message regarding the Hospital and Clinics' purpose. The revised Mission Statement, shown in Section II, was subsequently endorsed by the Hospital Advisory Board. The remainder of the Five Year Plan was based on this Mission Statement.

Patient care, education and research are primary to the mission of the Hospital and Clinics. Therefore, the plan is divided into these main areas. In addition, finance, facilities, outreach/public relations and information systems are critical supporting functions. For this reason, goals for these areas are included in the Five Year Plan.

Patient care and education will continue to be priorities for the Hospital and Clinics. Major emphasis is also given to research to reflect the institutional agenda for greater productivity in this area.

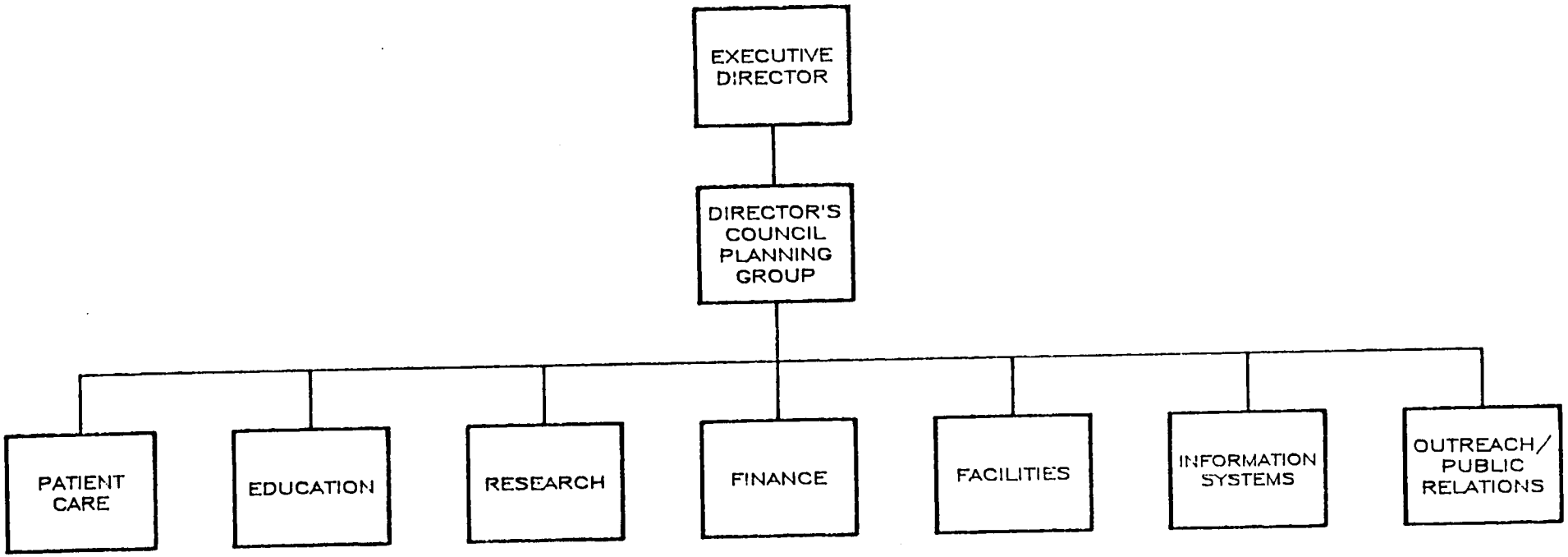
The plan for finance is extracted from the comprehensive Long Range Financial Plan developed under the leadership of the Associate Hospital Director for Finance and endorsed by the Hospital Advisory Board. Similarly, the facilities five year plan is a condensation of a comprehensive facilities document.

The information systems plan will be developed in more detail at a later date pending further recommendations from the on-going Price Waterhouse study. The importance of this area was emphasized throughout the Five Year Plan.

Public service is one of the missions of the Hospital and Clinics and was not overlooked. The health status of the citizens of Georgia is of paramount concern to the Hospital and Clinics. Goals in the patient care, education, research and outreach/public relations plans are established to enable the institution to fulfill this mission.

While specific objectives for each goal are not included in the Five Year Plan, strategies or enabling conditions are provided. The Hospital and Clinics annually establishes management goals with clear enumeration of strategies, action plans, and responsible persons. These goals are subsequently endorsed by the President of MCG. This process makes evaluation possible, allowing the Hospital and Clinics to measure its effectiveness in carrying out the Five Year Plan. The 1990-1995 Plan will be the basis for annual Hospital and Clinics goals and priorities.

EXHIBIT 1
MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 – 1995
PLANNING ORGANIZATION



Director's Council Planning Group

R. Edward Howell, Executive Director
Robert J. Adams, M.D., Housestaff Affairs
Richard R. Blas, Associate Director, Operations
Lois T. Ellison, M.D., Associate Vice President, Planning
Patricia K. Findling, Associate Director, Operations
Betty M. Golden, Associate Director, Patient Care
J. Duane Hoverkamp, Hospital Planning
Thomas Kelly, Jr., Associate Director, Finance
Charles W. Linder, M.D., Chief of Staff
Windsor R. Westbrook, Administrative Fellow
David L. Wilkerson, Hospital Architect

08/24/90

EXHIBIT 2
MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 – 1995
DIRECTOR'S COUNCIL PLANNING GROUP ASSIGNMENTS

	PATIENT CARE	EDUCATION	RESEARCH	FINANCE	FACILITIES	INFORMATION SYSTEMS	OUTREACH/ PUBLIC RELATIONS
ADAMS		X	X				
BIAS			X			X	
FINDLING		X					X
GOLDEN	X	X					
KELLY				X		X	
LINDER	X						
WESTBROOK				X			X
WILKERSON					X		

1. Director's Council Planning Group chaired by R. Edward Howell.

2. Overall planning coordinated by Ellison, Hoverkamp, and Westbrook.

EXHIBIT 3

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

PLANNING COMMITTEES

PATIENT CARE

*Betty Golden
*Charles W. Linder, M.D.
Harold L. Anderson, Jr.
Cameron D. Andrews
Joseph W. Griffin, Jr., M.D.
Mary Wallace Johnson
Geraldine Rinker
Keturah M. Sanders
Charles H. Wray, M.D.

EDUCATION

*Robert J. Adams, M.D.
*Patricia K. Findling
*Betty M. Golden
Scott T. Gregory
Claudia T. Morin
John C. Norcross
Lucille N. Pogue
Carol S. Suhrland

RESEARCH

*Robert J. Adams, M.D.
*Richard R. Bias
Philip Baroni
J. Russell May
Kathy Rufo, EDD
Betty B. Wray, M.D.

FINANCE

*Thomas Kelly, Jr.
*Windsor R. Westbrook
Hospital Advisory Board

FACILITIES

*David L. Wilkerson
Anita L. Black
Harry A. Jacobs
Judith L. McCool
William Y. McLean
James J. Potyraj
Jeanne B. Robinson
Angeline K. Williams

INFORMATION SYSTEMS

*Thomas Kelly, Jr.
*Richard R. Bias
Hospital Information Systems Subcommittee

OUTREACH/PUBLIC RELATIONS

*Patricia K. Findling
*Windsor R. Westbrook
Thomas W. Von Dohlen, M.D.
George H. Foster
William P. Kanto, Jr., M.D.
Sally L. Simkins
Robert P. Thames
Daniel F. Ward, M.D.

*Denotes Committee Facilitators

II. MISSION STATEMENT

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS

MISSION STATEMENT

The Medical College of Georgia Hospital and Clinics is a leading referral center for the State of Georgia and region offering a full spectrum of medical and health services. The Hospital and Clinics serves the medical and health care needs of the citizens of Georgia by providing quality patient care and education and by active participation in the quest for new knowledge. As a unit of the Medical College of Georgia, the Hospital and Clinics is dedicated to the development of professional and technical knowledge and skills through the provision of an environment in which students and practitioners gain exemplary clinical experience, and to the support of organized programs of teaching in medicine, nursing, dentistry, and the allied health professions.

August 24, 1990

Endorsed by the
Hospital Advisory Board

III. PLANS TO ACCOMPLISH H&C MISSION

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

PATIENT CARE

The ultimate goal of any hospital is to provide high quality patient care. In an academic medical center, this care should be supportive of and enhanced by educational and research activities. It is the desire of the Medical College of Georgia Hospital and Clinics to be a model of compassionate and state-of-the-art clinical care while supporting the academic mission of the Medical College of Georgia. The goals that follow are viewed as essential components of the Five Year Plan for Patient Care.

I. **To develop a coordinated, patient-centered and cost effective system which optimally utilizes all health care professionals and support staff involved in the delivery of patient care.**

A. Enhance the coordination of outpatient and inpatient care.

B. Encourage and support increased faculty leadership and participation in the provision of patient care.

C. Encourage and provide opportunities for participation in patient care by faculty from all schools involved in the education of health care professionals.

D. Evaluate the planning process for new clinical programs and monitor the effectiveness of all previously approved programs.

1. Assess the desirability for the institution to provide needed services unavailable in the state.

2. Provide opportunities for clinical research efforts that lead to innovative and improved patient care.

3. Facilitate the development and successful provision of multidisciplinary services.

E. Develop and enhance patient and family education programs (as identified in the Education Plan).

F. Expand and/or enhance patient, family and visitor relations programs.

II. To recruit and retain highly competent personnel to provide quality patient care.

A. Utilize wage and salary studies, employee surveys and other information to evaluate the capability of the institution to recruit and retain qualified personnel in a competitive environment.

B. Develop and gain approval of flexible systems and policies which allow the institution to maintain and improve its position as a leading health care employer.

1. Identify the unique requirements of the Hospital and Clinics.

2. Examine personnel policies relevant to health care providers.

3. Examine institutional business policies and their impact on the competitiveness of the Hospital and Clinics.

4. Communicate the unique differences and needs of the Hospital and Clinics to the appropriate administration.

III. To develop effective communications to improve coordination of health care.

A. Develop an effective orientation system which is mandatory for all hospital employees and campus personnel who interface with patients, families and visitors.

B. Improve internal communication through enhanced publications and other mechanisms.

C. Improve and expand staff development and continuing education programs.

IV. To improve access to pertinent patient care information through improved information systems, data collection and user education.

V. To develop and implement an improved, integrated Quality Assurance and Risk Management program.

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

EDUCATION

The Hospital and Clinics desires to enhance the knowledge and skills of health practitioners, students, patients and family members, and the general public in order to improve the health of the citizens of Georgia and region, and support the overall mission of the MCG Hospital and Clinics.

I. **To continue to provide clinical resources and appropriate staff for the education of medical, dental, nursing, allied health and other students in training for health care professions.**

A. Continue support of education in contemporary facilities and with resources which represent progressive health care and professional practice.

B. Evaluate the establishment of a hospital-based information resource/learning center for students, housestaff and hospital employees (perhaps in conjunction with the development of the proposed Multidisciplinary Research Center).

II. **To develop an organized, systematic approach to continuing education for all hospital employees.**

A. Develop among faculty and staff an increased awareness and support of all missions of the Hospital and Clinics.

B. Identify and review:
- current requirements for periodic training/ recertification for hospital employees.
- existing training/recertification programs offered through MCG.

C. Develop a formalized orientation program that satisfies accreditation requirements and is attended by all new employees that interface with patients, families and visitors. This program should be designed to address the unique needs of patient care and service (as identified in the Patient Care Plan).

D. Develop a process for ensuring that orientation and ongoing training requirements are met.

E. Assess department-based orientation programs for new employees, and the institutional resources available to support/assist in the development of departmental programs.

F. Continue evaluation of previously-established management development programs (i.e., Health Management Institute).

G. Formalize communication of service locations and systems to every employee.

H. Communicate mission statement as well as develop and communicate beliefs and values of the Hospital and Clinics.

III. To develop a comprehensive system of patient education for Hospital and Clinics patients which encompasses inpatient and outpatient services, as well as outreach activities in the Hospital and Clinics service area.

A. Assess current patient education programs, including:
- Content of existing programs
- Location (i.e. inpatient vs. outpatient settings)
- Methods used for existing programs (i.e. personnel involved, video vs. one to one teaching, etc.)

B. Assess current educational activities including sponsorship, location, and content.

C. Evaluate the need for a centralized/clearinghouse function for educational programs and activities.

D. Assess the potential for support from schools within MCG relative to participation in educational activities.

E. Evaluate the financial aspects of these programs.

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

RESEARCH

The MCG Hospital and Clinics desires to foster, facilitate and promote clinical and operations research by Medical College of Georgia faculty and Hospital and Clinics staff that will improve patient care, increase operational effectiveness, address health care manpower needs, and enhance the research and teaching missions of the Medical College of Georgia, while facilitating collaboration between Hospital and Clinics departments and MCG schools.

I. **To provide for organizational support to H&C-oriented research, particularly that having a multidisciplinary focus.**

A. Review the existing organizational structure and revise as appropriate. Particular attention should be given to creation of a Hospital and Clinics-based organization and liaison relationships with existing campus research organizations, particularly the MCG Research Institute (MCGRI).

B. Identify a group of experienced researchers willing to serve as facilitators and mentors, advising prospective researchers and hospital administration, and identifying potential investigators and granting sources for good research ideas.

C. Develop and publish a handbook to guide the novice researcher through the necessary process and procedures for Hospital and Clinics and campus review and approval, and submission to possible funding sources.

D. Encourage and support collaboration among Hospital and Clinics departments to promote a multidisciplinary approach to research projects.

E. Provide educational sessions, in collaboration with existing programs on campus, for Hospital and Clinics staff, fellows, young faculty and coordinators interested in conducting research. Sessions should not only include information on the research process, but also MCG protocols, data collection and analysis, computer use, possible funding sources, and publication of study results.

F. Communicate the results of MCG research that affect patient care or improve its delivery in the Hospital and Clinics. This would include a periodic H&C Research Symposium and a regular publication describing current research projects, principal investigators, and applications within the Hospital and Clinics. This mechanism would also be used to keep Institutional Relations informed of current activities for potential media releases or marketing purposes.

G. Develop a central office or clearinghouse to evaluate the feasibility and resource impact of proposed research. This office would notify administration and department heads of all research being proposed and conducted within the Hospital and Clinics. It also would be responsible for seeing that pertinent findings are shared with administration.

H. Establish an independent, self-supporting, hospital-based research fund available to graduate students and H&C staff who have research ideas relevant to the delivery of patient care and services.

I. Establish a consistent method of addressing funding issues, patient billing and collections, and any other issues related to the financing of research projects within the Hospital and Clinics. This would include the implementation of a MCG Hospital and Clinics discount policy and procedure for funded projects.

J. Ensure that campus and Hospital and Clinics information systems development incorporates the need for "research-friendly" interfaces. This should include participation in planning information systems by users to encourage systems and databases that will permit ready access for clinical and operational research. It could also involve developing a computer network that links data on current research to facilitate interdisciplinary activities, guides new investigators to faculty and staff with similar interests, and identifies available equipment, procedures, and other resources. Implementation of the Price Waterhouse strategic plan is an enabling condition for this action.

II. **To create clinical research facilities for both inpatient and outpatient studies that can provide the necessary spectrum of care depending upon patient acuity.**

A. Establish the ancillary system support necessary to conduct clinical research. This includes appropriate nursing staff, diagnostic services and administrative systems.

B. Create an advisory group of representatives from participating clinical investigators, nursing, Hospital and Clinics administration, laboratories, pharmacy, radiology, the MCGRI and Grants and Contracts. The charge of this group would be to develop mechanisms to improve the quantity and quality of clinical research at MCG while enhancing patient care.

C. Develop a functional space program for clinical research facilities and identify possible locations in the Hospital and Clinics.

D. Review the need for a clinical research support team, including at least one nurse clinician, physician, and administrator, whose responsibility would be to manage the administrative and clerical support of clinical research throughout the Hospital and Clinics. This group may serve as an alternative (or at least an interim step) to the designation of assigned patient-care space for clinical research.

III. To develop an institutional process for the assessment of new methodologies and/or technologies and their impact on the overall environment and the MCG Hospital and Clinics mission.

IV. To foster inter-institutional studies through other units of the University System, associations, and organizations, (e.g., University Hospital Consortium, Association of American Medical Colleges, National Association of Children's Hospitals and Related Institutions).

A. Identify individuals responsible to function as liaison for research with external groups.

B. Communicate research opportunities using the Hospital and Clinics organization (see Goal I).

IV. PLANS TO SUPPORT H&C MISSION

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

FINANCE

The Five Year Plan proposed for the Medical College of Georgia Hospital and Clinics is reflective of the threefold mission of the institution - teaching, research and patient care. Financial viability of the institution is a critical element in the success of the hospital in reaching its stated goals. In order to facilitate a healthy financial environment, the adoption of financial policies and goals are essential.

The Medical College of Georgia Hospital and Clinics must realize a 4% operating margin of net revenues and state appropriations to be applied toward the application of new knowledge, the acquisition of advanced technology to support patient care activities and the development of new health care delivery systems. (The hospital industry reports that 1988 operating margins at the 75th percentile for governmental and non-profit hospitals with 400 beds or more were 4.03 percent and 6.15 percent, respectively.) To achieve a minimum operating margin of 4% will require the adoption of financial goals and policies related to patient volume, payor mix, pricing and resource allocation.

I. **The following financial targets have been developed in relation to patient volume and payor mix to achieve financial goals.**

A. Specific marketing initiatives will be required to maintain or improve inpatient utilization beyond 1990 levels.

B. Focused marketing initiatives will be implemented in fiscal year 1991 with the objective of achieving a minimum 2% annual growth in Blue Cross and Commercial Insurance admissions.

C. Uninsured admissions will not exceed a maximum annual growth of 1 percent.

D. Overall outpatient activities will increase at a minimum 2.4 percent annual growth rate through 1992 and thereafter realize an annual growth rate of at least 3 percent.

E. GeorgiaCare activity will grow at a rate commensurate with Blue Cross admissions.

F. Revenue deductions will be limited for inpatient and outpatient activities to a maximum of 47 percent of gross revenue.

G. Elective, non-covered services provided to Medicaid and Medicare patients will be restricted. (Exceptions to this policy will be considered by Hospital Management provided the Departmental Chairperson identifies specific patient volume as a requirement to support educational programs).

H. Elective and non-emergency services to patients who have the ability to pay but refuse to satisfy previous outstanding balances or to establish an acceptable financial arrangement will be restricted.

I. Elective and non-emergency services for patients who refuse to participate in seeking Medicaid certification for which they have been deemed eligible will be restricted.

II. Projections of gross revenue are predicated on the following pricing policy assumptions:

A. Future price increases will be limited to the DRI updating factor. (The Data Resources Incorporated updating factor measures price changes for goods and services purchased by the hospital industry).

B. Negotiation of managed health care plan discounts will be based on additional volume rather than existing volume. (Exceptions may be made if present volume is essential to the economic viability of the hospital and/or the patient volume is critical to fulfill educational requirements).

C. Increases in operating expenses will be limited to variable cost increases for inpatient and outpatient activities plus the DRI updating factor.

III. Goals related to operating expenses are:

A. The Hospital and Clinics committment to patient care, education and research requires a minimum capital improvement budget equivalent to 3.54 percent of the Hospital & Clinics operating budget.

B. The increase in additional outpatient personnel will be limited to .95 FTE per 1000 outpatient visits in excess of the base year (1990).

C. The increase in additional inpatient personnel will be limited to 1 FTE per 36 inpatient admissions in excess of the base year (1990).

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

FACILITIES

The purpose of this Facility Plan is to identify and describe the facilities necessary to support the patient care, education, and research mission of the Hospital and Clinics. The location, design and construction of programs will be planned to maximize the productivity of staff, facilitate the care of patients, enhance the interdisciplinary teaching of students, residents and fellows, and properly utilize support services.

The following operational planning guidelines were used in the development of this Plan and will be used in the development of Hospital and Clinics annual goals and priorities.

1. A Space/Renovation Master Plan must be developed for the Hospital and Clinics which incorporates all facilities and new construction.

2. The Plan must be developed as a part of total campus planning.

3. The Plan must be developed to support programs and related functions.

4. The Plan will be a guide for all space/renovation decisions.

5. Renovations must proceed in a continuum, that is, to proceed on an annual basis.

6. Funding from the Board of Regents will be established annually.

7. Every effort should be made to avoid multiple relocations and renovations.

8. The Plan will allow for flexibility and adaptability in the event of new programs or needs of the Hospital and Clinics.

9. Communication and cooperative planning with Hospital and Clinics administrative staff, medical staff, and institutional administration will be carried out in the development and implementation of the Plan.

I. To complete the construction and implement the operation of the Ambulatory Care Center/Specialized Care Center (ACC/SCC).

The new ACC/SCC building will be connected to the east side of the Sydenstricker Wing of the Hospital and will span Harper Street to also occupy a site adjacent to the Medical Arts Building. Completion of construction of the 338,785 square foot facility is scheduled in the spring of 1992 with occupancy as early as the fall of 1992.

The ACC will incorporate outpatient clinics and diagnostic and support facilities. This facility will respond to trends toward increasing outpatient care, as well as consolidate outpatient services which currently are provided throughout the campus. Although specific areas of the facility are designated for certain clinics, it has always been an important part of the plan that sharing among clinics will occur as needed. This will allow flexibility of scheduling and more efficient use of personnel and space.

The SCC will accommodate a new and expanded Emergency Department, three 12-bed intensive care units, space for a fourth 12-bed unit in the future, and diagnostic and support facilities. As the Regional Trauma Center for East Central Georgia, this facility will respond to increased demands for emergency and intensive care services.

As a part of this project, the space vacated by the Emergency Department will be renovated to accommodate the Blood Bank and Blood Donor/Pheresis. This will enable the Blood Bank to be in close proximity to the Emergency Department, the Operating Room Suite and the new intensive care units in the SCC.

II. To facilitate the planning, design, and construction of the Children's Medical Center (CMC).

The CMC facility is envisioned as a major patient care, educational and clinical research facility. The CMC will be a part of the Hospital and Clinics complex and take advantage of existing support facilities and selected diagnostic and treatment capabilities. The CMC will provide comprehensive pediatric services for the Central Savannah River Area and referral services for the state of Georgia and neighboring states.

The CMC will be located on Harper Street on the site of the present School of Nursing Administration Building. It will be connected to the ACC/SCC and be accessible from the Sydenstricker Wing.

Patient care capacity is anticipated to be approximately 175 beds. Medical staff will include MCG faculty and community physicians.

III. To continue renovations of the existing Hospital to comply with all current life safety codes and applicable building standards.

The Hospital has been systematically renovated for this purpose since 1977. As a part of these renovations, the Hospital has also been able to renovate these areas to respond to programmatic needs. Below is the projected schedule in which these renovations will occur.

FISCAL YEAR	PROJECT
90/91	2 North (Anesthesiology, OR, etc.) Sydenstricker Smoke Compartmentation & Dampers Boiler and Mechanical Rooms
91/92	6 West (PT/OT and Office Space)
92/93	Research Wing (1-9, P)
93/94	2 South/West 8 North
94/95	5 South/5 Ancillary 2 Ancillary (Computer Area)

IV. To facilitate ongoing renovations and/or relocations within the Hospital and Clinics in order to respond to programmatic needs.

The Hospital and Clinics facilities must be responsive to change in order to accommodate new or expanded methods of patient care, education, and research. The following is a list of projects which either have been approved or should be considered for approval for implementation in the next five years. These projects involve renovation, relocation and/or refurbishment.

A. Relocate and expand the Burn Unit.

B. Expand the Children's Medical Center as needed in the Hospital prior to construction and operation of the new Children's Medical Center facility.

C. Refurbish the current Rehabilitative Services (PT/OT) area.

D. Develop a comprehensive Women's Center in the Hospital.

E. Renovate and expand the inpatient and outpatient Hemodialysis Unit in its current location and plan the eventual relocation of this unit.

F. Renovate and expand the Epilepsy Monitoring Unit.

G. Evaluate and implement plans for the consolidation of faculty and administrative offices.

H. Relocate and expand Employee Health.

I. Develop and implement a 23:59 Day Unit for Ambulatory Procedure Center patients requiring additional observation beyond recovery time, but who do not require inpatient hospitalization.

J. Develop and implement a Pre-Admission Unit for patients awaiting admission. Laboratory work, electrocardiograms, physical examinations, etc. could be done while patients are in this unit.

K. Develop and implement a Discharge Holding Unit for patients who have been discharged but are awaiting family pick-up. This would free up beds for other patients being admitted to the hospital.

L. Complete the consolidation of Housestaff Facilities in the Pavilion I building (except those identified as requiring immediate access to patients).

V. To support the research mission of MCG through the development and implementation of a Clinical Research Center.

These facilities will be composed of administrative and support areas, outpatient clinic, and an inpatient unit.

VI. To evaluate and implement methods of improving patient access and convenience at the Hospital.

A. Make available hotel-like accommodations to meet the needs of out-of-town ambulatory and special procedures patients.

B. Develop a systematic program for managing traffic patterns, signage and communications for patients and visitors.

C. Identify and implement improvements of the use of signage and information for consistency and clarity.

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

OUTREACH/PUBLIC RELATIONS

The MCG Hospital and Clinics desires to enhance the overall Hospital and Clinics' mission by increasing the patient referral base, patient volume, changing patient mix, improving institutional image and increasing awareness and support of MCG programs and services.

I. To create and define the image of the Medical College of Georgia Hospital and Clinics as a premier academic medical center.

   A. Assess the current status of the MCG Hospital and Clinics image and progress.

   B. Promote the MCG Hospital and Clinics to housestaff and students as potential users of MCG services.

   C. Communicate the progress of the Hospital and Clinics to various publics.

II. To identify and address underserved areas in order to improve the referral base of the Hospital and Clinics and to improve access to quality health care.

   A. Identify and evaluate areas for possible satellite facilities.

   B. Develop rural hospital emergency room affiliations.

   C. Evaluate the feasibility of industrial medicine programs.

   D. Establish consultative linkages via telemedicine and telephone conferencing.

   E. Facilitate seminars for referring physician groups.

   F. Strategically position residents to market MCG Hospital and Clinics within referring facilities.

   G. Further develop and promote community wellness and health education.

   H. Increase referrals and service to the state through an enhanced patient transport system.

III. To market MCG specialized services and outstanding faculty and staff.

MEDICAL COLLEGE OF GEORGIA HOSPITAL AND CLINICS
FIVE YEAR PLAN, 1990 - 1995

INFORMATION SYSTEMS

Improved information system support is clearly an enabling condition for accomplishing the Hospital and Clinics' mission. Accurate, up-to-date information that is readily available when and where needed is vital to the delivery of high quality patient care. The education portion of our mission requires an environment that emulates future working environments. Access to patient data, specialized data collection techniques, and support for data analyses are essential to the success of clinical research efforts.

Ongoing consultation being provided to MCG by Price Waterhouse provide the basis from which to begin improvements, and guidance on organizational, software, hardware, and support acquisition issues. A detailed Hospital and Clinics information systems plan will be developed based on this consultation and an MCG information system plan.

V. CLOSING STATEMENT and LOOKING FORWARD

CLOSING STATEMENT and LOOKING FORWARD

This Five Year Plan, 1990-1995, reflects the combined work and opinions of the Medical College of Georgia Hospital and Clinics administration, faculty and staff. It was developed with the realization that the Hospital and Clinics is a partner with the Medical College of Georgia Schools, working together to accomplish our mission in patient care, education and research. The plan defines the Hospital and Clinics' mission, goals and enabling conditions. It provides the basic direction and focus to accomplish the mission for the next five years and beyond. We anticipate that modifications to the Plan will be needed in an ever changing environment.

We are optimistic regarding the future and approach the next five years as a time of growth in response to program needs and a renewed commitment to strive for excellence. We are confident that we will be recognized as a leading academic medical center and will be a source of pride for the State of Georgia. **Certainly, if the goals as described in this Plan are realized, we will achieve our mission.**

UCLA MEDICAL CENTER

Strategic Plan 1990 - 2000

January 1990

UCLA Medical Center

Office of the Director
Mail Code: 173016

January, 1990

Medical Center Friends and Family Members:

On the following pages you will find the Medical Center's Strategic Plan. The Plan has been revised following its original publication in 1987 to reflect new issues and priorities that have developed since then. The Strategic Plan continues to set the course we have charted to meet our future. Our goals are ambitious. Working together, we can achieve them.

The success of our Strategic Plan will rely on teamwork, especially on the partnership we in the Medical Center maintain with the faculty of the School of Medicine. The new Plan version underscores our recognition of the importance of this relationship and our commitment to make it work to serve the shared needs of both institutions.

The Strategic Plan also demonstrates our commitment to continue to provide excellent care and service. Despite constant change in health care delivery, accompanied by uncertainty about where the future may lead us, the Strategic Plan sets forth the basic principles we will use to guide us, no matter where the road goes. To maintain the patient volumes that will support our teaching commitments and financial requirements, we will seek to identify and satisfy the needs of our markets; provide comprehensive patient services; acquire appropriate managed care contracts; recruit and retain an excellent workforce, maintain modern facilities, and manage costs and efficiency. These objectives will be realized in a setting where humanistic and hospitable care will be the hallmarks of the service we offer.

I look forward to working with you toward achievement of the Medical Center's goals.

Raymond G. Schultze, M.D.
Director
UCLA Medical Center

UCLA MEDICAL CENTER
STRATEGIC PLAN
1989-2000
January 1, 1990

In 1988-89 Medical Center Administration sponsored a formal effort to review, revise and update the Medical Center's Strategic Plan. Since the time when this plan originally was developed in 1985-86, continuing changes in the field of health care delivery have brought new issues to the foreground. The Strategic Plan review process was a means of evaluating the impact of these issues on the Medical Center's future, and of incorporating an approach to them in the official Strategic Plan document. The results of the Plan review and revision process follow.

Key Issues

The key issues which became the focus of planning discussions leading to the revision of the Strategic Plan were the Medical Center's facilities, indigent care, managed care contracts, utilization management, and the Medical Center's relationship with the School of Medicine. Each of these issues has significant implications for the Medical Center:

- **The Facilities** - should the Medical Center make a commitment to plan, build and finance a replacement

hospital? If no, what are the alternatives? If yes, what are the initiatives that must be undertaken to finance the project and to develop constituent support of the program?

- Indigent Care - what should be the approach to indigent care? Should there continue to be unrestricted access or must access be limited to the extent of available resources? How should the amount of resources used for indigent care be determined? What community problems would changes in the indigent care program cause and how should they be managed?

- Managed Care Contracts - how can the Medical Center and the faculty of the School of Medicine develop a joint approach to acquiring and administering managed care contracts? How can the risk assumed by the Practice Plans be determined in a managed care environment? Once determined, to what extent should this risk be shared by the Medical Center? To what extent should the Medical Center's risk be shared by the Practice Plans?

- Utilization Management and Cost Control - how can a team approach to increased efficiencies, and cost reduction involving the medical staff, medical center

staff, and house staff, be developed? What kind of programs will be necessary to convince these groups of the need to improve resource management? How can behaviors be changed?

- Medical Center - School of Medicine Relationships - what joint approaches to planning and resource allocation would promote the cohesion of the Medical Center and School? In what areas of common interest should efforts toward strengthening partnerships be focused?

The planning discussions also featured many continuing concerns:

- What markets does or should the Medical Center be serving? How can the Medical Center protect and increase its market share?

- Staff shortages plague multiple health care fields. How can qualified staff be recruited? What must be done to ensure that, once recruited, staff members will want to stay?

- Changes in health care financing and delivery systems have fostered an era of price and market share

competition among all hospitals and other health care providers. What steps must the Medical Center take to increase productivity? How can the costs of care be managed more effectively? What must be done to maintain and strengthen a commitment to humanistic care and service? Can the Medical Center demonstrate its quality on a quantifiable basis?

- Demands for information and an explosive growth of available technology have led to the continuing need to pour resources into information systems development and use. How can the Medical Center ensure its information needs are met? What systems does it need? What training needs do they, in turn, impose?

Discussion of these issues and concerns, along with a reassessment of the Medical Center's strengths, weaknesses, and opportunities, led the strategic planning process participants to identification of ten specific strategies on which future activities should be founded.

An Expression of Values

The ten strategies in the Strategic Plan, and the planning process itself, are an expression of the values of the Medical Center's leaders and key constituents. These shared values give strength to the Strategic Plan. They include:

- A commitment to education and research
- Teamwork and partnerships
- Service
- Efficient and effective use of resources
- Quality of care
- Consensus
- Innovation
- Communication
- Human resource development

The Mission Statement

The Strategic Plan's foundation is the mission statement. This statement describes the purpose of the Medical Center.

The mission of UCLA Medical Center is to develop and maintain an environment in which the educational and scientific programs of the Schools of the UCLA Center for the Health Sciences are integrated with exemplary patient care.

UCLA Medical Center

Strategic Goals

1989 - 2000

The mission statement is articulated through development of a set of goals. The goals will serve to guide the Medical Center's planning activities through the next decade. These goals set targets toward which the Medical Center's future strategies should aim. The goals also describe principles and a framework to guide the Medical Center's future development.

The goals first were developed in 1986. They were reaffirmed during the second strategic planning cycle in 1988-89 by members of the Strategic Plan Implementation Committee.

PATIENT CARE GOALS

Scope of Services

I. UCLAMC will ensure patient access to a vertically integrated, comprehensive care system covering the full continuum of care.

II. UCLAMC will ensure that the quality of its medical and nursing care, its technical expertise, and its commitment to excellent patient service meet or exceed the expectations of present and future health care consumers.

Relations with the Evolving Health Care Market

I. UCLAMC will develop relationships with an array of financing and delivery systems necessary to ensure the maintenance of a patient base with adequate numbers and types of patients to support the institution's academic objectives.

Competition

I. UCLAMC will acquire or strengthen the characteristics considered important by physicians, health care consumers, and their representatives and will communicate these strengths to facilitate their choice of UCLAMC.

Service to the Community

I. UCLAMC will strive to provide access to special services and technologies not available at other hospitals, recognizing that it may be the only site where such services may be obtained by economically disadvantaged persons.

II. UCLAMC and its medical staff will provide care to population groups, including economically disadvantaged persons, who are representative of the general socioeconomic composition of the region.

III. UCLAMC will contribute to the general social welfare to the extent of available resources by serving as a source of medical care for economically disadvantaged persons.

EDUCATION AND RESEARCH GOALS

I. UCLAMC will continue to be the principal clinical training and research resource of the UCLA School of Medicine and a significant resource for other health professional training.

II. UCLAMC will continue to promote opportunities for instruction in a full range of delivery settings that preserve excellence in medical care.

III. UCLAMC will participate in developing, testing and evaluating advances in medical research and technology.

IV. UCLAMC will participate in programs that support the academic requirements of the School of Medicine and the financial health of the Practice Plans.

ORGANIZATIONAL AND OPERATIONAL GOALS

Facilities

I. UCLAMC will develop space resources to meet current and future program needs.

II. UCLAMC will improve the ambience and accessibility of Medical Center facilities, and remodel or refurbish them where appropriate.

III. UCLAMC will increase the flexibility of its physical facilities to achieve maximum efficiency of systems, equipment, and human resource utilization.

Finance

I. UCLAMC will maintain sufficient financial strength and growth to meet current and future operating and capital needs. Financial strategies will be adopted in order to meet these needs as well as maintain UCLAMC's attractiveness to potential funding resources and competitiveness in the managed care environment.

Human Resources

I. UCLAMC will continue to develop ways to attract, develop, and retain personnel of the highest caliber.

II. UCLAMC will educate and motivate its personnel to provide excellent, humanistic, considerate and responsive service.

III. UCLAMC will continue its efforts to maximize the efficient use of its human resources.

IV. UCLAMC will meet workforce diversity objectives, measured by a work force characterized by an ethnic and gender mix reflecting the demographics of UCLAMC's pool of qualified applicants.

Administrative

I. UCLAMC will continue to enhance local control and accountability for support services essential to the Medical Center's operations, including the areas of personnel, financial services, parking, legal counsel, facilities operations, and architecture and engineering.

II. UCLAMC will seek adoption of University administrative structures which are more responsive to the needs of the medical centers of the University.

Management

I. UCLAMC will make strategic planning and marketing integral parts of Medical Center management and operations.

II. UCLAMC will develop participative management structures for planning, developing, implementing, and evaluating programs.

III. UCLAMC will strengthen the participation of the medical staff and the School of Medicine in its decision-making processes.

IV. UCLAMC will seek to integrate and complement the clinical components of its Strategic Plan with the other Health Science schools, especially the School of Medicine, and with the Neuropsychiatric Hospital.

The Medical Center's Future

The actions taken by Medical Center Management, in conjunction with the Medical Staff, will create the future of the Medical Center. Success in achieving the goals set forth in the Strategic Plan through implementation of the strategies will result in a Medical Center in the year 2000 with these characteristics:

- Excellent and humanistic service
- Modern facilities and continued commitment to maintaining state-of-the-art technologies
- Fiscal strength to support building programs
- Competitive strength on a regional and national basis for multiple specialized or unique clinical services
- Participation in multiple systems of health care delivery
- Competitive and responsive in the local community
- Closer relationship with the School of Medicine to develop clinical programs and ensure optimum service delivery
- Demonstrated superior quality
- Cost management
- Leadership on healthcare issues at the local, state, and national levels
- Staffing to match service commitments
- Futurist information networks

The Strategies and Initiatives

The purpose of this Strategic Plan is to position UCLA Medical Center to develop a sustainable long-term advantage in the patient care market while serving the interests of students and faculty who rely on the clinical effectiveness of the Medical Center. The strategies in this Plan are consistent with the Medical Center's goals; take advantage of factors in the external environment and of the Medical Center's strengths; and will help move the Medical Center in the direction of its ideal future.

The planning process has produced both strategic and operational recommendations. This document focuses on ten broad strategies and a number of initiatives to support them.

The strategies are divided into two groups: market strategies to assure the Medical Center's competitiveness and to maintain the appropriate patient mix and volume, and organizational-operational strategies.

Market Strategies

The Medical Center and its medical staff and faculty have a joint interest in achieving an ideal patient mix and volume. Patient mix and volume are critical factors in meeting the academic and financial goals of the School of Medicine and Practice Plans as well as the Medical Center.

The Medical Center and medical staff must work together to develop a unified approach to managing mix and volume. They need to support activities that will protect the existing patient population base from competitors and accommodate new patient populations for new clinical programs. Before any services are marketed, the Medical Center and its medical staff must address any system or capacity limitations that might prevent patient access to the services.

Implementation of any marketing strategies at UCLAMC must be carried out in a manner consistent with UCLAMC's reputation as a source of excellent and humane care.

Strategy 1:
Marketing

CULTIVATE PROGRAMS TO MAXIMIZE REFERRALS TO UCLA MEDICAL CENTER BY PROMOTING POSITIVE PROFESSIONAL RELATIONSHIPS BETWEEN UCLA FACULTY AND REFERRING PHYSICIANS, BY EXPANDING SERVICES TO ATTRACT SELF-REFERRED PATIENTS, AND BY ASSESSING NEW MARKET OPPORTUNITIES THAT WILL RESULT IN NEW PATIENT VOLUME.

In order to manage the appropriate volume of tertiary activity, UCLA Medical Center and its medical staff need to undertake initiatives focused on two key markets: patients and referring physicians. The Medical Center needs to:

- Maintain and strengthen current referrals from physicians in private practice;

- Develop new referral patterns; and

- Improve patients' understanding of the services and advantages of care at UCLAMC.

The Medical Center and medical staff need to develop the systems and the capacity to cross-refer patients to other UCLA medical staff.

Finally, the Medical Center and its medical staff must continually assess the market need and demands for new services and opportunities for attracting new patients through technology development at UCLA Medical Center. Both to attract patients and to promote the Medical Center's excellent reputation, the availability of these services should be communicated to referring physicians and potential patients.

<u>Initiatives</u>

a. Referring Physicians

(1) Expand physician relations program in geographical areas outside Los Angeles County to inform community physicians about the availability of UCLAMC's tertiary referral services.

(2) Expand mechanisms to assist community physicians in referring patients to UCLA Medical Center and to inform them about UCLA-sponsored educational and research activities.

(3) Develop a communications system between UCLAMC faculty/housestaff and referring physicians regarding the care of referred patients, including automated announcements regarding admission and discharge.

b. Self-Referred Patients

(1) Expand and promote services that attract self-referred patients, i.e., physician referral service, new resident mailings, etc.

(2) Develop a communications program, which will include advertising, to project UCLAMC's image as a primary and tertiary care provider.

(3) Expand UCLAMC's role as a source of medical second opinions.

c. New Markets

(1) Assess the feasibility of UCLAMC establishing formal referral programs to attract patients from international markets.

(2) Evaluate the feasibility of establishing satellite centers for selected clinical services and programs.

Strategy 2:
Managed Care Contracts

CULTIVATE UCLA MEDICAL CENTER'S RELATIONSHIPS WITH THIRD PARTY PAYORS IN ORDER TO MAINTAIN AND EXPAND PATIENT ACTIVITY AT UCLAMC AND TO SUPPORT THE INSTITUTION'S ACADEMIC AND FINANCIAL OBJECTIVES.

As more third party payors seek to control patient access to health care providers, the Medical Center needs to ensure that an adequate patient base is able to receive both primary and tertiary care at UCLAMC. The Medical Center also must demonstrate to the managed care systems the benefits and value of contracting with UCLAMC for service. Both the Medical Center and medical staff need to ensure routine services are priced at competitive rates. In seeking and administering managed care contracts, UCLAMC and the medical staff must assure that patient care is delivered in a manner consistent with market expectations, operating capacity, and professional standards of care.

Initiatives

a. Expand UCLAMC's capacity to prepare and offer "packaged services" to HMOs and other payers that include both Medical Center and professional fees.

b. Evaluate means to expand full-risk contracts while mitigating the effects of adverse selection.

c. Develop a unified Medical Center/School of Medicine strategic approach and structure for negotiating and implementing managed care contracts.

d. Establish relationships with large employer groups both to explore direct contracting and to support UCLAMC involvement in managed care networks.

e. Develop better means of explaining the costs of hospital and professional charges at UCLAMC.

f. Improve internal data collection to track resource utilization for both inpatient and outpatient episodes of care.

Organizational And Operational Strategies

The goal of these seven strategies is to improve UCLA Medical Center's ability to deliver the service features increasingly required by the market and provide an optimal environment for future innovation. The development of organizational and operational strategies is motivated by several factors.

- Market research has identified shortcomings in the Medical Center's delivery of key hospital service features desired by patients (such as accessibility). These must be corrected if patient mix and volume are to be managed appropriately.

- The Medical Center's enlarged focus on managed care and ambulatory care programs will require continued cost control efforts by management and greater program cooperation among the medical staff.

- The Medical Center's ongoing internal assessment and goal-setting processes identified several key areas where the operating environment of the Medical Center may be improved. The success of these strategies will require that Medical Center management and medical

staff collaborate in a number of areas to improve both the service provided at UCLAMC and its operating environment.

Strategy 3:
Human Resources

DEVELOP RECRUITMENT, RETENTION AND PRODUCTIVITY MANAGEMENT PROGRAMS TO ENSURE THE MAINTENANCE OF A SUFFICIENT BASE OF QUALIFIED STAFF NEEDED TO PROVIDE EFFICIENT AND RESPONSIVE MEDICAL CENTER SERVICES TO ITS PATIENTS AND PHYSICIANS.

The Medical Center's human resources are one of its principal strengths. The staff who provide service are the source of humanistic care and clearly the Medical Center could not fulfill its mission without them. Yet the skills, knowledges and abilities needed by the staff of a modern hospital are becoming more technical; the demand for qualified staff is great; and recruiting, retaining and developing adequate staff is a growing challenge. This challenge is complicated by the high cost of staffing a hospital, especially when costs need to be reduced. These are the issues the human resources initiatives are intended to address.

Initiatives

a) Recruitment

1. Implement both short and long range strategies to access quality personnel in difficult to fill classifications.

2. While continuing to strengthen the attractiveness of UCLAMC as an employer, endeavor to increase supply and reduce demand for human resources in shortage markets through restructuring of the system(s) for delivering health care at UCLAMC.

3. Strive toward workforce diversity and internal development/promotion in all recruitment activity.

4. Develop ways to address the recruitment impact of factors in the economic environment such as local housing costs and the travel distances to work faced by most employees.

b) Retention

1. Promote the Medical Center's flexibility to establish new personnel programs or adapt existing programs of the University of California to respond to the distinct needs of the healthcare market.

2. Assess organizational effectiveness, turnover and employee relations data, and develop initiatives to promote employee retention, and a positive work environment.

3. Assess external compensation and benefit practices and internal alignments (focusing on healthcare professional, technical and management positions) and appropriately restructure UCLAMC programs to ensure competitive, motivating and cost-effective pay and benefit systems.

c) Development

1. Develop or expand allied health programs in areas of critical shortages through the establishment of internal training and certification programs, or collaboration with schools having existing programs.

2. Promote succession planning and internship/mentorship in key management, professional and technical roles, with particular emphasis on promoting cultural diversity. Work with the School of Medicine in departments/programs with shared staff.

3. Develop technical, interpersonal, supervisory and management skills to foster the growth and contribution of all Medical Center employees and managers.

d) Productivity

1. Assess and revise operational systems, work methods, organizational structure, job design, and program priorities to maximize the productive use of FTE and the quality of services.

2. Initiate a performance-based incentive system for managers which provides rewards for the attainment of defined productivity targets.

3. Mobilize employee involvement in clarifying and affirming Medical Center objectives, building on organizational strengths and focusing on high performance opportunities.

e) Service

1. Reinforce service orientation as a fundamental value of the Medical Center through the use of orientation, recognition, evaluation, feedback and other personnel systems.

2. Expand physician and product line team awareness of service issues, and promote team problem-solving to enhance Hospitality and the quality of patient services.

Strategy 4:
Facilities

DEVELOP AND IMPLEMENT PLANS TO DESIGN, FINANCE AND CONSTRUCT A REPLACEMENT HOSPITAL.

Lack of space within the Medical Center is one of the most critical operating impediments. The physical plant is also aging, and its adaptability to modification for new use is limited. Further, the cost of remodelling or retrofitting the old facility to accommodate changing technologies is prohibitively high -- perhaps two to three times or more the cost of new construction.

During the first strategic planning cycle at UCLA Medical Center in 1986-89, a site study was conducted to identify potential sites for a replacement hospital. Assessment of the options will continue as plans for the new facility are developed.

Initiatives

a. Build community support for the project, including faculty, staff, the Campus, Board of Advisors, Regents, local residents and local/State government.

b. Contribute to development of the capital resources needed to support the building plan through cost containment and reduction programs.

c. Ensure that new facility design incorporates flexible concepts of future health care delivery models.

d. Identify the departments/programs that might be displaced by the new building project. Identify alternate sites/replacement space for them.

e. Maintain the existing facility, making necessary investments in it to ensure continued compliance with all required codes, to keep pace with changing service needs, and to enable provision of modern health care service in a pleasant, clean environment.

Strategy 5:
Utilization Management/Quality Assurance

STRENGTHEN THE MEDICAL CENTER'S ABILITY TO COMPETE FOR LIMITED HEALTH CARE RESOURCES THROUGH MORE EFFICIENT INTERNAL RESOURCE MANAGEMENT.

External review agencies, working on behalf of the Federal government as well as the private insurance industry, are in the process of developing methodologies for assessing both utilization and the quality of care. It is anticipated that, unless a hospital can demonstrate its own capability to manage utilization and quality, the agency standards will be imposed on the hospitals, whether or not they are compatible with the hospital's own culture. The initiatives below are intended as a proactive response to this advance notice.

The Medical Center will provide support for these efforts, but the key to this strategy and its related initiatives is medical staff leadership and participation in their implementation.

Initiatives

a. Develop and implement a utilization management program predicated on the idea that properly structured utilization management fosters high quality and effective care delivered in a cost-efficient manner.

b. Evaluate development of a program for demonstrating the quality of clinical outcomes to meet information demands from licensing/financing agencies and from potential markets.

c. Continue development of the product management program.

Strategy 6:
Underfunded Care

DEVELOP A JOINT MEDICAL CENTER - SCHOOL OF MEDICINE APPROACH TO MANAGING THE PROVISION OF UNDERFUNDED CARE.

With fewer Medi-Cal providers in the community to share the load, the Medical Center's Medi-Cal population has doubled. Medicare no longer pays the full cost of care for its beneficiaries. These two groups comprise more than half of the Medical Center's patients.

Private insurers also have begun to scrutinize closely the costs of their beneficiaries' care, seeking to assess how much cost-shifting of indigent patients' care has occurred. These groups seek to avoid paying for the indigent patients care by demanding discounts from charges for the services their subscribers receive.

Thus, fewer and fewer patient sponsors are willing or able to pay the full costs of care. UCLAMC recognizes its public responsibility to continue to serve as a health care provider for underfunded patients. Maintaining solvency will require that the Medical Center achieve a balance in the sponsorship of its patients -- in other words, the sponsorship mix must be managed. Because the patient mix also affects the professional income practice plans, the Medical Center and faculty of the School of Medicine must work together to cope with this issue.

Initiatives

a. Define the level of underfunded care that the Medical Center and the Practice Plans can afford without jeopardizing their ability to meet the training program needs.

b. Identify the issues that must be addressed to enable the Medical Center and its medical staff and faculty implement the underfunded care strategy -- patient need, resource utilization, EMC access, community expectations, etc.

c. Develop programs aimed at managing the underfunded care volume.

d. Coordinate a joint UC Medical Center-Neuropsychiatric Hospital effort to increase awareness by the Office of the President of the implications for each hospital of Systemwide policies on underfunded care.

Strategy 7:
Medical Center - School of Medicine Opportunities for Joint Planning

DEVELOP FORMAL METHODS OF REGULAR COMMUNICATION BETWEEN THE MEDICAL CENTER AND SCHOOL OF MEDICINE TO ENSURE THAT THE STRATEGIC PLANS AND OBJECTIVES OF BOTH INSTITUTIONS ARE MUTUALLY SUPPORTIVE IN THE AREAS OF THEIR COMMON INTEREST.

Although there are multiple existing communication channels in both the Medical Center and School of Medicine, they could be used more effectively. Establishing and maintaining active communication links should be beneficial to both institutions as the future success of each is dependent on the future success of the other.

Initiatives

a. Establish and maintain a forum through which topics of common interest would be identified.

b. Periodically identify the issues and areas of common interest where joint planning is needed.

c. Develop and implement appropriate action plan(s) to address the issues identified in (b) above.

d. Develop and implement appropriate action plan(s) to address strategic issues and areas of common interest shared by the Medical Center and the Neuropsychiatric Hospital. Establish a work group to conduct this process, with members from UCLAMC and NPH.

e. Continue to monitor the strategic plan implementation process, including the implementation activities set forth above, under the guidance of the Implementation Committee.

Strategy 8:
Information Systems

MAINTAIN OR DEVELOP MANAGEMENT INFORMATION SYSTEMS TO ENHANCE SERVICE TO PHYSICIANS AND PATIENTS AND TO SUPPORT MANAGEMENT DECISION-MAKING.

The Medical Center's future is dependent on its ability to manage information in a readily accessible, efficient and cost-effective network that links clinical and administrative data. Many Medical Center resources have been dedicated to the creation of this network, demonstrating the commitment to this goal.

Initiatives

a. Revise and provide new systems to support the day-to-day task of providing patient care, and supporting business activities of the Medical Center. Support departmental automation activities, i.e., Radiology, O/R, Labs, and Pharmacy.

b. Executive Information Systems. Develop and implement systems to provide Medical Center management the necessary tools to make prudent decisions in operations and planning.

c. Clinical Computing. Procure and/or support the development of clinical systems that will aid physicians and other patient care professionals in providing patient care.

d. Physician Office Support. Provide necessary systems and support to allow physician offices to have access to the Medical Center computer system.

Strategy 9:
Finance

SUSTAIN THE MEDICAL CENTER'S ABILITY TO MEET ITS FINANCIAL OBLIGATIONS AND TO SUPPORT ITS STRATEGIC OBJECTIVES.

Part of the Medical Center's responsibility is to maintain its fiscal solvency. All of the strategies in the Strategic Plan in some way support this objective. The finance strategy is a statement of the Medical Center's commitment to fulfilling its responsibility.

Initiatives

a. Update the capital plan annually. Communicate the capital formation goals and strategies to the various Medical Center constituencies, as feasible, to increase understanding of, support for, and compliance with the plan.

b. Seek to keep the Medical Center competitive with other health care providers by aggressively promoting cost containment and productivity enhancement programs. Support those initiatives with relevant and timely management information.

c. Periodically review and modify as needed the Medical Center's Financial Management Policies and Procedures to ensure that systems, such as the budget process, are meeting the organization's needs and contributing to financial vitality.

Strategy 10:
Comprehensive Health Care Services

WORKING WITH THE MEDICAL CENTER STAFF AND SCHOOL OF MEDICINE FACULTY, DEVELOP UCLAMC'S CAPACITY TO PROVIDE COMPREHENSIVE HEALTH CARE SERVICES IN A COORDINATED SYSTEM.

UCLAMC serves a broad array of patients whose health needs range from basic preventative measures to highly complex care. While these services are sophisticated, their delivery system has been fragmented and uncoordinated. A number of factors support the idea that UCLAMC should eliminate system fragmentation and offer a continuum of care that makes available all of the services a patient needs:

- As more patients are seen as outpatients, remaining inpatients are only those with complex, long-term illnesses who need a complex array of services.

- Consumers, including contracting groups, are demanding simplified access to a comprehensive range of services for a predictable price.

- A well organized continuum maximizes utilization of resources and revenues by keeping patient referrals within the network.

- Coordinated, comprehensive care represents better patient care; it also is more cost-effective than fragmented episodes of care.

- Future clinicians need training at multiple points along the continuum of care so they can serve their patients' changing needs.

There are many different services offered in a continuum, including extended care, acute hospital care, ambulatory care and home care. An organization like UCLAMC does not have to provide all the services itself. Access to the range of services can be facilitated through informal arrangements or a network of affiliations. UCLAMC's challenge is to ensure that all the services it provides either directly or through a network uphold its accepted standards of high quality care.

Initiatives

a. Identify the system components needed to facilitate patient access to appropriate levels of care, settings and resources. Evaluate UCLAMC's existing or potential role as either a direct or network-link provider of the various services. Determine a priority order for component development at UCLAMC. Create an implementation plan for each step/phase. Activate the plan(s).

b. Evaluate the acquisition of or affiliation with a long-term care facility. Include an assessment of the financial implications, reimbursement potential, joint ventures with either proprietary ornot-for-profit partners and other key decision factors. Recommend a course of action to the Medical Center Director, Implementation Committee, Board of Advisors, and other constituent groups.

c. Evaluate the implications of establishing a case management/care coordination system at UCLAMC. Recommend a course of action.

The Implementation Process

Responsibility for implementing each of the strategies in this Plan has been assigned to a member of the senior management team; a list of these people is presented in Appendix 1. Each of them has prepared specific implementation action plans relating to particular strategies. Throughout the next 12-18 months progress reports describing the results of the action plans will be made periodically to the Implementation Committee.

The Implementation Committee is the body responsible for monitoring the Strategic Plan. A list of the members of this group is shown in Appendix 2. Throughout the implementation phase of the planning process, this Committee will meet at least quarterly to review progress reports and to discuss other strategic issues that may arise from time to time. Appendix 3 shows the planning schedule for fiscal years 1989-90 and 1990-91.

During the planning process, many people contributed to the development of the issues and ideas that led to this Strategic Plan. A list of these people is presented in Appendix 4.

APPENDIX 1

IMPLEMENTATION ASSIGNMENTS

Strategy 1 - Marketing -- Mark Laret

Strategy 2 - Managed Care -- Mark Laret

Strategy 3 - Human Resources -- Marilyn Sharpe

Strategy 4 - Facilities -- Aaron Lohr

Strategy 5 - Utilization Management -- David Auerbach, M.D.

Strategy 6 - Underfunded Care -- Jeff Otten

Strategy 7 - Medical Center - School of Medicine Opportunities for Joint Planning -- Pasquale Cancilla, M.D.

Strategy 8 - Information Systems -- Tom Sowle

Strategy 9 - Finance -- Jeff Otten

Strategy 10 - Comprehensive Health Care Services -- Jay Rudman

APPENDIX 2

IMPLEMENTATION COMMITTEE

1989-90

Pasquale Cancilla, M.D., Chairman

Heidi Crooks, R.N., Associate Director, Director, Nursing Services

Margaret A. Cunningham, Director, Strategic Planning

Helene DesRuisseaux, Executive Assistant to the Director

Raymond Eden, Associate Dean, School of Medicine

William Friedman, M.D., Chairman, Department of Pediatrics

Donald T. Gillin, Board of Advisors

Vay Liang W. Go, M.D., Chairman, Department of Medicine

Hooshang Kangarloo, M.D., Chairman, Department of Radiology Sciences

Mark Laret, Associate Director, Director of Marketing and Planning

Aaron Lohr, Deputy Director

Herbert Machleder, M.D., Chief of Staff, Ex officio

Jeffrey Otten, Associate Director, Director of Finance

Roy Pitkin, M.D., Chairman, Department of OB-GYN

Don Rockwell, M.D., Director, Neuropsychiatric Hospital

Lise Luttgens Santulli, Associate Director

Raymond G. Schultze, M.D., Director, Ex officio

Marilyn Sharpe, Associate Director, Director of Human Resources

Bradley Straatsma, M.D., Chairman, Department of Ophthamology

Michael Zinner, M.D., Chairman, Department of Surgery

APPENDIX 3

Strategic Planning Schedule

1989-90 and 1990-91

1.	Development of implementation plans	July/Aug/Sept - 1989
2.	Strategic Plan approval by Implementation Committee	Sept - 1989
3.	Implementation plan approval	Dec - 1989
4.	Periodic implementation progress reports	Dec 1989 - June 1991
5.	Review of Plan need for revision	Jan-March 1991
6.	Retreat to Develop New Strategies	April-May 1991
7.	Plan redraft, circulation and approval	1991-92

II. PROJECT DESCRIPTION

A. PROJECT OBJECTIVES

GENERAL MISSION

To maintain UCSF's role as one of the leading academic medical centers in the United States, UCSF must continue to have the physical facilities necessary to:

- recruit and retain highly qualified faculty physicians for teaching, research, and patient care;
- offer patients the most advanced techniques available for diagnosis and treatment; and
- provide the clinical experiences necessary to offer the highest quality of training to medical students and residents.

The most critical factor in maintaining the strength of UCSF as an academic medical center has been its ability to recruit and retain a medical faculty of noteworthy achievement. As one measure of the UCSF School of Medicine's special capacity to make significant biomedical research contributions, the School of Medicine has led all other medical schools in the nation in the amount of research funding received from the National Institutes of Health (NIH) for each of the last sixteen years.

The public benefits generally from UCSF's role in advancing the current understanding of human health, aging, and disease. Californians and others, nationally and internationally, benefit directly from the application of the expertise of UCSF's medical faculty to patient care and the education of medical students and residents. As a regional referral center for the western United States, the UCSF Medical Center offers its patients access to care that incorporates the latest research developments. Regional services include cancer treatment, neurosurgery, cardiac care, transplantation, AIDS treatment, high-risk obstetrics, newborn intensive care, and specialized pediatric care, among others. The patient care and research programs at UCSF Medical Center also provide an exemplary setting for the education of medical students and residents, many of whom will later practice in California.

To continue to make such contributions to the public health and welfare, UCSF must have the flexibility to offer the most qualified medical faculty adequate space for patient care, research, and administration and support service.

PROJECT PLANNING BACKGROUND

Demand for Space

While the requirements for office and classroom teaching space per faculty member have remained stable over time, changes in research methods in the biomedical sciences and in the technologies that support patient care and clinical education have escalated the space needs of faculty physicians. For example, advances in transplantation, cardiac surgery, and other surgical procedures have led to new standards for the size and design of operating suites in order to accommodate large surgical teams and specialized equipment.

Because few new developments in patient care totally displace earlier practice, teaching hospital facilities must accommodate both old and new technologies vital to the educational and service needs of the faculty. For instance, radiology suites in university teaching hospitals now include magnetic resonance imaging and interventional radiology as well as CT (computerized tomography) scanners and diagnostic X-ray equipment developed decades earlier. These expanded facilities are necessary to train the physicians of tomorrow.

Additional space is essential both to recruit new faculty who are pioneering new techniques and to retain faculty who have created clinical programs that now need room for reasonable growth. Further, to capitalize on the new understandings and possibilities created by current research, additional faculty must be recruited in fields that have not previously existed. In 1980, for example, no one could have foreseen the explosion in both patient care and research in response to the AIDS epidemic.

Adequate space must be developed to support academic programs and related faculty recruitments that cannot be predicted today, but are likely to flow from rapid advances in molecular biology, genetics, and immunology. UCSF's leadership role in the basic sciences of medicine gives UCSF both the opportunity and the obligation to apply

those research findings to patient care and to the education of medical students and residents. With that obligation goes the need to marshall the necessary physical facilities to support those patient care, teaching, and research activities.

Clinical Space Supply

The completion of Joseph Long Hospital at Parnassus Heights in 1983 gave UCSF Medical Center its last major opportunity to add space for patient care and clinical teaching. In the years since, UCSF Medical Center has experienced a surge of patient activity that has taxed both its inpatient and outpatient facilities. In 1988/1989, faculty physicians hospitalized an average of 52 more patients each day at UCSF Medical Center than they did only four years before. UCSF Medical Center filled an average 80% of the beds in service in 1988/89, and mid-week occupancy climbed past 90% on many occasions. According to the most recent state health planning data (for the year ending September 30, 1988), UCSF Medical Center, with an occupancy rate of 74% for its licensed beds, filled more licensed beds than any other acute care hospital in San Francisco (Office of Statewide Health Planning and Development, 1989).

This growth in inpatient activity at UCSF Medical Center has occurred despite an increased emphasis on outpatient care. Over the past four years, outpatient visits at UCSF Medical Center have increased by 20% and outpatient surgical hours have increased by 30%. The increasing importance placed on teaching in the outpatient setting has further increased demands for space.

In 1987, as evidence of clinical space shortages began to mount, an ad hoc committee of the School of Medicine reviewed all of the physical resources available to clinical programs at Parnassus Heights, analyzed existing uses, and queried the chairs of clinical departments about the space requirements associated with their academic plans. The clinical department chairs outlined faculty recruitment goals over a five year period that would respond to clearly identifiable opportunities to improve clinical care through the application of recent research developments. At that time, the projected needs for facilities included 80-100 additional beds, operating room time for 1,000 additional surgeries annually, and 92,000 assignable square feet (asf) of office, practice, and research space for faculty physicians. Following a review of these and other foreseeable clinical and educational program requirements, the ad hoc committee

concluded that projected clinical program needs far exceeded UCSF's ability to reallocate existing space to accommodate those needs within existing UCSF facilities.

To maximize the amount of clinical space available in the existing Parnassus Heights patient care facilities (Moffitt and Long Hospitals and the Ambulatory Care Center), UCSF Medical Center has already moved administration and support service functions to off-site locations. More than 320 staff in hospital finance, information systems, laundry, and other functions work at UCSF facilities at the Center for Educational Development (CED) at 1855 Folsom Street in San Francisco, or at Oyster Point at 612 Forbes Boulevard in South San Francisco.

Additional clinical program and support space cannot and should not be carved out of areas designed for teaching and patient comfort. Facilities for resident sleep rooms and offices are so minimal that they create morale problems for current residents and result in obstacles to recruiting new ones. Conference rooms are in such short supply that medical student conferences are forced to convene in patient care areas, such as solaria and family crisis rooms. Additional space for teaching is needed to protect space for patients and their families and to provide an appropriate environment for UCSF Medical Center trainees.

Periodically, UCSF prepares a Long Range Development Plan (LRDP), which is a general land use plan based upon the academic goals and objectives of UCSF. The 1982 *LRDP* confirmed the severe physical space constraints associated with further development at Parnassus Heights. Parnassus Heights is currently the most densely developed of the University of California campuses, and is operating within space and population constraints established in 1976 (following adoption of the 1976 *LRDP*) and confirmed, following environmental review in conformance with CEQA, in the 1982 *LRDP* (both LRDPs, as well as their accompanying EIRs, are incorporated herein by reference). With the completion of the new medical library, UCSF will be very close to the limitation on total square footage adopted for Parnassus Heights by The Regents in 1976. UCSF cannot undertake construction of new patient care facilities and related teaching, research, and administration and support service space at Parnassus Heights without demolishing other major facilities that are essential to its overall academic programs.

In sum, the combination of inadequate existing space, space limitations at Parnassus Heights, and the need for space to accommodate expanding and new programs requires that UCSF expand its clinical capacity to maintain the quality of clinical teaching, research, and patient care at UCSF.

Medical Education

As part of the effort to identify additional clinical capacity, UCSF must also consider the needs of the School of Medicine to supplement the clinical training experiences now available for medical students and residents. While the School of Medicine plans to maintain relatively stable student enrollments, access to additional patient care facilities will be required to keep pace with changing requirements for clinical experiences for those trainees.

As hospital lengths of stay have shortened, residents and students must have exposure to an increasing number of admissions to gain the required level of experience in evaluating and caring for patients. In a growing number of specialties, residents in training must perform a specified number of patient procedures to meet credentialing requirements for specialty certification. In addition, the increasing emphasis on teaching in ambulatory care settings calls for the development of more clinical experiences in hospital clinics or office practices. In order to provide the relevant clinical experiences, UCSF's training programs will need to draw more fully upon community hospital resources than they have in the past.

Development of a comprehensive teaching program in a community hospital would also balance the specialized clinical experiences offered by UCSF's three primary teaching sites: UCSF Medical Center, San Francisco General Hospital, and the Veterans Administration Medical Center. UCSF Medical Center has evolved primarily into a referral center that handles very specialized cases that are referred by physicians throughout California and elsewhere. UCSF's medical education experiences at San Francisco General Hospital and the Veterans Administration Medical Center tend to concentrate on the types of care required by their special missions and patient populations. A community hospital teaching program would offer medical students and residents a needed opportunity to see patients with common medical problems who usually receive their care outside the setting of an academic

medical center. Similarly, the community hospital setting could present the Schools of Dentistry, Nursing, and Pharmacy with new opportunities for clinical teaching. While UCSF students and residents have opportunities to do a portion of their training at community hospitals under affiliation agreements with UCSF, establishing a comprehensive teaching program at a community hospital under the University's direction would enhance the range of training experiences available.

PROJECT OBJECTIVES

To meet the overall needs discussed above, UCSF has identified the following specific project objectives:

1. In order to meet the present and future needs of UCSF faculty and students, the project should be in a facility that offers both immediate space and room for expansion within its current licensed bed complement.

UCSF seeks 100 unoccupied acute care hospital beds for its use beginning in 1990 with further expansion potential of up to 100 additional licensed and available beds, if needed, over the following ten to twenty years. Inpatient facilities should offer additional capacity for diagnostic facilities, operating rooms, and other patient care and administration and support service appropriate to the operation of such 100 to 200 additional beds.

UCSF prefers facilities that could offer the additional needed beds within a current complement of licensed hospital beds. If UCSF could accommodate its programs in a hospital that is currently underutilized, the overall health care costs to the community should be less than if it were necessary to build a new hospital or convert a facility that does not currently provide hospital services.

In addition to inpatient facilities, the project should also have available or permit the development by the mid-1990's of at least 50,000 departmental gross square feet (dgsf) (37,500 asf) for related outpatient care and office space, as well as 80,000 dgsf (60,000 asf) for research and animal care space for faculty physicians who practice on the site. The development of an additional increment of 100,000 dgsf (75,000 asf) for future expansion of outpatient, research and administrative/support uses should be possible within ten to twenty years.

2. In order to integrate faculty, students, and staff into the general UCSF academic community, the project should be within a relatively short commuting distance from Parnassus Heights and other UCSF facilities.

Because UCSF has decentralized many of its research, teaching, and patient care activities over the last two decades, it has become essential to UCSF to foster constant interaction among the personnel at its facilities to protect the cohesiveness and integrity of its academic programs. UCSF is concerned that isolation can lead not only to poor morale and the loss of a sense of common mission, but also to decreased productivity, costly duplication of equipment and facilities, and missed opportunities for collaboration in research and teaching.

In an academic setting it is important for faculty members to have frequent informal encounters with colleagues in their own and related disciplines. They should attend common faculty meetings, grand rounds, and departmental lectures. Faculty should have the flexibility to serve as preceptors for students at more than one location, and they should have reasonable access to specialized research, library, and patient care facilities and staff at Parnassus Heights and other UCSF facilities. Medical students, residents, and fellows should be able to train at clinical sites that are within a reasonable commuting radius. Students at all levels should have ready access to the medical library and other important student resources at Parnassus Heights, and they should not be divorced from the larger student community. Staff should have opportunities to interact with others in their fields, and should have reasonable access to training opportunities available at Parnassus Heights. All UCSF employees and students should be able to share in the cultural and recreational activities at UCSF.

To keep the problems of separation and the amount of traveling time to a minimum, any new clinical site should be within easy commuting distance of Parnassus Heights, as well as UCSF's other major facilities and affiliates in San Francisco.

3. The project should be in an existing hospital with an active medical staff possessing the interest and qualifications to teach medical students and residents, and with patient populations that would offer a broad array of learning experiences.

In order for UCSF to develop a comprehensive community hospital teaching program, the project should offer access to a community medical staff experienced in acting as preceptors to medical students and residents. The presence of a medical staff with active involvement in medical education would also permit UCSF to expand medical education programs at the new facility while gradually recruiting needed full-time faculty.

Because the growth in new UCSF clinical programs on a new site would be gradual, there should be a pre-existing population of patients who would become the core of future UCSF educational programs. Patients should be available for teaching programs across a wide range of medical and surgical subspecialties. Within specialties, the patients should present medical problems commonly found in the general population.

4. The project should be in a setting where biomedical research is currently under way and where faculty could pursue their investigations close to their clinical service and teaching duties.

Research is an essential activity and responsibility of the full-time faculty in the clinical departments of UCSF's School of Medicine. Faculty recruited for clinical programs at the new site would be expected, as a matter of course, to conduct research as well as to teach. Research facilities should be convenient to patient care areas so that faculty physicians may move back and forth among their roles as medical practitioners, teachers, and researchers and still maintain a productive schedule.

Because UCSF must raise funds before new construction for research can begin, a new site should currently have at least limited laboratory research space and capacity for animal care, to permit the immediate recruitment of key faculty for new clinical programs at the site.

Newly recruited UCSF faculty would also benefit from the presence of other researchers both in their day-to-day interactions and in more formal opportunities for collaboration. Furthermore, UCSF would prefer to choose a facility that has valued and supported research as a means to advance the care of patients. The presence of research attracts practitioners who are interested in clinical investigation and in the solutions to individual patient problems that research may suggest.

5. The project should be in a facility in which the University would have a long-term presence, as well as management and financial control.

UCSF can best develop and sustain clinical teaching, research, and patient care programs in a medical center under the University's long-term control. The underlying purpose of a medical center governed by a university is to provide a setting in which academic programs may flourish. University administrators and governing boards undertake to safeguard academic interests in their oversight of the teaching hospitals that they own and operate.

In a university medical center, hospital administrators, deans, department chairs, and other faculty physicians share in decisions that directly or indirectly affect the academic programs of the school of medicine. Such issues go well beyond the size, structure, and financing of teaching programs for medical students, residents, and fellows. The School of Medicine and UCSF Medical Center must and do reconcile their interests in decisions as diverse as the introduction of new technology, changes in clinical service offerings, use of hospital space, nurse staffing, and the financing of uncompensated care.

In addition to the broadly defined benefits of university governance, control is necessary for the University to justify any capital improvements made under the project. Common management and financial control of the new facility and UCSF Medical Center would offer several desirable operational advantages. By combining resources of UCSF Medical Center and a new facility, UCSF would have the flexibility to base decisions about the location of clinical services upon program needs, rather than upon financial or management considerations. By pooling reserve funds, UCSF could fund the highest priority capital needs at both facilities. Common UCSF control would also create potential for consolidation of administrative and support services. In addition, because staff in both settings would be University employees, current and future shortages of certain health professionals could be addressed in flexible recruitment, retention, and staffing plans. These operational advantages support the objective of identifying a clinical facility that would offer the University a long-term governance role.

REFERENCE

Office of Statewide Health Planning and Development, *Quarterly Individual Hospital Data for California, Third Quarter 1988*, January 13, 1989.

B. HISTORY OF THE PROJECT

The Faculty Committee on the Future of UCSF, appointed by the Chancellor in 1987 to represent all Schools at UCSF, reviewed the need for additional clinical capacity as part of its overall charge to consider alternatives for growth in UCSF's future academic programs. In January 1988, the committee recommended that UCSF acquire an additional hospital facility.

An initial review of options to address the clinical capacity needs followed, including consideration of the opportunities offered under existing and proposed affiliations with local hospitals. In addition to its three major hospital affiliates (UCSF Medical Center, San Francisco General Hospital, and the VA Medical Center), UCSF has historically maintained a series of teaching affiliations with other local hospitals, including Mount Zion. In the spring of 1988, following preliminary planning discussions with UCSF, the leadership of Mount Zion urged UCSF to consider a permanent relationship between the two medical centers.

The Mount Zion proposal presented an opportunity to meet UCSF's projected space and educational needs in an institution with which UCSF already had a successful, established relationship. In December 1984, UCSF and Mount Zion had entered into a letter of understanding designed to promote the development of joint educational and community service programs. The first products of the letter of understanding were the merging of the home care programs and the establishment of the Center for Aging Services Research. The Center is a joint venture of the San Francisco Institute on Aging at Mount Zion and the Institute for Health and Aging of UCSF's School of Nursing. Effective in February 1988, the Mount Zion/UCSF Joint Perinatal Program integrated the residency programs in obstetrics and pediatrics, began offering a joint fellowship in neonatology, and began to provide consolidated program direction and financial management for the obstetrics and neonatology services of the two hospitals.

The discussions between UCSF and Mount Zion in the spring of 1988 made it clear that any further development of the relationship would be a substantial departure from the existing programmatic affiliation. As noted in Section II.A, above, UCSF was confronting a space crisis, but faculty members would not be willing to establish clinical programs away from Parnassus Heights without the assurance that those programs would have long-term space commitments. Permanent University control

would also be necessary to justify significant capital expenditures for clinical programs at another site. If UCSF Medical Center were to have the ultimate flexibility to locate clinical programs at Parnassus Heights or in another facility, it must have management and financial responsibility for the other facility.

Mount Zion also experienced a change in its circumstances. It became questionable whether Mount Zion could withstand the economic and other forces that were making it difficult for community teaching hospitals to continue as independent institutions. Teaching programs were threatened both by cutbacks in financing for graduate medical education and by increasingly stringent accreditation requirements that require faculty and research commitments at levels more easily achieved in university hospital settings. A reduction in the teaching program would also threaten Mount Zion's ability to attract physicians capable of sustaining its existing research programs. Further, as an independent institution suffering ongoing economic losses, Mount Zion could not afford to sustain the existing levels of community service, especially to patients who could not pay fully for their care. Integration with UCSF presented an opportunity for Mount Zion to continue to offer general acute care services and to preserve long-standing commitments to teaching, research, and community service.

On May 31, 1988, representatives of UCSF and Mount Zion signed a letter of intent to develop a plan to integrate the two medical centers. The letter proposed that UCSF assume overall programmatic and academic authority and fiscal responsibility for Mount Zion. The letter also set forth general principles to guide preparation of a comprehensive integration agreement proposal to be submitted for consideration and formal action by The Regents, in conformance with CEQA, and by the Board of Mount Zion Health Systems.

UCSF and Mount Zion then began extensive negotiations relating to the terms of the proposed integration agreement. UCSF developed preliminary program plans consistent with the project objectives, and commissioned additional studies of Mount Zion's physical facilities and the financial feasibility of the integration proposal.

In March 1989, The Regents and the Board of Mount Zion Health Systems reviewed an outline of the principal features of the proposed integration agreement that was acceptable to Mount Zion and UCSF. UCSF presented to The Regents an evaluation

of its existing and projected clinical program needs, a preliminary analysis of the inability of the campus to meet those needs at Parnassus Heights, a description of the alternatives considered by UCSF in its planning efforts to date, and a summary of the structure of the proposed Mount Zion affiliation. Following this presentation, the Regents directed UCSF to undertake a detailed environmental analysis of the Mount Zion integration proposal and other alternatives to resolve the UCSF's clinical space shortage and educational needs. In conformance with CEQA, UCSF determined in an Initial Study that the project could have a significant effect on the environment and thus that an EIR must be prepared. UCSF sent out a Notice of Preparation (NOP) and the Initial Study for the project to interested agencies and concerned persons and organizations on June 2, 1989. The NOP and Initial Study are included in this EIR as Appendix A.

While the execution and implementation of the proposed Mount Zion integration agreement is the preferred UCSF solution to its clinical space and education needs (and is thus the "preferred project" analyzed in this EIR), The Regents will consider potential approval of this project only after analysis of environmental impacts, community concerns, and project alternatives, in accordance with CEQA. Consideration of this EIR will precede any action by The Regents on the integration agreement.

C. EXISTING SITE

SITE LOCATION

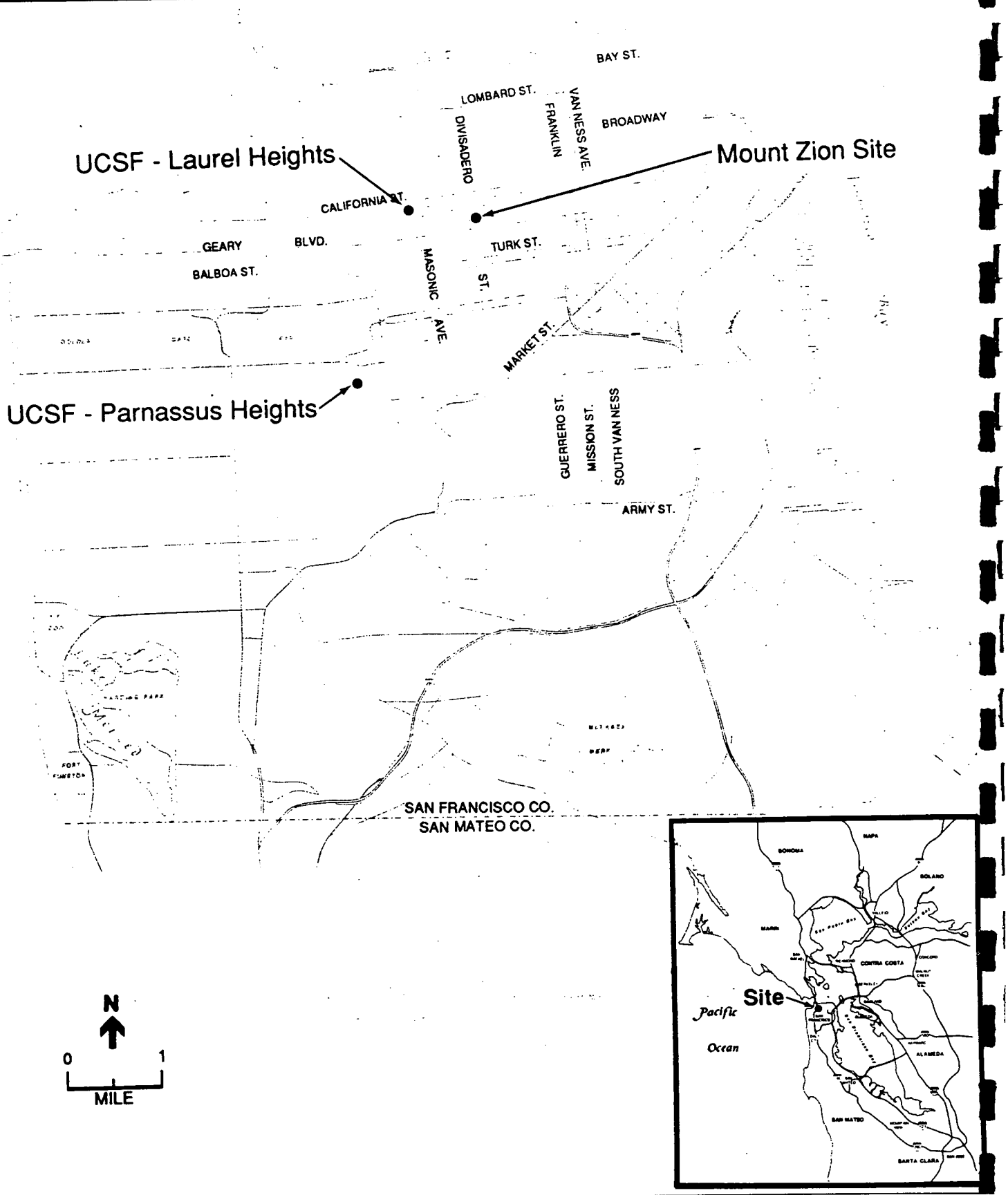
Mount Zion currently occupies about 559,635 gross square feet in owned and leased buildings on seven blocks in the Western Addition area of San Francisco (see Figures 1 and 2). In addition, Mount Zion owns or leases 120 parking spaces. The combined site area of all Mount Zion property is approximately 240,000 square feet, or approximately 5.5 acres.

Mount Zion consists of twenty-one buildings and six associated parking areas. Of this total, seventeen buildings and three parking areas are included as part of the project. Mount Zion Health Systems would continue to retain control of the following properties that would not be included in the project: the land for the Ronald McDonald House (1640-1646 Scott Street); the Management Information Systems building (1606 Scott Street); the Crisis Clinic (2330 Post Street); the land for the San Francisco Medical Center at the northwest corner of Divisadero and Post Streets and the adjacent parking garage; and the parking lot on the east side of Scott Street between Post and Sutter Streets.

Mount Zion occupies all of the block bounded by Divisadero, Sutter, Scott, and Post Streets. The Main Hospital, which consists of Buildings A, B, and R, is on that block. The Assessor's Block Number for the Main Hospital block is 1077 (see Figure 2). Additional facilities, including an inpatient facility, laboratories, medical offices, a warehouse, and parking areas, are located on the six adjoining blocks to the north, northeast, east, south, southwest, and west. The Assessor's Block Numbers for these blocks are 1051, 680, 681, 1078, 1079 and 1076, respectively.

Mount Zion is about two miles from the main portion of the UCSF campus at Parnassus Heights and less than one mile from the UCSF facility at Laurel Heights (see Figure 3, which shows the location of UCSF facilities).

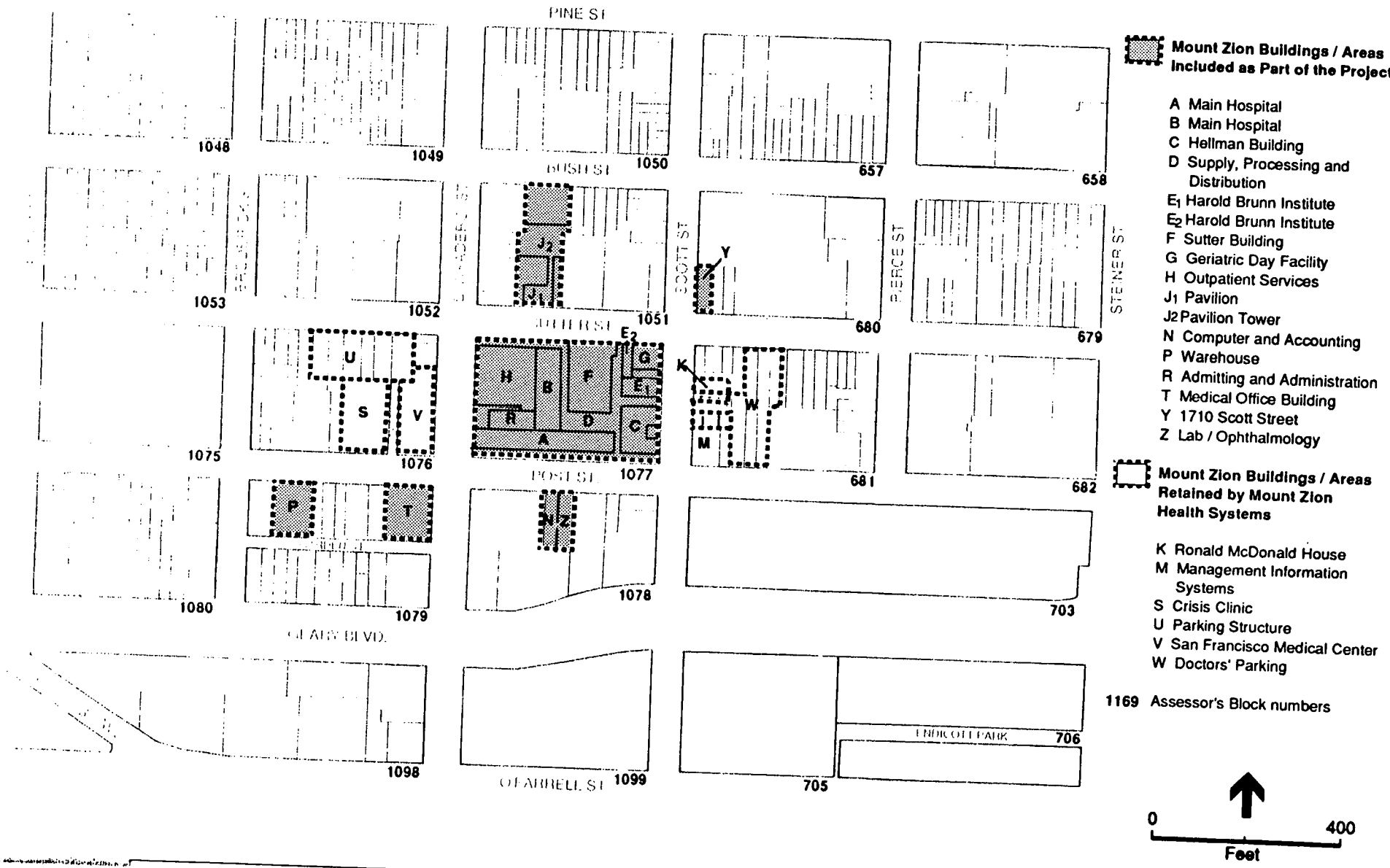
Primary north-south access to Mount Zion is provided by Divisadero Street, which borders the Main Hospital on the west. East-west access routes include Geary Expressway, one block south of the Main Hospital, and Bush and Pine Streets, companion one-way streets located one and two blocks north of the Main Hospital, respectively.



MOUNT ZION EIR

FIGURE
SITE LOCATIO

SOURCE: Environmental Science Associates, Inc.



Mount Zion Buildings / Areas Included as Part of the Project

- A Main Hospital
- B Main Hospital
- C Hellman Building
- D Supply, Processing and Distribution
- E_1 Harold Brunn Institute
- E_2 Harold Brunn Institute
- F Sutter Building
- G Geriatric Day Facility
- H Outpatient Services
- J_1 Pavilion
- J_2 Pavilion Tower
- N Computer and Accounting
- P Warehouse
- R Admitting and Administration
- T Medical Office Building
- Y 1710 Scott Street
- Z Lab / Ophthalmology

Mount Zion Buildings / Areas Retained by Mount Zion Health Systems

- K Ronald McDonald House
- M Management Information Systems
- S Crisis Clinic
- U Parking Structure
- V San Francisco Medical Center
- W Doctors' Parking

1169 Assessor's Block numbers

SOURCE: Environmental Science Associates, Inc.

FIGURE 2
SITE LOCATION AND
EXISTING BUILDING LOCATIONS

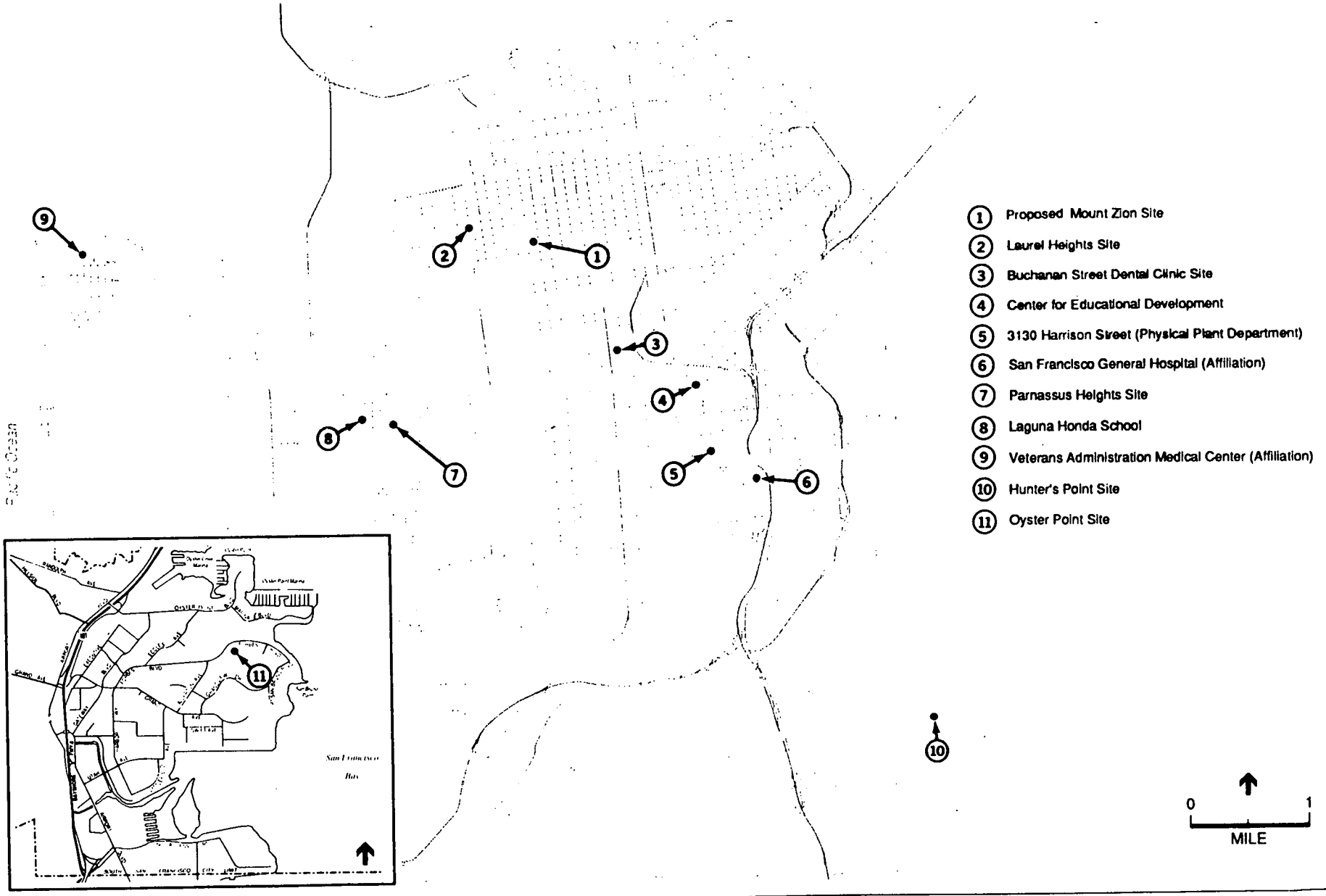


FIGURE 3
UCSF FACILITIES
IN SAN FRANCISCO

SOURCE: Environmental Science Associates, Inc.

Mount Zion is in a densely developed portion of San Francisco. Surrounding neighborhoods include Pacific Heights and Presidio Heights to the north, Japantown and Cathedral Hill to the east, Hayes Valley and Buena Vista/Duboce Triangle to the south, and Laurel Heights and the Richmond District to the west.

The immediate neighborhood, known as the Western Addition, includes commercial and residential development. The site vicinity includes several medical office buildings, pharmacies, and other services related to the presence of Mount Zion and the Kaiser-Permanente San Francisco Medical Center southwest of Mount Zion.

EXISTING USES AT MOUNT ZION

Existing uses at Mount Zion (as well as uses under the proposed project) basically break down into three categories of uses that each generate their own types of environmental impacts. These use categories are (1) patient care, (2) research, and (3) administration and support services. Table 1 presents the existing uses at Mount Zion by building. A separate category for instructional uses has not been identified because teaching in a hospital setting occurs in areas designated for other uses.

Patient Care

Patient care uses encompass inpatient nursing units, outpatient clinics and medical offices, clinical support laboratories, diagnostic services and patient care programs. Table 2 presents existing patient care services at Mount Zion.

Research

Mount Zion has had an active program of biomedical research since 1929. Current research uses include a variety of laboratories, associated offices, and animal care facilities. Research resources located in the Harold Brunn Institute at Mount Zion include laboratories and animal care facilities. UCSF's School of Nursing and Mount Zion Health Systems' San Francisco Institute on Aging also sponsor a joint Center for Aging Services Research.

TABLE 1: EXISTING USES AND SPACE BY USE AT MOUNT ZION, 1989

Building/Area/a/		1989 Building/Area Use/b/
Buildings/Areas Included as Part of the Project		
A	Main Hospital	PC, A
B	Main Hospital	PC, A
C	Hellman Building	PC, A
D	Supply, Processing and Distribution	A
E1	Harold Brunn Institute	R
E2	Harold Brunn Institute	R
F	Sutter Building	A
G	Geriatric Day Facility	PC, A
H	Outpatient Services	PC, A
J1	Pavilion	PC, A
J2	Pavilion Tower	PC, A
N	Computer and Accounting	A
P	Warehouse	A
R	Admitting and Administration	A
T	Medical Office Building	A
Y	1710 Scott Street	A
Z	Lab/Ophthalmology	PC, A
Buildings/Areas Retained by Mount Zion Health Systems		
K	Ronald McDonald House	A
M	Management Information Systems	A
S	Crisis Clinic	PC
U	Parking Garage	A
V	San Francisco Medical Center	A
W	Doctors' Parking Lot	A

Use	Space/c/	Percentage of Total Space
Patient Care	262,200	62
Research	14,500	3
Administration and Support Services	148,500	35

/a/ See Figure 2, page 28, for building locations.
/b/ PC = patient care; R = research; A = administration and support services.
/c/ In dgsf.

SOURCE: Mount Zion Hospital and Medical Center and Environmental Science Associates, Inc.

TABLE 2: EXISTING PATIENT CARE FACILITIES, DIAGNOSTIC SERVICES AND PROGRAMS AT MOUNT ZION, 1989

FACILITIES

- 439 Licensed Beds (408 licensed acute care beds and 31 licensed skilled nursing care beds)
- 25 Outpatient Clinics
- Cardiac Monitoring Units
- Radiation Therapy
- Oncology Care Unit
- Skilled Nursing Facility
- 17 Departments of Medical and Surgical Services
- Intensive Care Units
- Intensive Care Nursery
- Acute Rehabilitation
- Ambulatory Surgery Center
- Hemodialysis
- Emergency Department (24 hours per day)

DIAGNOSTIC SERVICES

- Cardiology Laboratory
- EKG
- Nuclear Medicine
- Magnetic Resonance Imaging
- EEG/EMG
- Clinical and Pathology Laboratories
- Pulmonary Laboratory
- Radiology (CT and Ultrasound Scanners)

PROGRAMS

- Adult Day Health Center
- Geriatric Assessment Service
- Cancer Care
- Children and Teen Care
- Geriatric Services
- Community Crisis Clinic
- Alzheimer's Day Care Program
- Pain Evaluation Center
- Maternal/Infant Care
- Mental Health Care

SOURCE: Mount Zion Hospital and Medical Center

Administration and Support Services

Administration and support services encompass all other uses and include diverse hospital functions such as admitting, social service, housekeeping, dietary, and building services.

Of the total square footage of Mount Zion, approximately 62% (262,200 dgsf) is occupied by patient care, approximately 3% (14,500 dgsf) is occupied by research, and approximately 35% (148,500 dgsf) is occupied by administration and support services.

EXISTING MOUNT ZION PHYSICAL FACILITIES

The total area occupied by Mount Zion buildings included in the project, not including parking areas, is approximately 540,065 bgsf (see Table 3). Table 4 identifies other Mount Zion buildings that are not included as part of the project because Mount Zion Health Systems would continue to control those properties. The parking areas associated with Mount Zion currently provide 120 parking spaces (see Table 5).

Project Space

The Main Hospital at Mount Zion consists of three buildings: Buildings A, B, and R. Building A contains the east and west wings of the Main Hospital. This seven-story structure contains approximately 118,750 bgsf. Building A was constructed as a five-story structure in 1948. The sixth and seventh floors were added in 1958 and 1981, respectively. Uses at Building A include adult medical/surgical nursing units, intensive care units, a pediatric unit, radiology, ambulatory surgery, the cardiac catheterization laboratory, the morgue, the pharmacy, and a cafeteria.

Building B contains the north wing of the Main Hospital. This seven-story structure contains approximately 106,360 bgsf. Building B was built in 1948 as a four-story structure. Floors five through seven were added in 1965. Building A and Building B wings of the Main Hospital have internal corridor connections on every floor. Uses in Building B include adult medical/surgical nursing units, the operating rooms and post-anesthesia recovery units, rehabilitation services, the emergency department, clinical laboratories, and a lecture hall.

Building R, constructed in 1976, is a two-story structure containing approximately 16,500 bgsf fronting Divisadero Street on the Main Hospital block. Building R functions as the main entrance to the Main Hospital and is connected to Buildings A and B via corridors on each floor. Building R contains the Main Hospital lobby, admitting office, and hospital administration and provides kitchen and dining facilities on the lower level.

TABLE 3: EXISTING BUILDINGS AT MOUNT ZION, EXCLUSIVE OF PARKING, PROPOSED AS PART OF THE PROJECT, 1989

Building/Area/a/		Number of Stories	BGSF/b/
Owned Buildings			
A	Main Hospital	7	118,750
B	Main Hospital	7	106,360
C	Hellman Building	5	65,900
D	Supply, Processing and Distribution	1/c/	9,500
E1	Harold Brunn Institute	2	11,070
E2	Harold Brunn Institute	1	2,330
F	Sutter Building	7	48,300
G	Geriatric Day Facility	2	5,200
H	Outpatient Services	2	38,340
J1	Pavilion	1	2,460
J2	Pavilion Tower	8	51,040
N	Computer and Accounting	2	7,800
P	Warehouse	2	20,750
R	Admitting and Administration	2	16,500
	SUBTOTAL FOR OWNED BUILDINGS		504,300
Leased Buildings			
T	Medical Office Building	2	16,500
Y	1710 Scott Street	3	7,715
Z	Lab/Ophthalmology	2	11,550
	SUBTOTAL FOR LEASED BUILDINGS		35,765
TOTAL			540,065

/a/ See Figure 2, page 28, for building locations.
/b/ Building gross square feet
/c/ The bgsf associated with Building D is underground.

SOURCES: Mount Zion Hospital and Medical Center and Environmental Science Associates, Inc.

TABLE 4: OTHER BUILDINGS AT MOUNT ZION, EXCLUSIVE OF PARKING, NOT INCLUDED AS PART OF THE PROJECT

Building/Area/a/		Number of Stories	BGSF/b/
K	Ronald McDonald House	2	6,200
M	Management Information Systems	1	2,335
S	Crisis Clinic	1	3,600
V	San Francisco Medical Center	2	7,435
TOTAL			19,570

/a/ See Figure 2, page 28, for building locations.
/b/ Building gross square feet

SOURCES: Mount Zion Hospital and Medical Center and Environmental Science Associates, Inc.

TABLE 5: EXISTING PARKING AT MOUNT ZION, 1989

Parking Area/a/		Number of Spaces
D	Supply, Processing and Distribution Parking Lot	10 spaces/b/
J	Pavilion Parking Lot	8 spaces/b/
S	Crisis Clinic Parking Lot (leased)	15 spaces/c/
T	Medical Offices Parking Lot (leased)	26 spaces
U	Parking Garage	0 spaces/d/
W	Doctors' Parking Lot	61 spaces/b,c/
TOTAL		120 spaces

/a/ See Figure 2, page 28, for locations of parking areas.
/b/ The spaces in this parking lot are not available for public use.
/c/ Not included as part of the project.
/d/ Mount Zion has not yet exercised its option to lease 150 spaces in the 460-space parking garage.

SOURCES: Mount Zion Hospital and Medical Center and Environmental Science Associates, Inc.

Building H, the outpatient services building, is adjacent to the Main Hospital entrance (Building R) and the north wing of the Main Hospital (Building B). The two-story structure, which was constructed in 1964, contains approximately 38,340 bgsf. Uses in Building H include outpatient clinics, chronic hemodialysis, and radiation therapy.

Building J, the Pavilion Building, is on the block immediately north of the Main Hospital block. The one-story entrance (Building J1) fronts Sutter Street and contains 2,460 bgsf. It is connected to the eight-story, 51,040-square-foot tower (Building J2) located at mid-block. Building J was originally constructed as a nursing home in 1948. Mount Zion acquired and remodeled the structure in 1978. The Institute on Aging occupies Building J1 and a portion of Building J2. Other uses in Building J2 include obstetrical services, the intensive care nursery, and inpatient psychiatry. In addition, an eight-space surface parking lot with access from Bush Street is on the north side of Building J.

Five buildings occupy the eastern end of the Main Hospital block. An incinerator, which has been shut down, is also on the eastern portion of the Main Hospital block.

Building C is the Hellman Building on the Main Hospital block at 2200 Post Street. It is a five-story structure containing approximately 65,900 bgsf. Building C was constructed in 1912 and functioned as the Main Hospital (and was called the Post-Scott Building) until Buildings A and B were opened. Uses in Building C include a diabetes education program, a work-related injury treatment center, pulmonary laboratory services, nuclear medicine, and offices for medical staff administration, research administration, environmental services, social service, home care, and patient billing. The building also contains the mail room, biomedical equipment repair shop and storage areas.

Building D is the supply, processing and distribution area for Mount Zion. The approximately 9,500 bgsf of space is located beneath an internal courtyard of the Main Hospital block with entrances from Sutter and Scott Streets. The courtyard contains 10 surface parking spaces for service and emergency physicians. One level below grade is occupied by supply distribution (receiving and central processing).

Building E is the L-shaped Harold Brunn Institute at the northeast corner of the Main Hospital block. It consists of two structures (Building E1 and Building E2) connected at the ground floor. Building E1 fronts Scott Street and contains approximately 11,070 bgsf on two levels. Building E2 fronts Sutter Street and contains approximately 2,330 bgsf on one level. Buildings E1 and E2 were constructed between 1930 and 1932. Buildings E1 and E2 provide space for research laboratories and animal care facilities.

Building F is the Sutter Building on the north-central portion of the Main Hospital block. The seven-story structure contains approximately 48,300 bgsf of space and is connected to Building B via a ground floor corridor. Building F was constructed in 1923 as the School of Nursing. Uses in Building F include administration, support, house staff quarters, security, and an auditorium.

Building G is the geriatric day care facility at the northeast corner of the Main Hospital block. It is a one-story structure with a mezzanine containing approximately 5,200 bgsf. The structure was constructed as a warehouse in 1963 and converted to a senior center in 1979.

Building Y, the 1710 Scott Street building, is on the block northeast of the Main Hospital block. The three-story structure contains 7,715 bgsf of leased office space. It is leased to Mount Zion by Sutter Street Investors for a three-year term ending in 1991.

Buildings N and Z are on the block immediately south of the Main Hospital block. Building N, at 2255 Post Street, contains computer and accounting offices in a two-story structure with approximately 7,800 bgsf. Building N was constructed in about 1946.

Building Z, at 2205 Post Street, is an approximately 11,550-bgsf, two-story structure. It is leased to Mount Zion by Harold Silen and Leonard Shaw for Daisy Biskind and the Gerson R. Biskind, M.D. Trust for a two-year term ending in 1989, with an option to renew for three years. Building Z contains a blood drawing station for the clinical laboratories and a private ophthalmology office. Building Z was constructed in about 1947.

Buildings P and T are on the block southwest of the Main Hospital block. Building P is a 20,750-bgsf, two-story structure that operates as a warehouse for Mount Zion and

includes storage space for medical records. Building P, at 2375 Post Street, was constructed about 1931.

Building T is a medical office building at 1545 Divisadero Street. The two-story structure at the southwest corner of Divisadero and Post Streets is leased by Mount Zion from 1545 Divisadero Street Associates for a 15-year term ending in 2000, with an option to renew for five years. The structure contains approximately 16,500 bgsf on two levels. Building T was constructed about 1936. In addition, a 26-space surface parking lot immediately west of Building T is leased to Mount Zion with the building.

Building U, described below, is on land owned by Mount Zion which is not part of the project. However, Mount Zion has an option to lease 150 parking spaces in Building U from the developer of the building and this option to lease would be conveyed to the University as part of the project.

Functionality of Project Space

Mount Zion's facilities have generally been well maintained, but several major buildings have exceeded their useful lives and have serious functional and technical problems (Drever/Berkoff, 1989; Yow, 1989). For instance, both Buildings C and F qualify for a seismic rating of F, the lowest rating under the Office of Statewide Health Planning and Development classification system for hospital facilities. Mount Zion could not undertake substantial remodeling of these facilities without major seismic upgrading and without entailing new electrical distribution and fire alarm systems, improvements to fire exits, improved access for the handicapped and new heating, ventilation, and cooling systems. Even with costly renovations which could potentially exceed the expense of new buildings, these facilities would not form an interconnected hospital facility with a logical distribution of patient service functions. Other small buildings (Buildings D, F and G) occupying the eastern end of the Main Hospital block pose similar technical and functional problems.

Building J2, which was built originally for nursing home care, has significant functional limitations for use as either a patient care or research facility. Renovations of Building J2 are restricted by the narrow interior layout, concrete interior walls, and low floor-to-ceiling heights, which are inadequate to support sophisticated

ventilation systems for research and inpatient care. Separated from the Main Hospital by Sutter Street, the site of Buildings J1 and J2 is not a functional location for inpatient care. Independent of the proposed integration agreement, Mount Zion has decided to vacate the current inpatient services at Buildings J1 and J2.

Space Not Included in Project

Under the proposed integration agreement, title to the following properties would be retained by Mount Zion Health Systems and are, therefore, excluded from the project.

Buildings K and M and Area W are on the block immediately east of the Main Hospital block. Building K is the Ronald McDonald House at 1640-1646 Scott Street. Mount Zion leases the land to The Ronald McDonald House of San Francisco, which owns and operates the 6,200-bgsf building. The ten-bedroom Ronald McDonald House was constructed in 1988 and provides accommodations for families of infants and children undergoing extended treatment at Mount Zion and other San Francisco hospitals.

Building M, at 1606 Scott Street, contains management information systems offices. The building contains approximately 2,335 bgsf in a one-story structure. Building M was constructed in about 1922 as a single-family residence and was converted to office use by Mount Zion.

Area W is a 61-space surface parking lot for Mount Zion physicians. Access to the lot is via Scott Street.

Buildings S, U, and V are on the block immediately west of the Main Hospital block. Building S is the Crisis Clinic at 2330 Post Street. It is a one-story modular building with approximately 3,600 bgsf. A 15-space surface parking lot is immediately north of Building S. The land occupied by Building S is leased to Mount Zion. Building S is used for the provision of psychiatric crisis intervention services for the severely disturbed.

Building U is a five-story, 560-space parking garage on the south side of Sutter Street between Divisadero and Broderick Streets. As mentioned above, Mount Zion owns the land occupied by Building U and has the option to lease 150 parking spaces from

the developer of the parking garage. These spaces would include 120 tandem spaces and 30 regular spaces. The garage was completed in 1988 and is connected to Building V via a series of corridors.

Building V is the San Francisco Medical Center at the northwest corner of Divisadero and Post Streets. The structure contains approximately 70,475 bgsf on five floors; however, Mount Zion only leases approximately 7,435 bgsf from Western Development Group for use by Mount Zion physicians for offices. Mount Zion holds a seven-year lease with an option to renew for seven additional years. Retail uses are on the ground floor. Both Buildings U and V are owned and operated by Western Development Group on land leased by Mount Zion.

EXISTING PATIENT POPULATIONS AND VISITORS

In fiscal year 1988/89, Mount Zion admitted 7,871 inpatients. The total number of inpatient days was approximately 57,844 for an average of 158 inpatients per day (see Table 6). Although Mount Zion is licensed to operate 439 inpatient beds, only 270 of those beds are currently available for service. On the basis of the 270 currently available beds, Mount Zion's acute care occupancy rate was approximately 58%. Previous traffic studies indicate that each inpatient receives approximately one visitor per day (City and County of San Francisco, 1986). Thus, it is estimated that approximately 158 persons visit Mount Zion inpatients every day.

The skilled nursing facility operates at full occupancy with an average 31 patients per day. The visitor generation ratio for skilled nursing patients is the same as for inpatients. Thus, 31 persons visit skilled nursing patients every day.

Mount Zion provided approximately 48,922 outpatient visits (including emergency visits) during fiscal year 1988/89, or about 188 daily outpatient visits. Since most outpatient visits occur during the regular work week (Monday-Friday), daily visits have been calculated on the basis of 260 work days per year. This calculation overstates daily visits because emergency visits occur across the full seven-day week. For outpatients, the daily ratio of visitors accompanying outpatients is approximately 0.5 persons per outpatient (Chambers and Associates, 1985). Thus, the number of visitors accompanying outpatients at Mount Zion is approximately 94 per day.

TABLE 6: EXISTING PATIENT AND VISITOR ACTIVITY AT MOUNT ZION, 1989

Inpatient Activity	
Inpatient Admissions Per Year	7,871
Inpatient Days Per Year	57,844
Inpatients Per Day	158
Visitors Per Day	158
Skilled Nursing Care	
Skilled Nursing Admissions Per Year	309
Skilled Nursing Days Per Year	11,189
Skilled Nursing Patients Per Day	31
Visitors Per Day	31
Outpatient Activity	
Outpatient Visits Per Year	48,922 /a/
Outpatients Per Day	188
Visitors Per Day	94
Other Visitors	
Staff/Seminar/Vendor Visitors Per Day	60

/a/ Outpatient visits include emergency room visits. The outpatient visit count excludes dental visits. Mount Zion closed its dental clinic on June 30, 1989.

SOURCE: Mount Zion Hospital and Medical Center

Other visitors at Mount Zion include persons visiting Mount Zion staff, attendees at seminars, and vendors. It is estimated that Mount Zion receives approximately 60 other visitors on a daily basis (Wallett, 1989).

STAFFING

Total existing staffing at Mount Zion is 1,661, which consists of hospital staff, students/residents/fellows, and medical staff. Table 7 presents a breakdown of the number of employees by staff categories.

TABLE 7: EXISTING STAFFING AT MOUNT ZION, 1989 /a/

Type of Staff	Number
Hospital Staff	1,419
Students/Residents/Fellows	78
Medical Staff	164
TOTAL	1,661

/a/ These numbers represent total staff at Mount Zion and include part-time staff.

SOURCES: Mount Zion Hospital and Medical Center and Environmental Science Associates, Inc.

REFERENCES

Chambers and Associates, "Patient/Visitor Transportation and Parking Demand Survey and Analysis for the Kaiser-Permanente Medical Center," August 1985.

Drever/Berkoff, Environmental Assessment of Mount Zion, March, 1989.

City and County of San Francisco, *Kaiser-Permanente Medical Center San Francisco North Wing Addition and Parking Garage Draft Environmental Impact Report*, 83.433E, August 1986.

Wallett, Jon, Facilities Manager, Mount Zion Hospital and Medical Center, telephone conversation, July 26, 1989.

Yow, Art, Stone, Marraicinni and Patterson, letter dated August, 1989.

D. PROJECT CHARACTERISTICS

PROJECT OVERVIEW

Introduction

The project would involve the implementation of a proposed agreement to integrate UCSF Medical Center and Mount Zion Hospital and Medical Center. The parties to the agreement would be The Regents of the University of California, Mount Zion Hospital and Medical Center, and Mount Zion Health Systems, the parent corporation of Mount Zion Hospital and Medical Center (Mount Zion). Under the proposed integration agreement, UCSF would become responsible over time for the programs and finances of Mount Zion. The Board of Mount Zion Health Systems would continue to participate in the governance of the hospital through a minority membership on the hospital board, and would continue to support the community service efforts of the hospital.

As noted in Section III.A, an LRDP is a general land use plan guiding the physical development of University of California campuses. Most University of California campuses are located on a contiguous parcel of land; hence, LRDPs are primarily used as a land use, or "zoning" plan, to guide development of these core campus areas.

The current UCSF *LRDP*, which was adopted in 1982, includes and plans for then-existing UCSF facilities. As a condition of approval to the Mount Zion project, UCSF would request that The Regents amend the 1982 *LRDP* to identify Mount Zion as a UCSF facility, and to include the short-term and long-term Mount Zion project analyzed in this EIR in the UCSF *LRDP*. Similarly, UCSF will request that The Regents amend the 1982 *LRDP* to include other facilities that may be acquired by UCSF. The only currently foreseeable projects of this type are Laurel Heights and the Center for Educational Development, both of which are described in greater detail in Section II.F. Since no changes in land use other than those identified in the 1982 *LRDP* are planned or reasonable foreseeable at Parnassus Heights, an overall amendment of the UCSF *LRDP* is not appropriate at this time.

Mount Zion Governance

On the effective date of the agreement (projected to be in early 1990), title to most of the property of Mount Zion (all property described as included in the project) would be conveyed to the University. In return for the transfer of the Mount Zion property, the University would agree to continue to operate Mount Zion as a general acute care hospital.

Full integration of the operations of the medical centers at Mount Zion and UCSF would follow a transition phase, expected to run from the effective date of the agreement to mid-1992. During the transition phase, the Board of Mount Zion Hospital and Medical Center, as currently constituted, would be responsible for the hospital operations of Mount Zion. A joint planning committee would have program planning and budgetary responsibility. UCSF would have control of planning committee decisions regarding capital projects, equipment, and their corresponding benefits. Working with the recommendations of the planning committee, UCSF would develop proposals for major capital expenditures to support the academic programs of the University at Mount Zion and would present those plans to the appropriate University official or body for approval. UCSF would finance capital improvements at Mount Zion. UCSF Medical Center also would share in Mount Zion's anticipated operating losses during the transition period.

At the end of the transition period, The Regents would assume full responsibility for Mount Zion's programs, operations, and finances through a controlling majority on the hospital board. The University would appoint ten of the seventeen members of the new hospital board. The Board of Mount Zion Health Systems would continue to participate in the hospital's governance through its appointment of six members of the hospital board. The Mount Zion hospital chief executive officer would serve as the seventeenth member.

The reconstituted hospital board would have the authority to:

- recommend to the President of the University of California for approval by The Regents the appointment of the Mount Zion chief executive officer and consult with that Mount Zion officer on the appointment of key deputies;

- recommend the approval of capital projects and annual operating and capital budgets to the UCSF Chancellor for appropriate University approval;
- approve all medical staff by-laws and appointments and meet trustee requirements as specified by the Joint Commission on the Accreditation of Health Organizations and State and local codes;
- set policies and program direction for Mount Zion in concert, as necessary, with the policies of UCSF; and
- allocate space to major functions at Mount Zion.

Under this final governance structure, Mount Zion would continue to maintain a separate corporate status, hospital license, accreditation status, and independent medical staff. After the end of the transition period, the University would, however, manage UCSF Medical Center and Mount Zion as a single financial entity. Hospital employees at both sites would be University employees. Common financial and personnel management would give UCSF the flexibility necessary to make decisions about the location of clinical services based on program and community needs, rather than on financial or personnel management considerations. By combining the proceeds of the hospital operations at both sites, UCSF could fund the highest priority needs for medical equipment and facilities improvements at either site.

Patient Care

Under the proposed integration agreement, Mount Zion would continue to provide inpatient medical and surgical services, outpatient services, and emergency care. Both Mount Zion Health Systems and UCSF have stated their intent to continue providing community service at Mount Zion to indigent patients within Mount Zion's available financial resources. UCSF Medical Center itself has provided more care to indigent patients than any other hospital in San Francisco, except San Francisco General Hospital, which is also staffed by UCSF faculty physicians and residents.

Medical Staff

The proposed integration agreement is designed to ensure that physicians on Mount Zion's medical staff would have the opportunity to continue their practices at Mount Zion. Medical staff appointments and reappointments for current members would be

continued in accordance with existing Mount Zion medical board policies. New medical staff would generally be expected to be qualified to join the faculty of the School of Medicine and to participate in UCSF's education program at Mount Zion.

The Mount Zion medical staff would maintain its responsibility for the quality of medical care through medical service chiefs appointed jointly by the hospital board and the Dean of the UCSF School of Medicine. Through the service chiefs, UCSF would be responsible for the undergraduate, graduate, and postgraduate education programs at Mount Zion.

Teaching Programs

The project would allow the UCSF School of Medicine to diversify its educational programs further in a community hospital setting. Mount Zion could provide more extensive exposure for students and residents to patients with common medical problems that typically are treated in community hospitals.

The School of Medicine would expect to extend the number and types of training experiences available at Mount Zion. About half of the Mount Zion medical staff already serve on UCSF's clinical faculty, and these staff would provide a strong foundation for the gradual development of new teaching programs.

Currently, Mount Zion is a program site for UCSF School of Medicine core clerkships for third- and fourth-year medical students in Family and Community Medicine, Medicine, Obstetrics and Gynecology, and Psychiatry. Elective clerkships for medical students have been available at Mount Zion in Cardiology, Pulmonary Medicine, Critical Care, Infectious Disease, Geriatric Medicine, Ambulatory Pediatrics, Neonatology, Developmental and Behavioral Pediatrics, and Radiation Oncology.

Mount Zion participates in UCSF's residency training programs in Cardiology, Endocrinology and Metabolism, Geriatric Medicine, Infectious Diseases, Internal Medicine, Neonatal-Perinatal Medicine, Obstetrics and Gynecology, Orthopaedic Surgery, Pathology, Pediatrics, Radiation Oncology, and Surgery. Mount Zion also participates in the educational programs of UCSF's Schools of Dentistry, Nursing, and Pharmacy.

Mount Zion is a program site for Dentistry residencies in Oral Surgery and General Practice, and Mount Zion's geriatrics programs have provided training opportunities for dentistry fellows in Geriatrics, nursing clinical specialists in Gerontology, and for a pharmacy program studying drug use by the aged. The proposed integration offers these Schools the potential for additional teaching programs in a community hospital setting.

Research

The proposed agreement also states that the intention of both Mount Zion Health Systems and the University is to enhance research activities currently conducted at Mount Zion. This project would extend the involvement of UCSF in research at Mount Zion and would increase the overall amount of research conducted at Mount Zion. Faculty recruited for clinical programs at Mount Zion would conduct research as well as teach and care for patients. Like faculty at UCSF Medical Center, San Francisco General Hospital, and the Veterans Administration Medical Center, most full-time faculty at Mount Zion would engage in some form of biomedical research that requires the use of laboratories. The project provides for the development of research facilities to support the research investigations of the faculty projected to practice at Mount Zion.

Even with the development of research space for faculty who would practice at Mount Zion, the predominant emphasis of the University's programs at Mount Zion would continue to be the provision of patient care and clinical teaching.

Administration and Support Services

Administration and support services are projected to increase in response to expanded patient care and research activities. No significant changes to the nature of administration/support uses are projected to occur with project implementation.

SHORT-RANGE PROGRAM

Building Renovation, Demolition and Construction

The short-range program is designed to permit UCSF to make the capital investments necessary to initiate several new patient care programs at Mount Zion and to develop

outpatient and research space for faculty physicians who would practice at Mount Zion. Without substantial additional investment in facilities, it would be difficult to retain the community physicians currently practicing at Mount Zion and to recruit faculty to a new UCSF site. In recent years, Mount Zion has, of necessity, severely restricted equipment purchases and commitments to other capital improvements of interest to its medical staff. Furthermore, current space for outpatient care, offices, and research is insufficient to accommodate the needs of additional UCSF full-time faculty who would join the Mount Zion medical staff under the proposed integration agreement.

The following discussion of the short-term program includes descriptions of preliminary program plans under initial consideration by UCSF. The proposed short-term program elements are analyzed in detail in this EIR. It is anticipated that final, specific plans would refine these elements; however, final program elements are anticipated to be consistent with the general uses described in this EIR. Significant deviations from these use categories are not reasonably foreseeable, and would require further environmental review in conformance with CEQA prior to approval or implementation. Final plans would be consistent with the general uses described.

Table 8 presents the projected uses, by category, for each building at Mount Zion at the end of the short-range program. Figure 4 presents the proposed short-term development program at Mount Zion. Tables 9 and 10 present the floor area projections and the number of projected parking spaces at Mount Zion for the short-range program. Of the total square footage available at the end of the short-range program, patient care would occupy approximately 56% (278,500 dgsf), research would occupy approximately 17% (85,700 dgsf), and administrative and support services would occupy approximately 27% (133,000 dgsf).

Each of the buildings included as part of the project and affected by the short-range program is addressed in turn below. As noted above, preliminary planning for specific program elements has taken place; however, this EIR is based upon general uses (patient care, research and administration/support).

TABLE 8: PROJECTED USES AND SPACE BY USE AT MOUNT ZION, 1996

Buildings/Areas Included as Part of the Project/a/		1996 Building/Area Use/b/
A	Main Hospital	PC, A
B	Main Hospital	PC, A
D	Supply, Processing and Distribution	A
H	Outpatient Services	PC, A
J	Pavilion	PC, R, A
N	Computer and Accounting	A
P	Warehouse	A
R	Admitting and Administration	A
T	Medical Office Building	A
Y	1710 Scott Street	A
Z	Lab/Ophthalmology	PC, A

Use	Space/c/	Percentage of Total Space
Patient Care	278,500	56
Research	85,700	17
Administration and Support Services	133,000	27

/a/ See Figure 4, page 50, for building locations.
/b/ PC = patient care; R = research; A = administration and support services.
/c/ In dgsf.

SOURCE: Mount Zion Hospital and Medical Center and Environmental Science Associates, Inc.

A major element of the short-range program is the development of an outpatient cancer center in Building H. Renovations to the ground, first, and second floors of Building H would provide updated radiation therapy facilities, physicians' offices for both medical and surgical cancer specialists, complete examination and treatment facilities, related diagnostic and support services, and day beds for chemotherapy and other infusion procedures that involve patient stays of up to 18 hours. Building H also would house the UCSF Medical Center melanoma program.

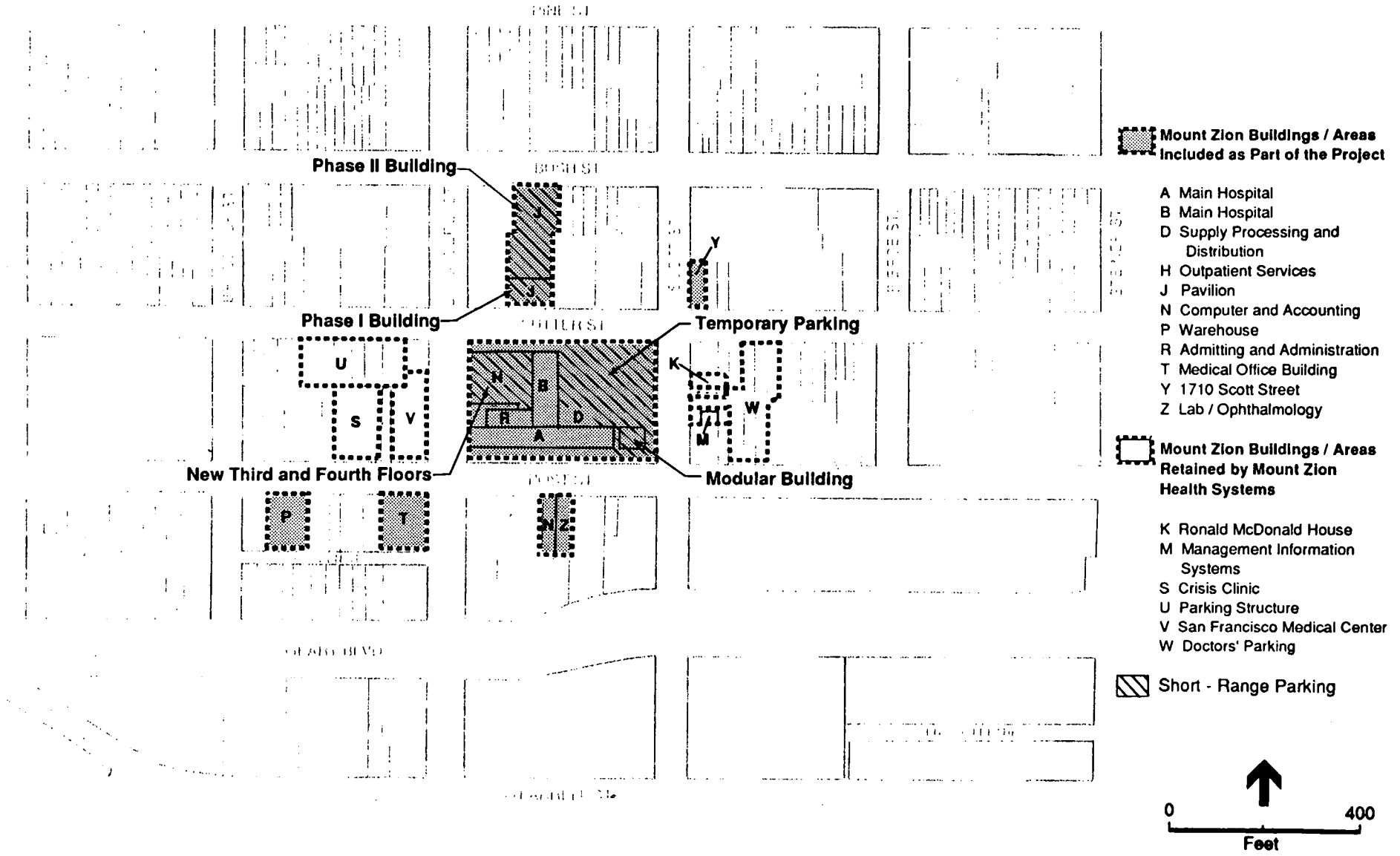


FIGURE 4
PROPOSED SHORT - RANGE (1996) PROGRAM AT MOUNT ZION

SOURCE: Environmental Science Associates, Inc.

TABLE 9: FLOOR AREA PROJECTIONS FOR SHORT-RANGE BUILDING PROGRAM AND FLOOR AREA CHANGES FROM 1989 TO 1996 AT MOUNT ZION /a/

Building/Area/b/		1989 BGSF	1996 BGSF	Change in BGSF
Owned Buildings				
A	Main Hospital	118,750	118,750	0
B	Main Hospital	106,360	106,360	0
C	Hellman Building	65,900	13,000	(52,900)/c/
D	Supply, Processing and Distribution	9,500 /d/	9,500	0
E1	Harold Brunn Institute	11,070	0	(11,070)/e/
E2	Harold Brunn Institute	2,330	0	(2,330)/e/
F	Sutter Building	48,300	0	(48,300)/e/
G	Geriatric Day Facility	5,200	0	(5,200)/e/
H	Outpatient Services	38,340	63,340	25,000 /f/
J1	Pavilion	2,460	79,050	76,590 /g/
J2	Pavilion Tower	51,040	130,900	79,860 /g/
N	Computer and Accounting	7,800	7,800	0
P	Warehouse	20,750	20,750	0
R	Admitting and Administration	16,500	16,500	0
	SUBTOTAL FOR OWNED BUILDINGS	504,300	565,950	61,650
Leased Buildings				
T	Medical Office Building	16,500	16,500	0
Y	1710 Scott Street	7,715	7,715	0
Z	Lab/Ophthalmology /h/	11,550	11,550	0
	SUBTOTAL FOR LEASED BUILDINGS	35,765	35,765	0
TOTAL		540,065	601,715	61,650

/a/ Buildings not included as part of the project are excluded from this table.
/b/ See Figure 4, page 50, for building locations.
/c/ Building to be demolished and replaced with a temporary, modular building.
/d/ The square footage associated with Building D is underground.
/e/ Building to be demolished and replaced with temporary surface parking.
/f/ Third and fourth floors to be added to Building H.
/g/ Buildings to be demolished and replaced with a new building that contains two levels of underground parking. The floor area for the underground parking is included in the bgsf.
/h/ This EIR assumes that the option to renew the lease for Building Z beyond 1989 would be exercised.

SOURCE: Mount Zion Hospital and Medical Center and University of California, San Francisco

TABLE 10: PROJECTED NUMBER OF PARKING SPACES AFTER COMPLETION OF SHORT-RANGE PROGRAM AND CHANGES IN THE NUMBER OF PARKING SPACES FROM 1989 TO 1996 AT MOUNT ZION

Parking Area/a/		1989 Number of Spaces	1996 Number of Spaces	Change in the Number of Spaces
D	Supply, Processing and Distribution Parking Lot	10 spaces/b/	10 spaces/b/	0 spaces
E	Harold Brunn Institute	0 spaces	26 spaces/c/	26 spaces
F	Sutter Building	0 spaces	23 spaces/c/	23 spaces
G	Geriatric Day Facility	0 spaces	9 spaces/c/	9 spaces
J	Pavilion Parking Lot	8 spaces/b/	150 spaces	142 spaces
S	Crisis Clinic Parking Lot (leased)	15 spaces	0 spaces/d/	(15 spaces)
T	Medical Offices Parking Lot (leased)	26 spaces	26 spaces	0 spaces
U	Parking Garage	0 spaces	150 spaces/e/	150 spaces
W	Doctor's Parking Lot	61 spaces/b/	0 spaces/d/	(61 spaces)
	TOTAL	120 spaces	394 spaces	274 spaces

/a/ See Figure 4, page 50, for locations.
/b/ The spaces in this parking lot are not for public use.
/c/ These spaces are project on the basis of the Transportation Engineers Handbook average of one space per 300-square-foot area.
/d/ This parking lot is not included as part of the project. Thus, the spaces associated with the lot have not been included in the total for 1996.
/e/ As part of the project, Mount Zion's option to lease 150 spaces in the parking garage would be exercised.

SOURCE: Mount Zion Hospital and Medical Center, University of California, San Francisco and Environmental Science Associates, Inc.

The short-range program also includes the addition of a third and fourth floor to the renovated or new Building H to develop additional outpatient care facilities and to expand the surgical suite currently on the third floor of the adjacent Building B. The surgical suite alterations would include the development of an expanded and modernized post-anesthesia recovery unit and the construction of operating rooms of adequate size to accommodate large surgical teams and highly specialized equipment.

Other space on the new third floor of Building H would be used as outpatient offices for surgeons or other physicians whose practices are related to the cancer center. Similarly, part of a new fourth floor would be available to house physicians' offices in an area adjacent to the new mechanical support space for the cancer center and the operating rooms. The third and fourth floors would provide an additional 17,800 dgsf for surgical facilities and outpatient care. Renovations to Building H would include upgrades to mechanical systems and structural and seismic upgrades. OSPHD could require a more substantial revision of Mount Zion's building systems than currently envisioned. If that occurs, it is possible that Building H might be demolished and a replacement building of four stories constructed to accommodate more extensive building support systems as well as outpatient and surgical space.

During the short-range program, nursing units in the Main Hospital would accommodate 293 acute care beds and 31 skilled nursing beds. Internal remodeling of nursing units in Buildings A and B would support the development of new clinical programs. Mount Zion would also reinstate nursing units that are currently closed. The sixth floor of Building B would house a renovated inpatient psychiatry unit that would move from Building J2. The existing surgical suite on the third floor of Building B would be renovated. The eastern portion of the sixth floor of Building A would accommodate an inpatient pediatric rehabilitation and chronic care unit. Also as a result of renovations, the inpatient cancer unit would be moved from the fifth floor of Building B to a sixth floor unit in Building A specially designed for the needs of cancer patients. Other remodeling and mechanical upgrades would occur to improve the functioning of current units.

Also in the short-range program, the inpatient psychiatry unit currently in Building J2 would move to a renovated and expanded unit in Building B. The offices for the Institute on Aging and geriatric service programs currently in Buildings J1 and J2 would move to nearby leased office space. For purposes of this EIR, it is assumed that the relocation of any particular Mount Zion activities to locations other than Mount Zion would occur only to off-site facilities that are already zoned for and currently occupied by commercial/office uses, and thus that these relocations would not result in any land use changes in the Mount Zion vicinity. The relocation of particular programs or activities from Mount Zion into space within the Mount Zion vicinity would, like other specific building proposals, constitute a separate "project" under CEQA and would be subject to additional project-specific environmental review. Since there are ample facilities zoned for commercial use within the

Mount Zion vicinity, and since the Mount Zion program activities that are projected to move off site as a result of project implementation are permitted uses within these commercial zones and are consistent with existing uses, it is not anticipated that such relocation of uses would result in significant environmental impacts. See also, Section III.A.

As discussed in Section II.C, the physical separation of Buildings J1 and J2 from the Main Hospital by Sutter Street makes the site a more appropriate location for outpatient care and research than for inpatient care.

During the first several years of the short-range program, Buildings J1 and J2 would accommodate outpatient clinics, hemodialysis, and limited research space. These functions would be moved from Building H when renovation and construction of the cancer center begins.

UCSF could not accommodate the expanded outpatient and research space necessary to meet UCSF's project objectives in Buildings J1 and J2 due to the physical and functional limitations discussed in Section II.C.

Construction to replace Buildings J1 and J2 would occur in two phases. In Phase I, Building J1 would be demolished to permit construction of a new building of approximately 79,050 bgsf. The Phase I new building would house both outpatient care and research, some of which would be moved from Building J2.

During Phase II of the short-range program, Building J2 would be demolished and replaced with a 130,900-bgsf building that would be contiguous to the Phase I new building. The Phase II new building would house additional outpatient care and research space.

Design of the two new buildings would await the development of detailed program plans for research and outpatient care. The two new buildings would each likely contain six stories above grade with two levels of underground parking. Accessible from either Sutter or Bush Streets, the underground parking garage would contain 150 spaces.

The short-range program also includes the demolition of older buildings on the eastern portion of the Main Hospital block (Buildings C, E, F and G). UCSF has determined that this area represents the logical site for the modernization of Mount Zion's inpatient facilities planned for the long-range program. Development of new inpatient facilities in an area contiguous to the Main Hospital would enable inpatient services to be organized within one hospital complex. Section II.C discusses the technical and functional deficiencies of the existing buildings on this site which make it infeasible to use these buildings as components of the modernized hospital facility.

Some of the administrative and support functions in Buildings C and F would be moved to Building B and the remaining functions moved to other University facilities (such as the CED building at 1855 Folsom Street) or leased office space in the Mount Zion vicinity. The research functions in Buildings E1 and E2 would move into the new Building J constructed during the short-range program. The San Francisco Institute on Aging's Adult Day Care program in Building G would be consolidated with the other geriatric services into leased space in the Mount Zion vicinity. The demolition program would include removal of the hospital incinerator, which Mount Zion has shut down and which UCSF would not use as part of this project.

After demolition of these buildings, the eastern portion of the Main Hospital block (Building sites E, F and G) would be occupied by a landscaped surface parking lot containing 58 spaces. The site of Building C may also be used to accommodate temporary modular buildings containing approximately 13,000 bgsf if adequate space cannot be found to house functions that cannot be moved away to leased office space; this EIR assumes that such modular space would be constructed.

During the short-range program, no facility or use changes are planned for Buildings D, N, P, R, T, Y and Z.

Upon completion of the short-range program, Mount Zion facilities would occupy a total of 601,715 bgsf, which would include 55,600 bgsf for underground parking (see Table 9, page 51). An increase of 274 parking spaces would be provided in Mount Zion underground and surface parking areas (see Table 10, page 52).

In addition, the short-range program would include the installation of emission control equipment on the hospital sterilizer. The emission control equipment (scrubbers) would reduce toxic air emissions from the sterilizer by about 98% (Bay Area Air Quality Management District, 1989).

Patient Populations and Visitors

As a result of implementation of the short-range program for the proposed project, the volume of patient care services provided by Mount Zion is projected to increase (see Table 11). With the involvement of current Mount Zion staff, UCSF plans to recruit faculty physicians to Mount Zion for new patient care programs, such as a planned center for outpatient cancer treatment and a pediatric rehabilitation and chronic care nursing unit. Clinical programs such as these, that address needs for community health services in San Francisco, would draw additional patients to Mount Zion. Patients also are likely to be attracted to Mount Zion by UCSF's ability to bring state-of-the-art medical technology and clinical information to the bedside, especially when those services are available in conjunction with qualified community physicians.

As discussed in Section I.B, for the purposes of this EIR, it is assumed that Mount Zion would be able to attain an 80% occupancy rate for its operating acute care beds in both the short-range and long-range programs. The "full occupancy" projections thus overstate the probable levels of patient activity and their potential impacts.

Until a modernized inpatient facility is built adjacent to the Main Hospital, Mount Zion can make available only about 293 acute care beds and 31 skilled nursing beds in the Main Hospital. On the basis of an 80% occupancy rate, the average daily number of acute care inpatients would be 235 under the short-range program. It is expected that Mount Zion's skilled nursing facility would continue to operate at full occupancy (31 patients per day).

The analysis assumes that the number of additional outpatient visits in 1996 would be commensurate with the overall inpatient volume. In 1996, approximately 520 outpatients are projected to visit Mount Zion on a daily basis. The numerical relationship between outpatient visits and inpatient admissions is based on new clinical program projections and current experience at UCSF Medical Center.

TABLE 11: PROJECTED PATIENT AND VISITOR ACTIVITY FOR THE SHORT-RANGE PROGRAM AND PATIENT AND VISITOR ACTIVITY CHANGES FROM 1989 TO 1996 AT MOUNT ZION

	1989	1996	Change
Inpatient Activity			
Inpatient Admissions Per Year	7,871	11,070	3,199
Inpatient Days Per Year	57,844	85,560	27,716
Inpatients Per Day	158	235	77
Visitors Per Day	158	235	77
Skilled Nursing Care			
Skilled Nursing Admissions Per Year	309	309	0
Skilled Nursing Days Per Year	11,189	11,189	0
Skilled Nursing Patients Per Day	31	31	0
Visitors Per Day	31	31	0
Outpatient Activity			
Outpatient Visits Per Year	48,922	135,330	86,408
Outpatients Per Day	188	520	332
Visitors Per Day	94	260	166
Other Visitors			
Staff/Seminar/Vendor Visitors Per Day	60	90	30

SOURCE: University of California, San Francisco

On the basis of previous traffic studies (City and County of San Francisco, 1986; Chambers and Associates, 1985) showing one visitor per hospitalized patient and 0.5 visitors accompanying each outpatient, the daily number of visitors to inpatients, skilled nursing patients and outpatients in 1996 would be 235, 31, and 260, respectively.

The number of persons visiting Mount Zion staff, attending seminars, and vendors would also increase commensurate with the increase in the clinical programs. For 1996, it is projected that the average daily number of other visitors would be 90.

Staffing

Upon completion of the short-range program, the total staffing at Mount Zion is anticipated to increase to 2,367 (see Table 12). This staffing level, which represents an increase of approximately 43% over current Mount Zion staffing, assumes that patient activity would rise to the "full occupancy" level.

The staffing and patient activity levels projected for the short-range program would not be fully realized until approximately 1996. In the years between initial integration and 1996, activity levels at Mount Zion would gradually increase. Depending on the precise timing of events under the short-range program (e.g., demolition of existing buildings, increased patient activity levels, and addition of parking facilities), certain potential impacts could be more significant in the relatively near term than by completion of the short-range program in 1996. Such impacts would, however, be only temporary. Nonetheless, where this potential exists, it is noted in the appropriate impact discussions in Section III.

LONG-RANGE PROGRAM

Building Renovation, Demolition and Construction

In the long term, UCSF foresees the need to modernize and expand Mount Zion's Main Hospital facilities. Because most of the Main Hospital is more than forty years old, it is likely that it would be necessary to relocate many of the highly specialized diagnostic and treatment services to new space within a twenty-year period. Over that period, substantial changes may occur in the technology of patient care that would make it difficult to renovate space satisfactorily within the aging facility. Diagnostic imaging suites, operating rooms, critical care areas, and even medical/surgical nursing units may have different configurations and equipment needs by the beginning of the next century. Other hospital functions that are less sensitive to technological changes could continue to be located in the Main Hospital.

UCSF may also need to replace the licensed acute care beds that would be out of service during the short-range program. During the short-range program, the closure of inpatient nursing units in Building J and the space constraints of the Main Hospital would limit the number of total acute care beds in service to 293. To replace the 115

TABLE 12: PROJECTED STAFFING FOR THE SHORT-RANGE PROGRAM AND STAFFING CHANGES FROM 1989 TO 1996 AT MOUNT ZION

Type of Staff	Number in 1989	Number in 1996	Change in the Number of Staff
Hospital Staff	1,419	2,202	783
Students/Residents/ Fellows	78	151	73
Medical Staff	164	214	50
TOTAL	1,661	2,567	906

SOURCE: Mount Zion Hospital and Medical Center, University of California, San Francisco and Environmental Science Associates, Inc.

acute care beds out of service during the short-range program would require new construction. It is foreseeable that the integrated UCSF/Mount Zion operation would create sufficient demand for patient care to require the use of the full complement of licensed beds at Mount Zion (408 acute care beds and 31 skilled nursing beds). In addition, an inpatient program of that size would require expanded space for additional faculty physicians.

The following discussion of the long-range program includes descriptions of preliminary program plans under initial consideration. Final plans are anticipated to be consistent with the general categories of uses described. Table 13 presents the projected uses at each Mount Zion building included in the project at the end of the long-range program. Upon completion of the long-range program, patient care would occupy approximately 59% of the total bgsf, research would occupy approximately 16%, and administration and support services would occupy approximately 25%. Figure 5 presents the proposed long-range development program at Mount Zion. Tables 14 and 15 present the floor area projections and the number of parking spaces at Mount Zion, respectively, for the reasonably foreseeable long-range program.

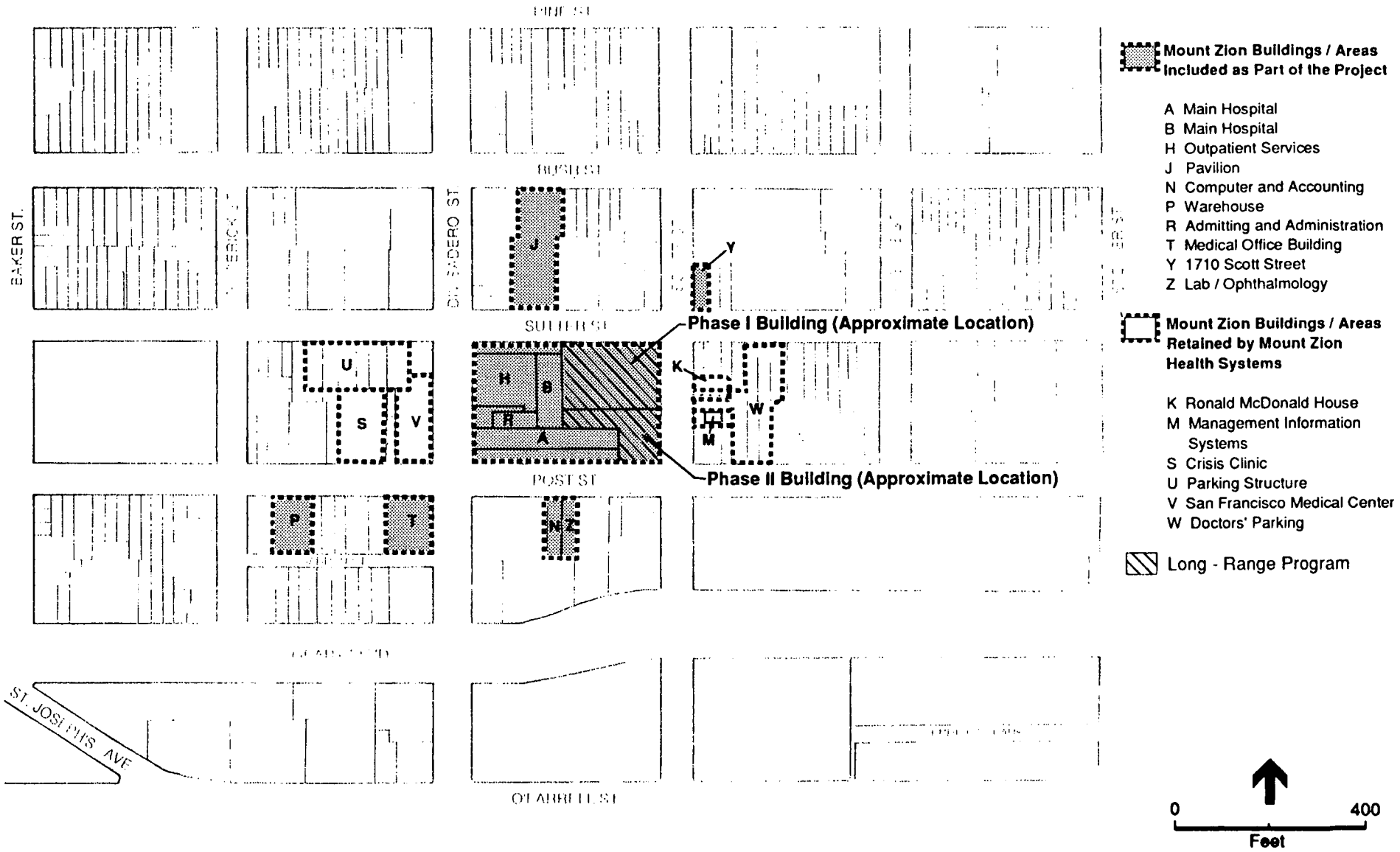
TABLE 13: PROJECTED USES AND SPACE BY USE AT MOUNT ZION, 2010

Buildings/Areas Included as Part of the Project/a/		2010 Building/Area Use/b/
A	Main Hospital	PC, A
B	Main Hospital	PC, A
H	Outpatient Services	PC, A
J	Pavilion	PC, R, A
N	Computer and Accounting	A
P	Warehouse	A
R	Admitting and Administration	A
T	Medical Office Building	A
Y	1710 Scott Street	A
Z	Lab/Ophthalmology	PC, A
Phase I New Building		PC, A
Phase II New Building		PC, A

Use	Space/c/	Percentage of Total Space
Patient Care	448,200	59
Research	121,700	16
Administration and Support Services	191,500	25

/a/ See Figure 5, page 61, for building locations.
/b/ PC = patient care; R = research; A = administration and support services.
/c/ In dgsf.
SOURCES: Mount Zion Hospital and Medical Center and Environmental Science Associates, Inc.

Foreseeable long-range development would probably occur in two phases. Phase I, which might be completed by 2004, would involve the construction of a new building for patient care of about 250,000 bgsf at the southwest corner of Sutter and Scott Streets. Phase II, with a potential completion date of 2010, would involve construction of a new 200,000-bgsf patient care building at the northwest corner of Post and Scott Streets. Both buildings would have two levels of underground parking. For the purposes of this analysis, the height of the buildings is assumed to be 105 feet above grade. Given a likely floor-to-ceiling height of 15 feet, the buildings are assumed to have seven stories above grade.



MOUNT ZION EIR

FIGURE 5
PROPOSED LONG - RANGE (2010) PROGRAM AT MOUNT ZION

SOURCE: Environmental Science Associates, Inc.

TABLE 14: FLOOR AREA PROJECTIONS FOR LONG-RANGE BUILDING PROGRAM AND FLOOR AREA CHANGES FROM 1989 TO 2010 AND 1996 TO 2010 AT MOUNT ZION

Building/Area/a/	1989 BGSF/b/	Projected 1996 BGSF/b/	Projected 2010 BGSF/b/	1989-2010 Change in BGSF/b/	1996-2010 Change in BGSF/b/
Owned Buildings					
A Main Hospital	118,750	118,750	118,750	0	0
B Main Hospital	106,360	106,360	106,360	0	0
C Hellman Building	65,900	13,000	0	(65,900)/c/	(13,000)/d/
D Supply, Processing and Distribution	9,500 /e/	9,500	0	(9,500)/f/	(9,500)
E1 Harold Brunn Institute	11,070	0	0	(11,070)/f/	0
E2 Harold Brunn Institute	2,330	0	0	(2,330)/f/	0
F Sutter Building	48,300	0	0	(48,300)/f/	0
G Geriatric Day Facility	5,200	0	0	(5,200)/f/	0
H Outpatient Services	38,340	63,340	63,340	25,000 /g/	0
J1 Pavilion	2,460	79,050	79,050	76,590 /h/	0
J2 Pavilion Tower	51,040	130,900	130,900	79,860 /h/	0
N Computer and Accounting	7,800	7,800	7,800	0	0
P Warehouse	20,750	20,750	20,750	0	0
R Admitting and Administration	16,500	16,500	16,500	0	0
PHASE I NEW BUILDING	NA	NA	250,000	250,000 /h/	250,000
PHASE II NEW BUILDING	NA	NA	200,000	200,000 /h/	200,000
SUBTOTAL FOR OWNED BUILDINGS	504,300	565,950	993,450	489,150	427,500
Leased Buildings					
T Medical Office Bldg.	16,500	16,500	16,500	0	0
Y 1710 Scott Street	7,715	7,715	7,715	0	0
Z Lab/Ophthalmology	11,550	11,550	11,550	0	0
SUBTOTAL FOR LEASED BUILDINGS	35,765	35,765	35,765	0	0
TOTAL	540,065	601,715	1,029,215	489,150	427,500

/a/ See Figure 5, page 61, for building locations.
/b/ Building gross square feet.
/c/ Building to be demolished and replaced with a temporary, modular building.
/d/ Temporary, modular building removed.
/e/ The square footage associated with Building D is underground.
/f/ Buildings to be demolished.
/g/ Third and fourth floors to be added to Building H.
/h/ New buildings would contain two levels of underground parking. The floor area for the underground parking is included in the bgsf.

SOURCE: Mount Zion Hospital and Medical Center and University of California, San Francisco

TABLE 15: PROJECTED NUMBER OF PARKING SPACES AFTER COMPLETION OF LONG-RANGE PROGRAM AND CHANGES IN THE NUMBER OF PARKING SPACES FROM 1989 TO 2010 AND 1996 TO 2010 AT MOUNT ZION

Parking Area/a/	Number of Spaces 1989	1996	2010	1989-2010 Change in Number of Spaces	1996-2010 Change in Number of Spaces
D Supply, Processing and Distribution Parking Lot	10 /b/	10 /b/	0	(10)	(10)
E Harold Brunn Institute	0	26 /c/	0	0	(26)
F Sutter Building	0	23 /c/	0	0	(23)
G Geriatric Day Facility	0	9 /c/	0	0	(9)
J Pavilion Parking Lot	8 /b/	150 /d/	150	142	0
S Crisis Clinic Parking Lot (leased)	15	0 /e/	0 /e/	(15)	(15)
T Medical Offices Parking Lot (leased)	26	26	26	0	0
U Parking Garage	0	150 /f/	150 /f/	150	0
W Doctors' Parking Lot	61 /b/	0 /e/	0 /e/	(61)	(61)
PHASE I NEW BUILDING	NA	NA	245 /d/	245	245
PHASE II NEW BUILDING	NA	NA	240 /d/	240	240
TOTAL	120	394	811	691	417

/a/ See Figure 5, page 61, for locations of parking areas.
/b/ The spaces in this parking lot are not for public use.
/c/ These spaces are projected on the basis of the Transportation Engineers Handbook average of one space per 300 square feet area.
/d/ New underground parking spaces associated with new construction at Mount Zion.
/e/ This parking lot is not included as part of the project. Thus, the spaces associated with the lot have not been included in the total for 1996 or 2010.
/f/ As part of the project, Mount Zion would exercise its option to lease 150 spaces in the parking garage.

SOURCE: Mount Zion Hospital and Medical Center, University of California, San Francisco and Environmental Science Associates, Inc.

As the new patient care buildings become available, functions such as a surgical suite or an intensive care unit would move out of Buildings A, B and H. This would permit the renovation of the buildings on the Main Hospital block that are retained. The underground Building D would be demolished during Phase II of the long-range

program to permit construction of the new 200,000 bgsf patient care building. Receiving and central processing would be moved to the 250,000 bgsf building constructed during Phase I.

During the long-range program, no facility or use changes are envisioned for Buildings N, P, T, Y, and Z.

Upon completion of the long-range program, Mount Zion would occupy approximately 1,029,215 bgsf, which would include 163,600 bgsf for underground parking (see Table 14, page 62). A net increase of 417 parking spaces would result from the construction of underground parking areas in new buildings in the long-range program (see Table 15, page 63). The total increase in parking spaces from 1989 to 2010 would be 691.

Patient Populations and Visitors

As in the short-range program, the long-range program assumes that Mount Zion would be able to reach an 80% occupancy rate for its acute care beds. With the development of the modernized hospital facilities on the eastern end of the Main Hospital block, Mount Zion would be able to make available all of its 408 acute care beds and 31 skilled nursing beds. With an occupancy rate of 80%, the average number of acute care patients hospitalized each day would be 326 (see Table 16). As in the short-range program, it is expected that the average number of skilled nursing patients per day would be 31.

The analysis assumes that the number of additional outpatient visits in 2010 would be commensurate with the overall inpatient volume. Approximately 839 outpatients would visit Mount Zion on a daily basis in 2010. The relationship between outpatient visits and inpatient admissions is based on current experience at UCSF Medical Center.

On the basis of previous traffic studies (City and County of San Francisco, 1986; Chambers and Associates, 1985) showing one visitor per hospitalized patient and 0.5 visitors per outpatient, the daily number of visitors to inpatients, skilled nursing patients and outpatients in 2010 would be 326, 31, and 420, respectively.

TABLE 16: PROJECTED PATIENT AND VISITOR ACTIVITY FOR THE LONG-RANGE PROGRAM AND PATIENT AND VISITOR ACTIVITY CHANGES FROM 1989 TO 2010 AT MOUNT ZION

Inpatient Activity	1989	2010	Change
Inpatient Admissions Per Year	7,871	15,610	7,739
Inpatient Days Per Year	57,844	119,100	61,256
Inpatients Per Day	158	326	168
Visitors Per Day	158	326	168
Skilled Nursing Care			
Skilled Nursing Admissions Per Year	309	309	0
Skilled Nursing Days Per Year	11,189	11,189	0
Skilled Nursing Patients Per Day	31	31	0
Visitors Per Day	31	31	0
Outpatient Activity			
Outpatient Visits Per Year	48,922	218,130	169,208
Outpatients Per Day	188	839	651
Visitors Per Day	94	420	326
Other Visitors			
Staff/Seminar/Vendor Visitors Per Day	60	125	65

SOURCE: University of California, San Francisco

The number of persons visiting Mount Zion staff, attending seminars, and vendors would also increase commensurate with the increase in inpatients. For 2010, it is projected that the average daily number of other visitors would be 125.

Staffing

Upon completion of the long-range program, the total staffing at Mount Zion is anticipated to increase to 3,197 (see Table 17). This would represent an increase of 92% over 1989 staffing levels and 25% over 1996 staffing levels.

TABLE 17: PROJECTED STAFFING FOR LONG-RANGE PROGRAM AND STAFFING CHANGES FROM 1989 TO 2010 AND 1996 TO 2010 AT MOUNT ZION

Type of Staff	Number of Staff			1989-2010 Change in Number of Staff	1996-2010 Change in Number of Staff
	1989	1996	2010		
Hospital Staff	1,419	2,202	2,705	1,286	503
Students/Residents/ Fellows	78	151	228	150	77
Medical Staff	164	214	264	100	50
TOTAL	1,661	2,567	3,197	1,536	630

SOURCE: Mount Zion Hospital and Medical Center, University of California, San Francisco and Environmental Science Associates, Inc.

REFERENCES

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City and County of San Francisco, *Kaiser-Permanente Medical Center San Francisco North Wing Addition and Parking Garage Draft Environmental Impact Report*, 83.433E, August 1986.

State of California Office of Statewide Health Planning and Development, *Annual Report of Hospitals*, 1987.

E. PROJECT SCHEDULE

The implementation of the proposed integration agreement would follow the review and approval of this EIR by The Regents and action by The Regents and the Board of Mount Zion Health Systems on the execution of the proposed integration agreement, projected to occur in 1990. The short-range program is projected to occur between 1990 and 1996. The long-range program is projected to occur between 1996 and 2010.

Approval by The Regents of the proposed integration agreement would not constitute a commitment to any particular building project or program at Mount Zion. Environmental consequences of specific future capital projects will be evaluated in a project-specific environmental review in conformance with CEQA; approval of such projects will proceed only following additional environmental review.

F. RELATIONSHIP TO OTHER UCSF PROJECTS

In addition to Mount Zion, UCSF is also pursuing a project at Laurel Heights and is planning instruction and research space improvements at Parnassus Heights in space to be released by the current library. A new library building is under construction on the north side of Parnassus Avenue, west of Millberry Union. UCSF and Far West Laboratories currently each own one-half condominium interest in the Center for Educational Development (CED) building at 1855 Folsom Street. UCSF has made an offer to purchase the remainder of CED from Far West Laboratories.

LAUREL HEIGHTS

UCSF proposes to occupy the Laurel Heights facility (see Figure 3, page 29) with University academic programs, including the School of Pharmacy basic sciences departments, now located at Parnassus Heights. Additional biomedical research and building support would occupy the remainder of available space. Administrative, instructional and clinical programs are also being analyzed as alternatives to the proposed project.

The Laurel Heights proposed project, for which a separate environmental impact report (scheduled for public release in the Fall of 1989) is being prepared, consists of the School of Pharmacy basic science departments (100,000 asf), and research support uses, such as Environmental Health and Safety and Material Management (10,000 asf). Existing uses, such as the Conference Center, Building Management, the Center on Deafness, Drug Products Services, Home Therapy Services, a small magnetic resonance facility, the Office of Research Affairs, and a cafeteria (36,000 asf), will also be evaluated as part of the project. Up to 20,000 asf is proposed to be constructed underground to house an animal care facility. As space currently leased to third parties (such as the California Department of Transportation, whose lease expires in 1990 with an option to extend through 1995) becomes available, the remainder of the building (117,700 asf) would be devoted to UCSF programs related to biomedical research (perhaps including research space and clinical support laboratories to support Mount Zion patient care activities). No programs that would receive patients on a regular basis are proposed for the preferred project at Laurel Heights.

Of the space allocated to biomedical research programs at Laurel Heights, when space becomes available, 30,000 asf would be allocated to the School of Pharmacy. Use of the space would not likely include relocation of any other School of Pharmacy departments from Parnassus Heights, but rather would involve Laurel Heights-based programs. In addition, collaboration in research between Laurel Heights and Mount Zion would likely occur.

Due to the proximity of Laurel Heights to Mount Zion, the proposed Laurel Heights project is one of the present, planned, or foreseeable future projects included within the cumulative impact analysis in this EIR. That analysis assumes that both the Mount Zion and Laurel Heights projects are approved by The Regents. In addition, wherever the potential implementation of the Laurel Heights project could affect activities at Mount Zion (such as traffic between the two facilities if clinical support laboratories are located at Laurel Heights), the possible effects of such activities have been taken into account in the analysis of environmental impacts contained in Section III. of this EIR.

LIBRARY RELEASE SPACE

In conformance with the 1982 *LRDP*, UCSF is completing construction of a new library at Parnassus Heights. In conjunction with this project, UCSF is also renovating the space formerly occupied by library uses (library release space) to create a centralized education area, including renovated classrooms and teaching laboratories. In accordance with CEQA, an environmental analysis of the library release space renovations was conducted; such review determined that the library release space would not generate potential significant environmental impacts. Potential impacts associated with the relationship between Parnassus Heights activities (including the library release space project) and the proposed Mount Zion project are taken into account in each relevant topical analysis of this EIR.

CENTER FOR EDUCATIONAL DEVELOPMENT

UCSF is also currently considering the purchase of the condominium interest of Far West Laboratories in three floors of the six-story Center for Educational Development (CED) building located at 1855 Folsom Street in San Francisco. UCSF already owns and occupies three floors of the approximately 280,000 bgsf CED building, and

UCSF also rents approximately 45,000 asf of space on portions of the three non-owned floors. Hence, UCSF's acquisition of Far West's half interest in CED would provide UCSF with an additional 40,000 asf at this facility.

Existing UCSF activities at CED are primarily administration and support (including Medical Center administration and computer-based research), with a small amount (about 30,000 asf) of biomedical research also located in this building. CED space not owned or occupied by UCSF is currently used for office and office support functions.

Space planning for the currently non-owned portions of CED is now very preliminary given the preliminary nature of the potential acquisition. However, if UCSF does acquire the remainder of CED, the existing facility is anticipated to accommodate additional administration and support uses, and the existing surface parking lot is aniticipated to be replaced with a parking structure. Like the Laurel Heights and the Library Release Space projects, an environmental analysis in compliance with CEQA must be conducted regarding the potential impacts of the CED purchase prior to review and approval by the Regents.

Due to the four mile distance between the two facilities, it is not reasonably foreseeable that the environmental effects of the Mount Zion and CED projects would overlap. Nonetheless, where potential interrelationships between CED and Mount Zion might affect the environment, such relationships have been taken into account in the analysis of environmental impacts contained in Section III. For instance, as mentioned in Section II.D, space at CED could be used for Mount Zion administration and support services, and potential trips by UCSF employees between the two sites has been factored into the Mount Zion traffic analysis contained in Section III.E.

CONCLUSION

Under ideal conditions, UCSF would prefer to keep all of its clinical, research and instructional programs at Parnassus Heights. Grouping interactive and supporting programs in contiguous physical space promotes collaborative teaching and research, efficiency in the utilization of academic resources and successful creation of an identity for programs housed together. The proximity of related disciplines stimulates both formal and informal communication, often leading to novel and productive teaching and research programs.

Given the space constraints at Parnassus Heights, and in conformance with the 1982 *LRDP*, programs related to student services, including core lecture and laboratory courses, and programs with close ties to Moffit and Long Hospitals should remain at Parnassus Heights. The Mount Zion, Laurel Heights and additional CED facilities are proposed as potential locations where patient care and research programs and administration and support services could be established with the fewest negative effects related to decentralization, such as loss of faculty and student interaction, loss of efficiency and related environmental effect resulting from increased travel between facilities, and the duplication of services and equipment.

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Final Strategic Plan

March 22, 1989

University Hospital
University of Kentucky
Medical Center

Lexington, Kentucky

Douglass Group

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in Health Care

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UNIVERSITY HOSPITAL
UNIVERSITY OF KENTUCKY MEDICAL CENTER
LEXINGTON, KENTUCKY
MARCH 1989

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UNIVERSITY HOSPITAL
UNIVERSITY OF KENTUCKY MEDICAL CENTER
LEXINGTON, KENTUCKY
MARCH 1989

UNIVERSITY HOSPITAL MISSION STATEMENT

Introduction

As a constituent unit of the Albert B. Chandler Medical Center, the University of Kentucky Hospital shares, with other Medical Center Units, the responsibility to accomplish the Medical Center's mission of service, education, research and health promotion. Thus, in cooperation with the Medical Center Colleges, the University Hospital will direct its major efforts toward providing quality patient care services to the citizens of Kentucky and, secondly, the region and the nation.

University Hospital Mission

The primary mission of University Hospital is to provide exemplary inpatient, outpatient and community service programs for the Commonwealth of Kentucky and to support the missions of education and research of the Colleges in the Medical Center. In the accomplishment of its mission, University Hospital will:

A. Provide quality, general and specialized inpatient and ambulatory patient care services that are programmatically and fiscally designed to be consistent with the service mission of the Hospital and the educational programs of the Medical Center;

B. Fulfill related legislatively mandated functions commensurate with resource allocations;

C. Develop health care delivery affiliations, enterprises and systems independently and with other members of the health care environment to meet the health service needs and educational needs of the state; and

D. Operate its patient care programs within the resources available, with the objective of assuring its financial viability and maximizing its effectiveness in accomplishing the institution's mission.

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TOPICAL AREA: DEVELOPMENT OF A COMPREHENSIVE HEALTH CARE SYSTEM

Goal:

To develop a comprehensive health care system to meet the service, educational and research missions of the University Hospital.

Objectives:

In conjunction with faculties of the Colleges of the Medical Center, University Hospital will seek:

- To strengthen University Hospital's participation in the delivery of full spectrum of health care in central and eastern Kentucky.
- To develop programs/services that enhance our ability to serve the Lexington marketplace.
- To further strengthen the relationship with Kentucky physicians and other health care providers.

TOPICAL AREA: AREAS OF PROGRAMMATIC EMPHASIS

Goal:

To enhance University Hospital's position as the major regional, referral center. In fulfillment of this goal, University Hospital, in conjunction with its medical staff, will focus resources on areas of recognized or potential program excellence.

Objectives:

- To develop a formal process of utilizing established criteria for evaluation of programs.
- To select a limited number of programs for allocation of resources which produce the desired outcomes of:
  - promotion of mission of the Hospital;
  - enhanced image and visibility of the Hospital and Medical Center;
  - creation of incremental service volumes and improved financial performance of specific programs;
  - coordination of program emphasis and faculty recruitment.

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TOPICAL AREA: INPATIENT BED RESOURCES

Goal:

To provide inpatient bed resources consistent with anticipated program requirements.

Objectives:

- To develop a mechanism to expand beds available for use within the existing licensed bed capacity of 461.
- To develop innovative programs to more efficiently accommodate subacute and observation type patients.
- To explore opportunities to expand beyond licensed capacity.

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TOPICAL AREA: ROLE IN AMBULATORY CARE AND OFFSITE SERVICES

Goal:

To strengthen the position of University Hospital through a comprehensive, medical center-wide approach to ambulatory care programs and facilities.

Objectives:

- To identify and develop, in conjunction with local interests, multidisciplinary patient care programs in eastern and central Kentucky locations.
- To create an environment where ambulatory care is organized and managed in a convenient, accessible manner for all patients.
- To establish ambulatory care systems which are responsive to the changing delivery of medical care.

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TOPICAL AREA: GOVERNANCE MECHANISMS

Goal:

To be governed and managed in a manner which assures sufficient organizational and operational flexibility in fulfillment of the mission, and allows the Hospital to successfully achieve its strategic initiatives.

Objectives:

- To develop an agreement with the Board of Trustees of the University regarding a structure that University Hospital could utilize to participate in acquisitions, joint ventures and other organizational arrangements.
- To review University systems which may influence University Hospital's ability to respond to changes in the marketplace.

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TOPICAL AREA: REFERRING PHYSICIAN RELATIONSHIPS

Goal:

To further strengthen relationships with referring physicians in order to provide the number of patients necessary to support educational needs and specialized patient care programs.

Objectives:

- To maintain an active communication system that keeps referring physicians informed about programs, services and clinical specialists of the Medical Center.
- To ensure that referring physicians have convenient access to clinical services of the Medical Center.
- To ensure that services of the Medical Center are available in a manner consistent with the needs of referring physicians.
- To adjust existing services or develop new services that fulfill the unmet clinical or informational needs of the referring physicians.

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TOPICAL AREA: DEVELOPMENT OF A COMPREHENSIVE HEALTH CARE SYSTEM

Strategies

In response to the need to develop a greater number of patients, strategies include:

1. Pursue acquisition or development of health care facilities consistent with programmatic requirements and fiscal resources.

2. Initiate development and/or placement of specific programs with selected central and eastern Kentucky hospitals consistent with programmatic requirements and fiscal resources. These programs should be highly focused and concentrated in areas with a population base sufficient to insure viability.

3. Develop a formal University Hospital marketing program which will serve as the focal point for marketing of all patient care activities for the University of Kentucky Albert B. Chandler Medical Center.

4. Develop a provider network to serve the state of Kentucky. This network will be developed through affiliation with providers and will develop preferred provider arrangements with defined patient populations.

5. Increase participation in health delivery networks/products and expand managed care programs for target market groups, such as University employees, and other well defined populations.

6. Expand the base of medical care services by providing facilities, systems, and programs conducive to the efficient delivery of medical care.

7. Improve the effectiveness of the Family Practice Department's relationship to the University health care system. This will be performed in conjunction with the College of Medicine.

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TOPICAL AREA: AREAS OF PROGRAMMATIC EMPHASIS

Strategies

1. Implement a formalized programmatic evaluation process using the four phase approach. These phases are:

   A. Conceptual Development - initial identification of services, finances, organization and facility requirements.

   B. Program Evaluation and Selection - evaluation of programs measured against the following evaluation criteria.

      1. Is the program compatible with the service, educational and research missions of the Hospital?

      2. How will the program impact or complement existing programs?

      3. Is the program expandable beyond the existing market area served?

      4. Is the market for this service large enough to justify program emphasis?

      5. Given our present market position, will we be able to achieve a prominent market position?

      6. Will the program improve the financial performance of the Hospital?

      7. Is the pool of available research funds relative to this program large enough to benefit from expansion of research?

      8. Is the service life cycle in a developing, mature or declining phase?

      9. Are there significant technological and regulatory barriers to entry?

      10. Are the human, material, clinical and physical resources needed to carry out the program available and readily attainable, efficiently and economically?

C. Business Plan Development - identification of the specific resources required and outcomes expected.

D. Implementation - allocation of resources to meet defined business plan.

2. Initiate development of program emphasis in cardiovascular, neuroscience and oncological services.

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TOPICAL AREA: INPATIENT BED RESOURCES

Strategies

1. Develop all available beds within existing license including:

   A. Completion of Markey, third floor

   B. Completion of third floor renovation for Psychiatry and Obstetrics

   C. Completion of Markey, fourth floor

   D. Completion of hospital addition shelled space

2. Decompress beds in existing facility through development of subacute bed alternatives such as observation beds, day beds or hotel facility.

3. Obtain beds beyond existing licensed capacity through acquisition, lease or sharing of beds in existing hospitals based on market availability and University Hospital need for inpatient beds.

4. Evaluate the need for inpatient bed resources for appropriate placement of patients. This would include:

   A. Rehabilitation beds

   B. Skilled nursing facility beds

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TOPICAL AREA: ROLE IN AMBULATORY CARE AND OFFSITE SERVICES

Strategies

1. Improve Hospital and College of Medicine ambulatory care facilities, systems and organization in order to develop an accessible, efficient and convenient ambulatory care setting.

2. Develop off hour clinics in present clinic space.

3. Develop offsite clinics in our service area targeted at specific population groups consistent with educational needs and program development plans.

4. Establish with existing providers, clinical services and programs central and eastern Kentucky. This would be performed through an organized effort of the Hospital and College of Medicine.

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TOPICAL AREA: GOVERNANCE MECHANISMS

Strategies

1. Develop proposed revised University Hospital structure for use in acquisitions, joint ventures and other organizational arrangements.

2. Appoint a task force to identify opportunities for improvement in University systems.

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TOPICAL AREA: REFERRING PHYSICIAN RELATIONSHIPS

Strategies

1. Implement mechanisms to communicate with referring physicians through advanced data and voice communication systems.

2. Establish a mechanism to collect and store data and respond appropriately to each patient referral.

3. Initiate ongoing physician and patient satisfaction market research with a defined mechanism to resolve identified deficiencies.

University Hospital

Strategic Plan

University of Nebraska
Medical Center

March 1991

Executive Summary

University
of Nebraska
Medical Center

University Hospital

Strategic Plan

[redacted]

March 1991

Vision

Total Customer Satisfaction Through Continuous Quality Improvement

Mission

University Hospital stands committed to providing the highest quality patient care and environment for health sciences education and research.

Executive Summary
University Hospital Strategic Plan
University of Nebraska Medical Center
March 1991

Introduction

Good strategic planning provides a basis for more effective problem-solving by providing a framework for anticipating problems and for generating alternative solutions. University Hospital and the University of Nebraska Medical Center have recognized the need to plan the future direction of their organizations through formal strategic planning since 1983.

The 1990-91 strategic planning process has been comprehensive and coordinated to ensure a focus on issues and involvement. The driving force behind the process is University Hospital's commitment to be the best in academic teaching hospitals and to integrate continuous quality improvement into the fabric of the organization.

The process was developed and coordinated by the Director of Planning and Market Development and has involved key groups within University Hospital and the UNMC campus, including the Board of Governors, Clinical Chiefs, Section Chiefs, Chancellor's Advisory Council, Hospital Administration and the Medical Center Management Organization (MCMO).

Guidance was provided by the Strategic Overview Group, consisting of the Hospital Director, Associate Directors, Chief of Staff, Dean of the College of Medicine, the Medical Director of the Clinical Practice Board and the Director for Planning and Market Development, with the Director for Employee Development serving as facilitator. For the first time, members of Hospital Administration, Management Services and Planning and Marketing have developed subsidiary operating, financial marketing and capital/facilities plans.

A formal evaluation of the plan and its subsidiaries will be conducted annually, with more frequent reassessment as necessary.

A Changing Health Care Environment

Numerous economic, social, and demographic factors are influencing the nation's health care system today, many of which are significantly impacting the delivery of health care. Advancements in medicine and technology are also radically changing the provision of health care. The future of this nation's health care system will be dictated by how today's providers respond to these changes and advancements.

An increasing number of Americans are without adequate health insurance coverage. The situation across Nebraska is worsening due to the sluggish rural economy and, within Omaha, due to an increasing number of jobs that offer few, if any, health insurance benefits. Academic medical centers have traditionally been the main providers of indigent care. University Hospital (UH) is no exception, providing about one-third of Omaha's indigent care. Federal initiatives to address this growing problem are not likely to occur for a few years until significant progress is made toward reducing the federal deficit.

Increasingly, "managed care systems," such as HMOs and PPOs, are negotiating contracts with health care providers in attempts to control health care costs through lower utilization and discounts on services.

Typically, academic teaching hospitals are not the first choice of purchasers in choosing health care providers due to the perception of their higher costs. UH has an opportunity to build better relationships with these groups, educating them about when and why costs may be higher and of the higher quality of care associated with an academic medical center. At the same time, UH must become "market sensitive" to managed care systems by knowing its actual costs of delivering care and more effectively managing utilization of its services, which will increase its ability to enter into contractual arrangements.

While use of inpatient services is decreasing, Omaha still has one of the highest inpatient utilization rates in the country. Managed care has not yet had a significant impact on the local health care market. When it does, the existing surplus of beds in Omaha will intensify competition for patients between providers.

Cost containment initiatives of the 1980s, such as managed care systems and the federal government's prospective payment system, do not address the underlying issues of rising health care costs: an aging population, rapid proliferation of expensive technology, and higher costs of scarce hospital labor and supplies. Hence, by the mid-1990s, significant changes in the structure, delivery and financing of health care may occur.

Cost containment efforts and advances in health care delivery have decreased inpatient use, creating excess hospital beds. UH has a unique problem of not having enough beds to support UNMC's growing clinical programs. During the 1990s, UH's challenge is to have enough beds available to accommodate UNMC's growth, while limiting its growth in expenses to a reasonable level.

Technological advancements in medicine have broadened the range of diagnostic and surgical procedures safely performed without hospitalization. Many have proven to be cost-effective by reducing hospital stays and eliminating the need for some types of care. Locally, the acquisition of new high-tech services by providers is very competitive, resulting in extensive duplication of some high-tech services. UH must have sufficient capital dollars to purchase expensive and, very often, first generation technology in order to stay on the leading edge, which is absolutely necessary for an academic medical center and teaching hospital.

A widespread staffing shortage exists in hospitals across the country. The post-baby boom era and more career opportunities for women have meant a smaller pool of applicants from which nursing and allied health programs can draw. Nebraska's shortage of nurses and allied health personnel is worsened by the fact that other states are recruiting Nebraska-trained students. UH is addressing this by developing aggressive recruitment and retention strategies for nursing and other "hard to recruit" positions and linking up with UNMC's professional schools.

Quality of care has become a major issue in health care during the last few years. Its definition and measurement is being debated among political, business, payor and provider groups. Successful health care providers will demonstrate their provision of high quality care at a reasonable cost. UH's commitment to continuous quality improvement will drive organizational endeavors to support the delivery of efficient quality care. Management believes this process is most urgent to face all the other critical environmental issues.

Rural health care is undergoing turmoil and transformation. As the nation's population continues to migrate to the nation's large cities and mid-sized communities, physician availability in many small communities has decreased. Six hospitals in Nebraska's rural areas closed during the past five years. Yet, hospitals in Nebraska's mid-sized communities have benefited from an increase in physician specialists and subspecialists, and have become regional referral centers, diverting patients away from larger medical centers in Lincoln and Omaha. UH must work closely with UNMC in addressing the rural health care needs of Nebraska, searching for innovative solutions that address the structure of rural health delivery.

The growth in consumerism has provided a challenge for UH and other health care providers to accommodate a more aggressive consumer, including the general public and insurance companies, in terms of services offered, prices of the services and convenience in accessing those services. UNMC must be especially cognizant of this in the delivery of outpatient services, which usually serves as the patient's first point of interaction with UNMC and functions as a primary feeder to its inpatient services.

University Hospital's Present Position and Future Challenges

UH has been successful in securing and increasing its market position over the past few years as utilization for its services continued to grow. Its market share has increased significantly, although it has leveled off during the past year, primarily due to a lack of bed availability. UH's referral base for patients now spans the entire nation and several foreign countries.

Through the University Health Care Project and Lutheran lease arrangement, UH is addressing many of its space problems. Increased utilization has intensified the need for appropriate inpatient beds and support space. UH management continues to address the long-term need for inpatient space.

UH faces an increasingly competitive local and regional market. As specialty care becomes available at a growing number of hospitals across the state and region, UH's source of patients is becoming unsure. This has been evident by the declining number of referring physicians and referrals to UH during the past three years.

While UH has continued to remain profitable over the past several years, its source of revenue has narrowed to a few of its clinical specialties. Also, payor mix has begun to weaken as UH's patient origin indicates a growing percentage of patients from Omaha. Payor mix has a significant impact on UH's ability to maintain financial viability. Continued deterioration will only decrease UH's ability to remain profitable.

Like many academic teaching hospitals, UH's costs of providing care are high. However, UH's costs are much higher than most other academic teaching hospitals. While this can partially be attributed to UH's education commitment, much of it is operational inefficiency and a significant growth in the number of staff over the past few years. The high profitability of UH's transplant services has made the need to address its high costs and operational inefficiencies less apparent.

UH management has realized that future viability and competitiveness will only be guaranteed through adopting a vision of "Total Customer Satisfaction through Continuous Quality Improvement." This drive for

quality will completely change organizational philosophy, culture and the "way of doing business." The foundation of UH's quality integration will be the definition of quality by its various constituent groups, including patients and public, referring physicians, house officers and medical students, employees, payors and employers. The ultimate impact will be the provision of the best patient care possible provided at a reasonable cost. UH's quality commitment is in support of UNMC's total quality management philosophy.

UH's past success is due to many factors, including its relationship to UNMC, dedicated and competent staff, quality nursing care, the broad expertise and young age of its medical staff, a work atmosphere characterized by "esprit de corps," progressive management, financially strong payor mix, and its geographic location for tertiary referrals.

However, UH also faces many weaknesses which must be overcome if it is going to continue building on its past accomplishments. These include high cost of providing care, lack of operating efficiency, old and overcrowded facilities, lack of inpatient beds, weak management of human resources, communication between UH and the College of Medicine, inadequate information systems, weak local image, inconsistent and declining referral patterns, lack of depth and diversification of clinical services and a lack of capital accumulation.

What follows are the strategies, strategic goals and objectives derived from a comprehensive analysis of UH's external environment and an in-depth internal assessment. UH's vision for quality underlies each strategy. The strategies, strategic goals and objectives and supporting operating, financial, capital/facilities and marketing plans will be instrumental for UH in defining where management and marketing attention will be focused and to provide direction in program planning and budgeting efforts. UH's strategies focus on:

Determining the appropriate mix of and support for UNMC clinical services, which involves better planning and communication with the College of Medicine, determining appropriate management and support strategies for UH's clinical services based on their strengths, academic mission, visibility and financial contribution;

Developing a hospital culture supportive of employee needs, which focuses on effective management of UH human resources and the implementation of continuous quality improvement;

Improving UH's operational efficiency to strengthen service delivery and financial viability, which addresses efficient resource allocation, cost-effective management and the development of quality-oriented information systems for administrative and clinical decision-making; and,

Improving UH's image among its diverse constituent groups, which focuses on better addressing referring physician and house officer needs and concerns, developing a market-oriented pricing philosophy, and appropriate positioning of UH's clinical services to secure a strong payor mix of patients.

It is essential that all UH staff have a clear understanding of the direction of the University Hospital and of their vital role in further positioning the hospital as a leader in quality patient care, education and research to Nebraska and beyond.

Vision
Total Customer Satisfaction through Continuous Quality Improvement

University Hospital Strategic Directions

Note: The following is confidential information for internal usage only.

Strategy I

Determine the appropriate mix of and support for UNMC clinical services to achieve the highest collective quality in patient care, education and research.

GOAL I.1: Increase joint planning and decision-making efforts between UH and the College of Medicine to strengthen shared commitments and program endeavors.

A. Assess the role, structure and process of planning between UH, the College of Medicine and the Clinical Practice Board.

B. Enhance communication between UH, College of Medicine and the CPB on programmatic, space, recruitment, marketing, financial and other issues that impact their abilities to support clinical programs.

C. With the College of Medicine and CPB, investigate the sharing of investment and risk for new programs and services to encourage strong joint commitments.

D. With UH medical staff, establish a model to integrate quality assurance, quality improvement for clinical services.

E. With UH medical staff, address medical ethical considerations in patient care activities.

GOAL I.2: Provide significant support to clinical services which have a strong national presence and competitive position and make a significant contribution to UH's financial viability.

A. Provide appropriate management support to UH's solid organ and bone marrow transplant and orthopedics programs.

B. Develop strategic and marketing plans for each of these services in order to determine their future direction and assure the necessary support from UH and the College of Medicine.

C. Commit appropriate resources to enhance collective quality and competitive strengths of these services.

GOAL I.3: With the College of Medicine, appropriately position clinical services that have the need for increased visibility, have potential for financial turnaround or contribute to UNMC's academic mission.

A. Determine management strategies to meet the needs and the level of resources UH is able to provide to these services which include:

- Diabetes/Endocrine/Metabolic
- Family Practice
- Gastroenterology
- General/High Risk Obstetrics
- Gen. Hematology/Oncology
- General Internal Medicine
- General Surgery
- Geriatrics/Geropsychiatry
- Neonatology
- Ophthalmology
- Otolaryngology
- Pediatrics
- Pulmonary
- Psychiatry
- Urologic Surgery
- Vascular Surgery

B. Commit appropriate resources or identify potential partners in the provision of these services to develop a strong local or regional presence and better meet the academic needs of the campus.

GOAL I.4: Invest in new programs that have the potential of becoming financially viable and highly competitive at the regional level.

A. Determine the most appropriate management and development strategies for these services, which include:

- Cardiology/CT Surgery
- Gynecological Oncology
- Neurosciences
- Reproductive Med.

B. Position UH as the high quality regional provider of these select services as they are developed.

C. Develop a model to analyze all new proposed programs to determine resource requirements, competitive potential, financial feasibility and overall education and research benefits.

D. Commit the necessary space, capital and other resources required for the success of identified programs.

E. Continuously identify customer needs to determine potential new programs/services.

GOAL I.5: Effectively manage the present and future mix of UNMC's clinical services.

A. Assess the current organizational structure and the method for providing administrative attention needed by clinical services, considering

the individual talents and strengths among UH management.

B. Develop an organizational structure which integrates financial, marketing and operational planning into quality management.

C. Creatively manage resource usage, recognizing the scarcity of staff and capital resources.

D. Provide necessary inpatient facilities and support space to support the changing needs of clinical services.

Strategy II

Cultivate a hospital culture which is supportive of employee needs and development, open communication, and enhances continuous quality improvement.

GOAL II.1: Manage UH human resources consistent with UNMC's quality vision to enhance employee satisfaction, morale and retention.

A. Empower employees to take initiatives to make their own jobs more effective to solve problems and enhance service at their own level.

B. Support the development of UH employees in their positions and career paths, recognizing the diversity in skills and talents each brings to the organization.

C. Investigate flexible reward mechanisms to reward employees for continuous quality improvement efforts.

D. Demonstrate to each employee the importance of his/her role to the overall organization.

E. Reinforce teamwork by rewarding team effort above individual endeavors.

F. Consider overall psychosocial needs of employees in addressing employee issues.

G. Recognize UH's obligation to promote and support employee wellness.

H. Develop a human resources plan to address future human resource availability and UH's ability to recruit and retain staff.

GOAL II.2: Implement continuous quality improvement processes within UH to support UNMC's quality commitment.

A. Begin awareness building of UH's commitment to continuous quality improvement among UH staff.

B. Complete quality training of all senior managers within one year.

C. Complete quality training of all middle managers and supervisors within two years.

D. Improve communication within UH's management structure in order to enhance cross-functional problem-solving, teamwork efforts and overall management effectiveness.

E. Assess various components of UH operations which have created ongoing patient concerns.

F. Determine UH's cost of quality.

G. Develop an effective model which utilizes a team approach to problem-solving.

H. Within twelve months, develop a separate quality subsidiary plan which extends beyond staff training.

Strategy III

Improve the operational efficiency of University Hospital to strengthen the quality of service delivery and financial viability.

GOAL III.1: Become more cost-effective by increasing productivity and utilization management.

A. Develop a better understanding of UH's cost of providing clinical care in order to control cost increases and possibly achieve cost decreases.

B. Determine the impact of education and research on the cost of providing patient care.

C. Increase understanding of UH's relative operational and financial position to compete on the basis of overall operational efficiency.

D. Educate all medical staff, employees and students on the importance and effective use of the productivity monitoring and cost accounting systems.

E. Integrate available resource monitoring tools, e.g. Medisgroups, Productivity Monitoring System, into cost control efforts at all levels of management.

F. Give managers accountability for managing productivity and costs within their respective areas.

GOAL III.2: Allocate resources to maximize efficiency and return on investment.

A. Build a management model to determine the most effective method for allocating resources.

B. Assess the acquisition of all new technology to assure clinical and cost-effectiveness and the contribution to clinical position.

C. Develop an alternative model for sharing technology investment with appropriate partners.

GOAL III.3: Invest in quality-oriented integrated information systems that provide timely and reliable support to strengthen administrative and clinical decision-making within UH, the College of Medicine and the CPB.

A. Within nine months, conduct a comprehensive assessment of present and future information needs from a management, marketing, financial, clinical and overall quality perspective.

B. Within twelve months, develop common data and information parameters for management decision-making.

C. Within twelve months, recommend a method of providing integrated financial systems.

D. Within two years, develop desktop PC access among managers to online financial, marketing and clinical utilization data for effective administrative decision-making.

E. Begin reporting cost, profitability, payor mix, patient origin, and referring physician information by clinical service/product line on a quarterly basis with the ultimate objective of up-to-date online access within two years.

Strategy IV

Improve University Hospital's image and appropriately position it as a major midwestern medical center to enhance UH's overall financial viability and competitive capability.

GOAL IV.1: Increase UH effectiveness in meeting the needs of current and potential UH referring physicians to maintain existing referrals and expand referral sources.

A. Upon completion of referring physician survey, assess and communicate results to address physician perceptions and their experiences in referring to UNMC.

B. Explore more effective ways of communicating with referring physicians.

C. Develop methods to continuously assess changing needs of referring physicians.

D. Define UH's role in outreach efforts.

E. Determine most effective role for UH in UNMC's Rural Health Education Network activities.

GOAL IV.2: Develop a pricing philosophy and process to ensure UH's ability to price its services according to market forces, competitive position of specific services, and the need to ensure financial viability.

A. Determine UH's true cost of providing services by type of patient and clinical service/product line.

B. Create innovative pricing structures, utilizing financial and marketing resources, that will enhance competitive positioning of select clinical services.

C. Increase awareness of UH specialty services among employers.

D. Develop a contracting philosophy to maximize UH's financial and competitive viability while considering UH's availability of resources.

GOAL IV.3: Become the hospital of choice for select specialty services among consumers in Nebraska and western Iowa in order to expand local and regional market share.

A. Upon completion of the House Officer/Student and Public/Former Patient surveys, assess and communicate results to address their experiences with and perceptions of UH/UNMC.

B. Utilize UH/UNMC staff as public relations advocates for UH/UNMC clinical services.

C. With the CPB, develop aggressive marketing strategies to position specialty services in the minds of consumers and referring physicians.

D. Build relationships with local employers to increase their awareness of UNMC's various services.

E. With the CPB, develop program, marketing and operational plans which recognize the UNMC clinics as the point of entry for UNMC's patient care programs.

GOAL IV.4: Improve local image of UNMC's clinical services in order to achieve a more favorable payor mix of local patients.

A. Develop coordinated marketing and public relations strategies with the College of Medicine and CPB that differentiate UNMC's services through quality and academics.

B. Educate employers and third-party payors on the unique and vital role of UNMC in health care delivery.

C. Develop a public relations plan that recognizes UH's constituent groups.