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THE HOSPITAL ADMINISTRATOR: YESTERDAY, TODAY, AND TOMORROW

An Analysis of the Changing Responsibilities of the Hospital Administrator in Response to the Needs and Wants of Constituent Groups.

A Dissertation Submitted to

Golden Gate University

in Candidacy for the Degree of

Doctor of Business Administration

by

Andrea Merrick Scheffelin

San Francisco, California

April 1995

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This Dissertation, as Submitted by

Andrea Merrick Scheffelin

in Partial Fulfillment of the

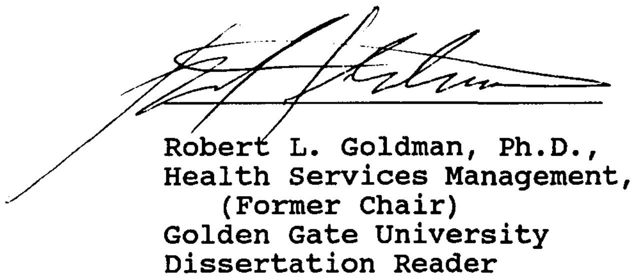
Requirements for the Degree,

Doctor of Business Administration,

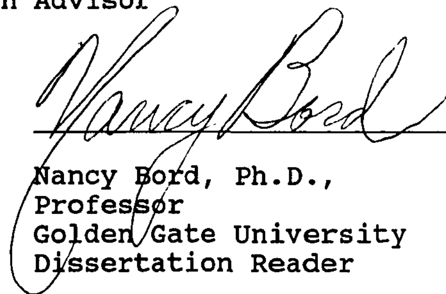
Golden Gate University,

Has Been Approved.

Edwin P. Merwin, Ph.D.,
Senior Adjunct Professor
Golden Gate University
Dissertation Advisor



Robert L. Goldman, Ph.D.,
Health Services Management,
(Former Chair)
Golden Gate University
Dissertation Reader



Nancy Bord, Ph.D.,
Professor
Golden Gate University
Dissertation Reader

Abstract for the Dissertation by:

Andrea Merrick Scheffelin

Advisor: Edwin P. Merwin, M.P.H., Ph.D.
Senior Adjunct Professor

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

An Analysis of the Changing Responsibilities of the Hospital Administrator in Response to the Needs and Wants of Constituent Groups.

An analysis of hospital administrators' roles in the past compared to current roles and expected future roles revealed a dramatic shift from the administration of a single hospital site by a medical professional to the administration of a major managed care health system or center by an equally well-trained business executive.

The period of "Yesterday" begins after World War II (1946) and continues until the advent of the Diagnosis Related Groups (DRGs) in 1983. Past data was gleaned from the literature.

The period of "Today" begins with the introduction of the DRG program in 1983 and is projected forward until the year 2000. Data was gathered from mailed questionnaires to the administrators of 100 hospitals in California.

The period of "Tomorrow" begins with the year 2000. Data was garnered through interviews with eighteen experts in the health care field.

Based on this analysis, a number of findings were reported. The major conclusions are as follows:

1. Administrators will be expected to be knowledgeable and competent in the business, financial, hospital information

systems, legal, negotiation skills, and human resource management aspects of health care administration.

2. Administrators will be expected to comply with rapid changes in laws, regulations, and guidelines in the operation of their facilities.

3. Administrators will be expected to be well-versed in the art of good communication, orally and written, as well as in the unspoken art of body language.

4. It is imperative that the administrator gain and maintain the trust of all those with whom he or she contacts.

The following recommendations were made:

1. Schools of Public Health should examine their curricula and intensify emphases on business, financial, hospital information systems, legal, negotiation skills, and personnel management aspects of the administration of major business enterprises which includes individual hospitals in addition to other health care settings.

2. Public health and other governmental agencies should strengthen their collaborative relationships and continue to reduce any conflicting laws, regulations, and guidelines on the operation of health care systems and hospitals.

3. Interested individuals should continue to monitor the operation of hospitals for efficient and effective provision of health care services.

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

An Analysis of the Changing Responsibilities of the Hospital Administrator in Response to the Needs and Wants of Constituent Groups.

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ORGANIZATION OF DISSERTATION

This document is organized into four chapters and ten appendices.

Chapter One, General Information, contains the Hypothesis, Statement of Objectives, General Background Information, Definition of Key Terms, Limitations of the Study, and Research Questions.

Chapter Two, Methodology, describes the Data Capture Frameworks, Delphi Process, Field Test, Questionnaire, and Structured Interviews.

Chapter Three, The Historical and Current Contexts of the Role of the Hospital Administrator, consists of six sections, one for each of the six constituent groups: Board of Trustees, Medical Staff, Other Staff, Patients, Community, and Third-Party Payers. Each section contains a description of the group, followed by tabular presentations of the findings, comparing responsibilities from "Yesterday" and "Today."

Chapter Four, The Future Role of Hospital Administrators as Health Care Managers, summarizes the content analysis of the responses to eleven discussion questions from eighteen experts in the health care field. These comments address the predicted future responsibilities of hospital administrators as health care managers.

The ten appendices are in the following sequence: Data Capture Frameworks of Eight Constituent Groups, Delphi Process, Questionnaire, Questionnaire Item Descriptions, Structured Interviews, California Hospital Characteristics, Analysis of Curricula of American Schools of Public Health, List of Tables, Cited Sources, and Selected Bibliography.

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Many thanks go to the fifty-four hospital administrators who found the time to fill out the six-page questionnaire sent as the data collection instrument for the time period "Today."

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EXECUTIVE SUMMARY

An analysis of hospital administrators' roles in the past compared to current roles and expected future roles revealed a dramatic shift from the administration of a single hospital site by a medical professional to the administration of a major managed care health system or center by an equally well-trained business executive.

Based on this analysis, a number of findings are reported, conclusions are drawn, and recommendations are made. The major findings are listed first, followed by the four conclusions and the three recommendations. Emphasis is placed on the future role of hospital administrators.

Findings from "Tomorrow"

At one time, hospital administrators were often hired on their fund-raising expertise and ability to establish rapport with people, such as involvement in community affairs, networking with the business establishment, and other social contacts with physicians and members of the Board of Trustees. The administrators were not trained as managers; they took no business classes. That was acceptable as long as hospitals had no problems with funding. However, now that health care insurance companies are often reducing reimbursement rates, and many hospitals are merging into health care systems, future as well as current

administrators must become at least health care managers, if not executives of health care systems.

Organization of Hospitals

The most predominant aspect will probably be new forms of organization of health care systems, to include the different areas of focus for which each chooses to emphasize.

Individual Hospitals

In rural areas a small, general hospital may not change, nor need to. Many other individual hospitals have decided they cannot maintain full-range health care services, and are downsizing or even closing, or finding new niches and specializing. For example, there will always be a need for some high technology, tertiary care facilities to perform sophisticated, complicated procedures such as transplants.

One of the major changes has been the perspective given to the inpatient load of a hospital. Hospital administrators have generally wanted to maximize their inpatient population. The health care provider community has recently determined that outpatient care is often better and usually provided at a lower cost. Now, after surgery, most people have fewer inpatient hospital days than twenty or thirty years ago, and more procedures are being done on an outpatient basis. As a result of this trend, many hospitals are decreasing

inpatient care services and increasing outpatient care services.

In response to the competition of Health Maintenance Organizations (HMOs) and other managed health care organizations, many individual hospitals are developing and promoting wellness programs and home care services. Therefore some hospitals will become centers for illness prevention, not only in the care of the sick or injured. Some future health care organizations may become dedicated to prevention of health problems.

Health Care Systems

Because of the increasing market for health care services, some hospitals are planning to grow. Some are building a full range of services to accommodate the foreseen increased needs. Other hospitals have found it prudent to merge with other hospitals or health care organizations in larger systems. They can become more integrated by purchasing third-party payers and Independent Practice Associations (IPAs)[1]. Health care corporation models will become more prevalent and dominant.

The survivability of an individual hospital within a system may not be nearly as threatened, because of its system affiliation. Yet, a health care system can

---

[1]An IPA is a prepaid health services system in which office-based physicians contract for the care of patients on a pre-negotiated fee-for-service basis.

become so large it evolves into a bureaucracy. Its focus may change, such as working to develop new products to fit its financial structure. Some of those systems will develop strategies to provide high quality care with appropriate care, at a reasonable cost.

Health Care as a Business

Health care is a service industry, and as such, hospitals must be run as businesses. Until recently, hospitals have been reluctant to look at other businesses to see how non-health care related government regulations will affect them. Such non-health care government regulations require additional emphasis on health care planning.

Health care institutions are much more flexible toward real time planning. In the past, hospitals had the privilege of forming five or ten year plans; now, two to three years into the future is all that can be projected. This need for planning requires addition emphasis of all who are concerned with the management of hospitals.

Currently, the three-legged stool of administration of a hospital is composed of three groups, the Board of Trustees, the medical staff, and the administrator. Occasionally there has been strife, especially between the administrator and the medical staff. Possibly a new stool will emerge, consisting of the third-party payers; the medical staff; and the

hospital, which will include the hospital administrator and the Board of Trustees. The new relationships among the groups will need to become more cooperative and collaborative.

Medical Staff

Hospitals are the places of work for physicians and others who treat or care for patients. The relationships are changing between hospitals and physicians. Some hospital administrators are trying to persuade their physicians to become involved more in the hospital. Most health care organization welcome the increased physician involvement in management.

Future hospitals will need to cooperate better with physicians, and not be in competition. One method is jointly to find the best treatments, share the knowledge, and increase the effectiveness of the system. Another could be to integrate physicians with hospital information systems to the advantage of both.

Patients and Community

Since hospitals exist primarily for the care and treatment of patients, hospitals can increase good outcomes by providing patients with more information, knowledge of support groups, outpatient clinics, and patient representatives. Patients often have an informal support system with family and friends, but the family usually consents with what the physician recommends.

Hospital administrators will need to look at the larger picture, not just the acute care episode of the patient, and the costs associated with direct services. The larger picture includes services to the community, and partnerships with constituents. Another method to benefit the community is to share specialized equipment, to more fully utilize each unit, and reduce duplication of expensive technology.

Findings from Comparing "Yesterday" and "Today"

The findings from the comparative analyses from "Yesterday" to "Today" of the wants and needs of the constituent groups showed changes in ratings of items, suggesting changes in importance for the responsibilities of the hospital administrators as follows:

1. The responsibility that remained highly important to the Constituent Group **Board of Trustees** was maintenance of financial solvency. Other highly important responsibilities were trust as an administrator, quality care, understanding of hospital's goals and purposes, and accountability from physicians and management.

2. The responsibilities that remained highly important to the Constituent Group **Medical Staff** were high quality of patient care and cooperation and trust from hospital administrator. Other highly important responsibilities were highly skilled nurses/other

staff, good reputation of hospital, good communication, and high quality of other physicians on staff.

3. The responsibilities that remained highly important to the Constituent Group **Other Staff** were good communication, fair performance appraisals, and appropriate salary ranges. The added highly important responsibilities were trust as an administrator, good supervision, job satisfaction, good working conditions, and protection from infectious diseases.

4. The responsibilities that remained highly important to the Constituent Group **Patients** were competent medical personnel/quality care, treated with respect/ consideration/dignity, safe environment in the hospital, understanding/compassion/empathy, and protection from infectious diseases/iatrogenics/ nosocomial infections. Other highly important responsibilities were responsiveness to patient's needs, protection from medication errors, emergency room availability, and confidentiality.

5. The responsibility that remained highly important to the Constituent Group **Community** was cost containment. Other highly important responsibilities were equality of access, comprehensive health care, patient information, and positive relations with the local media.

6. The responsibilities that remained highly important to the Constituent Group **Third-Party Payers**

were reasonable cost reimbursement, efficient allocation of resources, and elimination of unneeded care. Other highly important responsibilities were quality care, willingness to negotiate contracts, and protection against over-utilization.

Conclusions

The conclusions of the content analysis of health care experts' predictions for "Tomorrow," and from the comparisons between "Yesterday" and "Today," synthesized over all constituent groups, indicate the extent of predicted changes of responsibilities as follows:

1. Administrators will be expected to be knowledgeable and competent in the business, financial, hospital information systems, legal, negotiation skills, and human resource management aspects of health care administration.

2. Administrators will be expected to comply with rapid changes in laws, regulations, and guidelines in the operation of their facilities.

3. Administrators will be expected to be well-versed in the art of good communication, orally and written, as well as in the unspoken art of body language.

4. It is imperative that the administrator gain and maintain the trust of all those with whom he or she contacts.

Recommendations

This shift in roles, which is still continuing, leads to the following recommendations:

1. Schools of Public Health should examine their curricula and intensify emphases on business, financial, hospital information systems, legal, negotiation skills, and personnel management aspects of the administration of major business enterprises which includes individual hospitals in addition to other health care settings.

2. Public health and other governmental agencies should strengthen their collaborative relationships and continue to reduce any conflicting laws, regulations, and guidelines on the operation of health care systems and hospitals.

3. Interested individuals should continue to monitor the operation of hospitals for efficient and effective provision of health care services.

These recommendations are based on analyses of interviews with experts in the health care field, results of surveys of hospital administrators in California, and an extensive review of the literature. The analyses for the past and present roles were conducted on the needs and wants of the six constituent groups: Board of Trustees, Medical Staff, Other Staff, Patients, Community, and Third-Party Payers.

A content analysis was performed on the interview material.

(Note: In the body of this dissertation, the reader may note an apparent lack of references in footnotes. Because of the multiplicity of sources used, and the repetition of items by author, the logistics of this dissertation precluded citing each and every reference regarding each particular concept.)

CHAPTER ONE: GENERAL INFORMATION

1. HYPOTHESIS

The spectrum and type of responsibilities of hospital administrators has not changed from Yesterday to Today, and is not expected to change for Tomorrow.

2. STATEMENT OF PURPOSE

The prime purpose of this dissertation is to explore the historical responsibilities of hospital administrators to their constituent groups, study and clarify the continuing responsibilities of current administrators, project the expected changes in anticipated responsibilities for future administrators, and make recommendations for curriculum content for Schools of Public Health, public health agencies, and other agencies interested in the field of health care administration.

3. GENERAL BACKGROUND INFORMATION

Today's hospital administrator is the leader of a health care system of which the hospital is the major core or function, around which satellite facilities, providers, functions, and services interact, with patients being referred within the system and/or to outside providers. With the advent of the Diagnosis Related Groups (DRGs)[2] concept in 1983, physicians no

[2]DRGs are categories that cover most illnesses and injuries that determine how much hospitals are paid for the treatment of Medicare patients.

longer have the primary role in ensuring that people have access to all health care facilities. Physicians are the admitting authority and the gatekeepers to the health care system, but it is the hospital administrator who ensures that all the functions of the health care facility are integrated, running smoothly, and available to the patient. As more ancillary centers, other health care providers, services, and a greater variety of patients are added, hospital administrators of the future will find their responsibilities drastically changing.

A hospital administrator has always had responsibilities to a number of constituent groups. The number and type of such groups has undergone a substantial change. In the past, many hospital administrators were either physicians or nurses. Typically, the administrator's primary objective was to assure the provision of quality patient care within an acute care hospital. A secondary objective was the administration of the physical setting.

With the advent of Medicare, Medicaid, and other third-party payers, hospital administrators soon discovered that their primary responsibilities were changing. The need for total planning and operation of a large, complex business center began to predominate. Thus, the field of hospital administration became

separated from the field of medicine and has become more comparable to a major business enterprise.

California hospital administrators are facing unprecedented challenges in managing such major business enterprises with rising costs and diminishing reimbursements, all in an environment of increasing demand for the amount and sophistication of health care services. By the year 2010, California's population is expected to rise from its current level of over thirty million people to forty-five million. The need for health care facilities and services, and thus administrators of these facilities and health care systems will grow proportionately. The education, training, and responsibilities of the administrators must change in relation to the demand.

Although many books and articles have been written on the general topic of hospital administration, there is a lack of current, relevant, and scholarly information on the scope of the responsibilities of hospital administrators. Further, there is little information on the range and type of responsibilities anticipated to be necessary for hospital administrators of the future, particularly after the year 2000.

4. DEFINITION OF KEY TERMS

Time Periods

The period of "Yesterday" begins after World War II (1946) and continues until the advent of the Diagnosis Related Groups (DRGs) in 1983.

The period of "Today" begins with the introduction of the DRG program in 1983 and is projected forward until the year 2000.

The period of "Tomorrow" begins with the year 2000.

Constituent Groups

Board of Trustees/Directors: Usually composed of business leaders of the community, physicians, and consumer members.

Medical Staff: All physicians who currently have treatment privileges at the health care facility, or any of its ancillary services locations, or clinics.

Other Staff: All non-physician persons employed, or volunteers utilized, by the health care facility.

Patient: A person who is, or has been, under some type of medical care or treatment, either in the health care facility, ancillary centers, or as an outpatient referral by a physician.

Community: The community is composed of many inter-related and overlapping groups. Some examples are: minority/ethnic groups, the media, researchers, service groups such as Rotary, Lions, Kiwanis, City Councils

and County Boards, planning commissions, other organizations, businesses, and individuals.

Third-Party Payers: Private health care plans such as the Foundation Health Plan, Blue Cross, or Omni Plan, and government programs such as Medicare, Medi-Cal, CHAMPUS, medically indigent adults (MIAs), and other publicly-funded programs.

5. HOSPITAL CHARACTERISTICS

During the proposal for this dissertation, the Doctoral Studies Committee expressed an interest in seeing an analysis based on the six commonly utilized characteristics of hospitals (profit/not for profit, geographic location, size as determined by the number of beds, membership in a health care system, and the category within the United States classification coding system) within California. However, because this analysis would have produced 840 cells, hundreds of cells would have been empty, and the majority of the rest would have contained only one or two hospitals. Therefore, any analysis of a comparison among these cells would have been meaningless.

Appendix F contains a more complete description of the characteristics of hospitals in California, and tables showing each hospital in five groups: sampled general hospitals whose administrators responded to the questionnaire; sampled general hospitals whose administrators did not respond to the questionnaire;

non-sampled general hospitals; summary of all general hospitals in California; summary of all sampled general hospitals in California.

6. LIMITATIONS OF THE STUDY

The data for "Yesterday" were obtained from publications and unpublished manuscripts dealing with hospital and health care administration available in the State Library in Sacramento, the library at the California State University, Sacramento, and the libraries at Golden Gate University, San Francisco and Sacramento campuses, including computer research of other library holdings.

The data sources for "Today" were the responses to the questionnaires sent to the administrators of one hundred general hospitals in California. Because of numerous problems, this was not a random sample of all California hospitals, and it is not necessarily applicable to all American hospitals.

The data sources for "Tomorrow" were interviews with a broad spectrum of eighteen persons, either hospital administrators or professionals knowledgeable of the health care field.

7. RESEARCH QUESTIONS

The research questions to be addressed are:

(1a) How have hospital administrators' responsibilities to constituent groups changed from Yesterday to Today?

(1b) How are such responsibilities expected to change for Tomorrow?

(2) What are some of the conclusions to be drawn from such changes?

(3) What recommendations can be made to Schools of Public Health, public health agencies, other governmental agencies, and interested individuals in response to the anticipated changes?

The discussion to Question 1a is contained in Chapter Three, Question 1b in Chapter Four, and Questions 2 and 3 in Chapter Five.

Because one of the major purposes of this report is to make recommendations to Schools of Public Health, especially pertaining to their curricula, an analysis of the required and elective courses for a graduate degree in Health Care Administration or related field was performed on nineteen schools. All courses were listed under major topical areas. It was then determined how many courses from a topical area were required, and how many schools required that topical area. A more complete description, Tables, and lists are portrayed in Appendix G.

CHAPTER TWO: METHODOLOGY

The purpose of this chapter is to explain each step of the process in the data collection, and the treatment performed on the data once collected and organized. Complete descriptions of procedures, documents, Tables, and results are included in Appendices A, B, C, D, and E.

1. DATA CAPTURE FRAMEWORK

The Data Capture Framework was designed to provide a form to record the needs and wants of the original eight constituent groups as found in the literature. The reason for the review was to determine the number of needs and wants available. The total of 412 needs and wants found were reduced to 120 items through a modified Delphi process, described below, which became the basis for the questionnaire mailed to 100 hospital administrators in California.

The first step of this research focussed on the review of all available books with the general topic of hospital or health care administration. A log of each different need or want as found in the literature was kept in a notebook, divided by constituent groups.

When the literature search was completed, almost 300 books had been reviewed in addition to other published and unpublished research. A tally form was created for each constituent group, listing all the cited needs and wants terms. This tabulation provided

a total score for each term, then the terms were ranked.

2. DELPHI PROCESS

First Phase

After the literature review, over four hundred needs and wants terms were divided among eight (later reduced to six) constituent groups. These terms were to be the basis for the questionnaire to be sent to the administrators of one hundred hospitals in California. A modified Delphi method was selected to rank and reduce this number to the most important needs and wants of each constituent group.

These four hundred needs and wants were grouped into small, relatively similar clusters of two to five terms per cluster.

Ten persons were selected to form the Delphi Panel. The panel was composed of the dissertation advisor and two readers, plus six other individuals chosen for their expertise. Their task was to rank order all terms in each cluster from 1 (most important) to 5 (least important). After all Delphi panel members had responded, a form was designed to consolidate and graphically portray each respondent's rank.

With this information, it was possible to determine which terms could be dropped in the first selection process. Each cluster was examined and

approximately one-third of the lowest ranking terms were dropped.

The results were tabulated for each need or want as shown on Table 1. After totalling all responses, the terms scoring in the highest two-thirds were retained from each constituent group. In this way the first list of 412 terms was reduced to 262.

TABLE 1

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Delphi Process: Responses of First Phase to Determine Needs and Wants of Hospital Administrators by Constituent Group and Reductions

Constituent Group	Total Terms	Lowest Third	Terms Left
Board of Trustees	56	drop 19	37
Medical Staff	60	drop 20	40
Other Staff	78	drop 26	52
Patients	83	drop 28	55
Community	56	drop 19	37
Third-Party	37	drop 12	25
Professional Orgs	17	drop 6	11
Reg Agen/Corp Hier	25	drop 8	17
Totals	412	drop 138	274

Source: Tabulated for this Dissertation

Second Phase

The Delphi Panel was then asked to assess the importance of the resulting needs and wants. The format was changed. The clusters were set in groups of five terms.

The set of 274 terms was to be rated differently than the first set. Each term was to be rated solely on its own merit, as opposed to rank ordering all the terms

in the cluster. The Delphi Panel members were asked to rate each term with either an "A," "B," "C," "D," or "E" in accord with the rank coding on the following page, depending on how important he or she felt that term would be to them, if he or she were a member of the particular constituent group being rated.

Rank Coding

A = crucial
B = very important
C = somewhat important
D = so-so
E = least important

After the Delphi Panel had responded, a form was designed to consolidate and portray all responses. Each term's score was totaled and rank ordered. Some of the terms were combined or modified. Approximately one-half were dropped, with some specific considerations and adjustments made.

After the second phase of the Delphi process, and with comments from the Panel, it was decided that the constituent groups - **Professional Organizations** - and - **Regulatory Agencies/Corporate Hierarchy** - were no longer needed, for although hospital administrators have ongoing responsibilities to those groups, the administrators have few options with regard to the meeting of such needs and wants. Therefore, the final list had only six constituent groups.

Third Phase

The Delphi Panel was asked to participate in the third and final phase of the Delphi process.

Each selected term was developed into a need or want item for the draft questionnaire. Each person in the Delphi Panel was given the proposed cover letter and instruction sheet to the hospital administrators, and a copy of the final questionnaire. They were asked for their comments, suggestions, or criticisms of the format, wording, or layout. They were asked to respond from the role of an administrator of a large California hospital, and to actually complete the questionnaire.

Following each item were five blocks, ranked from "1" to "5." The respondents were asked to place an "X" in the block that corresponded to their opinion of how important they felt their responsibility was to the group for that particular item. Each item was to be considered individually and rated solely on its own merit.

The following rating scheme was used:

1 = least important
2 = somewhat important
3 = important
4 = very important
5 = most important

The Panel members' responses were tabulated, displayed on a form, and copies were provided to the members of the Delphi Panel. Some members had a few comments or suggestions, which were taken into

consideration when preparing the final draft questionnaire for the field test.

3. FIELD TEST

The three hospital administrators chosen to field test the questionnaire were selected because all are well known in the health care field, all had graduate degrees in Health Services, all expressed an interest in this dissertation and a willingness to participate in the field test.

A sample package was assembled for the field testers consisting of a cover letter, an instruction sheet, a questionnaire, and a return envelope.

The field test consisted of a brief discussion of the goals of the dissertation and the desired outcome of the field test. The administrators read and commented on the cover letter and instruction sheet. Each administrator was then asked to complete the survey, and to make any comments, suggestions, criticisms, or to ask questions throughout the process. On the basis of the collective comments, the questionnaire was modified in several areas.

4. QUESTIONNAIRE

First Mailing

After the field testing, the questionnaire was organized into its final form. The Office of Statewide Health Planning and Development, State of California, provided a list of all the hospitals in California.

From this list one hundred hospitals were selected as shown on the listing pages. Eight of the hospitals were in the smallest category of fewer than 200 beds. There were some hospitals in the largest category (500 or more beds) that were not sampled because of other characteristics, such as federal government ownership.

The administrators of the selected 100 hospitals received a cover letter, instruction sheet, and questionnaire. (Please see Appendix C.) The names of the administrators and addresses of the hospitals were used to mail-merge the cover letter to individualize the letters. Checks, made out to the administrator for $1.00, were typed and signed, then attached to the bottom of the letter, for easy removal, with a small Post-It. The check was considered to be a "marketing ploy," to assure a greater response due to the individualized attention being given to the questionnaires.

For the questionnaire, all six constituent groups were presented, one to a page, with a short explanation of what constituted the group.

The cover letter, instruction sheet, questionnaire, and a pre-stamped, pre-addressed envelope were placed into a larger envelope, sealed, and mailed.

Nineteen usable surveys were received by the end of the first week. At the end of four weeks, forty completed surveys had been returned, and seven others

had been returned undone. To those who returned the survey completed, a postcard was sent thanking them.

Second Mailing

After one month, a second mailing was prepared for the fifty-three who did not respond. The packages were prepared as in the first mailing, with a second, different cover letter, and another check. This mailing resulted in twelve more questionnaires being completed and returned. In addition, one of the original questionnaires was also completed and returned.

Follow-up Contact

A follow-up contact by phone was made to all administrators who did not respond to the second mailing. One additional questionnaire was returned, bringing the total to fifty-four usable questionnaires. Thirteen questionnaires were returned undone, often with a letter or note of regret attached explaining why it was not completed.

Some authorities indicate that mailed studies may have response rates as low as 10 percent, and 50 percent is considered acceptable.[3] For this dissertation, the percentage of usable responses to questionnaires sent was 54 percent. The percentage of total responses was 67 percent.

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[3]Kenneth D. Bailey. Methods of Social Research, 2nd ed., (New York: The Free Press, 1982), 157.

Tabulation

Respondents had been asked to place an "X" in the block ranging from "1" to "5" that corresponded to their opinion of how important they felt their responsibility was to the group for that particular item. The responses were tabulated. The item's score was obtained by multiplying the number of administrators who placed an "X" in each block by the value of the block. The sums were then added together, thus providing a total weighted score. Finally, all items were ranked according to their score as a measure of their importance.

The highest ranking item was - Trust as an Administrator - for the constituent group, **Board of Trustees**, with a score of 263. Almost all the administrators ranked this item with a "5." The lowest ranking item was - Recognition of Employee Organizations - for the constituent group, **Other Staff**, with a score of 152. Although this was the lowest score, it received an average of almost a "3" from the administrators, indicating it was still considered important.

5. STRUCTURED INTERVIEWS

Selection of Interviewees

Letters were sent to twenty-two persons selected from an alumni roster and participants in the Health Services Management Executive Advisory Board supplied by the graduate program in Health Services Administration

from a San Francisco Bay Area university. The letters asked if the recipient would agree to be interviewed as part of the data collection for this dissertation. Enclosed with the letter was a one-page dissertation overview. Fifteen agreed, plus the three field testers, bringing the total to eighteen. Each was sent a letter of appointment confirmation and a Structured Interview Guide. This guide consisted of an information/ instruction sheet; Part I, a two-page questionnaire; and Part II, a list of eleven discussion questions.

<u>Interview</u>

All interviews were scheduled within a two-week period. At the start of the interview, the dissertation process and objectives were described. Part I was completed. Most had selected certain questions to discuss.

The interviewer took notes, then entered the notes into a computer as rough drafts. These drafts were sent to the interviewee with a cover letter asking them to review the draft, and that the interviewer would call them the following week for corrections and additional comments. The follow-up calls were made, and changes made as a result of the clarifications.

<u>Part I: Two-Page Questionnaire</u>

The interviewees were asked to assess the future importance of the top quarter of the items from the mailed questionnaires. Their choices were "Less,"

"Same," and "More" with regard to how the future importance will compare to today's importance. A total score was calculated for each item. The score was obtained by multiplying the number of respondents who placed an "X" in each block by a "1" for the block marked "Less," by a "3" for the block marked "Same," and by a "5" for the block marked "More." The sums were then added together, thus providing a total weighted score. Finally, all items were ranked according to their anticipated future importance.

Part II: Discussion Questions

The interviewees discussed the questions previously sent. When all had been contacted to confirm the accuracy of their comments, the responses to each question were compiled and content analyzed. This section comprised the major focus of this dissertation, and is found in Part Two.

CHAPTER THREE: THE HISTORICAL AND CURRENT CONTEXTS OF THE ROLE OF THE HOSPITAL ADMINISTRATOR

This chapter contains a summary of the relevant portions of the findings on the six constituent groups, as determined by the literature search and the responses from current administrators to the mailed questionnaire.

The chapter contains six sections, one for each constituent group. Each section begins with a short description of the constituent group, followed by three Tables. The first Table presents the items in rank order for the time period "Yesterday" only. The second Table presents the items in rank order for the time period "Today" only. The third Table presents the items alphabetically. The rankings of each item, by number, are portrayed for both time periods "Yesterday" and "Today." The final portion of each section concludes with a listing of all items and changes in rankings.

The Appendix contains an explanation of each want or need item, paired with short discussions of any relevant findings.

1. BOARD OF TRUSTEES

In California, a hospital is governed by a collective body usually called the Board of Trustees. In recent years, the composition of such boards has changed from the physicians, professional colleagues and members of the socially elite often found on the boards in the past, to a board made up of other professionals, business experts, and consumer representation.

One of the most important responsibilities of the Board of Trustees is the recruiting, selection, and evaluation of the hospital's chief executive officer (CEO). This person is their representative in the implementation of the Board's policies. The CEO is responsible for assembling and organizing resources and developing the systems to carry out the policies and programs which the governing body has determined are desirable. The CEO is also expected to provide feedback and new information to the Board so it may develop policies and programs, monitor their implementation, and oversee results.

The hospital administrator meets with the governing body to inform it of the hospital's revenue and expenditures, budget, status of contracts, and any management problems. The administrator is in the key position through whom all dealings regarding the hospital among the Board of Trustees, medical staff, and other personnel are transacted.

The following statements were developed by the American Hospital Association in 1982 as part of its Guidelines: Role and Functions of the Hospital Governing Board. "The governing body:

> 1. Has the responsibility for organizing itself effectively, for establishing and following the procedures necessary to discharge its responsibilities, and for adopting bylaws in accordance with legal requirements;
>
> 2. Has the responsibility for selecting a qualified chief executive officer and for delegating to that person the necessary authority to manage ... effectively;
>
> 3. Has the authority and responsibility for ensuring proper organization of the ... medical staff and for monitoring the quality of care;
>
> 4. Has the authority and responsibility for monitoring and influencing public policies concerning the delivery of health care and for ensuring the establishment and maintenance of appropriate external relationships;
>
> 5. Has the responsibility and authority, subject to the ... charter, for determining the ... mission and for establishing a strategic plan, goals, objectives, and policies to achieve that mission;
>
> 6. Is entrusted with the resources ... and the proper development, utilization, and maintenance of those resources;
>
> 7. Has the responsibility and authority for the organization, protection, and enhancement of ... human resources; and
>
> 8. Is responsible for the provision of health care education and research programs that further the ... mission."[4]

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[4]Jonathan S. Rakish, Beaufort S. Longest, and Kurt Darr. Managing Health Services Organizations, (Philadelphia: W. D. Saunders Company, 1985), 184.

The following three Tables present the findings of the rank order of importance of the needs and wants for the constituent group **Board of Trustees.** Table 2 presents the items in rank order for the time period "Yesterday" only. For example, the item ranked eighth, **Accountability from Physicians and Management**, was mentioned twice in the literature. Table 3 presents the items in rank order for the time period "Today" only. The same item ranked number four, with a score of 253 from the questionnaires. Table 4 displays the items alphabetically. The rankings of each item, by number, alphabetically, are portrayed for both time periods, "Yesterday" and "Today."

TABLE 2

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: BOARD OF TRUSTEES: Yesterday: Literature Mentions by Rank and Frequency

Rank	Frequency	Item
1	15	Have Policies and Have Implemented
	15	Maintenance of Financial Solvency
2	13	Information on Health Care in General and Hospital Specifically
3	7	Communication Between Physicians and Administrator
4	6	Knowledge of Board's Obligations and Responsibilities
	6	Trust as an Administrator
	6	Understanding of Hospital's Goals and Purposes
5	5	Assist New Board Members
6	4	Quality Care
7	3	Have More Time Prior to Making Decisions
	3	Well-Qualified Hospital Team
8	2	Accountability from Physicians and Management
	2	Integrity of Board Members
	2	Physicians Conform to Bylaws
	2	Safety in Hospital
9	1	High Professional Status of Hospital
	1	Knowledge of Hospital's Purposes

Source: Tabulated for this dissertation

TABLE 3

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: BOARD OF TRUSTEES: Today: Questionnaire Responses by Rank and Score

Rank	Score	Item
1	263	Trust as an Administrator
2	260	Quality Care
3	257	Understanding of Hospital's Goals
4	253	Accountability from Physicians and Management
	253	Maintenance of Financial Solvency
5	243	Well-Qualified Hospital Team
6	241	Integrity of Board Members
7	235	Knowledge of Hospital's Obligations
	235	Knowledge of Hospital's Purposes
8	227	Safety in Hospital
9	225	Communication between Physicians and Administrator
	225	High Professional Status of Hospital
10	214	Physicians Conform to Bylaws
11	210	Assist New Board Members
12	208	Develop Policies and have Implemented
13	193	Information on Health Care in General and Hospital Specifically
14	170	Have More Time Prior to Making Decisions

Source: Tabulated for this dissertation

TABLE 4

THE HOSPITAL ADMINISTRATOR: YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: BOARD OF TRUSTEES: as Ranked by the Time Periods of Yesterday and Today

Number	Item	Rank Yesterday	Rank Today
1	Accountability from Physicians and Management	8	4
2	Assist New Board Members	5	11
3	Communication between Physicians and Administrator	3	9
4	Develop Policies and Have Implemented	1	12
5	Have More Time Prior to Making Decisions	7	14
6	High Professional Status of Hospital	9	9
7	Information on Health Care in General and Hospital Specifically	2	13
8	Integrity of Board Members	8	6
9	Knowledge of Board's Obligations and Responsibilities	4	7
10	Knowledge of Hospital's Purposes	9	7
11	Maintenance of Financial Solvency	1	4
12	Physicians Conform to Bylaws	8	10
13	Quality Care	6	2
14	Safety in Hospital	8	8
15	Trust as an Administrator	4	1
16	Understanding of Hospital's Goals and Purposes	4	3
17	Well-Qualified Hospital Team	7	5

Source: Tabulated for this dissertation

Twelve of the 17 needs or wants items showed changes in ranking from "Yesterday" to "Today." This is evidenced from the changes in the ranking from the literature findings to the questionnaire responses.

For "Yesterday," the three items in the top division received 13 or 15 mentions in the literature. The six items in the middle division received four to seven mentions, and the eight items in the bottom division received one to three mentions.

For "Today," the five items in the top division received a score of 253 to 263 from the responses to the questionnaire. The seven items in the middle division received a score of 225 to 243, and the five items in the bottom division received a score of 170 to 214.

Nine items showed a positive change in ranking between the two periods, thus suggesting an increase in importance from "Yesterday" to "Today." This was evidenced from their rise from a lower division from the literature findings to a higher division from the questionnaire responses. These items were: **Accountability from Physicians and Management, High Professional Status of Hospital, Integrity of Board Members, Knowledge of Hospital's Purposes, Quality Care, Safety in Hospital, Trust as an Administrator, Understanding of Hospital's Goals and Purposes,** and **Well-Qualified Hospital Team.**

Five items showed no change in ranking between the two periods, thus suggesting no change in importance from "Yesterday" to "Today." This was evidenced from their ranking in the same division in both time periods. These items were: **Communication between Physicians and Administrator, Have More Time Prior to Making Decisions, Knowledge of Board's Obligations and Responsibilities, Maintenance of Financial Solvency,** and **Physicians Conform to Bylaws.**

Three items showed a negative change in ranking between the two periods, thus suggesting a decrease in importance from "Yesterday" to "Today." This was evidenced from their fall from a higher division in the literature findings to a lower division from the questionnaire responses. These items were: **Assist New Board Members, Develop Policies and Have Implemented,** and **Information on Health Care in General and Hospital Specifically.**

2. MEDICAL STAFF

Most hospitals exist essentially for the care and treatment of patients. These are provided by several groups of people, most notably physicians. As the admitting and treating physicians who prescribe services and medications, the total medical staff is one of the more important components of a hospital. The nursing staff carry the responsibility for the day-to-day nursing care of the patients.

Historically, very few hospitals had an organized medical staff. Because few physicians were salaried, the medical staff was virtually independent in every sense, and little control was exercised over it by the governing body. When hospitals were small and community-based, often physicians were on the governing board, and in many cases the administrator was also a physician.

Currently, physicians are the third part of the hospital triad consisting of the governing body, administration or management, and the medical staff. This is increasingly seen as a deficient organizational structure. The major problem lies in the process of monitoring of physicians' services and determining the quality of care provided at the facility.

The problem of inadequate monitoring occurs regardless of type of ownership or size of the health care facility. The physicians' high degree of

independence has been fostered by the historical training and development of the medical field. The highly technical nature of their activities promoted it. It was formerly considered unethical by the medical profession for non-physicians to review the content of their institutional practice since it could be considered as an interference in the physician-patient relationship. In addition, the importance of the medical profession made "lay" persons who were management and governing body members reluctant to become involved. Consequently, most boards of trustees were content to accept reassurances by the medical staff that all was well and the quality of care rendered was at least satisfactory, if not superior.

Today, in the more complicated health care organizations and systems, physicians are no longer able to maintain such absolute autonomy. On the one hand, as one writer put it,

> "A physician's training motivates him to do the utmost for the individual patient without much thought for the consequences of his action in terms of cost and efficient use of services."[5]

On the other hand, when many physicians are doing similar procedures and treating similar problems, administrators and boards of trustees wish to see some

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[5]John Rea, Jeffrey J. Frommelt, and Malcom D. MacCoun, Building a Hospital: A Primer for Administrators, (Chicago: American Hospital Association, 1978), 3.

semblance of uniformity in terms of resources used. This dichotomy of opinions can lead to serious control problems.

Several suggestions have been postulated in the building of a good relationship between the medical staff on one side and the board and administrator on the other. One that has been expounded upon by many experts is bringing back physicians to the board of trustees.

> "Giving physicians a voice in hospital management and governance is vital to having a healthy alliance between a hospital and its medical staff. Serving on a board together gives CEOs and physician trustees a marvelous opportunity to develop new understandings and appreciation of each others' knowledges and skills."[6]

Many other methods are possible in helping hospitals foster good relations with the medical staff. According to Russell Coile, "One of the crucial factors in hospital-physician relationships will be 'collaborative practice' - the doctor-nurse relationship..."[7] As registered nurses receive more medical training, they become more indispensable to the physicians with whom they work. Hospitals that support

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[6]Julie Johnsson, "How to build partnerships with physician trustees," Hospitals, 2 February 1992, 80.

[7]Russell Coile, "The 'Medical Price' of Hospital Strategy," Healthcare Forum Journal, September/October 1991, 39.

these collaborative practice teams may find they are more sought after by physicians and patients alike.

Although most physicians have considerable medical equipment in their offices, many are finding it is too expensive to have high technology equipment in their private or small group practices. They are forming alliances with hospitals that have the specialized equipment. In a city with several hospitals, often there is competition in acquiring the newest treatment modality, regardless of the justification for the expenditure. Administrators, in the past, have felt they needed to keep their hospitals continually up-to-date. Physicians who had privileges at more than one hospital admitted their patients to the most up-to-date. As the reality of budgetary constraints became known and accepted, patients were admitted to the hospital that best suited their needs. "Physicians are ceasing to play hospitals against each other, and are looking to the managerial support and economies of scale that a hospital [partnership] can bring."[8]

As single hospitals merge into health care systems, especially when spread over a large geographic area, certain components of the system may specialize. For example, a large system of skilled nursing facilities may have several facilities for general care, yet certain ones specifically for patients with

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[8]Johnsson, ibid., 23.

particular problems, such as Alzheimer's Disease or Multiple Sclerosis. In this manner, patients may receive care more relevant to their needs.

The following three Tables present the findings of the rank order of importance of the needs and wants for the constituent group **Medical Staff.** Table 5 presents the items in rank order for the time period "Yesterday" only. For example, the item ranked number eight, **Physicians have Authority over Patient Care**, was mentioned three times in the literature. Table 6 presents the items in rank order for the time period "Today" only. The same item ranked number seven, with a score of 222 from the questionnaires. Table 7 displays the items alphabetically. The rankings of each item, by number, alphabetically, are portrayed for both time periods "Yesterday" and "Today."

TABLE 5

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: MEDICAL STAFF: Yesterday:
Literature Mentions by Rank and Frequency

Rank	Frequency	Item
1	17	Continuing Medical Education
	17	Training for Interns and Residents
2	15	Best/Latest/Suitable Equipment
3	10	Cooperation and Trust from Hospital Administrator
4	8	High Quality of Patient Care
5	6	Choice in When, Where, and How They Practice Medicine
	6	Highly Skilled Nurses/Other Staff
	6	Protection from Malpractice Suits
6	5	High Quality of Other Physicians on Staff
	5	Well-Maintained Equipment and Facilities
7	4	Complete and Accurate Medical Records
	4	Good Communication
	4	Participation in Decision Making
8	3	Good Reputation of Hospital
	3	Physicians have Authority over Patient Care
	3	Professional Advancement
9	2	Board Certification Encouraged
	2	Protection from Infectious Diseases
10	1	Freedom from Administrative Details
	1	Hospital Includes both Inpatient and Outpatient Services

Source: Tabulated for this dissertation

TABLE 6

THE HOSPITAL ADMINISTRATOR: YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: MEDICAL STAFF: Today: Questionnaire Responses by Rank and Score

Rank	Score	Item
1	253	High Quality of Patient Care
2	252	Cooperation and Trust from Hospital Administrator
3	244	Highly Skilled Nurses/Other Staff
4	240	Good Reputation of Hospital
5	236	Good Communication
	236	High Quality of Other Physicians on Staff
6	223	Complete and Accurate Medical Records
7	222	Physicians have Authority over Patient Care
	222	Well-Maintained Equipment and Facilities
8	220	Participation in Decision Making
9	219	Hospital Includes both Inpatient and Outpatient Services
10	205	Best/Latest/Suitable Equipment
	205	Protection from Infectious Diseases
11	202	Board Certification Encouraged
12	196	Continuing Medical Education
	196	Protection from Malpractice Suits
13	183	Choice in When, Where, and How They Practice Medicine
14	176	Freedom from Administrative Details
15	157	Professional Advancement
16	154	Training for Interns and Residents

Source: Tabulated for this dissertation

TABLE 7

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: MEDICAL STAFF: as Ranked by the Time Periods of Yesterday and Today

Number	Item	Rank Yesterday	Rank Today
1.	Best/Latest/Suitable Equipment	2	10
2.	Board Certification Encouraged	9	11
3.	Choice in When, Where, and How They Practice Medicine	5	13
4.	Complete and Accurate Medical Records	7	6
5.	Continuing Medical Education	1	12
6.	Cooperation and Trust from Hospital Administrator	3	2
7.	Freedom from Administrative Details	10	14
8.	Good Communication	7	5
9.	Good Reputation of Hospital	8	4
10.	High Quality of Other Physicians on Staff	6	5
11.	High Quality of Patient Care	4	1
12.	Highly Skilled Nurses/Other Staff	5	3
13.	Hospital Includes Both Inpatient and Outpatient Services	10	9
14.	Participation in Decision Making	7	8
15.	Physicians have Authority Over Patient Care	8	7
16.	Professional Advancement	8	15
17.	Protection from Infectious Diseases	9	10
18.	Protection from Malpractice Suits	5	12
19.	Training for Interns and Residents	1	16
20.	Well-Maintained Equipment and Facilities	6	7

Source: Tabulated for this dissertation

Thirteen of the 20 needs or wants items showed changes in ranking from "Yesterday" to "Today." This is evidenced from the rise or fall in the ranking from the literature findings to the questionnaire responses.

For "Yesterday," the five items in the top division received eight to 17 mentions in the literature. The eight items in the middle division received four to six mentions, and the seven items in the bottom division received one to three mentions.

For "Today," the six items in the top division received a score of 236 to 253 from the responses to the questionnaire. The eight items in the middle division received a score of 202 to 223, and the six items in the bottom division received a score of 154 to 196.

More items showed a rise from a lower division to a higher division than items showed a drop because more items fell into the middle and bottom divisions from the literature than the top division. The range of the number of mentions did not allow for equitable distribution into the three divisions: top, middle, and bottom.

Eight items showed a positive change in ranking between the two periods, thus suggesting an increase in importance from "Yesterday" to "Today." This was evidenced from their rise from a lower division in the literature findings to a higher division from the

questionnaire responses. These items were: **Board Certification Encouraged; Good Communication; Good Reputation of Hospital; High Quality of Other Physicians on Staff; Highly Skilled Nurses/Other Staff; Hospital Includes Both Inpatient and Outpatient Services; Physicians have Authority Over Patient Care;** and **Protection from Infectious Diseases.**

Seven items showed no change in ranking between the two periods, thus suggesting no change in importance from "Yesterday" to "Today." This was evidenced from their ranking in the same division in both time periods. These items were: **Complete and Accurate Medical Records; Cooperation and Trust from Hospital Administrator; High Quality of Patient Care; Freedom from Administrative Details; Participation in Decision Making; Professional Advancement;** and **Well-Maintained Equipment and Facilities.**

Five items showed a negative change in ranking between the two periods, thus suggesting a decrease in importance from "Yesterday" to "Today." This was evidenced from their fall from a higher division in the literature findings to a lower division from the questionnaire responses. These items were: **Best/Latest/Suitable Equipment; Choice in When, Where, and How They Practice Medicine; Continuing Medical Education; Protection from Malpractice Suits;** and **Training for Interns and Residents.**

3. OTHER STAFF

Most hospitals exist essentially for the care and treatment of patients. This care is provided by several groups of people, other than physicians. Many are involved with direct patient care, such as nurses and physical therapists. Others are concerned with indirect patient care, such as medical laboratory technicians and dieticians. Still others work in departments that pertain to the running of the hospital, such as the business office or housekeeping.

All departments are essential to the operation of a hospital. The functions performed by these employees are indispensable to the care and treatment of patients. Without these non-physician staff and their collective expertise, physicians could not do an adequate job in caring for the sick and injured.

Volunteers:

The volunteers constitute another very important group working in hospitals. Some hospitals can have as much as ten percent of their total staff time performed by volunteers.

Because the hospital is of service to the community, some community members wish to volunteer in the hospital, so as to return, in some measure, personal service to the community. One way they can do that is through volunteering.

A particular need which must be supplied through appeals to the community is for volunteer workers, and the administrator can encourage the formation or enlargement of hospital auxiliaries to which certain work can be delegated. He or she can also open the hospital to the training of volunteer nurses' aides under a program sponsored by the American Red Cross.

The following three Tables present the findings of the rank order of importance of the needs and wants for the constituent group **Other Staff**. Table 8 presents the items in rank order for the time period "Yesterday" only. For example, the item ranked number fourteen, **Training about HIV/AIDS**, was mentioned once in the literature. Table 9 presents the items in rank order for the time period "Today" only. The same item ranked number nine, with a score of 212 from the questionnaires. Table 10 displays the items alphabetically. The rankings of each item, by number, alphabetically, are portrayed for both time periods "Yesterday" and "Today."

TABLE 8

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: OTHER STAFF: Yesterday:
Literature Mentions by Rank and Frequency

Rank	Frequency	Item
1	24	Inservice Training Sessions
2	21	Appropriate Salary Ranges
3	17	Good Communication
	17	Recognition of Employee Organizations/Unions
4	13	Fair Benefits
5	10	Fair Performance Appraisals
6	9	Continuing Education
	9	Opportunities for Promotion
7	8	Good Supervision
	8	Good Working Conditions
	8	Higher Professional Recognition
	8	Job Satisfaction
8	7	Retirement Plans
9	6	Protection from Infectious Diseases
10	5	On-the-Job Training (OJT)
11	4	Counseling for Staff Who Work with Terminally Ill Patients
	4	More Say in Patient Care
12	3	Incentives for Efficiency
13	2	Higher Salary Ranges for Advanced Degrees
14	1	Trust as an Administrator
	1	Training about HIV/AIDS
Volunteers:		
1	12	Recognition
2	8	Good Supervision
3	7	Training
	7	Orientation

Source: Tabulated for this dissertation

TABLE 9

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: OTHER STAFF: Today:
Questionnaire Responses by Rank and Score

Rank	Score	Item
1	254	Trust as an Administrator
2	245	Good Communication
3	235	Fair Performance Appraisals
4	228	Good Supervision
5	226	Job Satisfaction
6	224	Appropriate Salary Ranges
7	222	Good Working Conditions
8	221	Protection from Infectious Diseases
9	212	Training about HIV/AIDS
10	211	Fair Benefits
11	205	Opportunities for Promotion
12	199	Retirement Plans
13	198	More Say in Patient Care
14	193	Inservice Training Sessions
15	189	Higher Professional Recognition
16	187	Incentives for Efficiency
	187	Continuing Education
17	184	On-the-Job Training (OJT)
18	183	Counseling for Staff Who Work with Terminally Ill Patients
19	154	Higher Salary Ranges for Advanced Degrees
20	152	Recognition of Employee Organizations/Unions

Volunteers:

Rank	Score	Need or Want Item
1	246	Recognition
2	222	Good Supervision
3	214	Orientation
4	208	Training

Source: Tabulated for this dissertation

TABLE 10

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: OTHER STAFF: as Ranked by the Time Periods of Yesterday and Today

Number	Item	Rank Yesterday	Rank Today
1	Appropriate Salary Ranges	2	6
2	Continuing Education	6	16
3	Counseling for Staff Who Work with Terminally Ill Patients	11	18
4	Fair Benefits	4	10
5	Fair Performance Appraisals	5	3
6	Good Communication	3	2
7	Good Supervision	7	4
8	Good Working Conditions	7	7
9	Higher Professional Recognition	7	15
10	Higher Salary Ranges for Advanced Degrees	13	17
11	Incentives for Efficiency	12	16
12	Inservice Training Sessions	1	14
13	Job Satisfaction	7	5
14	More Say in Patient Care	11	13
15	On-the-Job Training (OJT)	10	17
16	Opportunities for Promotion	6	11
17	Protection from Infectious Diseases	9	8
18	Recognition of Employee Organizations/Unions	3	20
19	Retirement Plans	8	12
20	Training about HIV/AIDS	14	9
21	Trust as an Administrator	14	1
Volunteers:			
1	Good Supervision	2	2
2	Orientation	3	3
3	Recognition	1	1
4	Training	3	4

Source: Tabulated for this dissertation

Twelve of the 21 needs or wants items showed changes in ranking from "Yesterday" to "Today." This is evidenced from the rise or fall in the ranking from the literature findings to the questionnaire responses.

For "Yesterday," the six items in the top division received ten to 24 mentions in the literature. The seven items in the middle division received seven to nine mentions, and the seven items in the bottom division received one to six mentions. There were only four items for the sub-group Volunteers. One item received 12 mentions, placing it in the top division, and the other three items received either seven or eight, placing them in the bottom division. There was no middle division assigned.

For "Today," the eight items in the top division received a score of 221 to 254 from the responses to the questionnaire. The six items in the middle division received a score of 193 to 212, and the seven items in the bottom division received a score of 152 to 189. For the sub-group Volunteers, one item received a score of 246, placing it in the top division, and the other three items received scores between 208 and 222, placing them in the bottom division. There was no middle division assigned.

More items showed a rise from a lower division to a higher division than items showed a drop because more items fell into the middle and bottom divisions from

the literature than the top division. The range of the number of mentions did not allow for equitable distribution into the three divisions: top, middle, and bottom.

Seven items showed a positive change in ranking between the two periods, thus suggesting an increase in importance from "Yesterday" to "Today." This was evidenced from their rise from a lower division in the literature findings to a higher division from the questionnaire responses. These items were: **Good Supervision; Good Working Conditions; Job Satisfaction; More Say in Patient Care; Protection from Infectious Diseases; Training about HIV/AIDS;** and **Trust as an Administrator.**

Nine items showed no change in ranking between the two periods, thus suggesting no change in importance from "Yesterday" to "Today." This was evidenced from their ranking in the same division in both time periods. These items were: **Appropriate Salary Ranges; Good Communication; Counseling for Staff Who Work with Terminally Ill Patients; Fair Performance Appraisals; Higher Salary Ranges for Advanced Degrees; Incentives for Efficiency; On-the-Job Training (OJT); Opportunities for Promotion;** and **Retirement Plans.**

Five items showed a negative change in ranking between the two periods, thus suggesting a decrease in importance from "Yesterday" to "Today." This was

evidenced from their fall from a higher division in the literature findings to a lower division from the questionnaire responses. These items were: **Continuing Education; Fair Benefits; Higher Professional Recognition; Inservice Training Sessions;** and **Recognition of Employee Organizations/Unions.**

All four items for the sub-group Volunteers remained in the same division for both time periods. These items were: **Good Supervision; Orientation; Recognition;** and **Training.**

4. PATIENTS

Most hospitals exist essentially for the care and treatment of patients. Even those hospitals dedicated to research or teaching require patients on whom to perform the necessary procedures and therapies. For the purpose of this dissertation, the word "patient" may also include the patient's family.

Other than hypochondriacs and others who enjoy the attention they receive in a hospital, most patients are not there by choice. Not too many people wish to become ill, or to be in need of medical treatment.

The length of time a person may be considered a patient ranges from a few minutes to many weeks. A patient may be in a hospital for a variety of reasons, ranging from a simple check-up or examination to treatments for minor illnesses or slight injuries, to more complicated treatments for major illnesses or significant injuries, to life-threatening illnesses or injuries, including surgeries.

Regardless of the reason, unless it is quite insignificant, when admitted to a hospital, a patient will probably be apprehensive about his or her illness, uneasy and insecure in a new environment, possibly worried about finances, and often psychologically turned inward. Many factors of daily hospital life are foreign to the patient. Therefore, almost every facet of the hospital will have an effect

on the patient's attitude. Non-patient care personnel, the quality of hospital food, visiting hours, and housekeeping all contribute to the patient's positive or negative attitude.

For the comfort of guests, whenever possible space should be provided where they can visit in comfort without being forced to sit at the bedside only. A communal room is ideal. This provides a measure of privacy and possibly a change of environment for the patient.

The primary mission of a hospital should be to restore to functioning health status, to the best extent possible, the patients who come to it. Second, to that goal, is to remain financially viable so that the hospital may continue its primary mission. Many other goals may follow.

The following three Tables present the findings of the rank order of importance of the needs and wants for the constituent group **Patients**. Table 11 presents the items in rank order for the time period "Yesterday" only. For example, the item ranked number eleven, **Confidentiality**, was mentioned four times in the literature. Table 12 presents the items in rank order for the time period "Today" only. The same item ranked number six, with a score of 235 from the questionnaires. Table 13 displays the items alphabetically. The rankings of each item, by number,

alphabetically, are portrayed for both time periods "Yesterday" and "Today."

TABLE 11

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: PATIENTS: Yesterday:
Literature Mentions by Rank and Frequency

Rank	Frequency	Item
1	22	Competent Medical Personnel/ Quality Care
2	21	Information about Diagnosis, Treatment, and Prognosis
3	15	Diet as Requested/Required
4	14	Protection from Infectious Diseases/ Iatrogenics/Nosocomial Infections
5	11	Rehabilitation to the Extent Possible
	11	Safe Environment in the Hospital
6	10	Treated with Respect/Consideration/ Dignity
	10	Understanding/Compassion/Empathy
7	8	Clean and Comfortable Surroundings
	8	Relief from Pain
8	7	Right to Refuse Treatment/Informed Consent
9	6	Access to Available Services
10	5	Disease Prevention
11	4	Confidentiality
	4	Emergency Room Availability
	4	Having a Say in Own Care/ Participation
12	3	Appropriate Testing/Treatment
	3	Expanded Visiting Hours
	3	Protection from Medication Errors
	3	Short Waiting Times for Obtaining Treatment
13	2	Latest Technology
	2	Responsive to Patient's Needs
14	1	Affordable Health Care
	1	Equitable Prices

Source: Tabulated for this dissertation

TABLE 12

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: PATIENTS: Today:
Questionnaire Responses by Rank and Score

Rank	Score	Item
1	247	Competent Medical Personnel/ Quality Care
2	244	Responsive to Patient's Needs
		Treated with Respect/Consideration/ Dignity
3	242	Safe Environment in the Hospital
4	237	Protection from Medication Errors
5	236	Emergency Room Availability
		Understanding/Compassion/Empathy
6	235	Confidentiality
		Protection from Infectious Diseases/ Iatrogenics/Nosocomial Infections
7	229	Appropriate Testing/Treatment
8	225	Affordable Health Care
		Clean and Comfortable Surroundings
9	224	Relief from Pain
10	219	Information about Diagnosis, Treatment, and Prognosis
11	216	Having a Say in Own Care/ Participation
12	213	Short Waiting Times for Obtaining Treatment
13	209	Access to Available Services
14	203	Right to Refuse Treatment/Informed Consent
15	199	Latest Technology
16	198	Disease Prevention
		Rehabilitation to the Extent Possible
17	197	Equitable Prices
18	196	Diet as Requested/Required
19	159	Expanded Visiting Hours

Source: Tabulated for this dissertation

TABLE 13

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The needs and Wants Items of the
Constituent Group: PATIENTS: as Ranked
by the Time Periods of Yesterday and Today

Number	Item	Rank Yesterday	Rank Today
1.	Access to Available Services	9	13
2.	Affordable Health Care	14	8
3.	Appropriate Testing/Treatment	12	9
4.	Clean and Comfortable Surroundings	7	8
5.	Competent Medical Personnel/ Quality Care	1	1
6.	Confidentiality	11	6
7.	Diet as Requested/Required	3	18
8.	Disease Prevention	10	16
9.	Emergency Room Availability	11	5
10.	Equitable Prices	14	17
11.	Expanded Visiting Hours	12	19
12.	Having a Say in Own Care/ Participation	11	11
13.	Information about Diagnosis, Treatment, and Prognosis	2	10
14.	Latest Technology	13	15
15.	Protection from Infectious Diseases/Iatrogenics/ Nosocomial Infections	4	6
16.	Protection from Medication Errors	12	4
17.	Rehabilitation to the Extent Possible	5	16
18.	Relief from Pain	7	9
19.	Responsive to Patient's Needs	13	2
20.	Right to Refuse Treatment/ Informed Consent	8	14
21.	Safe Environment in the Hospital	5	3
22.	Short Waiting Times for Obtaining Treatment	12	12
23.	Treated with Respect/Consideration/ Dignity	6	2
24.	Understanding/Compassion/Empathy	6	5

Source: Tabulated for this dissertation

Twelve of the 24 needs or wants items showed changes in ranking from "Yesterday" to "Today." This is evidenced from the rise or fall in the ranking from the literature findings to the questionnaire responses.

For "Yesterday," the eight items in the top division received ten to 22 mentions in the literature. The eight items in the middle division received four to eight mentions, and the eight items in the bottom division received one to three mentions.

A special note should be made about the top two items - **Access to Available Services** and **Affordable Health Care.** They received 22 and 21 mentions in the literature, more than double the number received by the last item in the top ranked division. Although they were clearly the most often mentioned, it was not possible to establish a special division only for those two.

For "Today," the nine items in the top division received a score of 235 to 247 from the responses to the questionnaire. The seven items in the middle division
received a score of 213 to 229, and the eight items in the bottom division received a score of 159 to 209.

Seven items showed a positive change in ranking between the two periods, thus suggesting an increase in importance from "Yesterday" to "Today." This was evidenced from their rise from a lower division in the

literature findings to a higher division from the questionnaire responses. These items were: **Affordable Health Care; Appropriate Testing/Treatment; Confidentiality; Emergency Room Availability; Protection from Medication Errors; Responsive to Patient's Needs;** and **Short Waiting Times for Obtaining Treatment.**

Twelve items showed no change in ranking between the two periods, thus suggesting no change in importance from "Yesterday" to "Today." This was evidenced from their ranking in the same division in both time periods. These items were: **Clean and Comfortable Surroundings; Competent Medical Personnel/Quality Care; Protection from Infectious Diseases/Iatrogenics/ Nosocomial Infections; Equitable Prices; Expanded Visiting Hours; Having a Say in Own Care/ Participation; Latest Technology; Relief from Pain; Safe Environment in the Hospital; Treated with Respect/Consideration/Dignity;** and **Understanding/ Compassion/Empathy.**

Five items showed a negative change in ranking between the two periods, thus suggesting a decrease in importance from "Yesterday" to "Today." This was evidenced from their fall from a higher division in the literature findings to a lower division from the questionnaire responses. These items were: **Access to Available Services; Diet as Requested/Required; Disease**

Prevention; Information about Diagnosis, Treatment, and Prognosis; Rehabilitation to the Extent Possible; and **Right to Refuse Treatment/Informed Consent.**

5. COMMUNITY

According to Malcolm T. MacEachern, M.D.,

> "The hospital exists for the good of the people in the community which it serves. It is an institution whose service should be interrelated with other health and welfare services in the community for the best interest of all."[9]

As the hospital is an integral part of any community, the administrator represents the hospital in its relationships with organizations and groups within the community. The administrator has now, more than ever, a sophisticated role in community health planning and policy formation. He or she should ensure that the community's health service needs are addressed properly, by taking a proactive position of leadership in the community and explaining the rationale for any decision that may affect the health or well-being of the population which it serves.

Hospital administrators need to pay attention to two aspects in particular that pertain to the community. The first is the combination of health education and disease prevention. The second is in the increased use of emergency departments, for primary care as well as for trauma and acute illness.

Health education and disease prevention: The hospital administrator should utilize the press,

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[9]Arthur C. Bachmeyer and Gerhard Hartman, The Hospital in Modern Society, (New York: The Commonwealth Fund, 1943), 204.

television, radio, and lecture platform in making known the progress of medical research and technology, and in urging preventive measures against disease and accidents. Preferably he or she should work with other hospitals in a joint program of public education, and the hospitals in turn should cooperate with other health and welfare agencies with this objective.

In a presentation on prevention, an editorial stated:

> "We must think less about reacting to illness and more about preventing it. Today, we can provide a prematurely born infant the best and most expensive technology modern medicine can offer. But all too often that infant's mother had no access to the prenatal care that might have averted the tragedy. We need to build health-care systems that emphasize the availability of cost-effective preventive care, and we need to provide more public education on disease prevention."[10]

Everyone can benefit by health education and disease prevention programs. "Concrete proof now exists that wellness programs pay off in lower health costs, reduced absenteeism, increased productivity, and higher morale."[11]

Increased use of emergency departments: Most emergency departments have seen an increase in their use, some to the point where, at many times, in the major cities, the department is full.

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[10] ________, Sacramento Bee, April 5, 1992, sec. Forum, 3.

[11] ________, Business and Health, Special Report, 1991, 10.

> "Among the reasons [of lack of emergency room beds] are an increase in both the number and severity of trauma cases, tied to various forms of social pathology: Drugs, violence and poverty all play a part."[12]

Another factor plays a part in the overuse of emergency rooms. A large number (in the United States, 37 million) people have no third-party payer and have no health insurance, and thus cannot pay medical bills on their own. They know that emergency rooms are not allowed to turn them away, so too many of them use the emergency room as a substitute for primary care.

According to Kimberly Belshe', in 1992 the deputy secretary of program and fiscal affairs for the California Health and Welfare Agency,

> "When the uninsured go to a hospital emergency room - 'if they have access to an emergency room'- they receive treatment. But those who cannot pay are insured, in a way, because the taxpayers ultimately foot the bill. However, the state ends up spending more money on these emergency-room patients than if they had received primary care."[13]

Dan Anderson, M.D., CEO of Parkland Memorial Hospital in Dallas, Texas, writes: "Trauma care is like a public utility and should be funded like one."[14] He gives two suggestions to ameliorate this disturbing trend. One, discourage patients from using the

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[12]Emily Freidman, "Emergency departments on the brink of crisis," Hospitals, 5 January 1992, 29.

[13]Arzu, Cocmen, "Rx for California Health Care?," Connections, Spring Issue, 1992, 23.

[14]Freidman, ibid.

emergency department for primary care by referring them to other providers whenever possible. Two,

> "they can recognize that their Eds [emergency departments] are doubling as the city's largest walk-in clinics, and they can configure their staff and resources so as to meet that need in the most cost-effective way as possible."[15]

A major responsibility to the community is in statistical reporting. The hospital administrator must cooperate fully with the public health organizations of the community in reporting births, deaths, communicable diseases, and similar statistics, as well as in supporting public health clinics. Hospitals are the major source of information for statistical data. Many public and private agencies rely on this information, and the data must be valid.

Most hospitals have a computer-based management information system which allows for easier record keeping than the antiquated manual methods used in the past. With computers, data are retrievable with any combination of information pieces, in any desired format. A favorable aspect of computers is their ability to collect and collate information from all patients without compromising personal privacy.

The following three Tables present the findings of the rank order of importance of the needs and wants for the constituent group **Community**. Table 14 presents

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[15]Ibid., 6.

the items in rank order for the time period "Yesterday" only. For example, the item ranked number ten, **Comprehensive Care**, was mentioned four times in the literature. Table 15 presents the items in rank order for the time period "Today" only. The same item ranked number three, with a score of 204 from the questionnaires. Table 16 displays the items alphabetically. The rankings of each item, by number, alphabetically, are portrayed for both time periods "Yesterday" and "Today."

TABLE 14

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: COMMUNITY: Yesterday: Literature Mentions by Rank and Frequency

Rank	Frequency	Item
1	14	Education of Disease Prevention and Health Matters
2	13	Home Care
3	12	Cost Containment
4	11	Health Education Programs/ Workshops/Health Fairs
5	10	Patient Education
6	8	Positive Relations with the Local Media
7	7	Screenings for Diseases such as HIV/AIDS
8	6	Equality of Access
9	5	Cooperation with Other Health Facilities or Hospitals
	5	Research on and Prevention of Diseases
10	4	Comprehensive Health Care
11	3	Chronic Disease Care
	3	Nursing Homes as Extensions of Hospitals/Long Term Care
	3	Vaccines/Immunizations
12	2	Cooperation with Medical, Nursing, and Allied Health Schools
	2	Equitable Distribution of Health Care Services
	2	Hospice Availability
	2	Public Service Announcements
13	0	Ease of Getting Health Information
	0	Patient Information

Source: Tabulated for this dissertation

TABLE 15

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: COMMUNITY: Today:
Questionnaire Responses by Rank and Score

Rank	Score	Item
1	230	Cost Containment
2	216	Equality of Access
3	204	Comprehensive Health Care
4	203	Patient Information
5	200	Positive Relations with the Local Media
6	195	Ease of Getting Health Information
	195	Education of Disease Prevention and Health Matters
	195	Screenings for Diseases such as HIV/AIDS
	195	Cooperation with Medical, Nursing, and Allied Health Schools
7	191	Patient Education
8	187	Cooperation with Other Health Facilities or Hospitals
9	186	Home Care
10	183	Hospice Availability
11	181	Chronic Disease Care
	181	Health Education Programs/Workshops/ Health Fairs
	181	Vaccines/Immunizations
12	164	Equitable Distribution of Health Care Services
13	163	Public Service Announcements
14	162	Nursing Homes as Extensions of Hospitals/Long Term Care
15	161	Research on and Prevention of Diseases

Source: Tabulated for this dissertation

TABLE 16

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: COMMUNITY: as Ranked
by the Time Periods of Yesterday and Today

Number	Item	Rank Yesterday	Rank Today
1.	Chronic Disease Care	11	11
2.	Comprehensive Health Care	10	3
3.	Cooperation with Medical, Nursing, and Allied Health Schools	12	6
4.	Cooperation with Other Health Facilities or Hospitals	9	8
5.	Cost Containment	3	1
6.	Ease of Getting Health Information	13	6
7.	Education of Disease Prevention and Health Matters	1	6
8.	Equality of Access	8	2
9.	Equitable Distribution of Health Care Services	12	12
10.	Health Education Programs/ Workshops/Health Fairs	4	11
11.	Home Care	2	9
12.	Hospice Availability	12	10
13.	Nursing Homes as Extensions of Hospitals/Long Term Care	11	14
14.	Research on and Prevention of Diseases	9	15
15.	Patient Education	5	7
16.	Patient Information	13	4
17.	Positive Relations with the Local Media	6	5
18.	Public Service Announcements	12	13
19.	Screenings for Diseases such as HIV/AIDS	7	6
20.	Vaccines/Immunizations	11	11

Source: Tabulated for this dissertation

Twelve of the 20 needs or wants items showed changes in ranking from "Yesterday" to "Today." This is evidenced from the rise or fall in the ranking from the literature findings to the questionnaire responses.

For "Yesterday," the five items in the top division received 10 to 14 mentions in the literature. The six items in the middle division received four to eight mentions, and the seven items in the bottom division received none to three mentions.

For "Today," the five items in the top division received a score of 200 to 230 from the responses to the questionnaire. The eight items in the middle division received a score of 183 to 195, and the seven items in the bottom division received a score of 161 to 281.

More items showed a rise from a lower division to a higher division than items showed a drop because more items fell into the middle division from the literature than the top division. The range of the number of mentions did not allow for equitable distribution into the three divisions: top, middle, and bottom.

Seven items showed a positive change in ranking between the two periods, thus suggesting an increase in importance from "Yesterday" to "Today." This was evidenced from their rise from a lower division in the literature findings to a higher division from the questionnaire responses. These items were:

Comprehensive Health Care; Cooperation with Medical, Nursing, and Allied Health Schools; Ease of Getting Health Information; Equality of Access; Hospice Availability; Patient Information; and **Positive Relations with the Local Media.**

Eight items showed no change in ranking between the two periods, thus suggesting no change in importance from "Yesterday" to "Today." This was evidenced from their ranking in the same division in both time periods. These items were: **Chronic Disease Care; Cooperation with Other Health Facilities or Hospitals; Cost Containment; Equitable Distribution of Health Care Services; Nursing Homes as Extensions of Hospitals/Long Term Care; Public Service Announcements; Screenings for Diseases such as HIV/AIDS;** and **Vaccines/Immunizations.**

Five items showed a negative change in ranking between the two periods, thus suggesting a decrease in importance from "Yesterday" to "Today." This was evidenced from their fall from a higher division in the literature findings to a lower division from the questionnaire responses. These items were: **Education of Disease Prevention and Health Matters; Health Education Programs/Workshops/Health Fairs; Home Care; Patient Education;** and **Research on and Prevention of Diseases.**

6. THIRD-PARTY PAYERS

Third-Party Payers have reached the position where, as a total group, they are providing the major source of reimbursement for hospitals. As such, they have introduced a substantial new force into the healthcare field. They negotiate contracts for care and treatment of members of most large organizations, to include, among others, large and small businesses, government agencies, as well as privately-insured persons. The representatives of Third-Party Payers "have begun to concern themselves with the way in which hospitals are run and are expressing their views in no uncertain terms."[16]

The hospital administrator or delegate represents the hospital in its relationships with Third-Party Payers, and maintains contact with them. The administrator's responsibilities to Third-Party Payers are many, most notably to keep them informed of any changes in policies or procedures which would affect the payers.

The major bone of contention between hospital administrators and Third-Party Payers is the cost of providing care to those persons insured or sponsored. Both sides profess to want and know what is best for the patient. And both use quality of health care to

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[16]Scott A. Mason, ed., Multi-Hospital Arrangements: Public Policy Implications (Chicago: American Hospital Association, 1979), 765.

support their position. According to a 1991 article in the Healthcare Forum Journal,

> "In trying to use quality to protect financing, providers fell into the same trap in which many payers have fallen: confusing quality with cost. The two sides are lined up along opposing edges of a trench. The providers are still saying that more is better, and quality is best protected by spending more money; the payers are saying that less is better, and that quality is best protected by limiting spending. Too often it's the patient who falls into the trench between them."[17]

Adding fuel to the friction between administrators and Third-Party Payers, those who actually provide medical care want the collective autonomy they had when the system was primarily fee-for-service or charity care. "Doctor after doctor bitterly complains of being second-guessed by insurers, regulators and 'reviewers' who question their charges and treatments and, they believe, often prevent them from doing the best for their patients."[18]

The potential for internal strife among the administrators, care providers, and Third-Party Payers generally does not affect the average person. Healthcare insurers want people to believe that their company will pay for their medical care. If people think that their insurance company is trying to skimp

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[17] ________, "Making Choices," Healthcare Forum Journal, Jul/Aug 1991, 14-15.

[18] ________, "Needed: 'A New Doctor'," Washington Post Health, June 9, 1992, 11.

on the care that will be reimbursed, they will switch to another insurer as soon as possible. Yet insurance companies are in business to make a profit, and they cannot do this if they are forced to pay out as much (or more) in medical claims as they receive in policy premiums.

Some controversy centers on for what kinds of procedures that insurers should cover or pay. One newspaper article addressed the issue of smoking cessation programs. It discussed whether or not insurers should cover the cost of programs designed to help smokers quit. Some people argued yes, because these programs reduce claims paid for smoking-related illnesses.

Opponents said no, for three reasons. One, it is not fair to ask insurance companies to foot the bill. Two, there is no guarantee that the person will quit (success rates are estimated at thirty percent). And three, why should non-smokers pay higher premiums to finance these programs?[19] There will probably not be any simple solutions to these types of questions.

A hospital administrator must be well-informed of these debates, as they affect the hospital's image, revenues, and non-inpatient programs offered to the community at large.

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[19] ________, "Should Insurers Cover Quitting Smoking?," Washington Post Health, June 9, 1992, 17.

The following three Tables present the findings of the rank order of importance of the needs and wants for the constituent group **Third-Party Payers.** Table 17 presents the items in rank order for the time period "Yesterday" only. For example, the item ranked number seven, **Willingness to Negotiate Contracts**, was mentioned twice in the literature. Table 18 presents the items in rank order for the time period "Today" only. The same item ranked number two, with a score of 227 from the questionnaires. Table 19 displays the items alphabetically. The rankings of each item, by number, alphabetically, are portrayed for both time periods "Yesterday" and "Today."

TABLE 17

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent
Constituent Group: THIRD-PARTY PAYERS: Yesterday:
Literature Mentions by Rank and Frequency

Rank	Frequency	Item
1	10	Controls on Price Increases/ Rate Setting
2	8	Limitations on Benefits
3	6	Efficient Allocation of Resources
	6	Reasonable Cost Reimbursement
4	5	Equitable Contracts for All Third-Party Payers
5	4	Elimination of Unneeded Care
6	3	Control Payments to Providers
	3	Negotiated Contracts
	3	Protection Against Over-Utilization
7	2	Quality Care
	2	Willingness to Negotiate Contracts
8	1	Focus on Managed Care
	1	Power to Define Quality Care
	1	Reduction of Duplication of Services
9	0	Physician Delivery Systems

Source: Tabulated for this dissertation

TABLE 18

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the Constituent Group: THIRD-PARTY PAYERS: Today: Questionnaire Responses by Rank and Score

Rank	Score	Item
1	231	Quality Care
2	227	Willingness to Negotiate Contracts
3	226	Reasonable Cost Reimbursement
4	225	Efficient Allocation of Resources
5	223	Protection Against Over-Utilization
6	221	Elimination of Unneeded Care
7	212	Focus on Managed Care
8	210	Negotiated Contracts
9	208	Controls on Price Increases/ Rate Setting
10	206	Physician Delivery Systems
11	194	Reduction of Duplication of Services
12	187	Power to Define Quality Care
13	186	Equitable Contracts for All Third-Party Payers
14	184	Control Payments to Providers
15	177	Limitations on Benefits

Source: Tabulated for this dissertation

TABLE 19

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

The Needs and Wants Items of the
Constituent Group: THIRD-PARTY PAYERS: as
Ranked by the Time Periods of Yesterday and Today

Number	Item	Rank Yesterday	Rank Today
1.	Control Payments to Providers	6	14
2.	Controls on Price Increases/ Rate Setting	1	9
3.	Efficient Allocation of Resources	3	4
4.	Elimination of Unneeded Care	5	6
5.	Equitable Contracts for All Third-Party Payers	4	13
6.	Focus on Managed Care	8	7
7.	Limitations on Benefits	2	15
8.	Negotiated Contracts	6	8
9.	Physician Delivery Systems	9	10
10.	Power to Define Quality Care	8	12
11.	Protection Against Over-Utilization	6	5
12.	Reasonable Cost Reimbursement	3	3
13.	Reduction of Duplication of Services	8	11
14.	Quality Care	7	1
15.	Willingness to Negotiate Contracts	7	2

Source: Tabulated for this dissertation

Nine of the 15 needs or wants items showed changes in ranking from "Yesterday" to "Today." This is evidenced from the rise or fall in the ranking from the literature findings to the questionnaire responses.

For "Yesterday," the six items in the top division received four to ten mentions in the literature. The five items in the middle division received two or three mentions, and the four items in the bottom division received zero or one mention.

For "Today," the six items in the top division received a score of 221 to 231 from the responses to the questionnaire. The four items in the middle division received a score of 206 to 212, and the five items in the bottom division received a score of 177 to 194.

Five items showed a positive change in ranking between the two periods, thus suggesting an increase in importance from "Yesterday" to "Today." This was evidenced from their rise from a lower division in the literature findings to a higher division from the questionnaire responses. These items were: **Focus on Managed Care; Physician Delivery Systems; Protection Against Over-Utilization; Quality Care;** and **Willingness to Negotiate Contracts.**

Six items showed no change in ranking between the two periods, thus suggesting no change in importance from "Yesterday" to "Today." This was evidenced from

their ranking in the same division in both time periods. These items were: **Efficient Allocation of Resources; Elimination of Unneeded Care; Negotiated Contracts; Power to Define Quality Care; Reasonable Cost Reimbursement**; and **Reduction of Duplication of Services.**

Four items showed a negative change in ranking between the two periods, thus suggesting a decrease in importance from "Yesterday" to "Today." This was evidenced from their fall from a higher division in the literature findings to a lower division from the questionnaire responses. These items were: **Control Payments to Providers; Controls on Price Increases/Rate Setting; Equitable Contracts for All Third-Party Payers**; and **Limitations on Benefits.**

In conclusion, the findings for this chapter showed that some items remained consistently high in apparent importance, others remained consistently low, and others indicated a possible change in importance.

However, it is important to remember that each of the 120 items were among the top of all 412 needs and wants found in the literature. On a scale of "1" to "5" ("5" being the highest), no item received less than a "3" as ranked by 54 hospital administrators.

CHAPTER FOUR: THE FUTURE ROLE OF HOSPITAL ADMINISTRATORS AS HEALTH CARE SYSTEM MANAGERS

A major focus of this chapter is on the future responsibilities of hospital administrators, especially regarding their evolution into health care system managers.

Eighteen experts in the health care field were interviewed for their opinions on the future of health care in the United States. The method for obtaining this information was through a set of eleven discussion questions which pertained to important issues at the time. Some of the questions and many of the responses were used to describe the changes in the total health care system which would produce a need for the changes in the role of future hospital administrators.

The responses to the questions were combined and analyzed. In this chapter, the questions are italicized, and the number of interviewees who responded to that question given. The responses were categorized and grouped by similar ideas.

It should be indicated that there are differences of opinions expressed, some of which are contrary to conventional wisdom but are shown for total coverage of the contents of the responses.

Following the responses is a statement regarding the predicted future role of hospital administrators as health care managers.

Question 1A: *What do you see as the one or two major health care issues beginning with Year 2000?*

Fourteen persons addressed Question 1A. Because of the different ideas of what constitutes a major health care issue, the comments have been grouped into sixteen categories. They are portrayed in descending order according to the amount of information within each category.

HEALTH CARE COSTS

Competition

-- Part of the problem is that there is too much competition - too many physicians, hospitals, and too much high technology equipment.

-- Competition was once thought to be a method for controlling costs. But as more physicians came into an area, total health care expenditures rose.

-- Most hospitals now do not now make a profit, and as a percentage of total hospitals, there are only a few for-profit hospitals. Hospitals need to develop programs and cooperate with physicians, and not compete.

-- Physicians want more high technology equipment to better serve their patients. They want to perform surgery rather than to employ less costly forms of care. Yet the patients are not necessarily better off. HMOs and physicians are

the gatekeepers to the system, and therefore must be part of the solution.

Control

-- There is a tug of war between physicians, hospitals, and third-party payers. Physicians often feel that they are losing control over health care delivery. A physician may want to keep a patient in the hospital, but the hospital administrator wants to discharge the patient after the maximum days that will be reimbursed are used.

Unnecessary Treatments

-- Another problem is the increased demand for more testing and treatments not necessarily medically indicated. It is not the high cost equipment that is the problem, but the fact that there is underutilization of equipment on a regional basis, and, at times, unnecessary utilization for the diagnosed condition or illness.

-- Many effectiveness studies should be done to see if something is effective or not, as opposed to just going along with something because that is the way it has always been done.

Ethics

-- Part of the overall problem involves ethical issues. So much money is spent during the last months of life. Yet it is often the family that

does not want the treatment to end. Hospitals may form ethics committees, who will make collective decisions.

-- The community needs to balance what is possible medically, with how and who will pay for the health care.

Total Cost

-- The percentage of GNP that will be spent on health care will increase, maybe as high as 20 percent by the year 2000. The locations of providing treatment will change, shifting from hospitals to Surgi-Centers or home care. A cost to the health care system still exists, although in some locations the costs may be lower, particularly in a managed care environment.

QUALITY OF HEALTH CARE

-- Corporations want treatment information on quality of care. Sometimes employers are getting impatient for answers. Some examples are: How much "value" does a fitness center have? How can you [a health care organization] prove you are providing high quality care? What are the indicators to quality care?

-- Regarding infant mortality in the USA vs. in Scandinavia: some people think America has a terrible health care system because of the number of poor outcome babies. America is a melting pot

vs a closed society, with many other factors involved, including low birth weight babies and high-risk mothers.

-- The quality of health care in America is excellent if a person can afford it. One suggestion: find the best treatments and share the knowledge.

-- Hospitals will begin to see that they have a responsibility to the community. Medical students in a Florida medical school have to treat homeless people as part of their curriculum, demonstrating community resource utilization and human compassion.

-- Hospitals and health care staff must heighten their awareness of humanity.

-- Hospitals can increase good outcomes by providing patients with more information, knowledge of support groups, and out-patient clinics.

-- Patient satisfaction is a very real part of quality patient care. Patient satisfaction is paramount, or they will not come back to a particular hospital.

LONG-TERM CARE

-- Too often elderly people are taken advantage of because of their age. They have no recourse through malpractice, because payments are based on productive life expectancy. So a person who

is 85 years old, and long since retired, cannot recoup as much from a malpractice claim as a younger person.

-- One source indicated that not enough people represent the patient's interests. Although family and friends often are an informal support system, the patient sometimes still is taken advantage of, because the family almost always complies with the doctor's advice.

-- In a hospital, physicians can usually do whatever they wish. Physicians can still do whatever they wish even if their patients have Living Wills.

-- Theoretically, a physician should honor a Health Care Directive. Yet whenever there is a Durable Power of Attorney for health care, the family will often do what the physician recommends rather than follow what the patient wanted.

-- Custodial care is a problem for many elderly persons. Many people will end up in Skilled Nursing Facilities.

-- Custodial Care insurance is very expensive, and most expensive when purchased by the elderly. A person has to be paying for it for many years when young. Then, there is the possibility the person will never need or use the care.

-- Medicare does not usually pay more than two weeks of long term (custodial or Skilled Nursing Facility) care.

-- An expanded notion of long term care is being utilized. Chinatown, in San Francisco, has its "On Lok" demonstration project. It provides many medical procedures that are reimbursed by Medicare. This was born of inspiration, not just the financial side of health care business and combines most available funding mechanisms.

-- On Lok harkens back to responsibility to the community. On Lok provides transportation to and from the facility, meals, social support, nursing care, and medical care. It is described as an expanded, innovative approach to long term care.

ACCESS TO HEALTH CARE

-- Hospitals may continue to downsize, develop home care services and outpatient care services, and decrease inpatient care services.

-- More physicians may refuse to perform certain procedures, or cease treating certain patients (such as Medicare and Medi-Cal), or quit practicing medicine outright.

-- Another issue related to access of health care is the difference between what access is needed vs what is wanted. The public should say and

participate in setting priorities about what is needed vs what is wanted.

- The United States may return to the early days of kidney dialysis, where there were committees who decided who received such treatment.

ACCESS TO HEALTH CARE INSURANCE

- The problem is not access to health care, but access to health insurance, at a reasonable cost, particularly as compensation mechanisms change.
- Public opinion polls have shown that the public wants to pay a premium of about $25 a month for health care insurance. Yet they spend an average of many times that amount per year, not including their premiums. Policy makers need to define a proper and fair premium.
- Even those who have health insurance may have trouble obtaining coverage. Third-party payers are reducing how much they will pay for any given item, and decreasing what they will pay for.
- One of the worst problems is if someone has a chronic medical illness, and for whatever reason they need to change insurance companies, often they can no longer acquire insurance coverage for what then becomes a pre-existing condition.
- The impact of the problem of health insurance access is driving people to managed care because of the lessening of the financial risk.

INSURANCE

-- People want portability, having the option to continue insurance with a new employer. The public often becomes confused when changing employers due to the changes in insurance company and coverage.

-- People also do not understand the differences between HMOs, PPOs, and fee-for-service. As time goes on, there will be less choice, higher co-payments, and more rules to learn in order to get service.

-- The profits of health care dollars are going to the insurance companies - not the caregivers. Physicians only receive 18 percent of the health care dollar. Insurance companies receive 30 percent, and 40 percent goes to hospitals and related people. Yet it is the physicians that have the headaches of patients calling them at 2:30 am.

NATIONAL HEALTH INSURANCE

-- At least 37 million Americans still do not have access to health care, other than by utilizing an emergency room.

-- Five of the six persons interviewed who mentioned National Health Insurance said that America will have some form of government support as part of

the health care system by the year 2000. One said it would not.

-- The federal government has made attempts at comprehensive health planning (such as Certificate of Need) but nothing has worked so far.

-- One of the key issues is rationing, and what should be in the basic health care package. The citizens of Mexico have a constitutional right to health care, but the constitution does not address what level of care.

-- Provisions to maintain good health are the most essential. The public needs to decide what goes in the basic package. Items such as infertility treatments or cosmetic surgery may be desired, but are not necessarily medically required.

-- The medical profession can help rank, but not make the cut-off lines between what is wanted and what is needed.

-- Everything has some level of good. But society will be required to do the apportioning.

-- There must be a rational basis for allocating health care based on need.

-- Everything is rooted in economics. Someone who wants more care or a higher level of care, and is willing to pay for it, should be able to do so.

-- One person interviewed sees the reimbursement system in terms of changing incrementally, and probably never going to a one-payer system like Canada. This person thinks America will probably always have some fee-for-service and indemnity plans.

-- Health care reform may be resolved by the year 2000. It is a public issue, and the politicians consider it a huge political issue.

REIMBURSEMENT

-- Reimbursement is still going to be extremely important in the year 2000, and far beyond. Some caregivers will get better at working within the system and will reap financial rewards.

-- America probably never will have a standard fee for anything. People want choices. They do not want an assigned physician. They do not want to be told, "You do not fit the criteria for such and such a procedure, therefore, we will not provide it for you."

-- When people do not have the responsibility to pay the bill, they do not care how much money is spent.

MEDICARE AND MEDI-CAL

-- At this time Medicare and Medi-Cal pays for too many things; the payments are spread too thin.

-- Yet Medicare is covering fewer and fewer services. Chronic problems also are not addressed by Medicare. Therefore, much of the costs will be shifted to the patients, particularly as fewer and fewer physicians accept Medicare patients.

-- More insurance companies will offer Medicare Supplement policies.

-- Elderly people do not often need acute care, but they need home care, partly because they often no longer have extended families as support systems.

-- What mechanisms will this country use to take care of the elderly? England has home health care as part of its delivery system.

-- Third-party payers like home care because it is less expensive than acute care. Yet Medicare was not designed to pay for home health care.

-- One of the biggest Medicare issues is: should the total dollars spent decrease in the last several weeks of life? Yet, no one can accurately predict when a patient's last day will be.

PREVENTION OF HEALTH PROBLEMS

-- America cannot provide every kind of health care treatment to everyone. We need to return to basics and prevent severe problems. We need to reduce demand for high technology, high cost diseases - particularly the self-inflicted ones

(smoking, substance abuse, accidents [even though seatbelts and helmets help]).

-- Older people are often taking better care of themselves. Yet many younger people are terribly self-abusive.

-- Hospitals are smaller and more specialized than ever before. Increasingly, more care is given on an outpatient basis, with emphasis on prevention.

HOSPITAL ORGANIZATION

-- Hospitals have to be health care organizations or parts of health care systems.

-- Hospital administrators have to look at the larger picture, not exclusively the acute care episode of the patient, and the costs associated with direct services. The larger picture includes services to the community, and partnerships with constituents.

-- Redesign of work and commitment to positive outcomes are at the forefront of the need for change.

-- Hospitals have to find a niche and attempt to garner market share. They cannot have a full range of services as they did in the past.

-- Health care is a service industry, yet hospitals must be run as businesses. Hospitals have been reluctant to look at other businesses to see how

government regulations and competition will affect them.

-- Departments in hospitals are becoming separate profit centers, and each one is being held individually accountable.

-- The health industry is changing. It is becoming more integrated and holistic.

-- There will always be a few sophisticated high technology tertiary care facilities to perform procedures such as transplants. However, particularly in urban areas, smaller health care organizations have merged into integrated systems.

-- The future health care system may resemble the Kaiser model.

-- When hospitals merge, duplication of services is reduced, and purchasing power increases. When a group of organizations unite, they can obtain lower prices; they have a lot more bargaining force.

-- Some people are optimistic that consolidations will begin to bring some systemization to health care.

-- If one organization does not make system/business decisions to rethink the delivery of health care, another organization will.

-- One person talked about two hospitals in the Midwest that merged, dropped the combined acute care beds from 750 to 500, then scrapped the whole thing and built a medical complex outside of town. The complex is composed of 120 acute care beds, a medical hotel (for the time that the patients do not need an expensive acute care bed, prior to surgery and/or testing), a huge diagnostic and treatment center, home health services and storefront (for purchases), resource center, long-term care facility, and a medical office building (for physician offices). Associated with it is a restaurant and fitness center. The total center has joined forces with the major employers (corporations, developers, community, and even a fitness center) in the area, and they are doing this collectively.

HOSPITAL LEADERSHIP

-- The health care system needs leadership, because now it is in a terrible disarray.

-- Hospital administrators are often not aggressive enough. Physicians will become more active - for their own survival.

-- One person interviewed thinks physicians caused the mess; they are described as being greedy for high incomes and clamor for expensive, high technology medical equipment, but they will not

admit fault. They want to blame the hospital administrators for not doing their jobs right.

-- Physicians are starting to take the lead again in the health care system. Physicians are attending conferences, getting into hospital management, and more involved with the community.

REGULATION

-- Regulating hospitals by "peer review" is better than by State review. Doctors should review doctors. Physicians must have the information in order to provide good review; peer review gives more protection.

-- The greater good (greater disclosure) has to come about within the profession.

-- The state can only hold an organization to a bare minimum of care; the Joint Commission on Accreditation of Hospitals (JCAH) and the Joint Commission on Accreditation of Healthcare Organization (JCAHO) can do more.

-- Optimal quality can be strived for through accreditation (a voluntary) process.

INFORMATION TECHNOLOGY

-- America is behind many other countries in this area. The health care industry is not as aggressive in the application of information technology as are other businesses.

-- America has the technology, but the health care system does not use it well, particularly in terms of dealing with patients. Other companies keep profiles of their customers (Domino Pizza and BlockBuster Video. The magazine _Parent_ sends copies tailored to the age of the child).

-- Information technology is being used extensively in customer service. In the future a physician will be able to look at the computer screen, see all the pertinent information on the next patient, and know why the patient is coming in.

-- Physicians need to be able to "bond" with their patients: remember to ask things like "How is Johnny doing in school?" That type of bonding will build patient loyalty.

Future Medical Problems

-- Within the next three decades, some new diseases will arise, such as mutations of viruses and bacteria, and, if they are communicable diseases, they will spread more readily because of the increased mobility of people.

-- Some of the causes of the diseases will be environmental and some due to changes in the lifestyle of the population.

-- It is not surprising that there is not yet a cure for AIDS. Viruses are extremely difficult to study. What is surprising is that researchers

have learned as much about AIDS as they have. According to an article, "One frustrating fact about the global AIDS epidemic is that almost every new case could have been prevented."[20]

-- Many other diseases can be prevented or alleviated through better nutrition or sanitation. Attitudes and behaviors, particularly sexual behavior, need to be changed, not only physical conditions.

ADDITIONAL DISCUSSION POINTS

-- Older women having babies generally have more health problems; also, their babies often have more medical problems.

-- Chemotherapy only controls symptoms; it cannot cure disease. It also does not lengthen life, it only makes the symptoms easier to bear until the patient dies.

-- Patients want their physicians to have plenty of confidence.

-- Schools should not train people to become hospital administrators only, because it is a dying breed. Instead, people should become trained as Service Care Specialists.

-- There are many compassionate caregivers. The health care system is not compassionate because

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[20] ________, "AIDS," The Economist, 21 September 1991, 21-24.

it is based on economics. The patients are the ones who are affected.

-- A Health Maintenance Organization (HMO) is similar to preventative maintenance on a new car. A person pays the money up front, then the car is taken care of for all these different things. People do not complain too much about paying several hundred dollars for car repairs, yet they may object to a $200 health check-up, and they will resist going to one.

-- Physicians should learn as much about the system as they can, so that the physician can use it to the best advantage.

-- A physician will not have many patients if the physician does not belong to an HMO or IPA. If people work for a company, and it offers several medical plans, if a physician does not belong to one or more of them, there will not be many patients left from which to choose.

-- Workman's Compensation and health insurance companies are often in conflict, and attorneys are in the middle.

-- No one group in any health care organization is in control anymore. Third-party payers pay the bill, and therefore they want control. The patient, as the client, is usually not paying the bill.

Question 1B: *How will these one or two major health care issues impact your organization?*

Seven persons addressed Question 1B.

-- A major health insurance company is going to do a better job of health promotion, such as through its publications which are available to subscribers, as well as doing a better job of being cost efficient, and assessing effectiveness of treatments.

-- The CEO of a health care organization welcomes the increased physician involvement into management.

-- A firm doing business with hospitals and physicians said that finding primary care physicians is their biggest problem.

-- Primary care physicians are on the low end of the totem pole status-wise, so fewer medical students go into that specialty. Yet, now they are in big demand from HMOs since they do the referrals to other specialists.

-- Health care institutions are much more flexible toward real time planning. No longer do they have five-year plans; two to three years is all they can project forward.

-- Most hospitals are now part of a system. The survivability of some individual hospitals within

systems may not be threatened, because of their system affiliation.

-- A hospital system can become so large it becomes a bureaucracy. Its focus may change, such as working to develop new products to fit its financial structure. Some of those systems will develop strategies to provide high quality care with appropriate care, at a reasonable cost.

Question 2A: *What do you see as the major changes that may occur?*

Seven persons addressed Question 2A.

ACCESS TO HEALTH CARE

-- Hospitals will not be able to continue to bear the costs of treating the medically uninsured. There will be changes to provide access to the 37 million uninsured; the changes will probably occur in incremental reforms.

-- If available access is not expanded, America will probably have some form of national health insurance coverage initiated for a portion of the population.

HOSPITAL ORGANIZATION AND SERVICES

-- Not as many hospitals are closing as predicted, but many are merging. Hospitals will consolidate into health care systems, often uniting with third-party payers. Merging results in shared services and less duplication.

-- Model hospitals will integrate physicians and information systems, and offer a wider range of outpatient services.

-- There are changes in the mind-set of individuals involved with the system. In the past, hospital administrators had always wanted to increase inpatient load. Now they know that outpatient care is often better and may be provided at a lower cost.

-- Tertiary care is different from outpatient care. There will always be a need for high technology medical services such as cardiac surgery, neonatal wards, and cancer treatment centers.

PERSONNEL

-- There is more room for the increasing number of people are coming into health care organizations.

-- Besides nurses being utilized in hospitals, they are needed by insurance companies as auditors. More layers of use exist in the field.

-- Some people think that a majority of Californians will be in a managed care system in the future.

PHYSICIAN CHANGES

-- Physicians will align themselves in the future with only one health care system. Physicians will need to pick one hospital or delivery system and remain with it.

-- Physicians will see more patients for less money, and they will find new ways to run their practices.

REIMBURSEMENT

-- A big change will be that Medicare and Medi-Cal will contract for health care through selected providers within a capitation system[21].

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[21]Capitation is a method of paying a physician for annual services based on a fee per patient.

Question 2B: *How will your organization adjust to the changes?*

Four persons addressed Question 2B.

-- A respondent for a health insurance company says it will adjust, and wishes to play a role in making changes and improving the health care system. If a National Health Insurance plan comes, most health insurance companies, as they exist today, will be out of business. They may evolve to something else.

-- One person said her health care organization will grow to accommodate the increasing market.

-- Another person said that internally this large health care system will simplify. It must become more efficient and less bureaucratic.

-- Another person interviewed from one large hospital system indicates that the organization is purchasing or merging with third-party payers and Independent Physician Associations (IPAs); it is becoming more integrated.

Question 2C: *What current plans does your organization have to prepare for the foreseen changes?*

Two persons addressed Question 2C.

-- The hospital of one respondent is in a good position. It is a model, and seen as a leader.

-- The health system of another respondent is present in much of Northern California. It is building a full range of services to accommodate the foreseen changes.

Question 3: *Which scenario is more likely? More emphasis on prevention of health problems and diseases or expensive equipment and high tech cures?*

Nine persons addressed Question 3.

SCENARIO ISSUE

-- Modern medicine cannot treat some chronic diseases, but it can prevent the onset of others (prenatal care does help prevent many neonatal problems). In an effort to address this issue, at least one insurance company has identified those women who would be potentially high risk patients if and when they are pregnant.

-- So many things are now taken for granted but which may come up in future research, years from now, as harmful to our health.

-- What are people doing now that will be found later to be deleterious? Is it possible that microwaving so much of our food has harmful effects that will not show up for many years?

-- Stress, environmental problems (such as air pollution which can lead to respiratory problems), and other influences may affect our collective health to a greater extent than now known.

EMPHASIS ON PREVENTION OF HEALTH PROBLEMS AND DISEASES

-- It makes more economic sense to put money into prevention; therefore the government may lead the system in that direction. Several of the persons

interviewed said they would <u>like</u> to think the emphasis will be on prevention.

EMPHASIS ON EXPENSIVE EQUIPMENT AND HIGH TECH CURES

-- Americans have not reduced their dependence on technology of any sort. People will almost always want the best care possible.

-- Short-term emphasis may be on high technology cures, because the machines and drugs are available for immediate use.

-- Over time, the costs of expensive treatments generally decrease. Already, lasers, non-invasive procedures, and other newer medical techniques have reduced some of the costs of health care.

-- Many people will not choose to have the healthy lifestyles needed to make prevention most cost effective in the total. There will be still be people who are overweight, smoke, and illegally abuse drugs.

-- The average person may disregard the knowledge on prevention of heart disease and eat what is wanted. When it is too late, the person will get a coronary bypass, <u>then</u> eat healthy food.

-- Other people will have diseases and accidents which will keep them dependent on technology.

EMPHASIS ON BOTH

-- One person interviewed sees not only an increasing emphasis on prevention, but also increased money spent on expensive equipment and high technology cures.

PROBABILITY

-- For the long-term, prevention will probably prevail. However, there will not be a cessation of high technology treatment modalities, and there will always be a demand market for advanced technology and expensive equipment.

-- In addition, decreasing funds for high technology equipment may also diminish benefits to research and development in general.

Question 4: *Is it reasonable to enforce healthy life-styles for employees in order to gain lower health insurance premiums for the employers?*

Nine persons addressed Question 4.

RESPONDENTS' COMMENTS

-- This is both a civil liberties issue dealing with attitudes and a labor relations/employee rights issue, which will probably be decided by the courts.

-- The issue is complex. Confidentiality needs to be considered. Not having a healthy lifestyle increases chances of getting ill, while other risks are genetic. Yet, can society separate negative lifestyle choices from involuntary medical problems?

-- The medical condition should be measurable and objective, and the employee should be able to control the problem (illegal drugs vs diabetes).

NO, IT IS NOT REASONABLE

-- Four of the nine people who responded to this question said that it was not reasonable. There is a limit on how much an employer can affect lifestyle.

-- The government cannot legislate a healthy lifestyle or morality. On this issue, there could well be a backlash if freedoms were limited.

<u>YES, IT IS REASONABLE</u>

-- Three of the nine people who responded to this question said that it was reasonable. The consensus was that the employer should pay the base premium for a healthy lifestyle. Any cost over that should be borne by the individual who chooses to engage in high risk behaviors.

-- As an example, smokers, or those persons considered obese, could pay a surcharge to cover the higher costs of health care associated with a non-healthy lifestyle.

<u>PROBABILITY</u>

-- In the future employers will likely provide incentives, such as a reward system for employees taking care of their health.

-- For example, if an employee uses the company gym on a regular basis for six months, that person could receive an extra week's vacation. Another possibility could be to provide a rebate to the employees who do not use all the health care monies "allocated" to them.

-- Health promotion programs will come into vogue, <u>if</u> there is a proven cost savings. Peer pressure and positive reinforcement are starting points.

Question 5: *What is your opinion of the Harvard resource-based relative value system (RBRVS)*[22] *on payment to physicians?*

Seven persons addressed Question 5.

<u>RESPONDENTS' COMMENTS</u>

-- RBRVS might have been created to provide a total cost reduction to Medicare.

-- Hospitals were starting to see the impact of RBRVS, in how RBRVS is squeezing some physicians.

-- In December 1991, 90 percent of physicians in a certain hospital had no idea how RBRVS would impact them. For example, the policy of HCFA (the financial arm of Medicare) was that on January 1, 1992, HCFA would pay primary care physicians a bit more to read EKGs, as opposed to having cardiologists read them in hospitals. The panel of cardiologists who used to read all the EKGs came to the administrator and said that the primary care physicians could not do an adequate job in reading the EKGs, and that the cardiologists are the only ones who know how to do it right. However, since Medicare was not going to pay them to read EKGs anymore, they wanted to be paid by the hospital.

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[22]RBRVS assigns monetary values to medical services based on resources used to provide services. RBRVS consists of three components, including physician work value and professional liability insurance value. Reimbursement rates are calculated using geographically modified relative values for local medical costs.

-- Yet, with some exceptions, it is illegal for hospitals to pay physicians. That would make physicians employees of the hospital, and California law specifically (at this time) forbids the corporate practice of medicine.

PROBLEMS WITH THE SYSTEM

-- The government has not done an adequate job of implementing the RBRVS.

-- The incomes of primary care physicians as well as specialists are dropping.

-- If the RBRVS system was designed just to decrease total expenditures, then it is a bad idea. If it was done to shift incomes from the specialists to primary care physicians, then it is fine. Either way, physicians will find a way to make money using the system.

OPINIONS

-- RBRVS is a good concept; however, it is not yet practical.

-- Fundamentally the system is sound, but it needs to be implemented as it was originally intended.

-- There were many complaints. Perhaps the factors are not quite accurate in terms of the training, performance time, and malpractice risks.

-- Even so, too many people do not understand it. More experience will determine if it will work. This is the best system we have to date.

Question 6: *Where does the consumer's desire to have information regarding a physician's or hospital's Patient Outcomes record stop in favor of the physician's or hospital's desire for privacy?*

Eight persons addressed Question 6.

<u>RESPONDENTS' COMMENTS</u>

-- All respondents gave the opinion that the information should be available to anyone. Much information on quality care (provided by epidemiology personnel) is already known in aggregate form for hospitals.

-- However, how does one measure the quality of care? The debate centers on what variables should be considered to measure the quality of care. The data should be risk-adjusted and explained before being released to the public.

-- Physicians should also reveal their outcomes records, but they should be able to explain the factors that affect their numbers. The patient should ask the physician in question. But one of the big problems is that patients do not always know what questions to ask.

-- People should have the information, and be allowed to choose a physician or hospital based on whatever factors the patient thinks is important.

Question 7: *Should health care insurance companies be able to engage in selective enrollment or refuse to enroll high risk patients?*

Nine persons addressed Question 7.

<u>RESPONDENTS' COMMENTS</u>

-- Of the nine persons who responded to this question, only one answered "yes," then qualified the response with the opinion that the government should tax (on profits) the third-party payers to fund the premiums for people in a high risk pool.

-- Eight persons responded "No" to this question. So many people are high risks, not by their choice, but by genetics or accidents.

-- One person asked, "<u>Who</u> should pay for these people?" Ultimately society will, no matter what mechanism is utilized.

-- Insurance companies should conform to standards. All should do the same thing - start with an even playing field.

-- One respondent would favor a return to a community rating, if all companies were under the same regulations.

-- All companies should spread risks, not avoid them, which will require legislation. Yet some insurance companies are starting to enroll higher risk people, thus spreading the total risk.

-- Payers and providers should be jointly charged with caring for people.

-- Health insurance companies should spread, not avoid risks. The insurance companies should be forced to enroll all comers, and compete in other ways.

-- Open enrollment will probably require legislation. Government intervention may be needed to fairly distribute high risk patients among the health care insurers and to ensure that the carriers conform to standards. Some states have systems in place now to perform this function.

Question 8: *Will health care rationing become more obvious?*

Ten persons addressed Question Eight.

RESPONDENTS' COMMENTS

-- Many of the persons who responded to this question commented on the various forms of rationing of health care already in existence in America.

-- One person said it has to become more obvious.

-- Another said that because the technology is available, many people feel we have to use it. America is the only country in the world which gives expensive technology to anyone and everyone because we feel it is their right - while millions go without any health care at all.

-- Consumers are becoming more aware of their choices. More people want choices of treatments (including the option to choose death). The patient has to decide.

-- Assisted suicide and euthanasia are two forms of health care rationing that are not always considered. Formerly most people died with dignity and at home. Later, because the technology was available, it became imperative for the physician to use every heroic method to save lives.

-- Older parents are beginning to tell their children what they do not want done, trying, in

advance, to exonerate the children of guilt for withholding treatments.

-- There will be an increasing acceptance of euthanasia. This increased acceptance should not interfere with proper treatment.

ECONOMICS AND ABILITY TO PAY

-- Economics dictates that we cannot afford everything that is medically possible. Cost and access will be the rationing agents.

-- There has always been rationing. It has been based on ability to pay, always has been, and always will. Every person cannot have everything, and then be able to sue if he/she does not have a perfect outcome.

-- Rationing is already in effect. It is based on the individual's or sponsor's ability to pay. Is America going to change the basis on how health care is rationed? Is need vs ability to pay the correct choice?

ETHICS

-- When kidney dialysis was new (in the 1960s), committees decided which patients would benefit most from the machine's use.

-- We, in America, value people because of what they can do for society rather than because they are made in God's image, and ergo, sacred.

- American health care rationing can be done by age, as in England.
- Some authors want to "desanctify" human life. These authors ask, "Why should animal life be sacrificed to find treatments and cures for human life - what is inherently more holy about human life?" This desanctifying of human life plus social dysfunction and the financial cost of health care may lead to euthanasia.
- One person interviewed sees nothing wrong with palliative care and comfort while dying. However, the "intent to kill" is always wrong in a health care setting.
- The uninsured should get some health care - but not all things. They do not necessarily have a right to tummy tucks and other cosmetic surgery.
- One person thought that health care is a right, and that the United States will evolve into a dual health care system. Everyone should be entitled to receive the basics, and those that can afford to get more, will.
- Medicare/Medi-Cal was designed to pay for everything. Soon the government learned it could not provide everything that everyone wanted.

Question 9: *By the year 2000, will "coordinated care" cover at least 75 percent of Americans who have health care insurance?*

Nine persons addressed Question 9.

RESPONDENTS' COMMENTS

-- Coordinated Care is a form of networks of physicians and hospitals with utilization review.

-- Coordinated Care is a euphemism for managed care. Indemnity plans used to market themselves as not being managed care.

-- Totally unmanaged fee-for-service health care is rare today.

YES, COORDINATED CARE WILL COVER AT LEAST 75 PERCENT OF AMERICANS

-- Seven of the persons who responded to this question answered "Yes." America is moving in that direction; California continues to be far ahead of the country. Almost 80 percent of the population is now covered in California. But it will probably never reach 100 percent due to the want of the population for some choice, however small, in a pluralistic health care system.

-- Of the people in the Bay Area, 53-54 percent are enrolled in a traditional HMO with a large percentage of the remainder in other managed care systems.

-- Larger companies are narrowing the health care insurance options for their employees. Instead of having half a dozen plans, there may be only

two: choice of Kaiser or a managed care plan (PPO, HMO, Blue Cross, Blue Shield) and fee-for-service.

-- Until the late 1980s, third-party payers paid whatever the bill totaled. Starting in the late 1980s they began to not pay the full bill, began reducing payment through contracts, and phasing out certain procedures for which they formerly reimbursed.

-- Complete coordinated care may be the first step to National Health Insurance or socialized medicine. At least one person interviewed believes that National Health Insurance will come, maybe not by the Year 2000, but soon thereafter.

INTERVIEWER'S COMMENT

-- It seemed as though people could only get insurance when they were relatively young and healthy, because companies were dropping people when they exceeded their monetary limit.

NO, COORDINATED CARE WILL NOT COVER AT LEAST 75 PERCENT OF AMERICANS

-- Two of the persons who responded to this question answered "No." There are too many health care insurance companies, too many different systems, too much paperwork to think that America will have that many people insured through a managed care system.

- Currently, 30-40 percent of every health care dollar spent is for the administration of insurance programs.
- Depending on the definitions used, many of the indemnity insurance programs could be considered managed care.

Question 10: *What, in your view, is the future of private health insurance in the United States?*

Eight persons addressed Question 10.

<u>ISSUE</u>

-- Under capitation, physicians have to work more cooperatively with hospitals.

-- The relationships are changing between hospitals and physicians. Some hospital administrators are trying to get their physicians involved more in the problems of the hospital.

<u>THE FUTURE OF PRIVATE HEALTH INSURANCE IS BLEAK</u>

-- Four persons who responded to this question saw the future of private health insurance as bleak. One person said that "moribund" explains it all.

-- Less than 10 percent of the people in Sacramento have indemnity insurance plans, because the plans are much too expensive. Most of the plans are employer-based, and since many people are not employed, or are employed but have no health benefits due to the high cost, there is no opportunity for coverage.

-- The above problems make the indemnity system terrible. It is being replaced by (HMOs) and Preferred Provider Organizations (PPOs); some type of managed health care will be the future.

THE FUTURE OF PRIVATE HEALTH INSURANCE IS BRIGHT

-- Three persons who responded to this question saw the future of private health insurance as bright. The private sector has much to offer.

-- Americans will probably be happier if private insurance companies survive, but the industry needs to find solutions to the problems of cost containment.

-- The industry will be strong and healthy, yet smaller.

-- In the United Kingdom, there is one system, and it is good.

-- One person who responded does not see a National Health Insurance plan in the near future. This person said that America has, and always will have, a pluralistic insurance system.

PROBABILITY

-- Several people saw a mix of systems. America will provide the availability of health insurance to everyone. A basic plan will include: prenatal care, emergency room care, physical examinations, and acute care. This may be accomplished through the existing health care providers and insurance carriers.

-- There would also be other health insurance plans to cover the extras. Not many insurance plans provide totally comprehensive anymore.

-- These supplemental plans would create a two-tiered system (national and private insurance), but America has a three-tiered system (private insurance, Medicare/Medi-Cal, and no insurance) now anyway.

-- Perhaps there will be a Regional Insurance Plan. This could be an answer, particularly if it included Medicare and Medi-Cal. All premiums would go into a pot, and perhaps the total expenditures could be less. Money will be spent on those things demonstrated to improve health status.

-- Indemnity plans probably will not survive much longer. One person thought that soon after the year 2000, the United States will have a National Health Insurance plan. In the early 1990s, there were too many groups who opposed it.

Question 11: *Is the traditional three-legged stool (Hospital Administrator, Board of Trustees, and Medical Staff) becoming obsolete? If so, what will replace it?*

Nine persons addressed Question 11.

RESPONDENTS' COMMENTS ON THE CURRENT SITUATION

-- The three-legged stool does not always work. Hospital administrators and physicians are often battling. Physicians want the expensive equipment, yet the hospital administrator must adhere to a budget.

-- The administrators are often taken aback if their authority is questioned. At one time, hospital administrators, were social beings. They were often hired on their fund-raising abilities, and ability to establish rapport with people, such as involvement in community affairs, networking with the business establishment, and other social contacts with physicians and members of the Board of Trustees. They were not trained as managers; they took no business classes. That was acceptable as long as hospitals had cost-plus reimbursement. But now that insurance companies are cutting back on reimbursement rates, and hospitals are closing, hospital administrators must be managerially trained.

-- If physicians take over management responsibilities to a greater degree, there may be fewer lay hospital administrator positions.

-- Physicians exert major control on the number of patients in the hospital, since they admit the patients.

-- Physicians do not report to the hospital administrator, nor to the Board of Trustees. They are within supervision of the hospital's Chief of Staff.

-- In the past, physicians were not allowed on the Board, then there came the debates on whether or not they belonged. In recent years, more physicians are becoming Board of Trustees members.

-- The Board of Trustees is still out to the side; it generally only becomes concerned if the hospital is in the red financially.

THE TRADITIONAL THREE-LEGGED STOOL IS BECOMING OBSOLETE

-- Six of the persons who responded to this question believe that the traditional three-legged stool is becoming obsolete.

-- Some hospitals have added more legs, perhaps as many as sixteen. The patient has been noticeably missing. However, lately, consumers have more choices in health care plans and hospitals to which to go.

THE TRADITIONAL THREE-LEGGED STOOL IS NOT BECOMING OBSOLETE

-- Three persons who responded to this question believe that the traditional three-legged stool is not becoming obsolete.

-- The three-legged stool is becoming more integrated. It is similar to a melting pot, leading to a single entity, as opposed to being three separate legs.

-- The three new legs will be the third-party payers; the medical staff; and the hospital management, which will be composed of the hospital administrator and the Board of Trustees. The relationships will become tighter.

-- The relationships among the three legs are more complex and related to the community, and the payers, whether the payers are the government or private plans.

-- There is more dependence on the three legs now than ever before.

-- Physicians should know what is in the best interest of the hospital. They are also realizing that the hospital has to operate within a budget.

-- The Board of Trustees is interested in ensuring high quality care, and how the hospital is doing financially. The medical staff is more interested now in the governance.

-- Hospital administrators, Board of Trustees, and medical staff need cooperative and collaborative relationships. Health care corporation models will take over.

ADDITIONAL DISCUSSION POINTS

-- The future of cancer treatment is outpatient, dealing with prevention and patient education. The M.D. Anderson (University of Texas Cancer Center, a state-funded research and teaching institute) does a superb job. They have made tremendous changes in the model of cancer treatment.

-- When asked, "Who is the hospital's client? The physician, patient, or Third-Party Payers?" one response was that anyone who walks in must be treated as a client. Vendors, third-party payers, patients, physicians, volunteers, families; anyone and everyone. That is why collaboration and partnerships are essential to a healthy health care system.

-- Another person said that the customer can be many people. Sometimes the customer is another employee. For example, if a physician needs some lab results prior to ward rounds, the lab technician's client is the physician, not the patient.

-- Hospitals should be built or remodeled to be easily updated and not rendered obsolete as soon as the doors are opened. Now, extra space is being built into the structure for additions as needed.

-- The three things people care about when they walk into a hospital is: How does the air smell?, how clean are the floors?, and do employees smile and ask how they may help?

-- One respondent said that Leland Kaiser, Ph.D., a health care futurist, believes the way people are treated will change. Perhaps back to the old Greek style, with theater and laughter as part of the therapy.

-- After surgery, most people have fewer inpatient hospital days than years ago, and more procedures are being done on an outpatient basis. Hospitals will get better at wellness promotion, not only in care of the sick.

The health care experts interviewed predicted many changes in hospitals and other health care organizations. Whenever such changes occur, and especially as hospitals merge to form health care systems, the administrator's role will correspondingly change; it will evolve to that of a health care manager. This striking shift in the role and responsibilities of hospital administrators to constituent groups is still occurring and will undoubtedly continue to change in the future.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

In the previous chapters, a number of findings were reported. The purpose of this chapter is to draw conclusions based upon those findings and to make recommendations to Schools of Public Health, public health and other governmental agencies, and interested individuals.

EDUCATION

Through the questionnaires, current hospital administrators indicated which needs or wants items they felt were most important in relationship to the six constituent groups. Most of the items that ranked in the top third could be learned, in addition to work experience in a health care organization, in a college or university from five educational areas: general business administration or management, finance, information systems, legal aspects, and human resource management.

The curricula from 19 American Schools of Public Health were examined for course content. The number and content of core courses and electives varied widely among the schools. Displayed in Table 20 on the following page are the number of core courses required and the number of schools that require these courses under the educational areas shown. Appendix G contains a more comprehensive listing of the schools and course curricula.

Table 20

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Number of Courses and Schools

Number of Courses	Number of Schools	Topical Areas
31	15	Hospital Administration/Management
18	12	Finance/Fiscal Management
14	10	Management Information Systems for Health Care/Computer Applications
11	11	Legal Aspects and Regulations in Health Care
7	7	Management Principles of Health Care
6	5	Human Resources Management in Health Care

Source: Course Catalogs from Schools of Public Health

Despite the apparent need for education in these areas, only four of the nineteen Schools of Public Health required at least one course in each area as a portion of its core curricula. Four schools required at least one course in four of the five areas. Four schools required at least one course in three of the five areas. One school required at least one course in two of the five areas. Six schools, one-third of the total of nineteen schools, required at least one course in only one of the five areas.

During the structured interviews, several themes recurred throughout the responses to the discussion questions. Specific points were made on the costs of health care, the need to follow budgets and regulations, trust in the hospital's leadership, using

computers as information systems, and the changing legal aspects of providing health care.

Many more general comments were made regarding the management and administration of hospitals, the need for quality care for patients, being responsive to clients' needs, universal aspects of human resource practices, and the need for hospitals to be operated as businesses, which includes negotiation with various groups.

Business

Hospitals have become increasingly complex in recent years. No longer are hospitals simply workplaces in which physicians ply their trade. The intricate nature of hospitals require that they be operated as businesses. Therefore, the Chief Executive Officer (CEO) must have a thorough knowledge in the principles of running a business.

Finance

Hospitals administrators have learned that the financial side of the operation requires a detailed knowledge of the financial world. Although most larger hospitals will have a Chief Financial Officer (CFO), the CEO has ultimate responsibility.

Information Systems

Computers have a myriad of capabilities, many of which hospitals have yet to adapt to their purposes. Many office procedures in a hospital can be made more

efficient by the appropriate use of computers. However, hospitals cannot cease activity because "their computer is down." Manual back-up methods and procedures must be ready at all times.

Legal

Legal issues are also becoming more prevalent and complex in health care settings. Although no administrator should attempt to be the legal expert, a thorough knowledge of the basics is essential. This knowledge should cover the personnel as well as patient care aspects.

Human Resources

In addition to the physicians, no hospital can be run without the support staff. To provide for a smooth operation, the administrator must be knowledgeable about the proven, yet current human resource management aspects.

REGULATIONS

Hospitals have been especially impacted by the expansion of laws and government regulations. A difficult problem with these regulations is that they are often obsolete by the time the hospitals receive the changes. An administrator will be expected to stay abreast of such changes, decide how they will impact the facility, and begin preparatory work to comply with them.

Another problem is that one or more different government agencies have jurisdiction over one or more aspects of the operation of hospitals. Often these agencies provide regulations or guidelines that conflict with each other, and there is no clear lines of which agency takes precedence.

COMMUNICATION

Every hospital administrator must be proficient in three forms of communication: oral, written, and body language. Communication includes negotiation skills.

Oral

The administrator speaks with the Board of Trustees, medical staff, other staff, patients and their families, various community groups, including the media, and third-party payers. Addressing each group could require a different perspective and therefore a distinct shift in demeanor. Although on a day-to-day basis most communication is oral, the spoken word is often misunderstood or forgotten, especially if much is spoken at one time.

Written

Written words will compose the most enduring from of communication, comprised of, among many others, policy statements, personnel action records, and reports. Critical writing skills, designed to eliminate as much ambiguity as possible, is necessary because written words may be open to misinterpretation.

Body Language

A more subtle form of communication is body language. However, one's initial interpretation of body language may not always be correct. For example, arms crossed over one's chest can indicate stubbornness, hostility, or simply coldness. The identical gesture may have distinctive and yet separate meanings to different ethnic groups. In this culturally diverse nation, particular attention needs to be focussed on the elimination of postures or motions that are easily open to misinterpretation. Hospital administrators should be masterful in this art, especially as it applies to the cultures of the patients using the hospital's services.

Negotiation

An administrator will need to negotiate with many groups of people, beginning with finding the site for the hospital. Therefore, the administrator must be adept at negotiation, to balance the needs of the community, patients and their families, personnel, and physicians. The administrator must never appear argumentative or inflexible; rather, a demeanor of striving for a win-win situation should be portrayed.

1. CONCLUSIONS

The analyses of these findings led to the conclusions that:

-- Hospital administrators will be expected to be knowledgeable and competent in general business administration and management, financial, hospital information systems, legal, and human resource management aspects of health care administration.

-- Hospital administrators will be expected to comply with rapid changes in laws, regulations, and guidelines in the operation of their facilities.

-- Hospital administrators will be expected to be well-versed in the art of good communication, oral and written, as well as in the unspoken art of body language.

-- Hospital administrators will be expected to have excellent negotiation skills in dealing with many different types of groups.

-- It is imperative that hospital administrators gain and maintain the trust of all persons with whom they contact.

2. RECOMMENDATIONS

Schools of Public Health should:

-- Examine their curricula and intensify emphases on business, financial, hospital information systems, legal, and human resource management aspects of the administration of individual hospitals in addition to other health care settings.

-- Provide the resources where future administrators can become informed of what changes to laws and regulations that will affect their hospitals.

-- Provide opportunities for future administrators to practice good communication techniques through a multitude of methods and to a variety of audiences.

-- Ensure that students develop negotiation skills through such methods as role-playing exercises.

-- Provide lessons that teach ethics, especially in health care settings, to develop the need for a sense of trust between the administrator and the constituent groups.

Public health and other governmental agencies should:

-- Strengthen their collaborative relationships and continue to reduce any conflicting laws, regulations, and guidelines on the operation of health care systems and hospitals.

Interested individuals should:

-- Continue to monitor the operation of hospitals for efficient and effective provision of health care services.

The hypothesis, **The spectrum and type of responsibilities of hospital administrators has not changed from Yesterday to Today, and is not expected to change for Tomorrow**, is judged to be false.

The analysis comparing the needs and wants from "Yesterday" to "Today" showed many responsibilities of hospital administrators have changed in spectrum and type as well as apparent importance.

The content analysis of the discussions of eighteen experts in the health care field indicate that future responsibilities will be greatly different.

These analyses of hospital administrators' roles in the past compared to current roles and expected future roles has revealed a dramatic shift from the administration of a single hospital site by a medical professional to the administration of a major managed care health system or center by an equally well-trained business executive.

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Appendix A: Data Capture Frameworks for Eight Constituent Groups

Appendix A consists of the Data Capture Frameworks developed for this dissertation. As each book, article, or completed dissertation was reviewed, any item found that pertained to a responsibility of hospital administrators was noted on a form, with the assigned number and year published.

There were eight forms, one for each of the eight constituent groups. After many books were reviewed, it became apparent that the groups - Professional Organizations - and - Higher Headquarters/Regulatory Agencies - were not needed for this study. However, the Data Capture Frameworks are included in this appendix.

Source	YR	Terms
M 1	59	communication between hospital administrator and physicians
B 7	68	carry out policies, prepare budgets and reports, do personnel stuff, maintain physical hospital, cooperate with medical staff, other duties as assigned, attend all meetings, serve as liaison between Board of Trustees and medical staff
B 11	65	keep Board of Trustees informed, health care in general and hospital specifically, watch finances, don't move too fast, understand hospital goals, keep Board of Trustees and hospital administrator duties separate, assist new board members, get medical staff on Board of Trustees team
B 17	82	overseeing the medical staff conform to the bylaws regarding quality care and implementing the policies
B 21	66	training for old members and orientation for the new, send information on agenda prior to the meetings, trust, advice
B 25	69	implement policies, provide liaison, make reports
B 31	81	keep informed, provide feedback, budgets
B 42	68	in order to know what policies to make, the board has to know what the community's needs are, high professional standards, finances
B 43	78	power, based on capitalization and legitimation
B 44	80	prestige, social recognition, hospital administrator deal with regulatory agencies, financial solvency

Source	YR	Terms
B 45	86	selected by: ability to raise funds, social prestige, political persuasion; responsibilities: legal, moral and ethical, quality patient care, safety of staff and patients, financial well-being, well qualified management team, accountability from management and physicians, hospital's purposes and objectives, surveillance of fiscal assets, short and long term planning needs, identification of resources to management, system to review the plans, ensure CME, organized board, knowledge of finances, ability to digest reports and budgets
B 47	69	orientation for new members, expenses paid (not a salary), status, prestige, self-aggrandizement, political machination, kept fully informed by hospital administrator, counsel on policy-making, budgets
B 48	62	provide insurance to hospital; qualities: high sense of public honor, integrity, education, prestige, loyalty to hospital, know how hospital is run, statistics and information reports
B 86	84	more information and time prior to decisions
B 89	85	accountability from physicians, ability to select own replacements, hospital bylaws, expenses paid for attending meetings, (future: may be full-time and paid), lack of conflict of interest - no physicians on board
B 104	82	financial solvency
B 105	48	participation on committees, hospital administrator responsibilities defined, mixed group, not only "elderly pillars of the community"
B 115	43	lack of conflicts of interest, not have medical staff on board, high qualifications

Source	YR	Terms
B 159	71	communication with the medical staff
B 165	81	safeguard hospital and its assets, satisfaction at having rendered a service to the community, status, see policies implemented and objectives achieved, review and approve hospital administrator's decisions, through hospital administrator pass on ideas, policies, and procedures, good communication
B 166	63	keep hospital solvent, good relations with medical staff, and between hospital administrator and medical staff
B 200	56	community prestige, inner satisfaction, high status, initiate, transmit and mediate policy, good reputation, confidence from community, positive relations with physicians, financial solvency, not be concerned with routine management, mutual understanding with physicians and hospital administrator
B 206	77	information on health care delivery, know the responsibilities and role of being on the board, financial responsibility, fund raising, review performance of staff, provide equipment and facility, choose own replacements, quality care in hospital, know hospital's mission, understand hospital's organization, knowledge of legal liabilities and responsibilities, educating/training of new trustees, financial reports, hospital's budget, training of responsibilities
B 211	67	hospital administrator carry out Board of Trustees's policies
B 213	78	self-perpetuating, ensure safety in hospitals, establish policies, delegation of authority, ensure quality care, competent hospital administrator, written financial policies and procedures, lack of conflict of interest between administrator, physicians, and Board of Trustees

Source	YR	Terms
B 219	74	know the community health needs, well informed on cost effective management, sensitive to public attitudes
B 220	76	financial knowledge of hospital and internal workings, written policy on what grounds to deny an physician privileges, contingency plans for strikes etc, open communication, knowledge of hospital's mission
B 224	83	adequate information before forming policies
B 227	78	determine policies, financial management skills, balance sheets, no physicians on Board of Trustees, good relations with physicians and public
B 228	89	policies carried out, reports, recommendations
B 248	62	Board of Trustees needs organizational structure
B 250	85	hospital administrator source of information
B 251	88	confidence in hospital administrator, timely information
B 253	79	understand physicians
B 262	68	competent hospital administrator, have policies carried out, competent and qualified medical staff, good communication between hospital administrator and medical staff, accurate records of finances and activities, knowledge of community's needs
B 266	67	good communication between hospital administrator and medical staff, policies carried out

Source	YR	Terms
B 276	74	background education and current information of health care affairs, specific information on hospital's daily affairs, know current and proposed federal and state health care legislation, reduced conflict with medical staff, understand relationship of hospital to other health care agencies and institutions in area, orientation, duties and responsibilities handbook, tours of own hospital and other hospitals
B 284	47	high autonomy, self-perpetuating, be informed of the administration of the hospital

Source	YR	Terms
M 1	59	privileges granted by Board of Trustees, best equipment, other providers for patient welfare
B 11	65	training for interns and residents, suitable equipment, CME, clerical help, records, hospitals reputation gives prestige to physicians, research opportunities, fellowships, hospital in convenient location, cooperation from hospital administrator
B 17	82	honesty and trust from hospital administrator
B 21	66	mutual understanding, respect, confidence, familiar with medical terminology, good communication and information to physicians
B 26	69	make reports
B 31	81	keep physicians informed, foster mutual respect, understanding, and trust, support physicians need for self-governance, provide tools of trade
B 40	65	residency, internship, CME
B 42	68	information
B 43	78	power, increased importance of technical skills, new toys, highly skilled nurses, place for research, self-policing and regulating, representation on governing boards
B 44	80	latest in facilities and equipment
B 45	86	needs hospital for services and bylaws
B 46	73	power
B 47	69	privileges, intern and residency programs, maintain facilities and equipment
B 48	62	CME, place to do research, practice medicine, and teach, reports from hospital administrator, autonomy

Source	YR	Terms
B 52	62	protection from infectious diseases
B 53	73	choice in when, where, and how physicians practice
B 58	61	place to teach and do research, training for interns and residents
B 69	87	physicians by 2000 = 707,000 (in 85 = 541,000) competition from hospitals and other physicians: lower money, from Medicare, HMOs, PPOs, malpractice premiums, nonpaying patients, etc; control own destiny, independence, power, fewer meetings and administrative work, high quality patient care, new technology, increased health promotion, less "industrialization" of medicine
B 72	88	protection from iatrogenics
B 75	81	quality care to patients, lack of administrative oversight, money, self-governance
B 78	85	allocate resources, influence policy, authority over patient care regardless of cost, peer pressure to conform to standards, kept board certified, prestige, high tech toys, professional advancement, diverse and more interesting patient population, more money, higher reputation, protection from malpractice suits
B 80	64	place to do research, self-governance
B 82	72	safety to physicians
B 86	84	decision-making, power, a place to practice
B 87	24	dressing/locker rooms, place to practice
B 89	85	place to practice, toys, protection from malpractice suits, complete and accurate medical records, quality of fellow physicians
B 90	84	protection from violence (mental patients)

Source	YR	Terms
B 95	76	salaried practice
B 97	85	peer pressure to conform to standards, prestige, high tech equipment, medical back-ups and referrals, professional advancement, defensive medicine against malpractice suits, freedom to arrange schedule
B 101	66	power
B 104	82	information, self-governance, self-regulating, organizational control, protection against liability suits
B 105	48	good organization of staff, high standards of professional care and treatment, policing policies, hospital layout (post WW II), individualism, fewer staff meetings, training of residents
B 106	48	definition of staff appointment, CME, training of interns and residents
B 115	43	CME, training of interns and residents
B 116	77	CME
B 157	73	prestige, power, status
B 159	71	training for interns and residents, CME, fellowships, place for research
B 165	81	mutual understanding, trust, and respect, keep informed of organizational changes and policies, support of need for self-governance, effective communication, right tools, training for interns and residents, board certified, CME
B 73	62	be the boss, status
B 200	56	prestige, independence, high income, power, responsibility to the patient, chance for research, freedom to practice medicine as she/he sees fit, teaching of interns and residents, opportunity to specialize, highly skilled nurses

Source	YR	Terms
B 207	79	right to govern themselves, peer review
B 211	67	hospital bylaws, rules and regulations, hospital as physicians "medical home," privileges, rewards, have physicians opinions sought, colleagues will provide quality care, skilled nurses and other staff, quality control checks, understanding hospital administrator and Board of Trustees, training for interns and residents, hospital physically comfortable for physicians' patients, appropriate equipment and supplies, CME for physicians and other staff
B 212	73	training - not just education in medical school
B 213	81	freedom from managerial controls, yet participation in management
B 214	78	right to medical staff appointment and privileges
B 215	74	training to medical school students
B 219	74	competent medical staff, representation on boards
B 224	83	the hospital as physicians' "workshops," authority over patient care, CME, high incomes, malpractice insurance, involved with hospital management
B 227	78	new toys, strong chief of staff, clinical freedom, hospital administrator's help in carrying out of chief of staff duties, CME
B 228	89	mutual understanding, respect and trust, good communication, proper tools at the right place and time, kept informed of organizational changes, Board of Trustees policies and decisions, support for their need for self-governance, available for consultation/ discussion of problems

Source	YR	Terms
B 230	86	expensive technology, support services, development of their practice (i.e. sports medicine), privileges, fair (high) payment for services from Medicare
B 242	85	CME, training for interns and residents, staff development, privileges
B 250	85	included in the decision-making process to some degree, honesty and trust from hospital administrator, good communication, common goals
B 251	88	latest equipment, supportive nurses
B 256	88	privileges, knowledge of community resources
B 262	68	accurate records and infectious diseases
B 265	71	privileges, graduate medical training for interns and residents, CME, opinions sought and welcomed, each colleague will provide quality medical care, quality and devoted nurses, hospital to provide creature comforts to physician's patients, CME for all hospital staff, checks of quality medical care, Board of Trustees and hospital administrator familiar with medical staff problems, hospital be fiscally solvent, health care provided at a cost to the patient consistent with the quality of care given, hospital administrator hold down costs whenever possible, hospital be a focus of activity to attract young persons into the health fields, physician's desires toward research encouraged and supported
B 278	78	privileges, autonomy, self-policing, protection against malpractice suits

Source	YR	Terms
B 280	46	medical students = training for interns and residents, confidence from hospital administrator, respect from other staff, cooperation from hospital administrator, affiliation with a hospital (privileges), professional accountability, accurate records, diagnostic and therapeutic facilities, staff conferences, membership in the AMA, etc
B 284	47	self-governing, competent fellow physicians, liaison arrangements between medical staff and hospital administrator and Board of Trustees, training for interns and residents, medical staff conferences, education programs, research opportunities

Source	YR	Terms
M 1	59	nurses want professional status, more technical abilities, total bedside charge of patient, ability to delegate to orderlies and LVNs, paramedical groups want high professional standards, thereby perpetuating personnel shortages
B 11	65	on-the-job-training, new employee orientation, newsletters/magazines, job analysis, salary, promotions, benefits, training, recognition of unions
B 15	75	inservice training sessions
B 17	82	ensure quality care among physicians
B 21	66	well planned layout of hospital
B 31	81	bargaining, benefits package, coordinate all efforts for the hospital's mission, salary, treat family, laud efforts, safe environment, keep informed
B 34	64	new employee orientation, training, benefits: group insurance, retirement, health, vacation and holiday pay, uniforms, laundry, cafeteria, morale, welfare, and recreation, credit unions; communication: newsletter, bulletin boards, notes with pay envelopes, suggestion program, recognition program
B 35	80	promotion, transfers, fair appraisals
B 42	68	orientation
B 43	78	unions, nurse associations, nurses want more respect from physicians, and more input to treatment
B 44	80	share discussion and policy-making roles
B 45	86	labor unions, workman's compensation
B 46	73	job satisfaction, money, good working condition, status

Source	YR	Terms
B 47	69	decent working conditions, money, incentives for efficiency, training, fair evaluations and supervision, promotion, transfers, employee lounges and parking, uniforms, retirement, holidays, vacations, sick pay
B 48	62	good communication, recognition, money, prestige, motivation, self-worth, concern
B 50	76	good supervision, unions
B 51	73	adequate free parking, short walking distance
B 52	67	protection from infectious diseases
B 58	61	training, orientation, fair appraisals, training and development, fair discipline, salary, fringe benefits: health, disability, and life insurance, pensions, vision care, vacation and sick pay, employee assistance programs, safety, out-placement help, pre-retirement planning
B 72	88	protection from iatrogenics, training about AIDS, counseling for staff who work with AIDS patients
B 73	78	recognition of unions and employee organizations
B 75	81	nurses - freedom from bureaucracy and paperwork, more patient contact, more input on matter concerning patients, high patient care standards, good salary, higher with more experience and advanced degrees, respect from physicians, increased status, flexible shifts and duties
B 78	85	more money, nurses and medical technicians want higher professional recognition, nurses: more prestige and status from physicians, more role in work design, more flexibility

Source	YR	Terms
B 79	82	good communication from supervisor, trust, confidence, fair appraisals, continuing education, recognition of unions
B 80	64	recognition of unions, status/prestige for whatever work person is doing
B 82	72	safety
B 86	84	nurses: bonuses, child care centers, different shifts, refresher courses, power in decision making, orientation, benefits
B 87	24	dressing/locker rooms
B 89	85	Independent Allied Health Professionals want more say in patient care, recognition of unions
B 90	84	protection from violence (mental patients)
B 92	69	training and education from non-medical ancillary staff
B 93	67	training to be a supervisor
B 98	67	training
B 99	70	nurses: more money with degrees and experience, tasks appropriate for skills/training, certification, acceptance as professionals
B 101	66	recognition of unions, higher wages
B 105	48	SOPs, pay raises, better working hours, more liberal vacation and sick policies, system for grievances, education and recreation programs, pension/retirement plans, health benefits, counseling services, booklets on personnel policies, fair pay, merit bonuses, union recognition, on-the-job-training and training plans
B 111	79	adequate staff to perform work, equitable policies, job descriptions, lack of racism and discrimination, adequate supplies and equipment, healthy working conditions

Source	YR	Terms
B 115	43	training, safety in hospital, maintenance of hospital
B 157	73	salary, work load, hours, working conditions, increased status, professionalism, nurses want to be recognized as professionals
B 165	81	good communication, knowledge of their place in hospital's mission, CME, volunteers: social status and recognition to self and spouse, training, supervision, orientation, provision for insurance coverage for injuries
B 172	54	protection from infectious diseases, safety overall
B 173	62	respect
B 187	81	safety
B 188	72	safety
B 191	66	protection from infectious diseases
B 192	74	safety
B 193	71	protection from infectious diseases
B 194	73	protection from infectious diseases
B 196	73	safety
B 200	56	recognition, job satisfaction, good communication, training, job descriptions, good supervision, upward mobility, respect from physicians and management, good relationships with physicians and nurses, autonomy, clear lines of responsibility and authority, job transfers
B 207	79	volunteers: match of interest with duties, "psychological payment," recognition, ceremonies, orientation, goal setting, space, leadership; CME, fair performance evaluations

Source	YR	Terms
B 213	67	focus on employee strengths
B 214	78	unions/employee representation, EEO, fair labor practices, workman's compensation
B 218	68	specific expectations from supervisors, performance standards, work problems solved, good communication
B 219	74	supervisory training, inservice training, fair and helpful supervisors, job satisfaction: personal development and accomplishment, sense of belonging, receiving recognition and appreciation, good benefits, fair wage scales
B 222	79	job analysis, job descriptions, and job evaluations, fair wages, good communication, training and development, fair and impartial grievance and arbitration procedures
B 223	77	new employee orientation, appraisals, training and development, wage and salary administration, job evaluation, health and safety, formal disciplinary procedures, pension program, recognition of union/collective bargaining, negotiation
B 224	83	nurses: treated as colleagues, career mobility, professional status, involved with clinical decisions, enlarged patient care role; other staff: collective bargaining, unions, higher wages, better conditions, fair overtime practices, in-house promotions, transfers, fringe benefits, discipline and grievance procedures, good treatment
B 226	84	fair appraisals, promotions, transfers, fair handling of grievances, recognition of union/shop steward
B 227	78	delegation, authority, recognition of unions, fair grievance procedures, good working conditions

Source	YR	Terms
B 228	89	informed of their critical role in hospital and mission
B 236	77	good communication, fairly distributed awards, job satisfaction, sense of achievement, advancement, fair discipline, fair appraisals, training
B 243	77	recognition of unions, more active voice in agency - governing, higher professional status
B 244	71	flexible schedules and hours, child care provisions, increased benefits, refresher courses, transportation, part time work, job satisfaction, good wages, interesting work, job security, benefits
B 245	83	training, new employee orientation, good communication, good working environment
B 249	85	fringe benefits, pay, job satisfaction, opportunities for promotion, development of skills and abilities, bonus awards, job security
B 251	88	career development, salary, prestige
B 252	72	incentives for efficiency
B 253	66	good supervision, inservice training, CME, training for new nurses
B 257	68	job satisfaction, clear orders, inservice training
B 258	80	new employee orientation, career development, training
B 261	75	training, orientation, CME
B 262	86	education, workshops, new supervisor orientation, quality circles, knowledge of hospital, loss and grief workshops for caregivers, pre-retirement planning, new employee orientation, bring college courses to the hospital

Source	YR	Terms
B 263	77	incentives for efficiency
B 265	71	training
B 269	68	volunteer: orientation, hospital tours, training, recognition
B 270	73	volunteer: job descriptions, appropriate assignments, orientation, training, recognition, workman's compensation
B 272	71	volunteer: need to be appreciated and accepted, and to "create" or self-express (Maslow), training and development, newsletters, orientation, recognition - awards, pins, and events; male volunteer: more flexibility, "masculine" title and duties
B 278	??	volunteer: motivation, recognition, personal satisfaction, challenge, monetary reimbursement, training, orientation, compensation if hurt, insurance if volunteer is negligent, careful, appropriate assignments, good supervision, good communication, performance appraisals
B 280	46	training, experience
B 284	47	job classification, duties and responsibilities outlined, conditions of employment, working relationships set up, orientation, inservice education, evaluations, adequate supervision, promotion and transfer policies, acceptable working conditions; hours, salaries, vacation and leaves of absence established in accordance with accepted standards in the community, health insurance, effective system of records and reports on employees, personal advancement encouraged

Source	YR	Terms
M 1	59	geriatric care, insurance for the aged (Medicare)
B 2	80	consideration, privacy, respect, information of treatment, diagnosis, prognosis, and cost, continuity of care, mail, participation
B 3	80	consideration, respect, information of diagnosis and treatment, right of informed consent, right to refuse treatment, privacy, experimentation, hospital rules, continuity of care, examination of bill, discharge planning, names of those involved with patient
B 5	75	private rooms to segregate insanity and contagious diseases, comfortable surroundings, good food
B 9	68	relieve pain, respect
B 10	65	death with dignity and pain free
B 11	65	access to available services, ambulance and emergency room service, good food, correct medical records, religious services, privacy, bibliotherapy, home care, 1-2 person rooms
B 15	75	patient's bill of rights, financial and medical information, freedom from abuse, respect, dignity, religious etc activities, share room with spouse in nursing home, patient rules, mail
B 21	66	(Future) private, or air conditioned rooms, meals kept in own freezer in room, disposable everything, amenities, toys for patients, bills explained
B 23	61	good communications
B 35	80	compassion, treated as an individual
B 36	87	(England) short appointment waiting times

Source	YR	Terms
B 39	67	reasonable visiting hours and convenient for family
B 40	65	competent medical personnel, equitable prices, quick and sure relief, quality care, short wait for appointments, respect
B 41	64	available bed and services for the level of care or treatment needed, appropriate meals - dining room or bedside
B 42	68	empathy, understanding
B 43	78	understandable bills, only needed surgery done
B 44	80	increased benefits, higher quality care, more compassion and understanding, more services
B 45	86	best quality care, protection from harming self - mental patients, protection from medication errors, safe environment
B 46	73	prevention of diseases
B 47	69	high quality care, early diagnosis, privacy
B 48	62	home care, house calls, easy access to services, ease from worry, soothing colors, compassion, kindness, provision for emotional, spiritual, and recreational needs, convalescent care, Media: news, features, pictures; informational publications, high quality care
B 49	67	decent outpatient clinics
B 51	73	adequate parking
B 52	67	protection from iatrogenics and other infectious diseases
B 54	80	TLC, latest technology, short waiting times

Source	YR	Terms
B 58	61	home care, rehabilitation, dignity, treated as an individual and as a whole person, privacy, freedom from fear of loneliness and neglect, more and better health care services, cures, take care of emotional and intellectual needs
B 65	70	hot and good food, clean rooms
B 72	88	protection from iatrogenics, confidentiality
B 80	64	rehabilitation, rest, food, hope, self-respect, hygiene, safety
B 82	72	safety for patients and their visitors
B 87	24	food service
B 89	85	right to refuse treatment, protection from malpractice
B 93	70	solace
B 95	76	desire for more humanistic, sue if not happy with outcome, compassionate and economical care, bill of rights, government policy states health care is a right
B 97	85	best care available, all possible treatments
B 101	66	absence of discrimination, hot food hot, cold food cold, protection from malpractice, truth of diagnosis and prognosis, safety inside hospital and for visitors too
B 102	86	care even if unable to pay (medically indigent)
B 103	65	self identity, individual attention, information on diagnosis/prognosis,freedom from worry, reassurance
B 111	79	adequate time with health practitioner

Source	YR	Terms
B 113	86	right to refuse treatment
B 115	43	special diets, not just cheap food
B 156	80	patient education using media techniques
B 157	73	alleviate acute or chronic conditions, prevention health services
B 158	84	privacy of information, yet increased access to information on own health matters
B 161	82	patient education, tests, health condition, information on treatment/prognosis, skills and knowledge to implement prescribed therapies and rehab, diet, activity limitations
B 162	85	information on condition, regimen and other health matters, patient education
B 163	77	patient education
B 164	85	patient education, patient needs knowledge, skills and attitude to help them attain behaviors to maximize positive health outcomes, patient as an individual, religious and cultural attitudes needs to be accounted for, get informed consent from patient/family, have information on diagnosis/ treatment choices, risks, prognosis, and consequences of not having treatment
B 165	63	early diagnosis
B 168	78	coordination of care, reasonable visiting hours, semi-private/private rooms, good food, patient education, books, and arts and crafts
B 169	70	patient information on own case, consideration, tolerance, knowledge of impending death

Source	YR	Terms
B 170	81	information on diagnosis/prognosis/treatment, reasonable visiting hours, proper diet, protection from medication errors, relief from pain, protection from infectious diseases, plain English used, not "medicalese," appropriate ancillary services, right to die
B 172	54	safety in many forms, protection of visitors
B 173	62	treated with dignity
B 178	81	access to services, quality of health care
B 180	79	information on diagnosis/treatment, empathy and compassion
B 182	81	treated as an individual, protection from infectious diseases and nosocomial infections, safety
B 185	46	large enough room to permit individualized care, quiet, adequate medical services, food well-cooked and hot
B 186	87	safety for patient and visitors, protection from medication errors and infectious diseases, quality care
B 187	81	safety for patient and visitors
B 188	72	safety
B 189	66	protection from infectious diseases
B 190	87	protection from infectious diseases and nosocomial infections
B 191	66	protection from infectious diseases
B 192	74	safety
B 193	71	protection from infectious diseases
B 194	73	protection from infectious diseases
B 195	61	protection from infectious diseases

Source	YR	Terms
B 196	73	safety
B 197	79	protection from infectious diseases
B 198	17	treated as an individual, treat cause, not just symptom
B 199	67	information on treatment/diagnosis/prognosis
B 200	56	information on treatment/diagnosis/prognosis, pleasant visitors
B 204	79	treated as an individual - not just "a case of ___, treatment of underlying causes of symptoms, say in own care, relief from pain
B 207	79	quality care
B 210	76	quality care, freedom from malpractice
B 211	67	appropriate diets
B 212	73	coordination of care
B 213	67	out of hospital fast
B 214	78	agree to proposed treatment, informed consent, disclosures of risks and alternative treatments, confidentiality, participation in own care, right to die, right to refuse an autopsy
B 224	83	rehabilitation services, relief from pain, early detection, cures, outpatient services, long-term care
B 225	73	comfortable temperature, quiet, privacy, variety in meals, activities, lack of boredom, information on condition, TLC, reasons for tests and treatments
B 228	89	general comfort and care, understanding of visitors and relatives, keep information confidential
B 230	86	protection from fraudulent physicians

Source	YR	Terms
B 234		information on diagnosis/treatment
B 241		saving life, alleviating pain, curing disease, concern for patients anxiety, explanation of hospital's policies, considerate and respectful care, dignity, information booklets
B 242	77	more humanistic physicians
B 245	81	appropriate feedback, information on policies, procedures, services, and available resources
B 251	88	friendly and nice staff
B 258	80	greater access to health information
B 267	72	patient education
B 268	75	(skilled nursing facilities) made to feel welcome, respect for own belongings, some measure of control and choice, appropriate meals, cleanliness, freedom from boredom, need to feel wanted, recreation, education, religious services available, knowledge of rules, regulations, and policies
B 273	66	rehabilitation to best extent possible
B 274	66	home care - provision of many services
B 275	79	follow-up care after discharge - continuity of care
B 279	67	protection from upsetting diagnoses, need to stay part of a family, outside help after hospital discharge, treated as an individual, feelings of self-worth, rehabilitation if possible

Source	YR	Terms
B 283	69	long-term care, comprehensive care, prevention of disease, early diagnosis and care, educate the population with known disease risks, emergency room services, outpatient departments, an aging center, home care services, ambulatory care, rehabilitation to maximum extent possible, emotional well-being for the dying, humane treatment of mentally ill patients
B 284	47	hospitals should have the essential services available for adequate treatment, prevention of diseases, education, rehabilitation programs

Source	YR	Terms
B 8	83	home care, meals on wheels, transportation services, visitation, home health aids, occupational and physical therapists, social services
B 11	65	prevention of disease and suicide, health education, cooperate with education - nurse trainees etc, care for the medically indigent, hospital administrator perform community speaking, social clubs (Red Cross), recognition of volunteers, accommodations for religious visitors/clergy, media - good stories, honesty, and ease of getting information, public service announcements
B 15	75	promotes public relations, obtains patient transfers and working relationships with other administrators
B 21	66	avoidance of excess duplication and not enough of something else, education of health and disease prevention - public lectures, media, printed newsletters, etc, hospital tours
B 31	81	education in health matters, speaking engagements, planning agencies, health fairs and screenings
B 40	65	special care and attention at critical periods of the child's growth, and assistance through all ages at times of inevitable life crises
B 44	80	satellite hospitals and clinics, comprehensive health care, stronger voice in programs
B 46	73	equitable distribution of health care services

Source	YR	Terms
B 47	69	outpatient activities, rehabilitation, education, prevention, service programs, cooperate with other hospitals, hospital administrator participate in local and national organizations, auxiliary: volunteers, fund-raising, and public relations, authority from Board of Trustees, recognition
B 48	62	volunteers: training, supervision, planning, an office, funds to cover expenses, recognition cooperate with other hospitals, hospital programs to public, news articles to the media
B 53	73	range of ambulatory care services, immunizations, public sanitation, health education, alcohol and drug abuse counseling, special clinics: posture, exercise, nutrition, family planning, prenatal and well baby care, early detection screenings
B 64	78	patient education, research
B 65	85	health promotion programs
B 69	87	employers want cost containment
B 70	81	volunteers: orientation, supervision, training, recognition, assignments public health fairs, media stories, patient information booklets, tours, community outreach, workshops
B 71	87	equality of access
B 72	88	screenings for HIV, public health programs
B 73	86	post disaster teams, be prepared at concerts and large gatherings
B 75	81	free-standing emergency room facilities, dialysis centers, post-hospital care and chronic disease care for oldsters, hospices

Source	YR	Terms
B 80	64	parity of physicians in rural areas, tours, fund-raising, vaccines, alcohol problems, lack of duplication, hospital administrator join civic clubs, care of the indigent, outpatient clinics, home care, chronically ill care, homes for the aged
B 82	72	safety for volunteers
B 87	24	adequate but not duplication of number of beds, outpatient services, convenient location
B 91	85	alternative settings where health care costs are lower
B 95	76	hospital administrator create liaisons with groups, judicious use of community resources
B 105	48	outpatient services, clinics, group practice, prepayment plans, screening inpatients and employees for TB, isolation units for contagious diseases, ambulance services, veteran affairs
B 106	77	home health care for elderly: aide visits to concentrated services, day care centers for oldsters
B 117	83	mental health clinics
B 157	73	programs suited to special groups and treatments, medical schools: teach, treat, research, number of physicians to population parity, available services
B 160	66	hospital = a teaching center
B 165	81	community activities, educating community on health matters, public relations, brochures, public speaking, fairs and screenings, services available to all, psychologically and socially acceptable to all, quality care, system should be comprehensive and stress maximum economy, hospital move from "sick" care to "health" care

Source	YR	Terms
B 167	63	media - based on credibility, professionalism, and mutual trust, disaster preparedness
B 168	70	recognition of culture and ethnicity
B 174	56	be prepared for disasters - floods, bombs, etc
B 175	85	provision for aging populations
B 179	82	media: clarity, honesty, and speed, health promotion
B 183	67	community hospital be adequate in size and services available
B 200	56	positive relations with media
B 201	63	hospitals instituted to care for indigent
B 202	80	not just a hospital, but a community health center
B 203	80	availability of: hospices, family-centered care, emergi-centers, home care programs, health education programs, family planning services, rehabilitation centers, health promotion programs
B 207	79	access to medical services, home health needs met
B 211	67	disaster planning
B 212	73	parity of physicians in rural/urban areas
B 224	83	health promotion, health screenings, disease prevention, environmental health programs
B 228	89	information brochures and pamphlets, PR on radio and TV, health fairs and screenings, information through media, proper ethics in dealing with vendors
B 237	70	vaccines

Source	YR	Terms
B 238	71	disaster planning and help community prepare
B 258	80	health information
B 260	74	ambulatory care centers
B 265	71	outpatient services, organized specialty clinics, emergency room services, preventive health services, promotion of disease prevention, medical research, social service workers, organized out-of-hospital care (long-term care), home care
B 266	67	more and better medical care, disaster planning
B 271	66	emergency rooms
B 284	47	not duplicate other hospitals' resources, public education, adequate care without discrimination

Source	YR	Terms
B 11	65	protection against over-utilization, equal and fair costs, extent of number of people covered, increasing coverage, work together on matters of economy and quality care
B 16	74	"reasonable cost" reimbursement
B 21	66	minimum treatment, fair costs, controls, standards
B 40	65	quality care, not unnecessary high costs
B 43	78	power to define quality care
B 45	86	control costs, limit types of services payable
B 48	62	negotiated contracts
B 67	80	limitations of benefits - either time or money, cost containment
B 68	88	Medicare: fair premiums from people, control payments to providers, raise premiums from beneficiaries, raise taxes, require higher co-payment, tightening of policies, cost reduction to physicians, efficient allocation of resources, cost-sharing, prior authorization, benefits cut-off, contracting with providers, provider-specific coverage, insurer financing out-of-pocket expenses, tax subsidies, lower prices, limits on reimbursements (pg 179: Community hospitals get one-half their revenue from Medicare and Medicaid) (pg 195: "Hospital Cost Containment" in 1977; defeated), (pg 207: eliminate services that make no contribution to health at the margin - unnecessary care)
B 69	87	lower costs - smaller than CPI increases
B 71	87	bargaining for rates, contain costs, not pay more than actual costs
B 75	81	trade-offs, alternatives to hospital care

Source	YR	Terms
B 76	86	hospital: decreased cost and fewer in-patient days, leading to increased outpatient visits
B 77	79	limits on payments, containing costs, reduce duplication of services, compliance, quality care
B 89	85	hospitals must have a contract with a PRO or lose Medicare reimbursement, not pay more than actual costs, no "cost shifting"
B 91	85	stem skyrocketing costs, control rate setting methods (like a PUC), conserve resources, increase out-of-pocket expenses to consumer, government: controls on capital expansion and new services, utilization review, rate setting, rationing outpatient services, not inpatient
B 95	76	federal programs paid for 40% of hospital care
B 99	70	only needed care, revenue = costs, make payments to patients and collections from hospitals convenient, lowest possible costs, fair rates, control
B 157	73	co-payments from patients
B 165	81	cost containment
B 224	83	cost containment, equitable prices, lack of fraud (fraud is rare)
B 231	80	cost containment, ability to govern hospital expenditures, constraining wage increases, principal influence in collective bargaining
B 232	84	cost containment, cost sharing with subscribers, health care costs under control

Source	YR	Terms
B 247	85	cost control, uniform DRG rates to all payers, a standard DRG rate for physician fees, a continuation of PROs, limits on hospital care, higher co-payments and deductibles, less comprehensive coverage
B 277	77	control over resource allocation - efficient use
B 281	80	ability to specify what benefits are entitled, limits to benefits - (time or money), exclusion for "pre-existing" conditions, co-payments

Source	YR	Terms
B 43	78	efficiency, Social Security Administration reviews Medicare reimbursement, quality control, labor laws, charity immunity has been eliminated
B 44	80	technology utilization, shared services, focus on financial, program planning, defined relationships with the governing body, RA - contain costs, Anti-Trust laws (Sherman Act of 1890, Clayton Act of 1914, and Robertson-Patman Act of 1914), Federal tax laws
B 45	86	OSHA and state laws, anti-trust laws, Civil Rights Act, EPA, building and fire codes, licensure
B 67	80	CONs, HSAs guide resource allocations, control bed supply, cost containment, investment controls (reimbursement and utilization), PSROs
B 70	81	control physical space requirements, patient eligibility
B 80	64	regional planning, HSAs
B 91	85	stem skyrocketing costs, control rate-setting methods (like a PUC), conserve resources, increase out-of-pocket expenses to consumer; government: 1) controls on capital expansion and new services, 2) utilization review, 3) rate setting, and 4) rationing more outpatient services - not inpatient

Source	YR	Terms
B 11	65	high quality care, no fires in hospital, cooperate, not compete with other hospitals - share resources, hospital meets standards
B 48	62	hospital administrator participate in meetings and conventions
B 89	85	ACHA - Code of Ethics, 1973 - conflict of interest and improper use of confidential information, AMA - no interference in physician-patient relationship

Appendix B: Delphi Process

There are three sections to this Appendix, to correspond with the three phases of the Delphi Process.

Section One: First Phase

Section One of Appendix B consists of the First Phase of the Delphi Process. There are three documents.

The first document is a one-page background and instruction sheet given to the ten people who agreed to be part of the Delphi process to winnow the 412 terms found in the literature to a more manageable number to be asked in the questionnaire sent to one hundred hospital administrators in California.

The second document is the eight-page listing of items, by constituent group. Those ten members of the Delphi Panel were asked to rank each cluster.

The third document is the tally form created after all ten members returned their listing.

DOCTORAL DISSERTATION

The Hospital Administrator: Yesterday, Today, and Tomorrow

An Analysis of the Changing Responsibilities of the Hospital Administrator in Response to the Needs and Wants of Constituent Groups.

Background

The role of the hospital administrator has changed since its inception. What has worked in the past is not necessarily what works today, and may not work for the future. Hospital administrators are finding their responsibilities drastically changing. The issue is that while hospital administrators have always had many responsibilities to a wide spectrum of constituent groups, the number and type of such groups have undergone a substantial change over time. More importantly, the wants and needs of yesterday may not be what is most important to the individuals in the groups now.

It is my task to discover what the current wants and needs are. So far, I have searched some of the literature to select the wants and needs written of in the past. However, I have found too many to devise a workable questionnaire for current hospital administrators in California. Somehow I must pare these hundreds down to a manageable number. This is where you come in.

Directions for Being Part of the Delphi Group

Thank you for agreeing to participate. I asked for your help because I believe you have an objective and thoughtful mind. Your task is in two parts.

First is the rank ordering of many clusters of the wants and needs of constituent groups. Please pretend you are a member of each group (Patients, Regulatory Agency/Corporate Hierarchy, Medical Staff, Other Staff, Professional Organization, Third-Party Payer, Board of Trustees/Directors, or Community). Each group will have several small clusters of two to five items. Please rank from 1 to 5, 1 being the most important, how you think these items are in importance to you as if you were a member of that group. Some of the items may not be clear to you. If so, please try to do the best you can.

The second part will come later, after I have tabulated and analyzed everyone's responses. I will reduce the number of items based on a prioritization of responses to no more than half the current number. I will ask you again to rank the winnowed group.

If I have left out anything you think is important, or if you have any comments, please write them on the back side of each sheet. I am still in the information gathering stage, and would welcome any ideas you have.

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking. **Page 1**

PATIENTS: A person who is or has been under some type of medical care or treatment, either in the health care facility or associated with it through her/his personal physician.

__ private rooms
__ two-person rooms
__ air-conditioned rooms
__ amenities
__ comfortable surroundings

__ appropriate meals (dining room or bedside)
__ private meals in own freezer
__ hot food
__ good food

__ protection from harming self (mental patients)
__ safety for visitors
__ safe environment
__ protection from iatrogenics

__ treated with respect
__ treated with dignity
__ treated with consideration
__ treated as a whole person
__ treated as an individual

__ geriatric care
__ rehabilitation
__ coordination of care
__ convalescent care
__ continuity of care

__ short waiting times for obtaining an appointment
__ short waiting times for obtaining treatment

__ having a say in own care
__ right to refuse treatment
__ right to accept or refuse experimentation
__ right of informed consent

__ information about treatment
__ information of diagnosis
__ information of prognosis
__ information publications
__ information on rules

__ kindness
__ tender loving care (TLC)
__ empathy
__ understanding
__ compassion

__ insurance for the aged (Medicare)
__ low cost health care
__ itemization of bills
__ equitable prices

__ confidentiality
__ hope
__ self respect
__ privacy
__ personal mail

__ religious services
__ provision for spirituality
__ provision for recreation
__ provision for emotions
__ provision for intellectual

__ soothing colors
__ reasonable visiting hours
__ place to rest
__ share room with spouse
__ ease from worry

__ relief from pain
__ freedom from abuse
__ freedom from loneliness
__ freedom from neglect
__ quick and sure relief

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking. **Page 2**

PATIENTS (CONTINUED)

__ competent medical personnel
__ names of those persons involved with patient care
__ disease prevention
__ good communications
__ latest technology

__ quality care
__ protection from malpractice
__ correct medical records
__ only needed surgery done
__ protection from medication errors

__ available bed for level of care for treatment needed
__ decent outpatient clinics
__ access to available services
__ ambulance service
__ emergency room availability

__ more health care services
__ easy access to services
__ assistance in discharge planning
__ adequate parking
__ increased benefits

REGULATORY AGENCIES/CORPORATE HIERARCHY: Hundreds of regulatory agencies have some jurisdiction over a health care facility. These agencies range from federal, state, county, and city to agencies without geographical boundaries. Corporate hierarchies direct the work of many hospitals which have expanded into health care systems during the last decade. When several hospitals are under a corporate umbrella each facility must answer to its regional base or corporate headquarters.

(HSA = Health Service Area and PSRO = Professional Standards Review Organizations)

__ Social Security Administration reviews Medicare reimbursement
__ HSAs guide resource allocation
__ HSAs control bed supply (reimbursement and utilization)
__ PSROs control physical space requirements
__ PSROs control patient eligibility

__ licensure
__ Certificate of Needs (CONs)
__ regional planning (HSAs etc)
__ quality control
__ building and fire codes

__ efficiency in hospital
__ control
__ technology utilization
__ shared services
__ program planning

__ EPA
__ defined relationships with the governing body
__ focus on monetary aspects
__ contain costs
__ OSHA and CAL-OSHA

__ labor laws
__ charity immunity has been eliminated
__ Anti-Trust laws
__ Civil Rights Act
__ tax laws

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking. **Page 3**

MEDICAL STAFF: All physicians who currently have privileges at the health care facility or ancillary services or clinics.

__ cooperation from hospital administrator
__ power
__ mutual understanding
__ control
__ decision making

__ support for MDs need for self governance
__ honesty
__ trust
__ confidence
__ good communication support

__ representation on governing
__ autonomy
__ control of own destiny
__ allocate resources
__ authority over patient care (regardless of cost)

__ choice in when, where, and how they practice medicine
__ self-governance
__ influence policy
__ good reputation
__ prestige

__ best equipment
__ suitable equipment
__ high tech equipment
__ latest in equipment
__ newest equipment

__ accurate patient records
__ maintenance of equipment
__ maintenance of facility
__ latest in facilities
__ hospital\place for services

__ needs hospital for bylaws
__ fellowships
__ diverse and more interesting patient population

__ fees
__ higher incomes
__ dressing/locker rooms
__ protection from malpractice suits

__ other providers for patient welfare
__ highly skilled nurses
__ less "industrialization" of medicine
__ complete medical records

__ clerical help
__ freedom from admin work
__ fewer meetings
__ lack of administrative oversight

__ training to interns and residents
__ general information reports
__ keep Mds informed
__ continuing medical education
__ familiar with medical technology

__ privileges granted by
__ Board of Trustees
__ place to practice
__ place to teach
__ research opportunities
__ maintain board certification

__ professional advancement
__ high quality of patient care
__ peer pressure to conform to standards
__ protection from infectious diseases and iatrogenesis
__ high quality of fellow Mds

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking. **Page 4**

OTHER STAFF: All non-physician persons employed by the health care facility: nurses, technicians, and support personnel including legal advisors as well as other categories such as per diem providers and other contractors of direct health care services. (Chaplain, secretaries, housekeepers, medical record librarians, RNs, LVNs, orderlies, lab techs, X-Ray techs, maintenance personnel, physical and occupational therapists, social service workers, engineers, volunteers, and auxiliary):

__ laud efforts
__ recognition program
__ increased status
__ prestige/respect
__ higher professional recognition

__ internal transfers
__ job satisfaction
__ good working conditions
__ free parking
__ short walking distance from parking

__ bonuses
__ employee assistance
__ outplacement help
__ pre-retirement programs

__ fair appraisals
__ incentives for efficiency
__ good supervision
__ concern for their problems
__ self-worth

__ trust from administrator
__ confidence from administrator
__ flexible shifts
__ flexible duties
__ more role in work design

__ good communications
__ share in policy-making
__ well-planned hospital layout
__ promotion opportunities
__ job analysis

__ more say in patient care
__ control
__ input on matters concerning patients
__ freedom from paperwork
__ freedom from bureaucracy

__ counseling for staff who work with AIDS patients
__ training about AIDS
__ safe environment
__ protection from infectious diseases

__ on-the-job training (OJT)
__ new employee orientation
__ inservice training sessions
__ continuing education
__ refresher courses

__ recognition of unions
__ recognition of employee organizations
__ labor unions
__ bargaining

__ retirement/pension plans
__ free uniforms
__ free laundry of uniforms
__ cafeteria
__ morale, welfare, and recreation facilities

__ credit union
__ workman's compensation
__ child care centers
__ dressing/locker rooms
__ different shifts

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking. **Page 5**

OTHER STAFF (CONTINUED):

__ group life insurance
__ disability insurance
__ health insurance
__ vision care plans
__ dental care plans

__ sick pay
__ vacation pay
__ holiday pay
__ higher salary with more experience
__ higher salary with advanced degrees

Volunteer Organizations only:

__ orientation
__ supervision
__ training
__ planning of assignments
__ funds to cover expenses
__ recognition

Nurses only:

__ more technical abilities
__ total bedside charge of patient
__ ability to delegate to LVNs and orderlies
__ RN associations
__ assurance of quality control of Mds

PROFESSIONAL ORGANIZATION: Any professional organization that has an impact or potential impact on the health care facility. Some examples are the American College of Healthcare Executives (ACHE), the American Medical Association (AMA), and the American Nurse Association (ANA).

__ range of ambulatory care services
__ early detection screenings
__ prenatal and well-baby care
__ alcohol\drug abuse counseling

Availability of:
__ posture classes
__ exercise classes
__ nutrition classes
__ family planning classes
__ immunizations

__ not compete with other hospitals - share resources
__ hospitals meet standards
__ ensure no conflict of interest (ACHA)
__ ensure no improper use of confidential information (ACHA)

__ high quality of patient care
__ cooperation
__ administrator participates in conventions and meetings
__ no interference in MD - patient relationship (AMA)

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking. **Page 6**

THIRD-PARTY PAYERS: Private health care plans such as the Foundation Health Plan or Blue Cross, and government programs such as Medicare, Medi-Cal, CHAMPUS, medically indigent, and other publicly-funded programs.

__ equal costs for all payers
__ control costs
__ reasonable cost reimbursement
__ not unnecessarily high costs
__ protection against over-utilization

__ cost reduction to Mds
__ smaller than CPI increases in cost bargaining for rates to contain costs
__ not pay more than actual costs
__ control payments to providers

__ fair premiums from people
__ raise premiums from beneficiaries
__ require higher copayments
__ cost sharing
__ insurer financing of out-of-pocket expenses

__ benefits cut-off
__ minimum treatment for patients
__ limitation on benefits (dollar amount or time)
__ tightening of policies
__ eliminate services that make no contribution to health at the margin - unneeded care

__ controls on price increases
__ standards of treatments
__ power to define quality care
__ limit to types of services payable
__ compliance to policies

__ negotiated contracts
__ contracting with providers
__ equitable contracts for all third-party payers

__ number of people covered
__ work together on matters of economy and quality of care
__ efficient allocation of resources
__ prior authorization
__ provider-specific coverage

__ quality care
__ hospitals must have a contract with a PRO (Professional Review Organization) or lose Medicare reimbursement
__ reduction of duplication of services

__ raise taxes
__ tax subsidies for lower premiums

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking.

BOARD OF TRUSTEES/DIRECTORS: Boards are usually composed of physicians, business leaders of the community, and often consumer members. The board provides the broad spectrum of the hospital's mission long range policy and strategic planning. The Board looks to the administrator for supervision of the day-to-day operations.

__ high professional status
__ power
__ prestige
__ social recognition
__ self-aggrandizement

__ communication between MDs and administrator
__ get MDs on board team
__ cooperate with MDs
__ serve as liaison to MDs
__ ensure MDs conform to bylaws

__ reports to board
__ personnel functions
__ maintain physical plant
__ ensure quality care
__ ensure safety

__ attend all board meetings
__ keep administrative and board functions separate
__ assist new board members
__ training for old members
__ orientation for the new

__ keep board informed of health care in general and hospital specifically
__ trust from administrator
__ advice from administrator
__ provide feedback
__ ability to select own replacements on board

__ well-qualified team
__ don't move too fast
__ administrator deal with regulatory agencies

__ makes policies
__ expects counsel from the administrator
__ policies implemented

__ budgets from administrator
__ monitor the finances
__ financial solvency
__ surveillance of fiscal assets
__ expenses paid - no salary

__ accountability for MDs and management
__ hospital purposes
__ hospital obligations
__ ensure CME (Continuing Medical Education)

__ provide information
__ give more time prior to decisions
__ money to attend meetings
__ lack of conflict
__ send information and agendas prior to meetings

__ ability to digest reports
__ ability to digest budgets
__ high sense of public honor
__ integrity
__ know how a hospital is run

__ understand hospital goals
__ high education
__ loyalty to hospital

__ identify resources
__ provide for hospital insurance
__ system to review plans

In each cluster below, please rank each item from 1 (most important) to 5 (least important). Pretend you are a part of the constituent group when ranking. **Page 8**

COMMUNITY: The community is composed of many inter-related and overlapping groups. Some examples are: ethnic groups, the media, community, researchers, service groups such as Rotary, Lions, Kiwanis, city and county councils, planning commissions, other organizations, businesses, and individuals.

__ community outreach programs
__ care for the medically indigent
__ comprehensive health care
__ equitable distribution of health care services
__ parity of MDs in rural areas

__ home care
__ visitation of health aid personnel
__ occupational therapists
__ physical therapists
__ social service workers

__ stronger voice in programs
__ post-disaster teams - be prepared at all large gatherings

__ public health fairs
__ health screenings
__ health workshops
__ screenings for HIV

__ rehabilitation
__ outpatient activities
__ satellite hospitals or clinics

__ dialysis centers
__ alcoholism centers
__ chronic disease care for the aged
__ hospices
__ free-standing ER facilities

__ public lectures
__ good stories for the media
__ honesty
__ ease of getting information
__ public service announcements

__ patient education
__ health promotion programs
__ patient information
__ health education programs
__ cooperation with education (nursing trainees etc)

__ newsletters, booklets, etc
__ Administrator should perform community speaking engagements
__ Public Relations promotion
__ education of health prevention
__ education of disease prevention

__ research
__ service clubs (Red Cross)
__ equality to access
__ administrator should join civic clubs

__ tours of hospital
__ employers want cost containment
__ transportation services
__ convenient location
__ meals-on-wheels

__ obtains transfers
__ cooperation with other hospitals/facilities
__ accommodation for religion
__ nursing homes as extensions of hospitals
__ avoidance of duplication of services

__ suicide prevention
__ prevention of diseases
__ vaccines

PATIENTS:	A	B	C	D	E	F	G	H	I	J	TOT
private rooms	2	4	2	4	4	3	5	4	4	1	33
two-person rooms	3	3	5	3	5	5	4	5	3	5	41
air-conditioned rooms	1	2	3	5	3	2	2	2	2	4	26
amenities	4	5	4	2	2	4	3	3	5	2	34
comfortable surroundings	5	1	1	1	1	1	1	1	1	3	16
protection from harming self (mental patients)	4	1	2	2	4	1	1	2	2	2	21
safety for visitors	3	3	3	3	3	3	3	4	4	3	32
safe environment	2	4	1	1	2	2	2	3	3	4	24
protection from iatrogenics	1	2	4	4	1	4	4	1	1	1	23
geriatric care	5	4	5	5	5	4	5	4	3	5	45
rehabilitation	4	2	4	4	2	3	1	5	1	4	30
coordination of care	1	1	1	2	1	1	3	1	5	2	18
convalescent care	2	3	3	3	4	5	4	3	4	3	34
continuity of care	3	5	2	1	3	2	2	2	2	1	23
having a say in own care	4	4	2	1	1	3	1	2	1	1	20
right to refuse treatment	1	3	3	2	4	4	3	4	2	3	29
right to accept or refuse experimentation	2	1	4	3	3	1	4	3	3	4	28
right of informed consent	3	2	1	4	2	2	2	1	4	2	23
kindness	3	2	2	3	5	3	3	2	2	3	28
tender loving care	5	5	4	4	3	5	5	3	1	1	36
empathy	2	3	3	2	2	2	4	4	5	2	29
understanding	1	4	1	1	1	1	1	1	3	4	18
compassion	4	1	5	5	4	4	2	5	4	5	39
confidentiality	1	1	1	3	1	4	1	3	3	2	20
hope	4	2	3	1	2	3	4	4	2	4	29
self respect	2	4	4	2	3	1	5	2	1	1	25
privacy	3	3	2	5	4	2	2	1	4	5	31
personal mail	5	5	5	4	5	5	3	5	5	3	45
soothing colors	5	5	5	5	5	5	5	3	3	5	46
reasonable visiting hours	1	4	1	3	1	2	4	1	1	4	22
place to rest	3	3	2	1	3	4	1	5	5	2	29
share room with spouse	4	2	3	4	4	1	3	2	4	3	30
ease from worry	2	1	4	2	2	3	2	4	2	1	23
appropriate meals (dining room or bedside)	1	3	1	3	2	3	1	2	2	3	21
private meals in own freezer	4	4	4	4	4	4	4	4	4	4	40
hot food	3	2	3	2	3	2	2	3	3	2	25
good food	2	1	2	1	1	1	3	1	1	1	14

PATIENTS: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
treated with respect	1	2	4	5	5	3	2	1	3	2	28
treated with dignity	2	1	5	4	4	4	1	2	1	3	27
treated with consideration	3	5	3	3	3	5	3	4	2	4	35
treated as a whole person	4	4	1	1	2	1	5	5	4	5	32
treated as an individual	5	3	2	2	1	2	4	3	5	1	28
short waiting times for obtaining an appointment	1	2	1	1	2	2	1	2	2	2	16
short waiting times for obtaining treatment	2	1	2	2	1	1	2	1	1	1	14
information about treatment	2	2	2	2	3	3	1	2	3	1	21
information of diagnosis	1	1	1	1	1	2	2	1	1	2	13
information of prognosis	3	3	3	3	2	1	3	3	2	3	26
information publications	5	5	5	5	4	5	4	5	4	4	46
information on rules	4	4	4	4	5	4	5	4	5	5	44
insurance for the aged	3	1	2	3	2	4	3	3	3	3	27
low cost health care	1	2	1	1	1	2	4	2	2	1	17
itemization of bills	4	4	4	4	4	3	2	4	4	4	37
equitable prices	2	3	3	2	3	1	1	1	1	2	19
religious services	5	2	5	5	5	5	5	5	5	5	47
provision for spirituality	4	1	4	3	4	4	4	4	4	4	36
provision for recreation	3	5	1	2	2	2	1	2	3	3	24
provision for emotions	1	3	2	1	3	1	2	3	2	2	20
provision for intellectual	2	4	3	4	1	3	3	1	1	1	23
relief from pain	3	1	1	2	2	3	5	2	2	2	23
freedom from abuse	1	2	4	1	5	1	1	3	4	5	27
freedom from loneliness	5	4	5	5	4	5	2	5	3	4	42
freedom from neglect	2	3	3	3	3	2	3	4	5	3	31
quick and sure relief	4	5	2	4	1	4	4	1	1	1	27
competent medical personnel	1	1	1	1	4	1	1	1	1	1	13
names of those persons involved with patient care	5	5	4	5	5	5	5	5	3	5	47
disease prevention	2	2	5	2	1	3	2	4	5	4	30
good communications	3	3	2	3	3	4	4	3	4	3	32
latest technology	4	4	3	4	2	2	3	2	2	2	28
available bed for level of care for treatment needed	1	4	2	5	5	5	1	4	2	4	33
decent outpatient clinics	4	5	5	2	2	4	5	2	3	2	34
access to available services	5	3	1	3	3	3	4	3	4	1	30
ambulance service	3	2	4	4	4	2	3	5	5	5	37
emergency room availability	2	1	3	1	1	1	2	1	1	3	16

PATIENTS: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
quality care	5	4	1	1	-	2	3	5	4	1	29
protection from malpractice	4	1	2	5	-	4	5	1	1	3	29
correct medical records	3	3	3	4	-	5	4	4	5	5	40
only needed surgery done	2	5	5	2	-	1	1	3	2	4	28
protection from medication errors	1	2	4	3	-	3	2	2	3	2	24
more health care services	2	2	1	3	-	3	3	1	1	1	19
easy access to services	1	1	2	2	-	2	1	2	3	2	18
assistance in discharge planning	3	5	4	4	-	1	5	4	4	3	37
adequate parking	5	3	5	5	-	5	2	5	5	4	43
increased benefits	4	4	3	1	-	4	4	3	2	5	33

MEDICAL STAFF:	A	B	C	D	E	F	G	H	I	J	TOT
cooperation from hospital administrator	4	2	1	1	1	1	4	2	1	5	22
power	2	5	5	5	5	5	3	5	5	3	43
mutual understanding	5	1	3	4	2	4	2	1	4	4	30
control	1	4	4	3	4	3	5	4	3	1	32
decision making	3	3	2	2	3	2	1	3	2	2	23
representation on governing board	5	2	3	4	5	4	4	4	5	5	41
autonomy	2	3	2	2	4	5	3	5	1	2	29
control of own destiny	3	1	5	1	2	2	5	3	2	3	27
allocate resources	4	4	4	5	1	3	2	2	3	4	32
authority over patient care (regardless of cost)	1	5	1	3	3	1	1	1	4	1	21
best equipment	1	2	1	1	1	1	1	3	4	3	18
suitable equipment	3	1	2	2	2	2	2	4	5	4	27
high tech equipment	2	5	4	4	3	3	3	2	3	5	34
latest in equipment	4	4	3	3	4	4	4	1	2	1	30
newest equipment	5	3	5	5	5	5	5	5	1	2	41
needs hospital for bylaws	3	1	1	1	3	1	3	2	3	3	21
fellowships	2	2	3	2	2	2	1	1	2	2	19
diverse and more interesting patient population	1	3	2	3	1	3	2	3	1	1	20
other providers for patient welfare	3	4	2	1	4	3	4	3	2	2	28
highly skilled nurses	2	2	1	2	1	1	2	1	1	1	14
less "industrialization" of medicine	4	3	4	4	3	4	3	4	3	4	36
complete medical records	1	1	3	3	2	2	1	2	4	3	22

MEDICAL STAFF: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
training to interns and residents	3	3	3	3	2	3	4	4	2	3	30
general information reports	5	5	5	4	5	5	2	5	5	4	45
keep MDs informed	1	4	4	5	1	1	3	2	1	5	27
continuing medical education	2	2	1	2	3	2	1	3	3	2	21
familiar with medical technology	4	1	2	1	4	4	5	1	4	1	27
professional advancement	3	4	3	2	4	2	2	4	4	-	31
high quality of patient care	2	3	1	5	1	1	5	1	2	-	23
peer pressure to conform to standards	5	5	5	3	5	5	4	5	5	-	47
protection from infectious diseases and iatrogenesis	1	1	4	1	3	4	1	3	1	-	21
high quality of fellow MDs	4	2	2	4	2	3	3	2	3	-	28
support for MDs need for self governance	1	4	5	1	5	1	2	2	2	5	28
honesty	3	1	3	5	2	5	3	5	3	2	32
trust	4	3	2	3	3	4	4	3	4	1	31
confidence	2	2	4	4	4	3	5	4	5	3	36
good communication	5	5	1	2	1	2	1	1	1	4	23
choice in when, where, and how they practice medicine	1	1	1	1	2	2	1	1	1	1	12
self-governance	3	2	5	4	3	4	3	4	2	2	32
influence policy	4	3	2	5	4	3	2	2	3	3	31
good reputation	2	5	3	2	1	1	4	3	4	4	29
prestige	5	4	4	3	5	5	5	5	5	5	46
accurate patient records	1	1	5	4	1	2	1	1	1	2	19
maintenance of equipment	3	2	4	3	2	4	2	4	2	4	30
maintenance of facility	4	4	3	2	4	3	3	5	3	5	36
latest in facilities	5	5	1	5	5	5	5	2	5	3	41
hospital\place for services	2	3	2	1	3	1	4	3	4	1	24
fees	2	2	2	2	3	3	2	2	2	2	22
higher incomes	3	3	3	3	1	2	3	3	3	3	27
dressing /locker rooms	4	4	4	4	4	4	4	4	4	4	40
protection from malpractice suits	1	1	1	1	2	1	1	1	1	1	11
clerical help	3	1	2	3	2	3	2	3	4	2	25
freedom from admin work	1	2	1	1	3	1	1	2	1	1	14
fewer meetings	2	3	4	4	1	4	4	1	2	4	29
lack of administrative oversight	4	4	3	2	4	2	3	4	3	3	32

MEDICAL STAFF: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
privileges granted by Board of Trustees	1	2	2	4	5	1	5	5	5	3	33
place to practice	2	1	1	2	1	2	2	2	1	4	18
place to teach	5	5	5	5	4	5	4	3	2	5	43
research opportunities	4	4	3	3	2	4	3	4	3	1	31
maintain board certification	3	3	4	1	3	3	1	1	4	2	25

OTHER STAFF:	A	B	C	D	E	F	G	H	I	J	TOT
laud efforts	5	4	5	5	5	5	4	5	-	5	48
recognition program	4	5	3	4	1	4	3	3	-	2	32
increased status	3	3	2	3	4	2	5	4	-	4	33
prestige/respect	2	1	4	2	3	3	2	2	-	3	24
higher professional recognition	1	2	1	1	2	1	1	1	-	1	12
bonuses	1	1	1	1	1	1	1	2	4	4	17
employee assistance	2	2	2	2	2	2	4	3	2	2	23
outplacement help	3	3	3	3	4	4	3	4	3	3	33
pre-retirement programs	4	4	4	4	3	3	2	1	1	1	27
trust from administrator	1	2	5	1	3	1	4	1	4	4	26
confidence from administrator	2	1	2	2	1	2	5	5	3	5	28
flexible shifts	4	5	3	5	5	5	1	3	2	3	36
flexible duties	5	4	4	4	4	4	2	4	1	2	34
more role in work design	3	3	1	3	2	3	3	2	5	1	26
more say in patient care	1	1	2	2	1	1	1	4	2	1	16
control	5	3	5	3	4	5	5	5	5	3	43
input on matters concerning patients	2	2	1	1	2	2	2	3	3	2	20
freedom from paperwork	3	5	4	5	5	3	3	1	4	4	37
freedom from bureaucracy	4	4	3	4	3	4	4	2	1	5	34
on-the-job training (OJT)	2	3	4	2	1	4	1	4	3	3	27
new employee orientation	3	5	5	1	2	5	5	5	5	2	38
inservice training sessions	4	1	2	3	3	3	3	1	1	1	22
continuing education	1	2	1	5	4	1	2	3	2	4	25
refresher courses	5	4	3	4	5	2	4	2	4	5	38
retirement/pension plans	4	1	2	1	1	1	1	2	1	1	15
free uniforms	1	3	5	4	3	4	4	4	3	2	33
free laundry of uniforms	2	4	4	5	5	5	5	3	2	3	38
cafeteria	3	2	3	2	4	3	3	5	4	4	33
morale, welfare, and recreation facilities	5	5	1	3	2	2	2	1	5	5	31

OTHER STAFF: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
internal transfers	3	3	3	3	2	2	2	3	1	5	27
job satisfaction	1	1	2	2	1	3	3	1	2	1	17
good working conditions	2	2	1	1	3	1	1	2	3	2	18
free parking	4	4	4	4	4	4	4	5	5	3	41
short walking distance from parking	5	5	5	5	5	5	5	4	4	4	47
fair appraisals	2	2	4	3	1	3	2	1	4	2	24
incentives for efficiency	3	3	2	5	3	4	1	3	5	1	30
good supervision	4	1	3	4	2	1	3	2	3	3	26
concern for their problems	5	5	1	2	4	2	5	4	1	5	34
self-worth	1	4	5	1	5	5	4	5	2	4	36
good communication	3	2	1	1	2	2	4	1	2	4	22
share in policy-making	4	3	2	3	3	3	3	4	1	3	29
well planned hospital layout	1	4	5	5	5	4	5	5	3	5	22
promotion opportunities	2	1	4	4	1	1	1	2	4	2	42
job analysis	5	5	3	2	4	5	2	3	5	1	35
counseling for staff who who work with AIDS patients	3	4	2	1	3	4	3	1	1	2	24
training about AIDS	4	3	4	2	2	3	4	2	2	1	27
safe environment	2	2	1	4	4	1	2	4	3	3	26
protection from infectious diseases	1	1	3	3	1	2	1	3	4	4	23
recognition of unions	3	3	2	3	4	3	3	2	2	4	29
recognition of employee organizations	1	2	1	1	1	1	1	1	1	3	13
labor unions	2	4	4	2	3	4	2	3	3	2	29
bargaining	4	1	3	4	2	2	4	4	4	1	29
credit union	3	2	5	3	4	4	4	5	4	5	39
workman's compensation	1	1	2	2	5	2	3	3	3	4	26
child care centers	2	4	1	1	1	1	1	1	2	3	17
dressing/locker rooms	5	3	4	4	3	5	5	4	5	1	39
different shifts	4	5	3	5	2	3	2	2	1	2	29
group life insurance	5	5	4	5	5	3	4	5	5	5	46
disability insurance	1	2	3	2	3	2	3	4	4	4	28
health insurance	2	1	1	1	1	1	1	1	1	1	11
vision care plans	4	4	5	4	4	5	5	3	2	3	39
dental care plans	3	3	2	3	2	4	2	2	3	2	26

OTHER STAFF: (Continued)

Volunteer Organizations:	A	B	C	D	E	F	G	H	I	J	TOT
orientation	2	1	2	3	6	1	3	1	1	2	22
supervision	5	2	3	6	5	4	2	6	3	3	39
training	3	3	4	4	4	2	6	4	2	4	36
planning of assignments	4	6	5	5	1	3	5	3	4	5	41
funds to cover expenses	1	4	6	2	3	6	4	5	6	1	38
recognition	6	5	1	1	2	5	1	2	5	6	34
Nurses only:											
sick pay	2	1	3	4	5	3	5	3	3	4	33
vacation pay	3	3	4	3	4	2	4	4	5	5	37
holiday pay	4	2	5	5	3	4	3	5	4	3	38
higher salary with more experience	1	4	2	1	1	1	1	2	1	2	16
higher salary with advanced degrees	5	5	1	2	2	5	2	1	2	1	26
more technical abilities	3	3	4	5	4	2	-	2	2	5	33
total bedside charge of patients	1	1	3	2	1	5	-	3	3	1	22
ability to delegate to LVNs and orderlies	4	4	5	3	3	3	-	4	1	3	33
RN associations	5	5	2	4	5	4	-	5	4	4	42
assurance of quality control of Mds	2	2	1	1	2	1	-	1	5	2	19

THIRD-PARTY PAYERS:	A	B	C	D	E	F	G	H	I	J	TOT
equal costs for all payers	5	5	5	5	1	5	3	2	2	5	38
control costs	1	3	2	1	5	4	4	3	5	4	32
reasonable cost reimbursement	3	4	3	2	3	2	5	1	3	3	29
not unnecessarily high costs	4	1	4	3	4	3	1	4	4	2	30
protection against over-utilization	2	2	1	4	2	1	2	5	1	1	21
fair premiums from people	4	1	2	4	1	3	1	1	2	5	24
raise premiums from beneficiaries	3	4	5	1	4	2	5	4	4	4	36
require higher co-payments	2	5	4	2	3	1	4	5	5	3	34
cost sharing	1	3	1	3	2	4	2	3	3	2	24
insurer financing of out-of-pocket expenses	5	2	3	5	5	5	3	2	1	1	32

THIRD-PARTY PAYERS: (Cont)	A	B	C	D	E	F	G	H	I	J	TOT
controls on price increases	1	1	2	3	2	2	4	5	2	2	24
standards of treatments	5	3	1	5	5	3	3	3	3	1	32
power to define quality care	2	4	3	4	3	5	1	1	4	3	30
limit to types of services payable	3	2	4	2	4	1	2	4	5	4	31
compliance to policies	4	5	5	1	1	4	5	2	1	5	33
number of people covered	4	5	5	1	1	5	2	2	5	2	32
work together on matters of economy and quality of care	5	2	4	5	2	4	5	5	2	3	37
efficient allocation of resources	3	1	1	2	3	2	1	4	3	1	21
prior authorization	1	4	3	4	4	1	3	1	4	4	29
provider-specific coverage	2	3	2	3	5	3	4	3	1	5	31
raise taxes	2	2	2	2	2	2	2	2	2	2	20
tax subsidies for lower premiums	1	1	1	1	1	1	1	1	1	1	10
cost reduction to MDs	4	4	3	4	4	3	1	4	4	3	34
smaller than CPI increases in bargaining for rates to contain costs	1	3	4	3	1	2	3	3	3	4	27
not pay more than actual costs	2	1	2	1	3	1	4	2	1	2	19
control payments to providers	3	2	1	2	2	4	2	1	2	1	20
benefits cut-off	3	5	3	3	5	4	2	4	5	3	37
minimum treatment for patients	4	3	4	5	4	5	4	5	4	4	42
limitation on benefits (dollar amount or time)	1	4	2	2	2	2	5	3	2	2	25
tightening of policies	5	2	5	4	3	3	3	2	3	5	35
eliminate services that make no contribution to health at the margin - unneeded care	2	1	1	1	1	1	1	1	1	1	11
negotiated contracts	1	1	3	2	1	2	1	1	2	3	17
contracting with providers	2	2	1	3	2	3	2	3	3	2	23
equitable contracts for all third-party payers	3	3	2	1	3	1	3	2	1	1	20
quality care	3	3	1	3	2	3	3	1	1	3	23
hospitals must have a contract with a PRO or lose Medicare reimbursement	1	1	3	2	3	1	2	3	3	2	21
reduction of duplication of services	2	2	2	1	1	2	1	2	2	1	16

PROFESSIONAL ORGANIZATIONS:	A	B	C	D	E	F	G	H	I	J	TOT
range of ambulatory care services	1	4	1	1	3	2	4	4	3	1	24
early detection screenings	3	1	2	2	2	1	3	2	1	2	19
prenatal and well-baby care	4	3	3	3	1	4	1	3	2	3	27
alcohol/drug abuse counseling	2	2	4	4	4	3	2	1	4	4	30
not compete with other hospitals - share resources	4	3	2	4	3	1	1	4	4	4	30
hospitals meet standards	3	2	1	1	2	2	3	2	3	3	22
ensure no conflict of interest (ACHA)	2	4	3	2	4	4	4	3	2	2	30
ensure no improper use of confidential information	1	1	4	3	1	3	2	1	1	1	18
Availability of:											
posture classes	4	5	5	5	5	3	5	5	5	5	47
exercise classes	5	2	4	4	4	2	3	4	4	4	36
nutrition classes	2	3	3	2	3	4	2	3	2	3	27
family planning classes	3	4	2	3	2	5	4	1	1	2	27
immunizations	1	1	1	1	1	1	1	2	3	1	13
high quality of patient care	2	2	1	2	1	1	2	2	1	2	16
cooperation	4	4	4	3	3	4	4	3	2	3	34
administer participates in conventions and meetings	3	3	3	4	2	2	3	4	3	4	31
no interference with MD - patient relationship (AMA)	1	1	2	1	4	3	1	1	4	1	19

REGULATORY AGENCIES/CORPORATE HIERARCHY:

	A	B	C	D	E	F	G	H	I	J	TOT
Security Administration reviews Medicare reimbursement	2	-	1	-	1	1	3	4	1	2	19
HSAs guide resource allocation	5	-	3	-	4	2	2	2	5	5	35
HSAs control bed supply (reimbursement and utilization)	3	-	2	-	5	4	1	1	4	4	30
PSROs control physical space requirements	4	-	4	-	3	5	5	3	3	3	38
PSROs control patient eligibility	1	-	5	-	2	3	4	5	2	1	29
licensure	1	1	1	2	1	1	1	2	1	4	15
Certificate of Needs (CONs)	3	4	5	4	4	3	2	4	2	3	34
regional planning (HSAs etc)	4	5	3	3	5	5	5	3	3	1	37
quality control	5	2	2	1	2	4	4	1	4	2	27
building and fire codes	2	3	4	5	3	2	3	5	5	5	37

REGULATORY AGENCIES/CORPORATE HIERARCHY: (Continued)

	A	B	C	D	E	F	G	H	I	J	TOT
Environmental Protection Agency	5	2	4	2	4	3	1	3	3	5	32
defined relationships with the governing body	4	5	1	3	1	4	5	4	1	1	29
focus on monetary aspects	2	1	3	5	2	5	4	5	2	2	31
contain costs	1	4	2	4	3	1	3	1	4	3	26
OSHA and CAL-OSHA	3	3	5	1	5	2	2	2	5	4	32
efficiency in hospital	2	1	1	2	1	1	2	2	2	2	16
control	1	5	5	3	3	5	5	5	4	3	39
technology utilization	4	2	4	5	2	4	3	3	3	4	34
shared services	3	4	2	4	4	2	1	4	1	5	30
program planning	5	3	3	1	5	3	4	1	5	1	31
labor laws	2	1	2	2	2	3	1	1	3	4	21
charity immunity has been eliminated	5	5	5	5	1	5	4	3	5	5	43
Anti-Trust laws	3	3	4	1	3	2	3	4	1	3	27
Civil Rights Act	1	4	1	3	5	4	5	2	2	1	28
tax laws	4	2	3	4	4	1	2	5	4	2	31

BOARD OF TRUSTEES/DIRECTORS:

	A	B	C	D	E	F	G	H	I	J	TOT
high professional status	1	2	1	3	3	1	2	1	1	4	19
power	4	1	4	5	2	3	5	4	2	1	31
prestige	2	3	2	2	1	4	3	3	3	2	25
social recognition	3	4	3	1	4	5	1	2	4	3	30
self-aggrandizement	5	5	5	4	5	2	4	5	5	5	45
communication between MDs and administrator	2	3	1	1	2	1	1	1	5	4	21
get MDs on board team	3	2	5	3	1	3	2	3	4	2	28
cooperate with MDs	5	5	3	4	3	5	3	4	1	3	36
serve as liaison to MDs	4	4	2	5	4	4	5	2	2	5	37
ensure MDs conform to bylaws	1	1	4	2	5	2	4	5	3	1	28
reports to board	2	5	4	3	5	3	4	3	3	3	35
personnel functions	3	3	2	5	4	5	5	4	5	4	40
maintain physical plant	4	4	3	4	3	4	1	5	4	5	37
ensure quality care	1	1	1	1	1	1	3	1	1	1	12
ensure safety	5	2	5	2	2	2	2	2	2	2	26
identify resources	2	2	1	2	2	1	1	2	1	3	17
provide hospital insurance	1	3	2	3	3	3	3	3	2	2	25
system to review plans	3	1	3	1	1	2	2	1	3	1	18

BOARD OF TRTS/DIRS: (Cont)	A	B	C	D	E	F	G	H	I	J	TOT
attend all board meetings	2	5	1	5	5	2	1	2	5	5	33
keep administrative and board functions separate	1	4	2	1	1	1	5	1	2	4	22
assist new board members	3	2	3	3	2	4	2	5	3	2	29
training for old members	5	3	5	4	3	5	3	3	4	3	38
orientation for the new	4	1	4	2	4	3	4	4	1	1	28
keep board informed of health care in general and hospital specifically	1	2	1	3	5	1	2	1	1	1	18
trust from administrator	2	1	3	2	4	3	4	2	4	3	28
advice from administrator	3	4	2	5	3	5	3	4	5	4	38
provide feedback	4	3	4	4	2	4	1	5	3	5	35
ability to select own replacements on board	5	5	5	1	1	2	5	3	2	2	31
well-qualified team	2	1	2	1	1	1	3	2	2	1	16
don't move too fast	3	3	3	2	3	3	2	3	1	2	25
administrator deal with regulatory agencies	1	2	1	3	2	2	1	1	3	3	19
makes policies	1	1	3	1	1	3	1	1	1	1	14
expects counsel from the HA	2	2	2	3	3	2	3	2	3	3	25
polices implemented	3	3	1	2	2	1	2	3	2	2	21
budgets from administrator	4	2	1	4	4	4	4	4	5	5	37
monitor the finances	3	3	2	3	2	1	5	3	4	4	30
financial solvency	1	1	4	1	1	2	1	1	3	1	16
surveillance of fiscal assets	2	4	3	2	3	3	3	2	2	2	26
expenses paid - no salary	5	5	5	5	5	5	2	5	1	3	41
accountability for MDs and management	3	1	1	1	3	1	4	2	1	1	18
hospital purposes	1	2	2	2	2	2	3	1	2	3	20
hospital obligations	2	3	3	3	1	3	2	3	3	4	27
ensure CME	4	4	4	4	4	4	1	4	4	2	35
provide information	3	2	2	2	3	4	3	2	2	2	25
give more time prior to decisions	2	3	3	4	2	1	2	3	3	3	26
money to attend meetings	5	4	4	5	4	5	4	5	4	4	44
lack of conflict	1	5	5	1	5	3	5	4	5	5	39
send information and agendas prior to meetings	4	1	1	3	1	2	1	1	1	1	16
understand hospital goals	1	1	1	1	1	1	3	1	2	1	13
high education	3	2	2	3	3	3	2	3	3	3	27
loyalty to hospital	2	3	3	2	2	2	1	2	1	2	20

BOARD OF TRUSTEES/DIRECTORS: (Continued)

	A	B	C	D	E	F	G	H	I	J	TOT
ability to digest reports	5	1	3	5	3	5	3	2	3	5	35
ability to digest budgets	4	2	4	4	2	4	4	3	4	4	35
high sense of public honor	1	5	5	2	5	2	5	5	1	2	33
integrity	2	3	2	3	4	1	2	1	2	3	23
know how a hospital is run	3	4	1	1	1	3	1	4	5	1	24

COMMUNITY:	A	B	C	D	E	F	G	H	I	J	TOT
community outreach programs	4	3	4	5	3	5	4	2	4	4	38
care for the medically indigent	3	4	3	3	5	4	3	3	2	3	33
comprehensive health care	2	1	1	2	2	1	5	4	3	1	22
equitable distribution of health care services	1	2	2	1	1	2	2	1	1	2	15
parity of MDs in rural areas	5	5	5	4	4	3	1	5	5	5	42
stronger voice in programs	2	2	1	1	1	2	2	1	1	1	14
post-disaster teams - be prepared at large gatherings	1	1	2	2	2	1	1	2	2	2	16
rehabilitation	3	2	3	3	2	2	2	3	1	1	22
outpatient activities	2	3	1	1	1	3	3	1	2	2	19
satellite hospitals or clinics	1	1	2	2	3	1	1	2	3	3	19
public lectures	5	4	3	5	3	4	1	3	5	5	38
good stories for the media	4	5	4	4	5	5	5	5	4	4	45
honesty	1	1	5	1	2	3	2	4	2	3	24
ease of getting information	2	2	2	2	1	2	4	1	3	1	20
public service announcements	3	3	1	3	4	1	3	2	1	2	23
newsletters, booklets, etc	1	5	3	2	3	3	3	3	4	4	31
Administrator should perform community speaking engagements	5	3	4	3	4	4	4	4	5	3	39
Public Relations promotion	2	4	2	4	5	5	5	5	1	5	38
education of health	4	2	5	-	1	1	2	1	2	2	22
education of disease prevention	3	1	1	1	2	2	1	2	3	1	17
obtains transfers	2	4	4	3	3	2	4	3	4	4	33
cooperation with other hospitals/facilities	1	3	1	2	1	3	3	4	3	1	22
accommodation for religion	5	2	5	5	5	5	5	5	5	5	47
nursing homes as extensions of hospitals	4	5	3	4	4	1	2	2	2	2	29
avoidance of duplication of services	3	1	2	1	2	4	1	1	1	3	19

COMMUNITY: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
home care	1	2	2	5	4	1	3	1	1	1	21
visitation of health aid personnel	4	1	5	2	3	4	4	2	2	2	29
occupational therapists	2	3	4	1	5	2	1	5	3	3	29
physical therapists	3	4	3	3	2	3	2	4	4	4	32
social service workers	5	5	1	4	1	5	5	3	5	5	39
public health fairs	4	3	3	4	3	3	4	4	1	4	33
health screenings	2	4	1	2	1	1	2	1	2	3	19
health workshops	3	2	2	3	2	2	3	3	3	1	24
screenings for HIV	1	1	4	1	4	4	1	2	4	2	24
dialysis centers	4	2	4	5	5	4	2	4	1	3	34
alcoholism centers	5	4	5	3	4	5	3	1	2	4	36
chronic disease care for the aged	3	3	3	4	1	2	4	3	3	2	28
hospices	2	5	2	1	2	1	5	2	4	5	29
free-standing ER facilities	1	1	1	2	3	3	1	5	5	1	23
patient education	5	2	4	4	4	1	1	4	4	2	31
health promotion programs	1	5	5	1	1	2	3	2	2	3	25
patient information	4	3	3	3	5	5	2	3	3	1	32
health education programs	3	4	2	2	2	3	5	1	5	4	31
cooperation with education (nursing trainees etc)	2	1	1	5	3	4	4	5	1	5	31
research	3	4	2	4	2	2	1	3	1	3	25
service clubs (Red Cross)	2	1	3	3	3	3	3	2	2	2	24
equality of access	1	2	1	1	1	1	4	1	3	1	16
administrator should join civic clubs	4	3	4	2	4	4	2	4	4	4	35
tours of hospital	2	5	5	5	5	5	2	5	5	3	42
employers want cost containment	5	2	1	1	1	4	5	4	4	2	29
transportation services	3	3	3	3	2	1	4	2	3	5	29
convenient location	1	1	2	2	3	2	1	3	1	1	17
meals-on-wheels	4	4	4	4	4	3	3	1	2	4	33
suicide prevention	3	1	2	3	3	3	3	2	2	3	25
prevention of diseases	1	2	1	2	1	1	1	1	3	1	14
vaccines	2	3	3	1	2	2	2	3	1	2	21

Section Two: Second Phase

Section Two of Appendix B consists of the Second Phase of the Delphi Process. There are five documents.

The first document is a one-page "Thank You" for completing the first phase and instructions for the second phase to the same ten Delphi Panel members.

The second document is the ten-page Second Phase of the Delphi process. The Panel Members were asked to rank each term as to how important it would be if the member were a part of that constituent group.

The third document is a one-page "Thank You" for completing the second phase of the Delphi process.

The fourth document is the ten-page tally form created after nine members returned their ranking.

The fifth document is an eight-page re-ranking of the above items, according to total score. From this list the lowest ranking items were dropped to become the list of items for the Third Phase of the Delphi Process.

The Hospital Administrator: Yesterday, Today, and Tomorrow

THANK YOU! THANK YOU! THANK YOU! THANK YOU! THANK YOU!

Results of the First Part of the Delphi Group

Here is a copy of the results of the first part of the Delphi Group. You can see (if you are interested) how your ranking compared to the rankings made by the other nine generous people who agreed to help me.

After totalling all responses, I retained the highest two-thirds from each constituent group. If an item received a borderline score, yet at least four people ranked it either a "1" or a "2," it stayed in. However, if an item was in a cluster with only three or four items, and everyone ranked it low in importance, it was dropped. In this way the first list of 412 items was pared to a smaller one of 262.

Directions for the Second Part of the Delphi Group

You will notice that the format has been changed. Each item is on a separate line, rather than two columns of items. Also, the items are arranged in random order. All are in small groups of either four or five items, but that is only for ease in reading. They are totally unrelated to the others in the group.

This set of 262 items is to be rated differently than the first set. Please consider each item individually. Please rate each item solely on its own merit. Here is the rating scheme to use:

A = crucial (That particular item is of utmost importance.)
B = very important (You really would want that item.)
C = somewhat important (You would miss its absence.)
D = so-so (Nice to have, but not necessary.)
E = least important (You could take it or leave it.)

All you need to do is place an "X" in the block that corresponds to the rating you would give that item. Please rate each item as though you were a part of that particular constituent group.

When I get everyone's ratings back, I'll tally each item and give you a copy of the total display. From that list I'll be able to select the items for a questionnaire to send to the hospital administrators. Once again, thank you so much for agreeing to do this for me.

Andrea Scheffelin June 27, 1991

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important. **Page 1**

PATIENTS: A person who is or has been under some type of medical care or treatment, either in the health care facility or associated with it through her/his personal physician.

	A	B	C	D	E
right to refuse treatment					
privacy					
provision for intellectual needs					
relief from pain					
protection from malpractice					
reasonable visiting hours					
one- or two-person rooms					
confidentiality					
rehabilitation					
appropriate meals (dining room or bedside)					
having a say in own care					
information about treatment					
disease prevention					
air conditioned rooms					
short waiting times for obtaining treatment					
low-cost health care					
safe environment					
emergency room availability					
freedom from abuse					
coordination of care					
hot food hot, cold food cold					
provision for recreation					
latest technology					
equitable prices					
comfortable surroundings					
empathy					
ease from worry					
information of diagnosis					
treated with dignity					
freedom from neglect					
provision for emotional needs					
quality care					
protection from harming self					
hope					
understanding					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important.

PATIENTS: (Continued)

	A	B	C	D	E
treated with respect					
kindness					
continuity of care					
right of informed consent					
protection from infectious diseases					
good food					
quick and sure relief					
self respect					
treated as an individual					
short waiting times for an appointment					
easy access to services					
more health care services					
information of prognosis					
competent medical personnel					
right to accept or refuse experimentation					
only needed surgery done					
place to rest					
access to available services					
insurance for the aged					
protection from medication errors					

MEDICAL STAFF: All physicians who currently have privileges at the health care facility or ancillary services or clinics.

	A	B	C	D	E
best equipment					
mutual understanding					
high quality of fellow MDs					
highly skilled nurses					
support for MDs need for self governance					
accurate patient records					
control over own destiny					
research opportunities					
good communication					
cooperation from hospital administrator					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important. **Page 3**

<u>**MEDICAL STAFF**</u>: (Continued)

	A	B	C	D	E
hospital as a place for services					
suitable equipment					
decision making					
mutual trust					
authority over patient care (regardless of cost)					
fellowships					
maintain board certification					
fees					
diverse and more interesting patient population					
latest in equipment					
continuing medical education					
autonomy					
high quality of patient care					
training for intern and residents					
complete medical records					
good reputation					
fewer meetings					
keep MDs informed					
other providers for patient welfare					
freedom from admin work					
maintenance of equipment					
professional advancement					
protection from infectious diseases					
place to practice					
clerical help					
familiar with medical technology					
needs hospital for by-laws					
choice in when, where, and how they practice medicine					
protection from malpractice suits					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important. **Page 4**

<u>OTHER STAFF</u>: All non-physician persons employed by the health care facility: nurses, technicians, and support personnel including legal advisors as well as other categories such as per diem providers and other contractors of direct health care services. (Chaplain, secretaries, housekeepers, medical record librarians, RNs, LVNs, orderlies, lab techs, X-Ray techs, social service workers, maintenance personnel, physical and occupational therapists, engineers, volunteers, and auxiliaries):

	A	B	C	D	E
different shifts					
continuing education					
promotion opportunities					
bonuses					
dental care plans					
prestige					
good working conditions					
good communication					
higher salary with advanced degrees					
on-the-job training (OJT)					
fair appraisals					
trust from administrator					
inservice training sessions					
safe environment					
pre-retirement programs					
training about AIDS					
labor unions					
more input on matters concerning patient care					
incentives for efficiency					
higher professional recognition					
good supervision					
confidence from administrator					
morale, welfare, and recreation facilities					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important.

OTHER STAFF: (Continued)

	A	B	C	D	E
respect					
health insurance					
workman's compensation					
employee assistance					
recognition of employee organizations					
sick leave					
child care centers					
retirement/pension plans					
job satisfaction					
protection from infectious diseases					
disability insurance					
bargaining					
more role in work design					
higher salary with more experience					
recognition programs					
internal transfers					
more say in patient care					
counseling for staff who work with AIDS patients					

Nurses Only:

	A	B	C	D	E
more technical abilities					
total bedside charge of patients					
authority to delegate to LVNs and orderlies					
assurance of quality control of MDs					

Volunteer organizations:

	A	B	C	D	E
orientation					
training					
recognition					
good supervision					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important.

THIRD-PARTY PAYERS: Private health care plans such as the Foundation Health Plan or Blue Cross, and government programs such as Medicare, Medi-Cal, CHAMPUS, medically indigent, and other publicly-funded programs.

	A	B	C	D	E
cost sharing					
contracting with providers					
controls on price increases					
not unnecessarily high costs					
protection against over-utilization					
prior authorization					
not pay more than actual costs					
quality care					
fair premiums from people					
efficient allocation of resources					
power to define quality care					
provider-specific coverage					
limitations on benefits (dollar amounts or time)					
tax subsidies for lower premiums					
limit on types of services payable					
reasonable cost reimbursement					
equitable contracts for all third-party payers					
reduction of duplication of services					
hospitals must have a contract with a Professional Review Organization or lose Medicare reimbursement					
control payments to providers					
eliminate services that make no contribution to health at the margin - unneeded care					
negotiated contracts					
smaller than consumer price index increases in bargaining for rates to contain costs					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important.

<u>BOARD OF TRUSTEES/DIRECTORS</u>: Boards are usually composed of physicians, business leaders of the community, and often consumer members. The board provides the broad spectrum of the hospital's mission, long range policy, and strategic planning. The Board looks to the administrator for supervision of the day-to-day operations.

	A	B	C	D	E
assist new board members					
get MDs on Board team					
prestige					
well-qualified team					
administrator deal with regulatory agencies					
ensure safety					
power					
monitor the finances					
trust from administrator					
ability to select own replacements on board					
have a system to review plans					
surveillance of fiscal assets					
integrity					
understand hospital's goals					
accountability from MDs and management					
have loyalty to hospital					
identify resources					
social recognition					
provide information					
have more time prior to making decisions					
have a high education					
knows hospital's obligations					
ensure MDs conform to bylaws					
high professional status					
communication between MDs and administrator					
know how a hospital is run					
makes policies					
orientation for new members					
ensure quality care					
keep administrative and board functions separate					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important.

BOARD OF TRUSTEES/DIRECTORS: (Continued)

	A	B	C	D	E
policies implemented	___	___	___	___	___
maintain financial solvency	___	___	___	___	___
send information and agenda prior to meetings	___	___	___	___	___
knows hospital's purposes	___	___	___	___	___
keep board informed of health care in general and hospital specifically	___	___	___	___	___

PROFESSIONAL ORGANIZATIONS: Any professional organization that has an impact or potential impact on the health care facility. Some examples are the American College of Healthcare Executives (ACHE), the American Medical Association (AMA), and the American Nurse Association (ANA).

	A	B	C	D	E
high quality of patient care	___	___	___	___	___
family planning classes	___	___	___	___	___
early detection screenings	___	___	___	___	___
ensure no conflict of interest	___	___	___	___	___
range of ambulatory care services	___	___	___	___	___
prenatal and well-baby care	___	___	___	___	___
nutrition classes	___	___	___	___	___
immunizations	___	___	___	___	___
no interference with MD-patient relationship (AMA)	___	___	___	___	___
alcohol/drug abuse counseling	___	___	___	___	___
hospitals meet standards	___	___	___	___	___
not compete with other hospitals (share resources)	___	___	___	___	___
ensure no improper use of confidential information	___	___	___	___	___

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important.

<u>COMMUNITY</u>: The community is composed of many inter-related and overlapping groups. Some examples are: ethnic groups, the media, community, researchers, service groups such as Rotary, Lions, Kiwanis, city and county councils, planning commissions, other organizations, businesses, and individuals.

	A	B	C	D	E
stronger voice in programs					
public service announcements					
home care					
chronic disease care					
ease of getting information					
health workshops					
screenings for HIV/AIDS					
equality of access					
health education programs					
equitable distribution of health care services					
rehabilitation					
hospice availability					
education of disease prevention					
cooperation with other health facilities or hospitals					
presence of occupational or physical therapists					
outpatient activities					
newsletters, booklets, etc					
comprehensive health care					
health screenings					
post-disaster teams - be prepared at large gatherings					
prevention of diseases					
vaccines					
patient information					
satellite hospitals or clinics					
nursing homes as extensions of hospitals					
honesty for media					
suicide prevention					
patient education					
education on health matters					
avoidance of duplication of services					

Please pretend you are a part of the group and rate each item independent of the others. A = crucial, B = very important, C = somewhat important, D = so-so, and E = least important. **Page 10**

COMMUNITY: (Continued)

	A	B	C	D	E
employers want cost containment					
transportation services					
convenient location					
visitation of health aid personnel					
free-standing emergency rooms					
research on diseases					
service clubs (Red Cross etc.)					
cooperation with schools (nursing schools etc.)					

REGULATORY AGENCIES/CORPORATE HIERARCHY: Hundreds of regulatory agencies have some jurisdiction over a health care facility. These agencies range from federal, state, county, and city to agencies without geographical boundaries. Corporate hierarchies direct the work of many hospitals which have expanded into health care systems during the last decade. When several hospitals are under a corporate umbrella each facility must answer to its regional base or corporate headquarters.

	A	B	C	D	E
tax laws					
Environmental Protection Agency					
efficiency in hospital					
Anti-Trust laws					
Social Security Administration reviews Medicare reimbursement					
quality control					
focus on monetary aspects					
shared services					
Civil Rights Act					
Occupational Safety and Health Administration					
contain costs					
labor laws					
licensure					
program planning					
defined relationships with the governing body					

The Hospital Administrator:
Yesterday, Today, and Tomorrow

THANK YOU! THANK YOU! THANK YOU! THANK YOU!

Here is a copy of the results of the second phase of the Delphi process. Nine responses were received. The score for each term was tabulated and ranked; the lowest score being considered the most important.

I examined each term in each constituent group. Some of the terms were combined or modified. I chose approximately half of the needs and wants to be included in the final selection list, which will be the basis for a draft questionnaire. I am also giving you a copy of that list.

Each selected term will be developed into a need or want item and will appear on a draft questionnaire. The final step will be to field test it with three hospital administrators suggested by my advisor. Based on their recommendations, the actual questionnaire will be finalized and sent to the hospital administrators of the 100 largest hospitals in California.

After the Delphi process was completed, my advisor and I decided that the constituent groups "Professional Organizations" and "Regulatory Agencies/Corporate Hierarchy" were no longer needed, for although hospital administrators have responsibilities to those groups, the administrators have few options with regard to the meeting of such needs and wants. Therefore, the final list has only six constituent groups.

With your help and through this entire Delphi process the number of terms was reduced from 412 to 126. I know you put a lot of time and thought into rating these terms for me. I appreciate it greatly.

Andrea Scheffelin August 15, 1991

RESULTS OF THE SECOND PART OF THE DELPHI GROUP

PATIENTS:	A	B	C	D	E	F	G	H	I	J	TOT
right to refuse treatment	1	1	4		2	1	1	1	2	1	14
privacy	2	2	2		2	3	5	2	1	1	20
provision for intellectual needs	4	2	5		3	5	5	3	3	5	35
relief from pain	1	1	1		1	1	4	1	3	1	14
protection from malpractice	1	3	4		2	2	1	1	1	1	16
reasonable visiting hours	4	3	3		3	3	2	2	3	3	26
one- or two-person rooms	2	3	3		4	3	3	5	2	3	28
confidentiality	1	2	1		2	1	1	1	2	1	12
rehabilitation	2	2	3		1	2	1	1	2	5	19
appropriate meals (dining or bedside)	5	3	3		2	4	5	3	2	3	30
having a say in own care	1	2	1		1	1	3	1	2	1	13
information about treatment	1	2	2		1	2	2	1	2	2	15
disease prevention	1	1	2		2	1	2	1	1	3	14
air conditioned rooms	2	3	3		2	2	5	3	3	2	25
short waiting times for obtaining treatment	2	2	2		2	3	1	2	2	3	19
low-cost health care	1	3	1		2	3	2	2	2	1	17
safe environment	1	3	2		2	2	1	2	1	1	15
emergency room availability	1	1	1		2	2	1	1	2	5	16
freedom from abuse	1	1	3		1	1	1	1	1	2	12
coordination of care	2	2	2		2	2	4	1	2	4	21
hot food hot, cold food cold	4	3	4		2	3	5	3	2	2	28
provision for recreation	4	3	4		3	5	4	4	3	5	35
latest technology	5	2	2		3	1	3	1	2	1	20
equitable prices	3	1	2		2	3	2	2	2	3	20
comfortable surroundings	3	3	2		2	3	4	2	2	3	24
empathy	3	2	4		1	3	4	1	2	2	22
ease from worry	1	2	4		2	3	5	2	2	2	22
information of diagnosis	1	1	3		1	1	2	1	2	1	13
treated with dignity	1	1	3		2	2	3	2	2	3	19
freedom from neglect	1	1	3		2	2	2	1	1	2	15

PATIENTS: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
provision for emotional needs	3	2	3		2	3	2	2	2	3	22
quality care	3	1	1		1	2	2	1	2	1	14
protection from harming self	3	1	3		2	1	4	1	1	3	19
hope	4	2	3		2	3	5	2	1	2	24
understanding	1	2	2		1	3	4	2	2	1	18
treated with respect	2	2	2		2	2	4	2	2	2	20
kindness	2	2	2		2	3	4	2	2	2	21
continuity of care	3	2	2		2	3	3	2	2	3	22
right of informed consent	1	1	2		2	2	2	1	2	1	14
protection from infectious diseases	1	1	2		1	1	1	1	1	1	10
good food	3	3	3		2	3	4	4	2	3	27
quick and sure relief	2	2	3		2	1	3	2	2	1	18
self respect	1	2	4		2	3	3	2	2	2	19
treated as an individual	1	2	3		2	2	3	2	2	2	19
short waiting times for an appointment	3	3	2		2	3	1	2	2	2	20
easy access to services	3	4	2		2	3	2	2	2	2	22
more health care services	2	4	2		5	3	3	2	2	2	25
information on prognosis	1	2	3		2	2	2	1	2	3	18
competent medical personnel	1	1	1		1	1	2	1	2	1	11
right to accept or refuse experimentation	1	1	3		1	1	1	1	1	1	11
only needed surgery done	1	2	3		1	1	1	1	1	1	12
place to rest	2	4	4		2	4	4	3	2	3	28
access to available services	1	3	2		2	2	3	2	2	2	19
insurance for the aged	1	2	2		1	3	3	2	1	5	20
protection from medication errors	1	1	1		1	1	1	1	1	1	9

MEDICAL STAFF:	A	B	C	D	E	F	G	H	I	J	TOT
best equipment	1	2	1		2	3	2	1	2	3	17
mutual understanding	3	3	2		1	3	3	1	2	4	22
high quality of fellow MDs	2	2	2		2	2	2	1	2	2	17
highly skilled nurses	1	2	1		1	1	2	1	2	1	12
support for MDs need for self governance	3	3	4		3	3	3	1	2	4	26

MEDICAL STAFF: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
accurate patient records	1	1	2		2	1	1	1	1	3	13
control over own destiny	2	3	4		4	1	4	2	1	4	25
research opportunities	3	4	4		3	3	5	2	2	5	31
good communication	3	2	2		1	2	3	2	2	3	20
cooperation from administrator	1	2	2		2	2	2	1	2	1	15
hospital as a place for services	1	2	2		3	3	2	1	2	3	19
suitable equipment	2	1	2		2	2	2	1	2	3	17
decision making	1	2	3		2	2	1	1	2	1	15
mutual trust	3	2	3		1	3	4	1	2	2	21
authority over patient care (regardless of cost)	1	2	2		2	1	3	1	2	1	15
fellowships	4	4	3		2	3	5	2	2	5	30
maintain board certification	1	3	2		1	3	1	1	2	3	17
fees	1	2	3		1	3	3	2	2	4	21
diverse and more interesting patient population	5	4	4		3	3	5	3	2	2	31
latest in equipment	1	2	2		2	3	4	1	1	2	18
continuing medical education	1	1	2		1	3	2	1	1	4	16
autonomy	1	2	3		1	2	3	2	1	1	16
high quality of patient care	2	1	1		1	1	2	1	1	3	13
training for interns and residents	2	1	2		2	3	1	2	1	4	18
complete medical records	1	1	2		2	2	1	1	1	1	12
good reputation	1	2	2		2	1	5	2	1	3	19
fewer meetings	4	3	4		2	4	4	3	2	2	28
keep MDs informed	3	3	2		1	2	2	2	2	3	20
other providers for patient welfare	4	4	3		2	3	2	2	2	3	25
freedom from admin work	1	4	3		2	3	2	2	1	2	20
maintenance of equipment	2	2	2		2	2	1	1	2	3	17
professional advancement	1	3	2		2	2	3	2	2	3	20
protection from infectious diseases	1	1	2		1	1	1	1	1	1	10

MEDICAL STAFF: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
place to practice	2	2	2		2	3	3	4	2	1	21
clerical help	3	3	2		2	3	2	3	2	3	23
familiar with medical technology	2	2	2		2	3	3	1	1	2	18
needs hospital for by-laws	5	2	3		3	3	2	3	2	4	27
choice in when, where, and how they practice medicine	1	2	1		1	1	2	3	2	1	14
protection from malpractice suits	1	2	2		1	1	1	1	1	2	12

OTHER STAFF:	A	B	C	D	E	F	G	H	I	J	TOT
different shifts	2	2	2		3	3	2	2	2	2	20
continuing education	3	1	2		2	2	2	1	1	3	17
promotion opportunities	1	1	2		1	1	1	1	1	1	10
bonuses	1	2	2		2	2	4	1	2	2	18
dental care plans	3	2	2		2	2	3	2	2	4	22
prestige	3	2	3		2	2	2	2	2	3	21
good working conditions	1	2	1		1	1	2	1	2	2	13
good communication	3	3	2		1	1	2	1	1	3	17
higher salary with advanced degrees	3	2	2		2	3	1	2	2	4	21
on-the-job training (OJT)	2	2	2		3	3	2	1	2	2	19
fair appraisals	1	2	2		1	2	3	2	2	1	16
trust from administrator	4	3	1		2	3	2	2	1	3	21
inservice training sessions	3	2	2		3	2	3	2	1	3	21
safe environment	1	3	2		2	1	1	1	1	2	14
pre-retirement programs	5	2	2		3	2	1	2	2	2	21
training about AIDS	1	3	2		3	2	1	1	2	1	16
labor unions	3	3	3		4	4	4	2	3	3	29
more input on matters concerning patient care	2	4	2		2	2	2	2	2	3	21
incentives for efficiency	3	2	2		2	2	2	2	2	1	18
higher professional recognition	1	2	2		3	2	2	2	2	2	18
good supervision	3	1	2		1	2	3	1	1	2	16
confidence from administrator	4	2	4		2	2	2	2	1	3	22
morale, welfare, and recreation facilities	5	4	2		3	4	5	2	2	4	31

OTHER STAFF: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
respect	3	2	3		2	2	2	2	1	2	19
health insurance	1	1	2		2	1	1	2	1	1	12
workman's compensation	1	1	2		3	2	3	2	2	4	20
employee assistance	2	2	2		4	3	3	2	2	3	23
recognition of employee organizations	1	3	4		4	3	5	2	2	4	28
sick leave	1	1	2		2	2	1	2	2	1	14
child care centers	3	1	4		2	3	1	3	2	3	22
retirement/pension plans	1	2	2		2	1	1	2	2	3	16
job satisfaction	1	3	1		1	2	4	2	1	2	17
protection from infectious diseases	1	2	3		1	1	1	1	1	1	12
disability insurance	3	2	2		2	1	1	2	2	3	18
bargaining	3	2	3		3	3	3	2	2	4	25
more role in work design	4	2	2		2	3	2	3	2	4	24
higher salary with more experience	1	1	2		2	2	1	2	2	2	15
recognition programs	5	3	2		2	2	2	3	2	2	23
internal transfers	5	2	4		2	3	3	4	2	3	28
more say in patient care	2	4	1		2	2	2	2	2	1	18
counseling for staff who work with AIDS patients	1	1	1		2	2	1	1	1	3	13

Nurses Only:

	A	B	C	D	E	F	G	H	I	J	TOT
more technical abilities	2	2	2		2	2	2	1	1	3	17
total bedside charge of patient	1	2	2		2	2	3	2	1	1	16
authority to delegate to LVNs and orderlies	1	3	2		2	2	3	2	1	1	17
assurance of quality control of MDs	1	1	4		1	1	2	2	1	1	14

Volunteer Organizations:

	A	B	C	D	E	F	G	H	I	J	TOT
orientation	1	2	2		2	2	2	1	1	2	15
training	1	3	2		2	2	2	1	1	2	16
recognition	1	3	3		1	2	4	2	2	2	20
good supervision	1	2	3		1	2	3	1	2	2	17

THIRD-PARTY PAYERS:	A	B	C	D	E	F	G	H	I	J	TOT
cost sharing	2	3	3		1	2	2	1	2	1	17
contracting with providers	1	2	2		1	2	2	1	2	2	15
controls on price increases	1	1	2		1	2	1	2	1	1	12
not unnecessarily high costs	2	2	2		1	3	1	2	2	3	18
protection against over-utilization	1	2	2		1	3	3	2	1	2	17
prior authorization	3	4	2		3	2	4	1	2	1	22
not pay more than actual costs	2	1	2		5	2	3	2	2	2	21
quality care	2	2	3		2	2	3	1	1	1	17
fair premiums from people	3	2	2		2	3	3	2	2	3	22
efficient allocation of resources	1	2	3		1	2	2	2	2	3	18
power to define quality care	1	2	3		2	3	2	2	1	2	18
provider-specific coverage	3	2	3		3	2	3	1	2	4	23
limitations on benefits (dollar amounts or time)	1	3	2		5	2	1	2	2	2	20
tax subsidies for lower premiums	3	4	4		2	2	3	1	2	1	22
limit on types of services payable	1	3	2		5	2	4	2	2	2	23
reasonable cost reimbursement	1	2	3		1	2	2	2	2	2	17
equitable contracts for all third-party payers	1	3	2		5	3	2	1	2	1	20
reduction of duplication of services	2	3	1		2	2	3	2	1	3	19
hospitals must have a PRO contract or lose Medicare reimbursement	2	4	3		5	1	2	1	1	4	24
control payments to providers	1	2	2		3	2	2	2	2	2	18
eliminate services that make no contribution to health at the margin - unneeded care	2	4	2		1	1	4	1	1	3	19
negotiated contracts	1	1	3		3	2	5	1	2	3	21
smaller than consumer price index increases in bargaining for rates to contain costs	2	2	3		3	3	4	2	2	4	25

BOARD OF TRUSTEES/DIRECTORS:

	A	B	C	D	E	F	G	H	I	J	TOT
assist new board members	1	3	3		2	3	2	2	2	3	21
get MDs on Board team	1	2	3		1	3	5	1	2	2	20
prestige	2	4	2		3	2	5	3	2	2	25
well-qualified team	3	1	2		1	1	5	1	1	1	16
administrator deal with regulatory agencies	3	2	2		4	3	3	1	1	3	22
ensure safety	1	2	2		1	2	1	1	1	3	14
power	2	1	4		5	2	4	4	2	2	26
monitor the finances	2	2	2		1	1	3	2	2	2	17
trust from administrator	3	2	2		2	2	4	2	1	1	19
ability to select own replacements on board	5	5	3		5	3	5	2	2	1	31
have a system to review plans	1	3	4		1	2	4	1	2	2	20
surveillance of fiscal assets	1	2	4		2	1	3	1	2	3	19
integrity	1	1	2		1	2	2	1	1	2	13
understand hospital's goals	1	1	1		1	3	1	2	1	3	14
accountability from MDs and management	1	1	2		2	2	4	2	1	1	16
have loyalty to hospital	1	2	2		2	2	5	2	1	3	26
identify resources	2	4	2		3	3	2	2	1	3	22
social recognition	3	5	4		3	3	3	4	2	3	30
provide information	3	3	3		4	3	4	3	1	2	26
have more time prior to making decisions	2	2	3		2	2	4	2	1	1	19
have a high education	3	2	3		5	3	5	4	2	2	29
knows hospital's obligations	1	2	2		1	3	1	3	2	1	16
ensure MDs conform to bylaws	1	1	2		4	1	3	2	1	1	16
high professional status	1	2	2			2	3	2	1	4	17
communication between MDs and administrator	1	2	1		2	2	3	1	1	3	16
know how a hospital is run	2	1	2		2	2	2	3	2	3	19
makes policies	1	2	2		1	2	2	1	2	3	16
orientation for new members	2	3	3		2	3	3	2	2	3	23
ensure quality care	2	2	1		1	1	3	1	1	1	13
keep administrative and board functions separate	1	4	3		3	2	4	1	1	2	21

BOARD OF TRUSTEES/DIRECTORS: (Continued)

	A	B	C	D	E	F	G	H	I	J	TOT
policies implemented	2	2	2		1	1	2	2	2	2	16
maintain financial solvency	1	1	1		1	2	1	1	1	1	10
send information and agenda prior to meetings	3	2	3		2	2	4	2	1	4	23
knows hospital's purposes	1	1	2		2	2	2	2	1	4	17
keep board informed of health care in general and hospital specifically	1	3	3		1	3	3	1	1	2	18

PROFESSIONAL ORGANIZATIONS:

	A	B	C	D	E	F	G	H	I	J	TOT
high quality of patient care	1	1	1		5	1	3	1	2	1	16
family planning classes	3	4	4		5	3	2	2	2	5	29
early detection screenings	2	4	3		5	2	2	1	1	5	25
ensure no conflict of interest	1	2	2		3	3	2	1	1	3	18
range of ambulatory care services	3	3	4		5	3	3	2	2	3	28
prenatal and well-baby care	2	2	3		5	2	1	2	2	2	21
nutrition classes	4	3	3		5	3	2	3	2	4	29
immunizations	1	2	4		5	1	1	2	1	5	22
no interference with MD-patient relationship (AMA)	1	4	2		2	2	3	1	1	1	17
alcohol/drug abuse counseling	5	2	3		5	3	2	3	1	1	25
hospitals meet standards	1	1	2		2	2	1	1	1	3	14
not compete with other hospitals (share resources)	2	3	2		4	1	3	1	2	3	21
ensure no improper use of confidential information	1	1	2		1	2	2	1	1	1	12

COMMUNITY:

	A	B	C	D	E	F	G	H	I	J	TOT
stronger voice in programs	2	4	3		2	2	3	3	2	2	23
public service announcements	3	2	2		5	2	3	3	2	5	22
home care	3	2	2		2	3	2	2	2	5	23
chronic disease care	3	3	3		2	2	1	2	2	3	21
ease of getting information	3	1	2		2	2	3	1	2	1	17

COMMUNITY: (Continued)	A	B	C	D	E	F	G	H	I	J	TOT
health workshops	3	2	2		2	3	3	2	2	2	21
screenings for HIV/AIDS	1	1	3		2	2	1	1	1	5	17
equality of access	2	2	2		1	2	3	2	1	3	18
health education programs	3	3	2		1	2	3	2	1	4	21
equitable distribution of health care services	1	2	2		1	1	3	1	1	4	16
rehabilitation	4	3	3		2	2	1	2	1	4	22
hospice availability	4	2	1		2	2	3	2	1	5	22
education of disease prevention	4	2	3		1	1	1	2	1	4	19
cooperation with other health facilities or hospitals	2	3	2		1	2	3	2	1	3	19
presence of occupational or physical therapists	4	2	2		2	2	1	2	1	4	20
outpatient activities	4	4	3		2	2	2	3	2	3	25
newsletters, booklets, etc	3	5	3		4	3	3	3	2	4	30
comprehensive health care	3	3	1		2	1	3	1	2	2	18
health screenings	3	3	3		2	2	3	1	2	3	22
post-disaster teams - be prepared at large gatherings	4	2	3		4	2	2	1	2	5	25
prevention of diseases	1	2	4		1	1	1	1	1	1	13
vaccines	1	1	4		2	1	1	1	1	5	17
patient information	3	3	2		2	2	3	1	2	2	20
satellite hospitals or clinics	3	2	3		5	2	3	2	2	3	25
nursing homes as extensions of hospitals	4	3	2		3	2	3	1	1	1	20
honesty for media	1	1	2		1	2	5	1	1	1	15
suicide prevention	4	2	3		2	2	5	2	2	2	24
patient education	4	3	2		2	2	3	2	2	2	22
education on health matters	4	3	2		2	2	3	2	2	5	25
avoidance of duplication of services	3	3	3		2	2	4	2	1	2	22
employers want cost containment	1	3	3		2	2	4	2	2	2	21
transportation services	1	4	4		2	3	4	2	2	4	26
convenient location	1	2	4		2	2	5	2	2	4	24
visitation of health aid personnel	3	2	3		3	2	4	3	2	4	26

COMMUNITY: (Continued)

	A	B	C	D	E	F	G	H	I	J	TOT
free-standing emergency rooms	3	2	2		4	3	3	1	2	3	23
research on diseases	5	3	3		4	2	2	2	2	5	28
service clubs (Red Cross etc.)	2	3	4		5	2	5	2	2	3	28
cooperation with schools (nursing schools etc.)	2	2	3		3	2	2	2	2	2	20

REGULATORY AGENCIES/CORPORATE HIERARCHY:

	A	B	C	D	E	F	G	H	I	J	TOT
tax laws	1	2	2		4	2	2	2	2	1	18
Environmental Protection Agency	1	3	2		2	2	1	2	2	3	18
efficiency in hospital	2	2	2		2	2	5	1	1	2	19
Anti-Trust laws	1	1	2		5	2	2	1	2	5	21
Social Security Administration reviews Medicare reimbursement	1	2	2		3	2	3	1	1	5	20
quality control	2	2	3		5	1	2	1	1	2	19
focus on monetary aspects	1	2	2		3	2	3	2	1	2	18
shared services	3	3	3		4	2	4	2	1	2	24
Civil Rights Act	1	3	2		2	2	5	3	1	1	20
Occupational Safety and Health Administration	1	2	1		2	2	1	1	1	2	13
contain costs	1	1	2		2	2	3	2	2	2	17
labor laws	1	2	2		4	2	2	2	2	3	20
licensure	1	1	2		1	2	1	1	2	1	12
program planning	3	2	3		5	2	4	1	2	3	25
defined relationships with the governing body	1	2	4		5	2	3	2	1	2	21

RESULTS OF THE SECOND PHASE OF THE DELPHI PROCESS
RANKED BY CONSTITUENT GROUP

PATIENTS:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Protection from medication errors	1	1	1		1	1	1	1	1	1	9
2. Protection from infectious diseases	1	1	2		1	1	1	1	1	1	10
3. Competent medical personnel	1	1	1		1	1	2	1	2	1	11
4. Right to accept or refuse experimentation	1	1	3		1	1	1	1	1	1	11
5. Only needed surgery done	1	2	3		1	1	1	1	1	1	12
6. Confidentiality	1	2	1		2	1	1	1	2	1	12
7. Freedom from abuse	1	1	3		1	1	1	1	1	2	12
8. Having a say in own care	1	2	1		1	1	3	1	2	1	13
9. Information of diagnosis	1	1	3		1	1	2	1	2	1	13
10. Right to refuse treatment	1	1	4		2	1	1	1	2	1	14
11. Relief from pain	1	1	1		1	1	4	1	3	1	14
12. Disease prevention	1	1	2		2	1	2	1	1	3	14
13. Quality care	3	1	1		1	2	2	1	2	1	14
14. Right of informed consent	1	1	2		2	2	2	1	2	1	14
15. Information about treatment	1	2	2		1	2	2	1	2	2	15
16. Safe environment	1	3	2		2	2	1	2	1	1	15
17. Freedom from neglect	1	1	3		2	2	2	1	1	2	15
18. Protection from malpractice	1	3	4		2	2	1	1	1	1	16
19. Emergency room availability	1	1	1		2	2	1	1	2	5	16
20. Low-cost health care	1	3	1		2	3	2	2	2	1	17
21. Understanding	1	2	2		1	3	4	2	2	1	18
22. Quick and sure relief	2	2	3		2	1	3	2	2	1	18
23. Information on prognosis	1	2	3		2	2	2	1	2	3	18
24. Access to available services	1	3	2		2	2	3	2	2	2	19
25. Self respect	1	2	4		2	3	3	2	2	2	19
26. Treated as an individual	1	2	3		2	2	3	2	2	2	19
27. Rehabilitation	2	2	3		1	2	1	1	2	5	19
28. Short waiting times for obtaining treatment	2	2	2		2	3	1	2	2	3	19
29. Treated with dignity	1	1	3		2	2	3	2	2	3	19
30. Protection from harming self	3	1	3		2	1	4	1	1	3	19
31. Privacy	2	2	2		2	3	5	2	1	1	20
32. Latest technology	5	2	2		3	1	3	1	2	1	20
33. Equitable prices	3	1	2		2	3	2	2	2	3	20
34. Treated with respect	2	2	2		2	2	4	2	2	2	20
35. Short waiting times for an appointment	3	3	2		2	3	1	2	2	2	20
36. Insurance for the aged	1	2	2		1	3	3	2	1	5	20
37. Kindness	2	2	2		2	3	4	2	2	2	21

PATIENTS: (Continued)

	A	B	C	D	E	F	G	H	I	J	TOT
38. Coordination of care	2	2	2		2	2	4	1	2	4	21
40. Empathy	3	2	4		1	3	4	1	2	2	22
41. Ease from worry	1	2	4		2	3	5	2	2	2	22
42. Provision for intellectual needs	4	2	5		3	5	5	3	3	5	35
43. Provision for emotional needs	3	2	3		2	3	2	2	2	3	22
44. Easy access to services	3	4	2		2	3	2	2	2	2	22
45. Continuity of care	3	2	2		2	3	3	2	2	3	22
46. Comfortable surroundings	3	3	2		2	3	4	2	2	3	24
47. Hope	4	2	3		2	3	5	2	1	2	24
48. Air conditioned rooms	2	3	3		2	2	5	3	3	2	25
49. More health care services	2	4	2		5	3	3	2	2	2	25
50. Reasonable visiting hours	4	3	3		3	3	2	2	3	3	26
51. Good food	3	3	3		2	3	4	4	2	3	27
52. Place to rest	2	4	4		2	4	4	3	2	3	28
53. Hot food hot, cold food cold	4	3	4		2	3	5	3	2	2	28
54. One- or two-person rooms	2	3	3		4	3	3	5	2	3	28
55. Appropriate meals (dining or bedside)	5	3	3		2	4	5	3	2	3	30
56. Provision for recreation	4	3	4		3	5	4	4	3	5	35

REGULATORY AGENCIES/CORPORATE HIERARCHY:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Licensure	1	1	2		1	2	1	1	2	1	12
2. Occupational Safety and Health Administration	1	2	1		2	2	1	1	1	2	13
3. Contain costs	1	1	2		2	2	3	2	2	2	17
4. Tax laws	1	2	2		4	2	2	2	2	1	18
5. Environmental Protection Agency	1	3	2		2	2	1	2	2	3	18
6. Focus on monetary aspects	1	2	2		3	2	3	2	1	2	18
7. Efficiency in hospital	2	2	2		2	2	5	1	1	2	19
8. Quality control	2	2	3		5	1	2	1	1	2	19
9. Social Security Administration reviews Medicare reimbursement	1	2	2		3	2	3	1	1	5	20
10. Civil Rights Act	1	3	2		2	2	5	3	1	1	20
11. Labor laws	1	2	2		4	2	2	2	2	3	20
12. Defined relationships with the governing body	1	2	4		5	2	3	2	1	2	21
13. Anti-Trust laws	1	1	2		5	2	2	1	2	5	21
14. Shared services	3	3	3		4	2	4	2	1	2	24
15. Program planning	3	2	3		5	2	4	1	2	3	25

MEDICAL STAFF:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Protection from infectious diseases	1	1	2		1	1	1	1	1	1	10
2. Highly skilled nurses	1	2	1		1	1	2	1	2	1	12
3. Complete medical records	1	1	2		2	2	1	1	1	1	12
4. Protection from malpractice suits	1	2	2		1	1	1	1	1	2	12
5. Accurate patient records	1	1	2		2	1	1	1	1	3	13
6. High quality of patient care	2	1	1		1	1	2	1	1	3	13
7. Choice in when, where, and how they practice medicine	1	2	1		1	1	2	3	2	1	14
8. Cooperation from administrator	1	2	2		2	2	2	1	2	1	15
9. Decision making	1	2	3		2	2	1	1	2	1	15
10. Authority over patient care (regardless of cost)	1	2	2		2	1	3	1	2	1	15
11. Continuing medical education	1	1	2		1	3	2	1	1	4	16
12. Autonomy	1	2	3		1	2	3	2	1	1	16
13. High quality of fellow MDs	2	2	2		2	2	2	1	2	2	17
14. Best equipment	1	2	1		2	3	2	1	2	3	17
15. Suitable equipment	2	1	2		2	2	2	1	2	3	17
16. Maintain board certification	1	3	2		1	3	1	1	2	3	17
17. Maintenance of equipment	2	2	2		2	2	1	1	2	3	17
18. Latest in equipment	1	2	2		2	3	4	1	1	2	18
19. Training for interns and residents	2	1	2		2	3	1	2	1	4	18
20. Familiar with medical technology	2	2	2		2	3	3	1	1	2	18
21. Hospital as a place for services	1	2	2		3	3	2	1	2	3	19
22. Good reputation	1	2	2		2	1	5	2	1	3	19
23. Good communication	3	2	2		1	2	3	2	2	3	20
24. Keep MDs informed	3	3	2		1	2	2	2	2	3	20
25. Freedom from admin work	1	4	3		2	3	2	2	1	2	20
26. Professional advancement	1	3	2		2	2	3	2	2	3	20
27. Mutual trust	3	2	3		1	3	4	1	2	2	21
28. Fees	1	2	3		1	3	3	2	2	4	21
29. Place to practice	2	2	2		2	3	3	4	2	1	21
30. Mutual understanding	3	3	2		1	3	3	1	2	4	22
31. Clerical help	3	3	2		2	3	2	3	2	3	23
32. Control over own destiny	2	3	4		4	1	4	2	1	4	25
33. Other providers for patient welfare	4	4	3		2	3	2	2	2	3	25
34. Support for MDs need for self governance	3	3	4		3	3	3	1	2	4	26
35. Needs hospital for by-laws	5	2	3		3	3	2	3	2	4	27
36. Fewer meetings	4	3	4		2	4	4	3	2	2	28
37. Fellowships	4	4	3		2	3	5	2	2	5	30
38. Research opportunities	3	4	4		3	3	5	2	2	5	31
39. Diverse patient population	5	4	4		3	3	5	3	2	2	31

OTHER STAFF:

	Item	A	B	C	D	E	F	G	H	I	J	TOT
1.	Promotion opportunities	1	1	2		1	1	1	1	1	1	10
2.	Protection from infectious diseases	1	2	3		1	1	1	1	1	1	12
3.	Health insurance	1	1	2		2	1	1	2	1	1	12
4.	Counseling for staff who work with AIDS patients	1	1	1		2	2	1	1	1	3	13
5.	Good working conditions	1	2	1		1	1	2	1	2	2	13
6.	Safe environment	1	3	2		2	1	1	1	1	2	14
7.	Sick leave	1	1	2		2	2	1	2	2	1	14
8.	Higher salary with more experience	1	1	2		2	2	1	2	2	2	15
9.	Fair appraisals	1	2	2		1	2	3	2	2	1	16
10.	Training about AIDS	1	3	2		3	2	1	1	2	1	16
11.	Good supervision	3	1	2		1	2	3	1	1	2	16
12.	Retirement/pension plans	1	2	2		2	1	1	2	2	3	16
13.	Continuing education	3	1	2		2	2	2	1	1	3	17
14.	Good communication	3	3	2		1	1	2	1	1	3	17
15.	Job satisfaction	1	3	1		1	2	4	2	1	2	17
16.	Incentives for efficiency	3	2	2		2	2	2	2	2	1	18
17.	Higher professional recognition	1	2	2		3	2	2	2	2	2	18
18.	Disability insurance	3	2	2		2	1	1	2	2	3	18
19.	Bonuses	1	2	2		2	2	4	1	2	2	18
20.	More say in patient care	2	4	1		2	2	2	2	2	1	18
21.	On-the-job training (OJT)	2	2	2		3	3	2	1	2	2	19
22.	Respect	3	2	3		2	2	2	2	1	2	19
23.	Different shifts	2	2	2		3	3	2	2	2	2	20
24.	Workman's compensation	1	1	2		3	2	3	2	2	4	20
25.	Prestige	3	2	3		2	2	2	2	2	3	21
26.	Higher salary with advanced degrees	3	2	2		2	3	1	2	2	4	21
27.	Trust from administrator	4	3	1		2	3	2	2	1	3	21
28.	In-service training sessions	3	2	2		3	2	3	2	1	3	21
29.	Pre-retirement programs	5	2	2		3	2	1	2	2	2	21
30.	More input on matters concerning patient care	2	4	2		2	2	2	2	2	3	21
31.	Dental care plans	3	2	2		2	2	3	2	2	4	22
32.	Confidence from administrator	4	2	4		2	2	2	2	1	3	22
33.	Child care centers	3	1	4		2	3	1	3	2	3	22
34.	Recognition programs	5	3	2		2	2	2	3	2	2	23
35.	Employee assistance	2	2	2		4	3	3	2	2	3	23
36.	More role in work design	4	2	2		2	3	2	3	2	4	24
37.	Bargaining	3	2	3		3	3	3	2	2	4	25

OTHER STAFF: (Continued)

	A	B	C	D	E	F	G	H	I	J	TOT
38. Recognition of employee organizations	1	3	4		4	3	5	2	2	4	28
39. Internal transfers	5	2	4		2	3	3	4	2	3	28
40. Labor unions	3	3	3		4	4	4	2	3	3	29
41. Morale, welfare, and recreation facilities	5	4	2		3	4	5	2	2	4	31

Nurses Only:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Assurance of quality control of MDs	1	1	4		1	1	2	2	1	1	14
2. Total bedside charge of patient	1	2	2		2	2	3	2	1	1	16
3. More technical abilities	2	2	2		2	2	2	1	1	3	17
4. Authority to delegate to LVNs and orderlies	1	3	2		2	2	3	2	1	1	17

Volunteer organizations:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Orientation	1	2	2		2	2	2	1	1	2	15
2. Training	1	3	2		2	2	2	1	1	2	16
3. Good supervision	1	2	3		1	2	3	1	2	2	17
4. Recognition	1	3	3		1	2	4	2	2	2	20

PROFESSIONAL ORGANIZATIONS:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Ensure no improper use of confidential information	1	1	2		1	2	2	1	1	1	12
2. Hospitals meet standards	1	1	2		2	2	1	1	1	3	14
3. High quality of patient care	1	1	1		5	1	3	1	2	1	16
4. No interference with MD-patient relationship (AMA)	1	4	2		2	2	3	1	1	1	17
5. Ensure no conflict of interest	1	2	2		3	3	2	1	1	3	18
6. Prenatal and well-baby care	2	2	3		5	2	1	2	2	2	21
7. Not compete with other hospitals (share resources	2	3	2		4	1	3	1	2	3	21
8. Immunizations	1	2	4		5	1	1	2	1	5	22
9. Early detection screenings	2	4	3		5	2	2	1	1	5	25
10. Alcohol/drug abuse counseling	5	2	3		5	3	2	3	1	1	25
11. Range of ambulatory care services	3	3	4		5	3	3	2	2	3	28
12. Family planning classes	3	4	4		5	3	2	2	2	5	29
13. Nutrition classes	4	3	3		5	3	2	3	2	4	29

THIRD-PARTY PAYERS:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Controls on price increases	1	1	2		1	2	1	2	1	1	12
2. Contracting with providers	1	2	2		1	2	2	1	2	2	15
3. Cost sharing	2	3	3		1	2	2	1	2	1	17
4. Protection against over-utilization	1	2	2		1	3	3	2	1	2	17
5. Quality care	2	2	3		2	2	3	1	1	1	17
6. Reasonable cost reimbursement	1	2	3		1	2	2	2	2	2	17
7. Control payments to providers	1	2	2		3	2	2	2	2	2	18
8. Not unnecessarily high costs	2	2	2		1	3	1	2	2	3	18
9. Efficient allocation of resources	1	2	3		1	2	2	2	2	3	18
10. Power to define quality care	1	2	3		2	3	2	2	1	2	18
11. Eliminate services that make no contribution to health at the margin - unneeded care	2	4	2		1	1	4	1	1	3	19
12. Reduction of duplication of services	2	3	1		2	2	3	2	1	3	19
13. Limitations on benefits (dollar amounts or time)	1	3	2		5	2	1	2	2	2	20
14. Equitable contracts for all third-party payers	1	3	2		5	3	2	1	2	1	20
15. Negotiated contracts	1	1	3		3	2	5	1	2	3	21
16. Not pay more than actual costs	2	1	2		5	2	3	2	2	2	21
17. Prior authorization	3	4	2		3	2	4	1	2	1	22
18. Tax subsidies for lower premiums	3	4	4		2	2	3	1	2	1	22
19. Fair premiums from people	3	2	2		2	3	3	2	2	3	22
20. Limit on types of services payable	1	3	2		5	2	4	2	2	2	23
21. Provider-specific coverage	3	2	3		3	2	3	1	2	4	23
22. Hospitals must have a PRO contract or lose Medicare reimbursement	2	4	3		5	1	2	1	1	4	24
23. Smaller than consumer price index increases in bargaining for rates to contain costs	2	2	3		3	3	4	2	2	4	25

BOARD OF TRUSTEES/DIRECTORS:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Maintain financial solvency	1	1	1		1	2	1	1	1	1	10
2. Ensure quality care	2	2	1		1	1	3	1	1	1	13
3. Integrity	1	1	2		1	2	2	1	1	2	13
4. Understand hospital's goals	1	1	1		1	3	1	2	1	3	14
5. Ensure safety	1	2	2		1	2	1	1	1	3	14
6. Well-qualified team	3	1	2		1	1	5	1	1	1	16
7. Accountability from MDs and management	1	1	2		2	2	4	2	1	1	16
8. Knows hospital's obligations	1	2	2		1	3	1	3	2	1	16
9. Ensure MDs conform to bylaws	1	1	2		4	1	3	2	1	1	16
10. Communication between MDs and administrator	1	2	1		2	2	3	1	1	3	16
11. Makes policies	1	2	2		1	2	2	1	2	3	16
12. Policies implemented	2	2	2		1	1	2	2	2	2	16
13. Knows hospital's purposes	1	1	2		2	2	2	2	1	4	17
14. Monitor the finances	2	2	2		1	1	3	2	2	2	17
15. High professional status	1	2	2		2	2	3	2	1	4	17
16. Keep board informed of health care in general and hospital specifically	1	3	3		1	3	3	1	1	2	18
17. Trust from administrator	3	2	2		2	2	4	2	1	1	19
18. Surveillance of fiscal assets	1	2	4		2	1	3	1	2	3	19
19. Have more time prior to making decisions	2	2	3		2	2	4	2	1	1	19
20. Know how a hospital is run	2	1	2		2	2	2	3	2	3	19
21. Get MDs on Board team	1	2	3		1	3	5	1	2	2	20
22. Have a system to review plans	1	3	4		1	2	4	1	2	2	20
23. Assist new board members	1	3	3		2	3	2	2	2	3	21
24. Keep administrative and board functions separate	1	4	3		3	2	4	1	1	2	21
25. Administrator deal with regulatory agencies	3	2	2		4	3	3	1	1	3	22
26. Identify resources	2	4	2		3	3	2	2	1	3	22
27. Orientation for new members	2	3	3		2	3	3	2	2	3	23
28. Send information and agenda prior to meetings	3	2	3		2	2	4	2	1	4	23
29. Prestige	2	4	2		3	2	5	3	2	2	25
30. Power	2	1	4		5	2	4	4	2	2	26
31. Have loyalty to hospital	1	2	2		2	2	5	2	1	3	20
32. Provide information	3	3	3		4	3	4	3	1	2	26
33. Have a high education	3	2	3		5	3	5	4	2	2	29
34. Social recognition	3	5	4		3	3	3	4	2	3	30
35. Ability to select own replacements on board	5	5	3		5	3	5	2	2	1	31

COMMUNITY:	A	B	C	D	E	F	G	H	I	J	TOT
1. Prevention of diseases	1	2	4		1	1	1	1	1	1	13
2. Honesty for media	1	1	2		1	2	5	1	1	1	15
3. Equitable distribution of health care services	1	2	2		1	1	3	1	1	4	16
4. Screenings for HIV/AIDS	1	1	3		2	2	1	1	1	5	17
5. Vaccines	1	1	4		2	1	1	1	1	5	17
6. Ease of getting information	3	1	2		2	2	3	1	2	1	17
7. Equality of access	2	2	2		1	2	3	2	1	3	18
8. Comprehensive health care	3	3	1		2	1	3	1	2	2	18
9. Education of disease prevention	4	2	3		1	1	1	2	1	4	19
10. Cooperation with other health facilities or hospitals	2	3	2		1	2	3	2	1	3	19
11. Presence of occupational or physical therapists	4	2	2		2	2	1	2	1	4	20
12. Patient information	3	3	2		2	2	3	1	2	2	20
13. Nursing homes as extensions of hospitals	4	3	2		3	2	3	1	1	1	20
14. Cooperation with schools (nursing schools etc.)	2	2	3		3	2	2	2	2	2	20
15. Chronic disease care	3	3	3		2	2	1	2	2	3	21
16. Health education programs	3	3	2		1	2	3	2	1	4	21
17. Health workshops	3	2	2		2	3	3	2	2	2	21
18. Employers want cost containment	1	3	3		2	2	4	2	2	2	21
19. Rehabilitation	4	3	3		2	2	1	2	1	4	22
20. Hospice availability	4	2	1		2	2	3	2	1	5	22
21. Health screenings	3	3	3		2	2	3	1	2	3	22
22. Patient education	4	3	2		2	2	3	2	2	2	22
23. Avoidance of duplication of services	3	3	3		2	2	4	2	1	2	22
24. Public service announcements	3	2	2		5	2	3	3	2	5	22
25. Stronger voice in programs	2	4	3		2	2	3	3	2	2	23
26. Home care	3	2	2		2	3	2	2	2	5	23
27. Free-standing emergency rooms	3	2	2		4	3	3	1	2	3	23
28. Convenient location	1	2	4		2	2	5	2	2	4	24
29. Suicide prevention	4	2	3		2	2	5	2	2	2	24
30. Outpatient activities	4	4	3		2	2	2	3	2	3	25
31. Post-disaster teams - be prepared at large gatherings	4	2	3		4	2	2	1	2	5	25
32. Satellite hospitals or clinics	3	2	3		5	2	3	2	2	3	25
33. Education on health matters	4	3	2		2	2	3	2	2	5	25
34. Transportation services	1	4	4		2	3	4	2	2	4	26
35. Visitation of health aid personnel	3	2	3		3	2	4	3	2	4	26
36. Research on diseases	5	3	3		4	2	2	2	2	5	28
37. Service clubs (Red Cross etc.)	2	3	4		5	2	5	2	2	3	28
38. Newsletters, booklets, etc	3	5	3		4	3	3	3	2	4	30

Section Three: Third Phase

Section Three of Appendix B consists of the Third Phase of the Delphi Process. There are seven documents.

The first document is a one-page instruction sheet for the third phase to the same ten Delphi Panel members.

The second document is the final draft of the cover letter that was to be sent to the actual hospital administrators in California chosen to receive the questionnaire.

The third document is the instruction sheet that was to go with the cover letter and questionnaire.

The fourth document is the six-page Third Phase of the Delphi process. The Panel Members were asked to rank each item as though he or she were a hospital administrator, as to how important he or she felt his or her responsibility would be to provide that item to the constituent group.

The fifth document is a one-page "Thank You" for completing the third phase of the Delphi process.

The sixth document is the five-page results tallied after nine members returned their ranking.

The seventh document is a five-page ranking of all the items after nine members returned their ranking. The items had been placed in descending order, according to how the Delphi Panel Members ranked each item.

The Hospital Administrator: Yesterday, Today, and Tomorrow

My questionnaire is ready to be field tested before being put into final form and sent to the hospital administrators. Enclosed are the cover letter, instruction sheet, and the questionnaire itself. This will be the last phase of the Delphi Group for the questionnaire.

Please give me your comments and suggestions, or criticize the format, wording, layout, or anything you think is relevant. I want this to be as perfect and readable as possible.

Please pretend you are an administrator of a large California hospital, and actually do the questionnaire. My advisor and I think it will be interesting to compare the Delphi group's responses with the actual administrators'.

Directions for the Third Part of the Delphi Group

Once again the format is changed. Following each item are five blocks, ranked from "1" to "5." Please place an "X" in the block that corresponds to your opinion of how important you feel your responsibility is to the group for that particular item. Please consider each item individually and rate each item solely on its own merit. Here is the rating scheme to use:

1 = least important
2 = somewhat important
3 = important
4 = very important
5 = most important

For example, if you feel your responsibility to make air conditioned rooms available to the group "Patients" is very high, you would place an "X" in the "5" block of the following item

PATIENTS

	1	2	3	4	5
1. Air conditioned rooms					X

As another example, if you feel your responsibility to provide fellowships to the group "Medical Staff" is very low, you would place an "X" in the "1" block of the following item.

MEDICAL STAFF

	1	2	3	4	5
1. Fellowships	X				

When I get everyone's ratings back, I'll tally each item and give you a copy of the total display. Once again, thank you so much for agreeing to do this for me.

Andrea Scheffelin September 6, 1991

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

Name of Hospital Administrator
Hospital
Address
City, California 9XXXX

October 10, 1991

Dear Hospital Administrator:

Please accept this check as a small token of my appreciation for what I am about to ask you to do and my thanks in advance for your time and effort. I am a doctoral candidate attending Golden Gate University in San Francisco. For my dissertation I am studying the changing responsibilities of hospital administrators in response to the needs and wants of constituent groups.

A hospital administrator's job has never been easy, and in today's health care environment it is tougher than ever. While hospital administrators have always had many responsibilities to a wide spectrum of constituent groups, the number and type of such groups have undergone a substantial change over time. More importantly, the needs and wants of yesterday may not be what is most important to the individuals in the groups now. In addition, the various groups have conflicting needs and wants.

What I would like to have is your opinion of how important you feel your responsibilities are to the needs and wants of six constituent groups as shown in the attached questionnaire. Completing the enclosed questionnaire should only take a few minutes.

My hope is that this study will help in the education and training of future hospital administrators, as well as clarify the responsibilities of those in the field now. I will send you an executive summary of my dissertation after it is completed.

For the return of the questionnaire, enclosed is a stamped, self-addressed envelope.

Thank you,

Andrea M. Scheffelin

INSTRUCTIONS

The Hospital Administrator: Yesterday, Today, and Tomorrow
An Analysis of the Changing Responsibilities of the Hospital Administrator
in Response to the Needs and Wants of Constituent Groups

Background

The role of hospital administrators has changed since its inception. What has worked in the past is not necessarily what works today, and may not work for the future. Hospital administrators are finding their responsibilities drastically changing. The issue is that while hospital administrators have always had many responsibilities to a wide spectrum of constituent groups, the number and type of such groups have undergone a substantial change over time. More importantly, the wants and needs of yesterday may not be what is most important to the individuals in the groups now.

Instructions

The attached questionnaire contains itemized needs or wants from six constituent groups obtained from a review of the literature. Following each item are five blocks, ranked from "1" to "5." Please place an "X" in the block that corresponds to your opinion of how important you feel your responsibility is to the group for that particular item. Please consider each item individually. Please rate each item solely on its own merit. Here is the rating scheme to use:

1 = least important
2 = somewhat important
3 = important
4 = very important
5 = most important

For example, if you feel your responsibility to make air conditioned rooms available to the group "Patients" is very high, you would place an "X" in the "5" block of the following item.

PATIENTS	1	2	3	4	5
1. Air conditioned rooms					X

As another example, if you feel your responsibility to provide fellowships to the group "Medical Staff" is very low, you would place an "X" in the "1" block of the following item

MEDICAL STAFF	1	2	3	4	5
1. Fellowships	X				

In addition to the ratings, feel free to add comments to any item or group.

PATIENTS: (A person who is or has been under some type of medical care or treatment, either in the health care facility or as an out-patient through her/his personal physician.) **Page 1**

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

Item	1	2	3	4	5
1. Emergency room availability					
2. Freedom from abuse					
3. Low-cost health care					
4. Latest technology					
5. Equitable prices					
6. Comfortable surroundings					
7. Freedom from neglect					
8. Understanding					
9. Treated with respect					
10. Protection from infectious diseases					
11. Good food					
12. Access to available services					
13. No unnecessary surgery					
14. Competent medical personnel					
15. Protection from medication errors					
16. Information about diagnosis, treatment, and prognosis					
17. Right to refuse treatment					
18. Relief from pain					
19. Reasonable visiting hours					
20. Confidentiality					
21 Short waiting times for obtaining treatment					
22. Rehabilitation					
23. Having a say in own care					
24. Disease prevention					
25. Safe environment in the hospital					

MEDICAL STAFF: (All physicians who currently have privileges at the health care facility, ancillary services locations, or clinics.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1	2	3	4	5
1. Authority over patient care					
2. High quality of other physicians on staff					
3. Highly skilled nurses/other staff					
4. Training for interns and residents					
5. Best/latest/suitable equipment					
6. Hospital as a place for inpatient or outpatient services					
7. Board certification					
8. Continuing medical education					
9. High quality of patient care					
10. Freedom from administrative details					
11. Cooperation and trust from hospital administrator					
12. Good reputation of hospital					
13. Decision making					
14. Keep physicians informed					
15. Complete and accurate medical records					
16. Choice in when, where, and how they practice medicine					
17. Professional advancement					
18. Protection from infectious diseases					
19. Protection from malpractice suits					
20. Well-maintained equipment					

OTHER STAFF: (All non-physician persons employed or volunteers utilized by the health care facility.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1 2 3 4 5
1. On-the-job training (OJT)	:__:__:__:__:__:
2. Fair performance appraisals	:__:__:__:__:__:
3. Trust from administrator	:__:__:__:__:__:
4. In-service training sessions	:__:__:__:__:__:
5. Incentives for efficiency	:__:__:__:__:__:
6. Sick leave	:__:__:__:__:__:
7. Job satisfaction	:__:__:__:__:__:
8. Appropriate salary ranges	:__:__:__:__:__:
9. Training about HIV/AIDS	:__:__:__:__:__:
10. Protection from infectious diseases	:__:__:__:__:__:
11. Recognition of employee organizations/unions	:__:__:__:__:__:
12. Higher professional recognition	:__:__:__:__:__:
13. Good supervision	:__:__:__:__:__:
14. Health benefits	:__:__:__:__:__:
15. Retirement plans	:__:__:__:__:__:
16. Higher salary ranges for advanced degrees	:__:__:__:__:__:
17. Promotion opportunities	:__:__:__:__:__:
18. Good working conditions	:__:__:__:__:__:
19. Good communication	:__:__:__:__:__:
20. Continuing education	:__:__:__:__:__:
21. Counseling for staff who work with HIV/AIDS patients	:__:__:__:__:__:
22. More say in patient care	:__:__:__:__:__:

Nurses Only:

	1 2 3 4 5
1. Authority to delegate to LVNs and orderlies	:__:__:__:__:__:
2. Total bedside charge of patients	:__:__:__:__:__:
3. Assurance of quality control of physicians	:__:__:__:__:__:
4. More technical abilities	:__:__:__:__:__:

Volunteer Organizations:

	1 2 3 4 5
1. Orientation	:__:__:__:__:__:
2. Training	:__:__:__:__:__:
3. Recognition	:__:__:__:__:__:
4. Good supervision	:__:__:__:__:__:

THIRD-PARTY PAYERS: (Private health care plans such as the Foundation Health Plan or Blue Cross, and government programs such Medicare, Medi-Cal, CHAMPUS, medically indigent, and other publicly-funded programs.) **Page 4**

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1	2	3	4	5
1. Contracting with providers					
2. Controls on price increases					
3. Cost sharing					
4. Quality care					
5. Protection against over-utilization					
6. Power to define quality care					
7. Limitations on benefits					
8. Reasonable cost reimbursement					
9. Efficient allocation of resources					
10. Negotiated contracts					
11. Equitable contracts for all third-party payers					
12. Reduction of duplication of services					
13. Control payments to providers					
14. Elimination of unneeded care					

BOARD OF TRUSTEES/DIRECTORS: (Boards as composed of physicians, business leaders of the community, and often consumer members.) **Page 5**

1 = least important, 2 = somewhat important, 3 = important. 4 = very important, 5 = most important

Item	1	2	3	4	5
1. Accountability from physicians and management					
2. Assist new board members					
3. Well-qualified team					
4. Trust from administrator					
5. Understanding of hospital's goals					
6 Have more time prior to making decisions					
7. Integrity of board members					
8. Knowledge of hospital's obligations					
9. Ensure physicians conform to bylaws					
10. Develops policies and have implemented					
11. Communication between physicians and administrator					
12. Ensure quality care					
13. High professional status					
14. Maintenance of financial solvency					
15. Ensure safety in hospital					
16. Information on health care in general and hospital specifically					
17. Knowledge of hospital's purposes					

COMMUNITY: (The community is composed of many inter-related and overlapping groups. Some examples are: minority/ethnic groups, the media, community, researchers, service groups such as Rotary, Lions, Kiwanis, city and county councils, planning commissions, other organizations, businesses, and individuals.) **Page 6**

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1 2 3 4 5
1. Education of disease prevention and health matters	:__:__:__:__:__:
2. Public service announcements	:__:__:__:__:__:
3. Home care	:__:__:__:__:__:
4. Chronic disease care	:__:__:__:__:__:
5. Ease of getting information	:__:__:__:__:__:
6. Equitable distribution of health care services	:__:__:__:__:__:
7. Hospice availability	:__:__:__:__:__:
8. Screenings for diseases such as HIV/AIDS	:__:__:__:__:__:
9. Equality of access	:__:__:__:__:__:
10. Health education programs/workshops	:__:__:__:__:__:
11. Cooperation with other health facilities or hospitals	:__:__:__:__:__:
12. Comprehensive health care	:__:__:__:__:__:
13. Research on and prevention of diseases	:__:__:__:__:__:
14. Patient information	:__:__:__:__:__:
15. Nursing homes as extensions of hospitals	:__:__:__:__:__:
16. Cooperation with medical, nursing, and allied health schools	:__:__:__:__:__:
17. Honest information for media	:__:__:__:__:__:
18. Vaccines	:__:__:__:__:__:
19. Patient education	:__:__:__:__:__:
20. Cost containment	:__:__:__:__:__:

Thank you for completing and returning this questionnaire. Your time and effort are greatly appreciated.

The Hospital Administrator:
Yesterday, Today, and Tomorrow

THANK YOU! **THANK YOU!** **THANK YOU!**

Here is a copy of the results of the third phase of the Delphi process. Nine responses were received. The score for each term was tabulated and ranked; the highest score being considered the most important responsibility of hospital administrators.

The final step will be to field test this questionnaire with three hospital administrators suggested by my advisor. I will be meeting with them this week. Based on their recommendations, the actual questionnaire will be finalized and sent to the hospital administrators of the 100 largest hospitals in California.

As always, thank you for giving so freely of your time and thoughtfulness.

Andrea Scheffelin September 29, 1991

RESULTS OF THE THIRD PHASE OF THE DELPHI GROUP

PATIENTS:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Emergency room availability	5	5	5		5	3	5	5	5	3	41
2. Freedom from abuse	5	5	3		4	5	4	5	5	5	41
3. Low-cost health care	3	4	3		3	3	3	3	5	1	28
4. Latest technology	3	4	5		2	3	3	4	5	3	32
5. Equitable prices	1	4	3		3	3	4	3	5	3	29
6. Comfortable surroundings	2	3	4		4	3	2	2	5	2	27
7. Freedom from neglect	4	4	3		5	4	2	5	5	5	37
8. Understanding	4	3	2		4	3	4	3	4	3	30
9. Treated with respect	4	3	4		5	4	3	3	5	2	33
10. Protection from infectious diseases	5	5	4		5	5	5	5	5	5	44
11. Good food	3	3	3		3	3	1	3	4	2	25
12. Access to available services	3	2	3		4	4	3	4	4	3	30
13. No unnecessary surgery	4	4	5		5	5	4	5	5	5	42
14. Competent medical personnel	5	5	5		5	5	3	5	4	5	42
15. Protection from medication errors	5	5	5		5	5	2	5	5	5	42
16. Information about diagnosis, treatment, and prognosis	3	4	4		4	4	4	5	4	2	34
17. Right to refuse treatment	3	3	3		5	5	3	1	4	2	29
18. Relief from pain	4	4	5		5	4	3	5	3	5	38
19. Reasonable visiting hours	3	2	2		3	3	2	2	3	1	21
20. Confidentiality	5	4	4		4	4	4	4	5	3	37
21. Short waiting times for obtaining treatment	4	3	4		4	3	2	4	4	2	30
22. Rehabilitation	2	2	3		4	4	3	5	4	1	28
23. Having a say in own care	3	4	4		5	4	4	4	4	1	33
24. Disease prevention	5	3	4		5	5	5	5	5	1	38
25. Safe environment in the hospital	5	4	4		5	5	5	5	5	2	40

MEDICAL STAFF:

Item	A	B	C	D	E	F	G	H	I	J	TOT
1. Authority over patient care	5	4	5		4	4	5	4	4	3	38
2. High quality of other physicians on staff	4	3	5		4	5	3	5	4	4	37
3. Highly skilled nurses/other staff	4	4	4		5	5	4	5	4	5	40
4. Training for interns and residents	3	3	4		3	3	2	2	5	2	27
5. Best/latest/suitable equipment	4	4	4		3	4	3	5	4	2	33
6. Hospital as a place for inpatient or outpatient services	2	5	3		5	4	4	4	4	3	34
7. Board certification	5	5	3		4	3	5	5	5	4	39
8. Continuing medical education	3	4	3		3	4	5	3	4	2	31
9. High quality of patient care	5	4	4		5	5	2	5	5	5	40
10. Freedom from administrative details	3	2	3		3	3	3	4	4	5	30
11. Cooperation and trust from hospital administrator	5	4	4		5	5	4	4	4	4	39
12. Good reputation of hospital	5	3	4		4	5	5	4	4	2	36
13. Decision making	3	4	3		5	4	4	1	4	3	31
14. Keep physicians informed	3	4	3		4	4	2	1	5	4	30
15. Complete and accurate medical records	5	5	4		5	5	5	5	5	5	44
16. Choice in when, where, and how they practice medicine	3	4	2		4	5	4	1	5	3	31
17. Professional advancement	2	2	2		3	4	3	1	5	1	23
18. Protection from infectious diseases	5	4	3		5	5	5	5	5	3	40
19. Protection from malpractice suits	5	3	4		3	5	4	5	5	2	36
20. Well maintained equipment	5	4	4		4	5	5	5	5	4	41

OTHER STAFF:

	A	B	C	D	E	F	G	H	I	J	TOT
1. On-the-job training (OJT)	3	4	3		4	4	5	3	4	3	33
2. Fair performance appraisals	3	4	3		4	4	5	5	5	4	37
3. Trust from administrator	5	3	3		5	5	3	4	5	3	36
4. In service training sessions	3	4	3		4	4	1	3	4	2	28
5. Incentives for efficiency	3	4	2		5	5	3	2	4	4	32
6. Sick leave	4	4	3		3	5	4	4	4	1	32
7. Job satisfaction	3	3	4		4	4	3	4	4	2	31
8. Appropriate salary ranges	3	4	4		3	5	4	4	4	2	33
9. Training about HIV/AIDS	5	4	4		5	4	5	5	5	5	42
10. Protection from infectious diseases	5	5	4		5	5	5	5	5	5	44
11. Recognition of employee organizations/unions	2	5	2		3	3	1	2	4	1	23
12. Higher professional recognition	2	4	1		3	4	3	2	4	3	26
13. Good supervision	4	5	4		5	5	4	5	4	4	40
14. Health benefits	5	5	4		3	5	4	4	5	2	37
15. Retirement plans	5	5	3		3	5	5	4	5	1	36
16. Higher salary ranges for advanced degrees	2	4	3		3	3	4	4	5	1	29
17. Promotion opportunities	2	4	2		3	4	4	4	4	3	30
18. Good working conditions	3	3	4		4	4	3	5	4	2	32
19. Good communications	3	4	4		5	5	2	4	4	4	35
20. Continuing education	3	2	4		4	4	1	3	4	2	27
21. Counseling for staff who work with HIV/AIDS patients	5	5	4		5	5	5	4	4	4	41
22. More say in patient care	2	4	4		4	4	3	4	4	4	33

Nurses:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Authority to delegate to LVNs and orderlies	5	4	4		5	4	4	4	4	4	38
2. Total bedside charge of patient	3	3	5		5	4	3	2	4	4	33
3. Assurance of quality control of physicians	5	4	3		5	5	4	5	4	5	40
4. More technical abilities	3	4	4		3	4	3	5	4	4	34

Volunteer Organizations:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Orientation	5	4	3		4	4	4	5	5	4	38
2. Training	5	5	3		3	5	2	4	5	3	35
3. Recognition	5	3	3		3	4	1	5	5	5	34
4. Good supervision	5	4	4		4	5	3	5	4	3	38

THIRD-PARTY PAYERS:

Item	A	B	C	D	E	F	G	H	I	J	TOT
1. Contracting with providers	5	4	4		4	3	3			5	36
2. Controls on price increases	5	5	4		5	4	4			3	39
3. Cost sharing	3	3	4		3	4	2			1	26
4. Quality care	5	5	4		5	5	3			3	39
5. Protection against over-utilization	4	4	5		3	4	2			5	35
6. Power to define quality care	3	3	3		4	4	4			2	30
7. Limitations on benefits	3	2	3		1	4	4			1	23
8. Reasonable cost reimbursement	5	3	3		5	4	2			5	35
9. Efficient allocation of resources	4	4	4		4	4	3			2	32
10. Negotiated contracts	5	5	4		3	4	1			1	30
11. Equitable contracts for all third-party payers	3	5	4		5	4	3			1	32
12. Reduction of duplication of services	4	4	4		2	5	2			2	30
13. Control payments to providers	3	3	3		2	4	3			3	27
14. Elimination of unneeded care	5	4	5		2	5	2			5	36

BOARD OF TRUSTEES/DIRECTORS:

Item	A	B	C	D	E	F	G	H	I	J	TOT
1. Accountability from physicians and management	5	5	4		4	4	2	5	4	5	38
2. Assist new board members	4	4	2		5	4	3	4	5	2	33
3. Well-qualified team	3	4	2		5	5	4	4	5	3	35
4. Trust from administrator	5	3	4		5	5	3	4	5	2	36
5. Understanding of hospital's goals	5	4	5		5	4	2	5	5	4	39
6. Have more time prior to making decisions	4	2	2		2	4	1	5	4	3	27
7. Integrity of board members	5	4	4		5	5	2	4	5	2	36
8. Knowledge of hospital's obligations	5	4	4		4	4	4	5	5	4	39
9. Ensure physicians conform to bylaws	5	4	4		3	4	3	5	5	4	37
10. Develops policies and have implemented	5	5	3		3	4	2	5	5	2	34
11. Communication between physicians and administrator	3	4	3		4	4	3	4	5	4	34
12. Ensure quality care	3	4	4		5	5	4	5	5	4	39
13. High professional status	4	2	3		3	5	3	5	4	3	32
14. Maintain financial solvency	5	4	5		5	5	4	5	4	2	39
15. Ensure safety in hospital	5	3	4		5	5	3	5	5	2	37
16. Information on health care in general and hospital specifically	4	4	2		3	3	2	4	4	4	30
17. Knowledge of hospital's purposes	5	4	5		4	4	3	4	4	4	37

COMMUNITY:

	A	B	C	D	E	F	G	H	I	J	TOT
1. Education of disease prevention and health matters	3	4	4		2	3	5	4	5	3	33
2. Public service announcements	2	4	3		1	3	4	4	4	4	29
3. Home care	1	3	4		3	4	2	5	4	5	31
4. Chronic disease care	3	3	2		3	4	5	5	4	5	34
5. Ease of getting information	3	4	2		4	4	3	4	4	2	30
6. Equitable distribution of health care services	3	5	4		3	4	2	4	4	1	30
7. Hospice availability	1	4	4		4	4	3	4	4	4	32
8. Screenings for diseases such as HIV/AIDS	5	5	4		2	5	5	4	5	4	39
9. Equality of access	2	5	3		5	5	2	5	4	2	33
10. Health education programs/workshops	2	4	3		2	4	1	4	4	4	28
11. Cooperation with other health facilities or hospitals	3	4	4		3	4	1	5	5	2	31
12. Comprehensive health care	1	4	4		3	4	2	3	4	3	28
13. Research on and prevention of diseases	2	4	2		4	5	5	3	4	1	30
14. Patient information	1	3	4		4	3	4	1	4	1	25
15. Nursing homes as extensions of hospitals	1	4	2		3	3	2	3	4	5	27
16. Cooperation with medical, nursing, and allied health schools	5	4	4		2	3	4	4	4	3	33
17. Honest information for media	1	5	3		3	4	5	4	4	1	30
18. Vaccines	5	3	3		3	5	5	3	5	4	36
19. Patient education	2	3	4		3	4	4	1	4	4	29
20. Cost containment	2	4	4		4	4	2	5	4	1	30

RESULTS OF THE THIRD PHASE OF THE DELPHI GROUP IN RANK ORDER

Page 1

SCORE	PATIENTS:
44	Protection from infectious diseases
42	No unnecessary surgery
42	Competent medical personnel
42	Protection from medication errors
41	Emergency room availability
41	Freedom from abuse
40	Safe environment in the hospital
38	Disease prevention
38	Relief from pain
37	Confidentiality
37	Freedom from neglect
34	Information about diagnosis, treatment, and prognosis
33	Treated with respect
33	Having a say in own care
32	Latest technology
30	Understanding
30	Access to available services
30	Short waiting times for obtaining treatment
29	Right to refuse treatment
29	Equitable prices
28	Low-cost health care
28	Rehabilitation
27	Comfortable surroundings
25	Good food
21	Reasonable visiting hours

SCORE	MEDICAL STAFF:
44	Complete and accurate medical records
41	Well maintained equipment
40	Protection from infectious diseases
40	Highly skilled nurses/other staff
40	High quality of patient care
39	Board certification
39	Cooperation and trust from hospital administrator
38	Authority over patient care
37	High quality of other physicians on staff
36	Good reputation of hospital
36	Protection from malpractice suits
34	Hospital as a place for inpatient or outpatient services
33	Best/latest/suitable equipment
31	Decision making
31	Choice in when, where, and how they practice medicine
31	Continuing medical education
30	Freedom from administrative details
30	Keep physicians informed
27	Training for interns and residents
23	Professional advancement

SCORE	OTHER STAFF:
44	Protection from infectious diseases
42	Training about HIV/AIDS
41	Counseling for staff who work with HIV/AIDS patients
40	Good supervision
37	Health benefits
37	Fair performance appraisals
36	Trust from administrator
36	Retirement plans
35	Good communications
33	More say in patient care
33	On-the-job training (OJT)
33	Appropriate salary ranges
32	Incentives for efficiency
32	Sick leave
32	Good working conditions
31	Job satisfaction
30	Promotion opportunities
29	Higher salary ranges for advanced degrees
28	In service training sessions
27	Continuing education
26	Higher professional recognition
23	Recognition of employee organizations/unions

Score	Nurses:
40	Assurance of quality control physicians
38	Authority to delegate to LVNs and orderlies
34	More technical abilities
33	Total bedside charge of patient

Score	Volunteer Organizations:
38	Orientation
38	Good supervision
35	Training
34	Recognition

SCORE	THIRD-PARTY PAYERS:
39	Controls on price increases
39	Quality care
36	Contracting with providers
36	Elimination of unneeded care
35	Protection against over-utilization
35	Reasonable cost reimbursement
32	Efficient allocation of resources
32	Equitable contracts for all third-party payers
30	Negotiated contracts
30	Power to define quality care
30	Reduction of duplication of services
27	Control payments to providers
26	Cost sharing
23	Limitations on benefits

SCORE	BOARD OF TRUSTEES/DIRECTORS:
39	Maintain financial solvency
39	Ensure quality care
39	Knowledge of hospital's obligations
39	Understanding of hospital's goals
38	Accountability from physicians and management
37	Ensure physicians conform to bylaws
37	Ensure safety in hospital
37	Knowledge of hospital's purposes
36	Integrity of board members
36	Trust from administrator
35	Well-qualified team
34	Develops policies and have implemented
34	Communication between physicians and administrator
33	Assist new board members
32	High professional status
30	Information on health care in general and hospital specifically
27	Have more time prior to making decisions

SCORE	COMMUNITY:
39	Screenings for diseases such as HIV/AIDS
36	Vaccines
34	Chronic disease care
33	Education of disease prevention and health matters
33	Equality of access
33	Cooperation with medical, nursing, and allied health schools
32	Hospice availability
31	Home care
31	Cooperation with other health facilities or hospitals
30	Ease of getting information
30	Equitable distribution of health care services
30	Research on and prevention of diseases
30	Honest information for media
30	Cost containment
29	Public service announcements
29	Patient education
28	Health education programs/workshops
28	Comprehensive health care
27	Nursing homes as extensions of hospitals
25	Patient information

Appendix C: Questionnaire

Appendix C consists of the Mailing of the Questionnaire. There are six documents. The first three were enclosed with the first mailing. The last two were also enclosed together.

The first document is a one-page cover letter to the Questionnaire that was sent to one hundred hospital administrators in California.

The second document is the one-page Instruction Sheet behind the cover letter.

The third document is the six-page Questionnaire.

The fourth document is the follow-up letter sent to the hospital administrators who did not respond to the first mailing.

The fifth document is the "Thank You" letter sent to all the administrators who completed the questionnaire.

The sixth document is the four-page consolidated ranking of the questionnaire, enclosed with the "Thank You" letter.

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

October 31, 1991

Hospital Administrator
Address

Dear Dr, Ms, or Mr:

Please accept this check as a small token of my appreciation for what I am about to ask you to do and my thanks in advance for your time and effort. I am a doctoral candidate attending Golden Gate University in San Francisco. For my dissertation I am studying the changing responsibilities of hospital administrators in response to the needs and wants of constituent groups.

A hospital administrator's job has never been easy, and in today's health care environment it is tougher than ever. While hospital administrators have always had many responsibilities to a wide spectrum of constituent groups, the number and type of such groups have undergone a substantial change over time. More importantly, the needs and wants of yesterday may not be what is most important to the individuals in the groups now. In addition, the various groups have conflicting needs and wants.

What I would like to have is your opinion of how important you feel your responsibilities are to the needs and wants of six constituent groups as shown in the attached questionnaire. Completing the enclosed questionnaire should only take a few minutes.

My hope is that this study will help in the education and training of future hospital administrators, as well as clarify the responsibilities of those in the field now. I will send you an executive summary of my dissertation after it is completed.

For the return of the questionnaire, enclosed is a stamped, self-addressed envelope.

Thank you,

Andrea M. Scheffelin

Survey of Hospital Administrators

The Hospital Administrator: Yesterday, Today, and Tomorrow
An Analysis of the Changing Responsibilities of the Hospital Administrator in Response to the Needs and Wants of Constituent Groups

Instructions:

The attached questionnaire contains itemized needs or wants from six constituent groups obtained from a review of the literature and consultation with hospital administrators. For each item there are five blocks, ranked from "1" to "5." Please place an "X" in the block that corresponds to your opinion of how important you feel your responsibility is to the group for that particular item. Please consider each item individually and rate each solely on its own merit. Here is the rating scheme to use:

1 = least important
2 = somewhat important
3 = important
4 = very important
5 = most important

For example, if you feel your responsibility to make air conditioned rooms available to the group "Patients" is very high, you would place an "X" in the "5" block of the following item.

PATIENTS

	1	2	3	4	5
1. Air conditioned rooms					X

As another example, if you feel your responsibility to provide locker rooms to the group "Medical Staff" is low, you would place an "X" in the "2" block of the following item.

MEDICAL STAFF

	1	2	3	4	5
1. Locker Rooms		X			

In addition to the ratings, feel free to add comments to any item or group.

Return to: Andrea M. Scheffelin, 3015 Root Avenue, Carmichael CA 95608-3538

Please rate each item according to how important you feel your responsibility is to that group for that item (on a scale of 1 to 5). **Page 1**

BOARD OF TRUSTEES/DIRECTORS: (Usually composed of physicians, business leaders of the community, and consumer members.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1	2	3	4	5
1. Accountability from physicians and management	:__	:__	:__	:__	:__:
2. Assist new board members	:__	:__	:__	:__	:__:
3. Well-qualified hospital team	:__	:__	:__	:__	:__:
4. Trust as an administrator	:__	:__	:__	:__	:__:
5. Understanding of hospital's goals	:__	:__	:__	:__	:__:
6. Have more time prior to making decisions	:__	:__	:__	:__	:__:
7. Integrity of board members	:__	:__	:__	:__	:__:
8. Knowledge of hospital's obligations	:__	:__	:__	:__	:__:
9. Physicians conform to bylaws	:__	:__	:__	:__	:__:
10. Develop policies and have implemented	:__	:__	:__	:__	:__:
11. Communication between physicians and administrator	:__	:__	:__	:__	:__:
12. Quality care	:__	:__	:__	:__	:__:
13. High professional status of hospital	:__	:__	:__	:__	:__:
14. Maintenance of financial solvency	:__	:__	:__	:__	:__:
15. Safety in hospital	:__	:__	:__	:__	:__:
16. Information on health care in general and hospital specifically	:__	:__	:__	:__	:__:
17. Knowledge of hospital's purposes	:__	:__	:__	:__	:__:

Return to: Andrea M. Scheffelin, 3015 Root Avenue, Carmichael CA 95608-3538

Please rate each item according to how important you feel your responsibility is to that group for that item (on a scale of 1 to 5).

MEDICAL STAFF: (All physicians who currently have privileges at the health care facility, its ancillary services locations, or clinics.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

		1	2	3	4	5
1.	Physicians have authority over patient care					
2.	High quality of other physicians on staff					
3.	Highly skilled nurses/other staff					
4.	Training for interns and residents					
5.	Best/latest/suitable equipment					
6.	Hospital includes both inpatient and outpatient services					
7.	Board certification encouraged					
8.	Continuing medical education					
9.	High quality of patient care					
10.	Freedom from administrative details					
11.	Cooperation and trust from hospital administrator					
12.	Good reputation of hospital					
13.	Participation in decision making					
14.	Good communications					
15.	Complete and accurate medical records					
16.	Choice in when, where, and how they practice medicine					
17.	Professional advancement					
18.	Protection from infectious diseases					
19.	Protection from malpractice suits					
20.	Well-maintained equipment					

Return to: Andrea M. Scheffelin, 3015 Root Avenue, Carmichael CA 95608-3538

Please rate each item according to how important you feel your responsibility is to that group for that item (on a scale of 1 to 5).

OTHER STAFF: (All non-physician persons employed or volunteers utilized by the health care facility.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1	2	3	4	5
1. On-the-job training (OJT)					
2. Fair performance appraisals					
3. Trust as an administrator.					
4. In-service training sessions					
5. Incentives for efficiency					
6. Fair benefits					
7. Job satisfaction					
8. Appropriate salary ranges					
9. Training about HIV/AIDS.					
10. Protection from infectious diseases					
11. Recognition of employee organizations/unions					
12. Higher professional recognition					
13. Good supervision					
14. Retirement plans					
15. Opportunities for promotion					
16. Higher salary ranges for advanced degrees					
17. Good working conditions.					
18. Good communication					
19. Continuing education					
20. More say in patient care					
21. Counseling for staff who work with terminally ill patients					

Volunteers:

	1	2	3	4	5
1. Orientation					
2. Training					
3. Recognition					
4. Good supervision					

Return to: Andrea M. Scheffelin, 3015 Root Avenue, Carmichael CA 95608-3538

Please rate each item according to how important you feel your responsibility is to that group for that item (on a scale of 1 to 5).

Page 4

THIRD-PARTY PAYERS: (Private health care plans such as the Foundation Health Plan or Blue Cross, and government programs such Medicare, Medi-Cal, CHAMPUS, medically indigent, and other publicly-funded programs.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

Item	1	2	3	4	5
1. Willingness to negotiate contracts					
2. Controls on price increases					
3. Quality care					
4. Protection against over-utilization					
5. Power to define quality care					
6. Limitations on benefits					
7. Reasonable cost reimbursement					
8. Efficient allocation of resources					
9. Negotiated contracts					
10. Elimination of unneeded care					
11. Equitable contracts for all third-party payers					
12. Reduction of duplication of services					
13. Control payments to providers					
14. Focus on managed care					
15. Physician delivery systems					

Return to: Andrea M. Scheffelin, 3015 Root Avenue, Carmichael CA 95608-3538

Please rate each item according to how important you feel your responsibility is to that group for that item (on a scale of 1 to 5).

PATIENT: (A person who is or has been under some type of medical care or treatment, either in the health care facility or as a referral by his/her personal physician.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1	2	3	4	5
1. Emergency room availability					
2. Affordable health care					
3. Latest technology					
4. Equitable prices					
5. Clean surroundings					
6. Responsive to patient's needs					
7. Understanding/compassion					
8. Treated with respect					
9. Protection from infectious diseases					
10. Diet as requested/required					
11. Access to available services					
12. Appropriate testing/treatment					
13. Competent medical personnel					
14. Protection from medication errors					
15. Right to refuse treatment					
16. Information about diagnosis, treatment, and prognosis					
17. Relief from pain					
18. Expanded visiting hours					
19. Confidentiality					
20. Rehabilitation to the extent possible					
21. Short waiting times for obtaining treatment					
22. Having a say in own care					
23. Disease prevention					
24. Safe environment in the hospital					

Return to: Andrea M. Scheffelin, 3015 Root Avenue, Carmichael CA 95608-3538

Please rate each item according to how important you feel your responsibility is to that group for that item (on a scale of 1 to 5).

COMMUNITY: (The community is composed of many inter-related and overlapping groups. Some examples are: minority/ethnic groups, the media, researchers, service groups such as Rotary, Lions, Kiwanis, city and county councils, planning commissions, other organizations, businesses, and individuals.)

1 = least important, 2 = somewhat important, 3 = important, 4 = very important, 5 = most important

	1	2	3	4	5
1. Equitable distribution of health care services					
2. Public service announcements					
3. Home care					
4. Chronic disease care					
5. Ease of getting health information					
6. Education of disease prevention and health matters					
7. Hospice availability					
8. Screenings for diseases such as HIV/AIDS					
9. Equality of access					
10. Health education programs/workshops					
11. Cooperation with other health facilities or hospitals					
12. Comprehensive health care					
13. Research on and prevention of diseases					
14. Patient information					
15. Nursing homes as extensions of hospitals					
16. Cooperation with medical, nursing, and allied health schools					
17. Positive relations with the local media					
18. Vaccines					
19. Patient education					
20. Cost containment					

Thank you for completing and returning this questionnaire. Your time and effort are greatly appreciated.

Name: ______________________________

Position Title: ______________________________

Return to: Andrea M. Scheffelin, 3015 Root Avenue, Carmichael CA 95608-3538

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

December 2, 1991

Hospital Administrator
Address

Dear Dr, Ms, or Mr:

Last month I sent you a check as a token of my appreciation for asking you to complete a survey about a hospital administrator's responsibilities as part of my dissertation for a Ph.D. from Golden Gate University in San Francisco.

Out of the 100 questionnaires I sent, 40 were completed and returned. Seven more were returned undone, some with notes thanking me for considering them, but that time constraints did not give them the opportunity to complete the survey, others with no comment.

Although the response rate was very gratifying, I still would like your opinion of how important you feel your responsibilities are to the needs and wants of six constituent groups as shown in the enclosed questionnaire. Completing it should only take a few minutes. Attached is another check for your favorite charity.

Your responses will be kept confidential.

For the return of the questionnaire, enclosed is a stamped, self-addressed envelope.

Again, many thanks for your help.

Andrea M. Scheffelin

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

March 13, 1992

Hospital Administrator
Address

Dear Dr, Ms, or Mr:

A few months ago you completed and returned a questionnaire I sent you as part of the data collection for my dissertation from Golden Gate University in San Francisco.

Although my dissertation is not finalized, I decided to send you the enclosed ranking in importance of needs and wants of the six constituent groups as ranked by the hospital administrators who participated in the survey.

Again, I want to thank you for your participation, and I hope you enjoy seeing how the needs and wants were ranked. In a few more months, when my dissertation is finalized, I will send you a copy of the Executive Summary.

Sincerely,

Andrea M. Scheffelin

Enc: Ranking in Importance of Needs and Wants

RANKING IN IMPORTANCE OF NEEDS AND WANTS OF SIX CONSTITUENT GROUPS

As part of the data collection for a
dissertation from Golden Gate University
in San Francisco, California

The Hospital Administrator: Yesterday, Today, and Tomorrow

An Analysis of the Changing Responsibilities
of the Hospital Administrator in Response to
the Needs and Wants of Constituent Groups.

For each of the constituent groups (Board of Trustees/Directors, Medical Staff, Other Staff, Third-Party Payers, Patient, and Community), the score for each item was tallied. Respondents had been asked to place an "X" in the block that corresponded to their opinion of how important they felt their responsibility was to the group for that particular item. There were five blocks, ranked from "1" to "5." The score was obtained by multiplying the number of administrators who placed an "X" in each block by the value of the block, then added together. Finally, all items were ranked according to their importance.

Fifty-four administrators responded. Therefore, the maximum possible score would have been 270, if all responding administrators had rated that item as "most important." Similarly, if all respondents had rated an item as "least important," it would have received a minimum possible score of 54.

The total scores ranged from 263 to 152. The item with the highest score was "Trust as an administrator" for the constituent group "Board of Trustees/Directors." The item with the lowest score was "Recognition of employee organizations/unions" for the constituent group "Other Staff."

Andrea M. Scheffelin (916) 485-8196
3015 Root Avenue Carmichael, CA 95608

March 13, 1992

RANKING IN IMPORTANCE OF NEEDS AND WANTS

Board of Trustees/Directors

Rank	Item	Total Score
1.	Trust as an administrator	263
2.	Quality care	260
3.	Understanding of hospital's goals	257
4.	Maintenance of financial solvency	253
5.	Accountability from physicians and management	253
6.	Well-qualified hospital team	243
7.	Integrity of board members	241
8.	Knowledge of hospital's obligations	235
9.	Knowledge of hospital's purposes	235
10.	Safety in hospital	227
11.	Communication between physicians and administrator	225
12.	High professional status of hospital	225
13.	Physicians conform to bylaws	214
14.	Assist new board members	210
15.	Develop policies and have implemented	208
16.	Information on health care in general and hospital specifically	193
17.	Have more time prior to making decisions	170

Medical Staff

Rank	Item	Total Score
1.	High quality of patient care	253
2.	Cooperation and trust from hospital administrator	252
3.	Highly skilled nurses/other staff	244
4.	Good reputation of hospital	240
5.	High quality of other physicians on staff	236
6.	Good communications	236
7.	Complete and accurate medical records	223
8.	Physicians have authority over patient care	222
9.	Well-maintained equipment	222
10.	Participation in decision making	220
11.	Hospital includes both inpatient and outpatient services	219
12.	Protection from infectious diseases	205
13.	Best/latest/suitable equipment	205
14.	Board certification encouraged	202
15.	Protection from malpractice suits	196
16.	Continuing medical education	196
17.	Choice in when, where, and how they practice medicine	183
18.	Freedom from administrative details	176
19.	Professional advancement	157
20.	Training for interns and residents	154

Andrea Scheffelin, 3015 Root Avenue, Carmichael, CA 95608-3538 (916) 485-8196

Other Staff

Rank	Item	Total Score
1.	Trust as an administrator	254
2.	Good communication	245
3.	Fair performance appraisals	235
4.	Good supervision	228
5.	Job satisfaction	226
6.	Appropriate salary ranges	224
7.	Good working conditions	222
8.	Protection from infectious diseases	221
9.	Training about HIV/AIDS	212
10.	Fair benefits	211
11.	Opportunities for promotion	205
12.	Retirement plans	199
13.	More say in patient care	198
14.	In-service training sessions	193
15.	Higher professional recognition	189
16.	Incentives for efficiency	187
17.	Continuing education	187
18.	On-the-job training (OJT)	184
19.	Counseling for staff who work with terminally ill patients	183
20.	Higher salary ranges for advanced degrees	154
21.	Recognition of employee organizations/unions	152

Volunteers:

Rank	Item	Total Score
1.	Recognition	246
2.	Good supervision	222
3.	Orientation	214
4.	Training	208

Third-Party Payers

Rank	Item	Total Score
1.	Quality care	231
2.	Willingness to negotiate contracts	227
3.	Reasonable cost reimbursement	226
4.	Efficient allocation of resources	225
5.	Protection against over-utilization	223
6.	Elimination of unneeded care	221
7.	Focus on managed care	212
8.	Negotiated contracts	210
9.	Controls on price increases	208
10.	Physician delivery systems	206
11.	Reduction of duplication of services	194
12.	Power to define quality care	187
13.	Equitable contracts for all third-party payers	186
14.	Control payments to providers	184
15.	Limitations on benefits	177

PATIENT

Rank	Item	Score
1.	Competent medical personnel	247
2.	Responsive to patient's needs	244
3.	Treated with respect	244
4.	Safe environment in the hospital	242
5.	Protection from medication errors	237
6.	Understanding/compassion	236
7.	Emergency room availability	236
8.	Protection from infectious diseases	235
9.	Confidentiality	235
10.	Appropriate testing/treatment	229
11.	Affordable health care	225
12.	Clean surroundings	225
13.	Relief from pain	224
14.	Information about diagnosis,treatment, and prognosis	219
15.	Having a say in own care	216
16.	Short waiting times for obtaining treatment	213
17.	Access to available services	209
18.	Right to refuse treatment	203
19.	Latest technology	199
20.	Rehabilitation to the extent possible	198
21.	Disease prevention	198
22.	Equitable prices	197
23.	Diet as requested/required	196
24.	Expanded visiting hours	159

COMMUNITY

Rank	Item	Score
1.	Cost containment	230
2.	Equality of access	216
3.	Comprehensive health care	204
4.	Patient information	203
5.	Positive relations with the local media	200
6.	Ease of getting health information	195
7.	Education of disease prevention and health matters	195
8.	Screenings for diseases such as HIV/AIDS	195
9.	Cooperation with medical,nursing, and allied health schools	195
10.	Patient education	191
11.	Cooperation with other health facilities or hospitals	187
12.	Home care	186
13.	Hospice availability	183
14.	Chronic disease care	181
15.	Health education programs/workshops	181
16.	Vaccines	181
17.	Equitable distribution of health care services	164
18.	Public service announcements	163
19.	Nursing homes as extensions of hospitals	162
20.	Research on and prevention of diseases	161

Andrea Scheffelin, 3015 Root Avenue, Carmichael, CA 95608-3538 (916) 485-8196

Appendix D: Item Descriptions

The 120 need or want items were developed for the mailed questionnaire to 100 California hospital administrators. The following are descriptions of each item, per Constituent Group, in alphabetical order.

1. BOARD OF TRUSTEES

1. **Accountability from Physicians and Management:** The Board of Trustees has always needed some amount of accountability from the physicians who practiced at the hospital and from the hospital administrator and other persons in management, particularly for monies received and expended. The Board should expect to receive various types of reports that reflect current fiscal and legal status, problems, recommend future action for improvement and/or correction, and indicate appropriate input from the department heads.

2. **Assist New Board Members:** Every new board member needs assistance in acquiring sufficient information to contribute to the board's deliberations. It is also important to the continuity of administration by the Board that all members have a common framework of reference and information. Other board members can help, but it is the administrator's responsibility to provide the main orientation. An administrator has several ways to orient new board members. These should include facility tours with meetings and discussions with other Board members of the hospital's policies, functions, and philosophy.

3. **Communication between Physicians and Administrator:** Because of the inherent nature of a hospital, good communication must exist between the physicians who admit their patients and the administrator who keeps the hospital operating. It is a responsibility of the administrator to the Board of Trustees to maintain good communication with the medical staff. This should be done through formal oral and written communication, as well as informal contact.

4. **Develop Policies and Have Implemented:** The Board of Trustees is the entity responsible for the overall operation of the hospital, which includes the final formulation and approval of the policies governing its administration. Before the board can perform its mission, the administrator must inform it of the hospitals's problems, and suggest the development of, or contribute to, solutions. In this way the board will have the input needed to develop the policies. Trustees will increasingly rely on the hospital administrator's expertise in recommendations on policy

matters. After the policies have been approved, it is the administrator's responsibility to ensure that the policies are implemented and that the hospital's available resources are applied intelligently to its day-to-day operation.

5. **Have More Time Prior to Making Decisions:** Before the board members can formulate sound policy decisions, they must have adequate time to think through all ramifications. Many administrators with high ideals, coupled with good creative ideas, have run into difficulty with their governing boards because they strove to make improvements too rapidly. Trustees usually want time to digest new proposals and to be sure that they are practical. Too often there is not sufficient time. An issue is raised at a board meeting, some discussion ensues, and the matter is put to a vote. One of the administrator's responsibilities is to provide to the board members the issues and background information sufficiently prior to the board meetings so as to allow a full analysis and formulation of opinion on all issues. The discussion and subsequent vote can then take place during the Board meetings with a better understanding of the issues.

6. **High Professional Status of Hospital:** Some authorities say that not many people like to be part of a losing team, unless someone has a special talent for bringing success to a previously poorly run organization. Hospital trustees generally care about the community they serve, and wish to be recognized as part of the team that brings good to the community. In this respect, the hospital should have a good reputation, both from the people it serves and the professionals who desire to work and practice there. Overall, it is the administrator's responsibility to ensure the hospital reaches and maintains a high professional status.

7. **Information on Health Care in General and Hospital Specifically:** A board member, prior to formulating sound hospital policy, needs to have current, general information on health care. Some of the difficulties that arise between administrators and their boards is that some trustees do not realize how widespread are the problems that hospitals face and what a multiplicity of forces are constantly acting upon each hospital, pulling it in a myriad of directions.

In addition, more precise information is required as to the role of the individual hospital, particularly if the hospital concentrates and provides treatment on a regional or tertiary basis or in a specialty.

These areas of information include, among others: finance, quality of patient care, condition of the

hospital and its equipment, services rendered, unmet medical needs of the community, morale of the medical staff and personnel, and any unusual incidents. The hospital administrator must continually educate the Trustees. A continuing part of the administrator's role is the presenting of information about broader health issues and the needs of society to the Board.

8. **Integrity of Board Members:** Integrity is a trait every board member must have. One of the hospital administrator's responsibilities is to ensure that each board member has a high sense of integrity. More importantly, the administrator must be alert to any information that belies this attribute and make the potential problem known to the others on the board.

9. **Knowledge of Board's Obligations and Responsibilities:** Every board member needs to know what are the board's obligations and responsibilities. Other board members can help in describing policy, but it is the administrator's task to provide a Trustee Handbook, approved by the Board, outlining the duties and responsibilities of each individual trustee, and an overview of the Board's duties and responsibilities.

10. **Knowledge of Hospital's Purposes:** Before board members can understand their responsibilities, they must understand the hospital's mission. It is up to the administrator to provide this information, preferably in a Trustee or Hospital Handbook.

11. **Maintenance of Financial Solvency:** No organization, for-profit or not-for-profit, can exist for long if it does not remain financially viable. Hospitals have to be especially careful. Staff must be compensated and supplies paid for, all within the current climate of decreasing reimbursement and increasing uncompensated care. Probably the most important responsibility of the administrator is to keep close tabs on the fiscal solvency of the hospital. Alden Mills wrote:

> "All too often, an administrator is judged largely by the financial results, with far less concern for the other important aspects of his work. Since this is so, administrators should give careful attention to hospital economics and see that the financial policy of the hospital, whatever it may be, is understood and faithfully carried out."[19]

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[19]Alden B. Mills, Hospital Public Relations Today (Berwyn: Physician's Record Company, 1965) 57.

12. **Physicians Conform to Bylaws:** In today's litigious environment, it is imperative that everyone connected with a hospital execute his or her duties as designated. Physicians particularly must adhere to the hospital's bylaws. One of the responsibilities of the administrator to the Board of Trustees is to ensure that the bylaws are enforced by the Board, medical staff, and all other employees.

13. **Quality Care:** Board members are concerned about the hospital providing quality care for continuing to draw patients. The administrator is tasked with ensuring all the staff members dispense quality care.

14. **Safety in Hospital:** Board members are concerned about the safety in their hospitals. The administrator is assigned the task of assuring this safety.

15. **Trust as an Administrator:** All the things a hospital administrator does, he or she does by the good graces of the Board of Trustees. The relationship maintained between the administrator and the Board members is based strongly on trust. The Board members especially need to trust the administrator, for that person handles the day-to-day affairs of the hospital. The Board must believe that the administrator is conducting the activities properly.

16. **Understanding of Hospital's Goals and Purposes:** Before board members can understand their responsibilities, they must understand the hospital's mission, in the form of the hospital's goals and purposes. It is up to the administrator to provide this information, preferably in a Trustee or Hospital Handbook. The administrator must have a firm understanding of his or her hospital's aims, prior to accepting the position. A fundamental difference of opinion concerning the objectives of the hospital between administrator and board is a wide gap to bridge.

17. **Well-Qualified Hospital Team:** The hospital administrator is akin to an orchestra leader, coordinating the efforts of all the talented players. The administrator must ensure to the board that the staff, both medical and ancillary, have all the proper credentials and that they perform their assignments responsibly. In addition, the administrator must get the medical staff on the Board of Trustees-Administrator team. A competent and cooperative medical staff is a great boon to an administrator; while an uncooperative staff can thwart his or her best efforts and stifle the enthusiasm of the whole hospital.

2. MEDICAL STAFF

1. **Best/Latest/Suitable Equipment:** Physicians cannot perform their medical duties in a hospital without the necessary equipment. As rapidly as technological changes have occurred, most hospitals attempt to keep their equipment as current as possible. No one wants to use poor quality nor antiquated equipment. In addition, the equipment must be appropriate for the procedures and treatment rendered.

A constant debate centers over cost versus effectiveness of some of the technology and equipment available. Some medical procedures, such as immunizations, are extremely inexpensive to administer as compared to the cost benefit of people not contracting the disease.

Other forms of medical care, which often includes specialized equipment, are extremely expensive to manufacture and operate, yet often do not have good outcomes associated with it in terms of costs "saved." For example, many hospitals may wish to buy a Magnetic Resonating Imaging (MRI) machine, at a cost of $2 million, yet may only actually need it 20% of the time. At that point the hospital has two options: rent out the use of the MRI to other medical organizations, or utilize it more often, even when it may not be completely warranted.

2. **Board Certification Encouraged:** When a student graduates from a medical school, he or she earns the title "Doctor." However, the process of becoming a licensed, practicing physician does not end there. They may not yet prescribe medication nor treat a patient without supervision.

In most states, California included, a residency of at least one year is required. After this residency (formerly called an internship) a physician may apply for a license. Then follows the continuation of the residency, for an additional one to eight years, depending on the specialty, during which a physician is given supplementary, more comprehensive training either in the chosen specialty or in general practice.

After successful completion of this training, a physician is board eligible for the chosen specialty. If he or she passes the board exam, the physician is deemed to be competent with the knowledge in the specialty, and becomes board certified. With this credential in hand, the physician may apply at one or more hospitals to be accepted on the medical staff as a specialist in the area in which he or she is board certified.

3. **Choice in When, Where, and How They Practice Medicine:** Although all medical students are exposed, in

essence, to the same information during their years at an accredited American medical school, each person is different in his or her preference in how this knowledge will be used. Most will practice medicine, some will wish to conduct research, some will teach, and a few will gravitate toward other professions. The desire for independence and freedom from controls is one of the hallmarks of most physicians. Although everyone is limited to some degree either by another person or a governmental agency, a hospital administrator can encourage a broad hospital policy to accommodate the many different treatment concepts presented by the medical staff.

4. **Complete and Accurate Medical Records:** Before a physician can competently treat a patient, the patient's medical chart must be both complete and accurate. Duplication occurs too easily when items are omitted from charts, or inserted in an untimely manner. Accuracy is of prime importance. No one can be expected to correctly diagnose or treat an illness if inaccurate information is in the patient's medical chart. With different people doing different things to a patient, whoever follows must be able to tell what has already been done. Hospital information systems are well on the way to solving this problem. Some computers in hospitals need to be dedicated to storing patient information.

5. **Continuing Medical Education (CME):** Professional education should never cease; the medical profession in particular, for technological breakthroughs occur at a rapid pace. Research brings new knowledge to diseases and conditions, and the accompanying new treatments. Physicians who graduated from medical schools many years ago may have much experience and their insights can be an enhancement to this new knowledge. Yet it takes CME to bring the two together.

6. **Cooperation and Trust from Hospital Administrator:** The hospital administrator is the Chief Executive Officer (CEO) of the hospital, and as such, is responsible for all that goes on within. The medical staff as a whole forms the third leg of the three-legged stool of command. The other two legs are the Board of Trustees and the administrator. In order to be effective, cooperation and trust must exist between all three legs. The medical staff usually understands that they, as a group, cannot have everything that they want. They should know, however, that if they cooperate with the administrator, he or she will do the best possible for the staff. Of course, that means the medical staff has to trust the administrator. Trust is a fragile commodity, and needs to be consistent.

7. **Freedom from Administrative Details:** A physician is trained to perform patient care. He or she must perform some types of administration within his or her personal practice or group offices, yet office managers are often hired to perform the administrative functions of the practice. In a hospital setting, physicians do not wish to become mired in administrative details. They often have practicing privileges in several hospitals, and it could be too cumbersome for them to have to know each hospital's routine unless it directly impacts the physician or patient.

8. **Good Communication:** Poor communication can undermine an otherwise well run organization. If people do not understand what is expected of them, they are often unable to perform satisfactorily. In a well-conducted and effective organization, communication must be clearly understood by all parties. In addition, information must pass freely up, down, and laterally throughout the structure.

Hospitals, particularly, must be vigilant about good communication. Patient safety is dependent upon correct orders. If communication between the physician and care-giver is confused, the patient's outcome will probably not be as satisfactory as it should be.

9. **Good Reputation of Hospital:** Although physicians will often seek practicing privileges at many, if not all of the hospitals in a town, they will usually have one or two they prefer. Some hospitals will specialize in certain procedures, or types of patients (such as children's hospitals). The general hospital which has a good reputation will attract physicians for the more routine cases in addition to the specialty cases.

Current changes may restrict physicians' options. Some health maintenance organizations have exclusive contracts with physicians. This practice may extend to large health care systems, and may broaden to individual hospitals over time.

10. **High Quality of Other Physicians on Staff:** The expression, "One bad apple spoils the barrel" holds true in hospitals too. When a physician becomes dysfunctional through any of a variety of ways, any hospital that gave him or her practicing privileges is suspect of all its physicians. Therefore, the medical staff on board a hospital expects the administrator to have a well-monitored system in place to ensure all physicians on staff are of high caliber. Yet at the same time, the administrator must take care not to appear as though he or she is attempting to usurp the physicians' right to oversee themselves.

11. **High Quality of Patient Care:** This item is closely related to the previous one - High Quality of Other Physicians on Staff - except that this item involves all the persons who partake in patient care. Physicians want to have privileges at hospitals that have a good reputation for providing excellent patient care. Therefore, it is an important responsibility of the administrator to ensure that the hospital is known for the high quality of patient care given from every person on staff.

12. **Highly Skilled Nurses/Other Staff:** Medical personnel, not only physicians, are expected to be highly skilled and well trained in their profession. Each person must know his or her job, and how it relates to the total patient care. Administrators have the responsibility to the physicians who practice at the hospital to ensure that the physicians' patients will receive the best possible care, because the physicians cannot be in attendance to their patients around the clock. They depend on the hospital personnel for that level of care.

13. **Hospital Includes Both Inpatient and Outpatient Services:** Not all of a physician's patients will need to be admitted to a hospital, but often they will need treatment or a test that a physician's office does not have. A hospital ideally would have these services. They include any other departments such as an EKG clinics, laboratory, out-patient surgery center, pharmacy, physical/occupational therapy, and X-Ray.

14. **Participation in Decision Making:** People do not like to have decisions that affect them made without their knowledge or consent. Physicians are no different. If policies in the hospital are changed, most would like to have some input in that decision-making process. Often they are, for in most hospitals, the medical staff is one leg of the three-legged stool that is responsible for the facility.

15. **Physicians have Authority Over Patient Care:** Physicians in the past have enjoyed almost total authority over the care and treatment of their patients. Recently this has changed. Third-party payers are attempting to place limits on what physicians may do without prior authorization. As one writer put it: "First, about regulation. Doctor after doctor bitterly complains of being second-guessed by insurers, regulators and 'reviewers' who question their charges and treatments and, they believe, often prevent

them from doing the best for their patients."[20] Hospitals, in an effort to standardize certain procedures within the hospital confines, are sometimes requiring adherence to various policies, further restricting physicians' authority. Administrators have a responsibility to provide the staff, management information systems, and equipment to enhance the physicians' practice within the hospital.

16. **Professional Advancement:** Many people may think that once a person graduates from medical school, he or she has achieved almost the top of his or her profession. Not so. Basic physicians have been trained to perform medical wonders. Most of them do not wish to stay at that entry level. Many want to branch out, teach, administrate, perform research, head projects, join and rise in the ranks of professional organizations. These are all forms of professional advancement. In addition, physicians can become more skilled in their chosen specialties. They can develop into recognized experts in only a minute portion of their specialties.

17. **Protection from Infectious Diseases:** Physicians (and anyone who comes into contact with persons with contagious diseases or conditions) have always run the risk of contracting whatever medical problem the patient has. Thankfully, much is now known in how to prevent the spread of many old diseases. However, new diseases arise to take the forefront. AIDS is a prime example. Prior to 1980, AIDS was unheard of. Now it often heads the medical news. Researchers do not always know everything there is to know about an infectious disease. Far too often new research contradicts what had been believed before. When treating patients with infectious diseases, physicians have the right to be protected as best possible. Administrators have the responsibility to physicians to have these protection measures available.

18. **Protection from Malpractice Suits:** No physician, when practicing in a hospital, works in a vacuum. When something goes wrong, and the patient (or family) is not pleased at the outcome, often the physician is sued, along with everyone remotely connected with the case or hospital. Physicians have had malpractice insurance available for many years, but with the rising costs of premiums, many physicians are reducing their insurance or changing their practice specialties to reduce premiums. Administrators need to ensure that

[20]"Needed: 'A New Doctor,'" Washington Post Health (9 June 1992): 11.

their hospitals have adequate insurance coverage for hospital liability. Different types of health care systems can offer complete malpractice protection to the physicians, i.e. Veterans Administration, government, staff HMOs. The availability of complete malpractice protection may become an item of major importance when used by a physician when he or she is seeking practicing privileges at various hospitals. Most hospitals do not grant practicing privileges to physicians without adequate malpractice insurance.

19. **Training for Interns and Residents:** When people graduate from an approved medical school, the title "Doctor" is conferred upon them. However, their education and training is not yet complete. They may not yet prescribe medication nor treat a patient without supervision. After a residency of one year, formerly called an internship, a physician may apply for a license. Then follows the continuation of the residency, for an additional one to eight years, depending on the specialty, during which a physician is given supplementary, more comprehensive training either in the chosen specialty or in general practice.

These training periods are costly to hospitals in terms of time taken from fully-qualified physicians to teach and observe the interns and residents, as well as the salaries paid to the teachers and trainers.

20. **Well-maintained Equipment and Facilities:** Physicians look to hospitals for providing some of their tools of the trade, as well as places for their patients when home care is insufficient or not feasible. The hospital administrator provides for maintenance and protection of buildings, equipment, and fixtures to ensure their continuous use and operation, and complies with building codes and accreditation standards. As for non-patient care, the hospital is the structure within which teaching and research may take place. This condition also require well maintained facilities.

3. OTHER STAFF

1. **Appropriate Salary Ranges:** Various types of work are compensated differently. Several factors are used to determine the salaries of job classifications. Knowledge, skills, and abilities are used the most frequently. Additionally, supervisory duties and the level of responsibility can be additional components of salaries.

When someone is hired with the knowledge and presumably the ability to perform the work, but little, if any, experience or demonstrated skills, that person usually receives the lowest salary for that job

classification. As he or she gains the experience through the years, raises, often called "steps" are customary within the salary range. Eventually the person will reach the top of that salary range; the alternatives then are to seek a promotion or a lateral change to another job classification with a higher salary range.

2. **Continuing Education:** As with most professions, new knowledge is discovered by those doing research in the field. The knowledge needs to become disseminated to those actually working in the field. Several methods exist to accomplish this continuing education. Articles may be published in the trade journals. The major drawbacks to journals is that there is no outlet for discussion or questions, and not everyone in the field will have access to the publications. Another common form of education is organized seminars. These draw the leaders in the field and representatives from companies in the business along with those who actually perform the work. Ideas are exchanged and discussions occur during these forums. Most state licensing agencies require that a certain amount of continuing education must be done yearly prior to renewal of said license.

An administrator has the responsibility to ensure that the personnel whose licenses require continuing education have the opportunities to attend seminars in their fields. Larger hospitals can sponsor forums on their own. A tracking system needs to be in place to monitor each person's continuing education credits.

3. **Counseling for Staff Who Work with Terminally Ill Patients:** The hospital staff who perform patient care need to develop personal protective mechanisms, especially those who work with terminally ill patients. Knowing the patient is going to die, despite the care-givers' best efforts, can exact a terrible toll on the staff. At some point most persons will require counseling to aid in working through grief.

4. **Fair Benefits:** Most employees expect a package of benefits besides a salary and legally required benefits. Common are: health, dental, vision, disability, and life insurance programs; and holiday, vacation, and sick pay. Other possible benefits could include: cafeterias; child care provisions; credit unions; employee assistance programs; employee lounges and parking; out-placement help; overtime practices; recreation programs; and uniforms.

5. **Fair Performance Appraisals:** Employees need to have their job performances reviewed at regular intervals. Most people in a group do not perform at the same

level, nor are an individual's performance levels constant over time. Regular appraisals are beneficial to employees because possible performance problems can be curtailed before they become severe. However, these appraisals must be fair, meaning free from personal biases or retaliation. Additionally, each time period must stand alone. Past superior or inferior performances, achievements, or mistakes from previous rating periods should not affect the current period.

It is the administrator's responsibility to ensure supervisors are knowledgeable about the hospital's performance appraisal policies, and that the policies are used. Periodic reviews of supervisors should be conducted to confirm appraisals are fair.

6. **Good Communication:** Communication encompasses spoken and written words. Words are used from top management down through the ranks of the lowest employees. Words are also used back up the chain of command, and across peer groups. Good communication is clear and free from ambiguity.

Communication from the top down is not simply directives, but also accurate explanations, anticipating reactions, and being prepared with responses. The flip side to that is eliciting reports from subordinate units. Sending and receiving accurate information is a process which must involve interpretation of the context from which that information arose.

7. **Good Supervision:** Employees need to know what is expected of them. They also need the tools and resources in accomplishing their tasks. Last, they need to know whether or not their work was successful, that is, if the goals were attained. They are also entitled to fair and humane supervision.

The functions of supervisors are many. Supervisors are expected to delegate the work in order to achieve a stated task or objective. They must provide guidance or instruction, monitor the work in progress, evaluate it when it is finished, and, if need be, suggest methods of improving the finished product if it was not performed to satisfaction.

Good supervision motivates the employees to perform the work well. People generally work better when there is no fear of their supervisor, when they believe their supervisor is concerned about them as individuals, yet knowing that the mission comes first. Effective supervisors can create an atmosphere that fosters cooperation among the workers.

The administrator must be involved with the selection of supervisors. He or she should ensure only competent persons are chosen to direct and supervise major departments. The administrator should assist supervisors in carrying out their duties.

8. **Good Working Conditions:** Good working conditions range from the physical environment to the emotional atmosphere fostered. Some aspects are mandated by the federal OSHA and the California version, Cal-OSHA.

The environmental factors include, among others: adequate cooling, heat, light, and ventilation; equipment in proper working order; furniture or stations appropriate to the type of work performed; and clean restrooms. Additionally, items such as parking areas for employees and lounges are appreciated. An increasingly critical factor in working conditions is security guards to help ensure the safety for hospital personnel, especially in emergency departments.

As for the emotional atmosphere, people need to feel that they are valuable contributors to the organization's mission. An aura lacking in animosity and fear will help support these feelings. An administrator cannot dictate an atmosphere, yet the attitude that he or she holds can permeate throughout the entire hospital.

9. **Higher Professional Recognition:** Many persons working in hospitals, in addition to physicians, have undergone numerous years of education prior to becoming licensed in their specialties. This is especially true for registered nurses. The knowledge and skills required for job performance should earn increased professional recognition.

10. **Higher Salary Ranges for Advanced Degrees:** It is often possible, and encouraged, for persons in most professional medical occupations to earn advanced degrees in their field. Research shows that the intrinsic rewards of expending the time, money, and effort into acquiring that advanced degree is usually accompanied by higher income or earnings. Therefore, to accompany other, non-monetary rewards, hospitals will often compensate employees with higher salaries for the additional education and training undertaken.

11. **Incentives for Efficiency:** Few procedures are so perfect that they cannot be improved upon. Time management techniques can be used on routine tasks so as to dispatch the tasks as quickly as possible, yet without sacrificing accuracy. Financial and other types of incentives should be offered to the person who discovers a better way. Suggestion programs are common vehicles for allocating rewards.

12. **Inservice Training Sessions:** As with continuing education, most people in medical and other health care occupations will benefit from additional training, not only in their specialties, but also in general medical knowledge. Regularly scheduled in-service training sessions can accomplish much in keeping all employees current.

13. **Job Satisfaction:** Numerous studies have shown that although salary is not necessarily the prime motivator in answering the question "why do people work?" Other motivators also have to be present. Job satisfaction ranks high as a motivator. People want to feel good about the work they do. They need to know that their contributions are valued by their supervisors and by the recipients of their labors. This is especially true in the health care professions.

14. **More Say in Patient Care:** This item applies almost exclusively to nurses. Physicians have traditionally provided all the instructions for patients, although they may only see their hospital patients briefly, once or twice a day. The rest of the time the care is rendered by nurses. Therefore, nurses often have clearer understandings of the patients' problems, and the effects of the treatments. Many nurses want to have greater influence in patient care. They often want to be more of a collaborative partner with the physicians. Some physicians welcome this sharing, others do not.

15. **On-the-Job Training (OJT):** College or vocational training for a particular career can teach the knowledge needed for that occupation, and sometimes the hand-on skills, but most health care positions need some amount of on-the-job training. Different hospitals have different duties for the same type of work performed. Other hospitals have specific tasks allocated to some workers within the same classification. As with in-service training, new employees need OJT, and experienced employees benefit from OJT whenever procedures are changed.

16. **Opportunities for Promotion:** Very few employees are content to work their entire career at the same position for which they were originally hired. Most people will want to have the opportunity to compete for promotions within the organization. When higher level positions are continually filled from outside the hospital, morale generally suffers, and valuable employees may look elsewhere for promotion opportunities.

17. **Protection from Infectious Diseases:** Anyone who comes into contact with persons with contagious diseases or conditions has always run the risk of contracting the medical problem the patient has. Thankfully, much is now known in how to prevent the spread of many old diseases. However, new diseases arise to take the forefront. AIDS is a prime example. Prior to 1980, AIDS was unheard of. Now it often heads the medical news. Researchers do not always know everything there is to know about an infectious disease. Far too often new research contradicts what had been believed before.

When treating patients with infectious diseases, patient caregivers have the right to be protected as best possible. Administrators have the responsibility to them to have these protection measures available.

18. **Recognition of Employee Organizations/Unions:** Although most non-federal hospitals do not have unions, many have employee organizations or associations. Many nurse and physician associations have bargained for increased wages and fringe benefits, and for influence over the work environment.

Union demands may range from cleaner restrooms to the dismissal of the administrator. However, the complaints and demands usually include general working conditions, hospital discounts or paid hospitalization, personnel policies, retirement programs, salary, shift differentials, vacations, and working hours. Others may concern administrative policies, lack of overtime, quality of patient care, and violation of labor laws relative to wages and hours.

19. **Retirement Plans:** Retirement plans encompass more than simply managing funds for paying pensions. Financial personnel should also be available to help employees decide what type(s) of individual retirement accounts (IRAs) are best suited for them, if any. Lastly, the hospital should have regularly scheduled pre-retirement planning sessions.

20. **Training about HIV/AIDS:** All contagious diseases are not created equal. Vaccinations and/or effective treatments have been found for most. One notable exception is HIV/AIDS. Although it is growing, the body of knowledge about this deadly disease is still rather scant. As research on this disease continues, some of the myths surrounding HIV/AIDS are being dispelled. Yet accepted treatments can change. It is imperative that hospital employees who treat patients with HIV/AIDS be kept fully current on the progress of this research.

21. **Trust as an Administrator:** The administrator is responsible for all that goes on within the hospital. In order to be effective, the administrator must have the employees' trust that he or she is ethical in all the dealings on behalf of the hospital. The staff needs to understand that they, as a group, cannot have everything that they want. They should know, however, that if they cooperate with the administrator, he or she will do the best possible for the staff.

Volunteers:

1. **Good Supervision:** Volunteers need to know what is expected of them, coupled with the tools and resources in accomplishing their tasks. Supervisors must provide guidance or instruction, monitor the volunteers, and tactfully suggest improvements. Good supervisors motivate volunteers, and make hospitals pleasant places in which volunteers wish to spend time and energy.

2. **Orientation:** New volunteers are not expected to be familiar with the organization of the hospital or its routines. They require orientation, to include a tour of the hospital, and its history. They need to be introduced to the employees, especially those in the departments in which the volunteers will be working.

3. **Recognition:** Volunteers freely give of their time and effort for the good of the patients. Indirectly the hospital benefits. Volunteers need to know that their endeavors are valued and greatly appreciated. Because they donate their services, volunteers are as priceless as employees. Several methods are available to accomplish this show of appreciation. One of the most common is to establish a Volunteer of the Month program. Another is to host a Volunteer Appreciation Luncheon. The small cost involved in these and other programs is negligible when weighed against the benefits the hospital derives from the volunteers.

4. **Training:** Volunteers are not expected to have the knowledge, skills, and abilities of paid employees. Some may be retired from other, completely different occupational fields. Although they may have valuable knowledge, they may not know much about their new duties as hospital volunteers. They need to be fully trained, particularly if they will be involved in patient care. In addition to initial training, volunteers should have regularly scheduled training meetings. These serve two functions. One, the volunteers get a non-hospital opportunity to meet each other, those who work in other departments. Two, training sessions can provide a forum for volunteers to air their problems and concerns.

4. PATIENTS

1. **Access to Available Services:** Access refers to time, location, passage, and availability. Patients can have need of medical services at any time of the day or night, yet some time periods will find more patients seeking care. Services should be open when the demand is sufficiently strong to warrant it, and obtainable when the need is urgent. The location should be placed in close proximity to where the greatest need is as well as satellite locations if warranted. For example, the pharmacy should be located in the hospital, as opposed to a separate building. Passage refers to the accommodations needed for patients with disabilities to gain entrance to the services. Availability refers to having a sufficient number of people staffing the needed services in addition to the equipment, supplies, and materials to treat the medical problem.

2. **Affordable Health Care:** Currently most people in America have some sort of health care insurance through a private third-party payer or through some form of the federal government. Very few pay for their medical care as needed (fee-for-service). In days long gone, physicians had modest fees, which were often waived if the patient was unable to pay, or payment was made through a trade with the product of the patient's labor. The unfortunate aspect of this system was that if badly needed care was too expensive, the patient may have had to do without, resulting in much suffering and often premature death. However, under the current system of third-party payers, "If a patient knows that someone else is paying the bill, he has no reason not to demand as much expensive healthcare as he can get."[21]

3. **Appropriate Testing/Treatment:** A particular symptom or set of symptoms can be indicative of more than one medical problem. Although it may not always seem as though the tests requested are germane to the symptoms, tests are usually run to eliminate certain possible diseases as well as confirm a suspected diagnosis. Some treatments may not appear to have anything to do with the medical problem, yet they could be an integral part of prevention of further problems. (Experimental medicine has not been included in this study.) Appropriateness is the key to both tests and treatment.

Sometimes tests are requested and treatments rendered that are not strictly required, but are

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[21] ________, "A Survey of Health Care," The Economist, (July 6, 1991): 5.

performed for the purpose of defensive medicine, to ward off mal-practice suits.

4. **Clean and Comfortable Surroundings:** Hospitals must be cleaner and more sanitary than an ordinary household. Dirt harbors germs and bacteria that can aggravate some diseases and cause others. Surgery patients have wounds that can drain, creating a haven for harmful bacteria. Therefore the dressings, bandages, pajamas, and bedding must be often changed, cleaned, and sterilized. Because it is easy for body fluids, liquids, and medicines to be spilled, the floors and wall surfaces need to be cleaned and disinfected routinely. These measures may help to ease a patient's mind, as he or she may believe that if the surroundings are clean, the treatment accorded the patient will be correspondingly meticulous.

A patient's surrounding should also be comfortable. Most people are accustomed to a certain way of living in their own homes. A hospital is often a new and frightening experience. The more at ease a person is made to feel, the less anxiety the patient may have about their medical situation.

5. **Competent Medical Personnel/Quality Care:** Every patient has a certain level of expectation that each person who provides some sort of health care, treatment, or service, possesses an adequate amount of competence. Patients expect the staff to be fully trained and to have kept up with continuing medical education (CME). While most people know that it is possible for anyone to make an error, they do not expect major, life-threatening mistakes to occur. It is the administrator's responsibility to ensure that all medical or nursing personnel have the appropriate licenses and/or credentials, and that CME is attended. In addition, the hospital should have a quality of care system to track errors, large or small, and methods to help prevent errors in the future.

6. **Confidentiality:** Medical problems are often of such a nature that they could be an embarrassment to the victim were the problem to become publicly known. Every patient has the right to privacy. Should this privacy become compromised, a lawsuit could easily ensue, and the reputation of the hospital could suffer. A prudent administrator will ensure the existence and adherence to a policy with regards to safeguarding the confidentiality of all patients, including out-patients who use the facility.

7. **Diet as Requested/Required:** Hospital food is not known for its haute cuisine. People have different tastes in food, and not everything offered on a menu

will be appreciated by all. Although some patients may need to be restricted to a few particular foods, and others may be on a strict diet, most patients will be allowed to choose what they would like amongst the various menu items. When the choices have been made, whether by the patient or physician, the meals should be delivered as ordered, with hot foods hot and cold foods cold.

8. **Disease Prevention:** People who suffer from a recurring problem often visit hospitals as out-patients. These persons could be educated as to measures they can take to delay, if possible, the onset, or diminish the symptoms, and perhaps stop the disease. People learning to accept responsibility for their own health will do much for themselves as individuals, as well as reduce the aggregate health care bill. It will also help to reallocate the available medical resources to other endeavors.

By the same token, in-patients can learn about related problems that often accompany their primary medical problems, and ways to relieve them.

9. **Emergency Room Availability:** Accidents, acute illnesses, and planned mayhem may occur at any time of the day or night, not only during normal business day hours. Ordinary people can become patients in an instant. Medical attention sometimes becomes paramount, frequently more than what an Emergency Medical Technician (EMT) from an ambulance is able to provide. Hospitals should have the availability of a fully equipped and staffed Emergency Room, complete with specially trained emergency personnel, to be able to deal with any medical situation presented to them.

10. **Equitable Prices:** Many factors go into a hospital's pricing structure. Government agencies such as Medicare and Medi-Cal have set reimbursement rates for persons covered by those programs. Although third-party payers negotiate specific reimbursement rates, all the people within that patient catchment area should be charged fairly for identical procedures.

11. **Expanded Visiting Hours:** Most hospitals allow their patients to have visitors, yet the hours are usually set for the convenience of the hospital staff, not for the patients or visitors. Additionally, the visiting hours allotted is frequently only for a few hours at a time. This can be inconvenient for visitors, especially if they have to make long trips to and from the hospital.

12. **Having a Say in Own Care/Participation:** In years past, patients trusted their physicians, and followed

their directions without question. However, more recently, people have learned much lay medical knowledge, and many wish to interject their own opinions as to possible courses of treatment. This participation is sometimes welcomed by physicians. When it is not, the patient most often finds another physician, one who is pleased to have a patient willing to take some personal interest in his or her own care.

13. **Information about Diagnosis, Treatment, and Prognosis:** People generally want to know when something is wrong with their general health. They sometimes may imagine their symptoms to be indicative of a disease or condition that may be much worse than what they actually have. People want to know the diagnosis. After the diagnosis is made, and possibly confirmed, if a second or subsequent opinion is sought, people want to know the choices of treatments available, and to understand the ramifications and expected results of each option.

Last, people want to know what to expect after the treatment is concluded. Years ago, physicians believed it was one of their duties to shield the patient from the news if the prognosis was death. Family members would be told, with strict instructions not to let the patient know. Happily this is ending. Topics dealing with death and dying are no longer inviolate.

14. **Latest Technology:** Patients, along with physicians, generally want the latest approved technology available. Not many want to be experimented upon, unless perhaps it is the last resort. While a few people may wish to cling to the older folk remedies, once he or she is convinced an archaic method of treatment may be more harmful than beneficial, a more contemporary form of therapy may be demanded.

15. **Protection from Infectious Diseases/Iatrogenics/ Nosocomial Infections:** Patients often enter hospitals in weakened conditions due to their own diseases or because of surgery. This usually makes them more susceptible to infection problems.

Some diseases are contained within one person and cannot be transmitted to another by casual contact. Others, such as the so-called common cold or an influenza, are highly infectious. Hospital patients or personnel with infectious diseases need to be kept from other patients, staff, and visitors. A quarantine may be required at times.

Iatrogenics are adverse conditions as a direct result of physician intervention. Most often the conditions are unforeseen and unavoidable.

Nosocomial infections are infections that a patient did not have prior to admittance into a

hospital. Generally the infection will appear within 72 hours after admittance. An example is an infection after surgery because germs entered the surgical wound.

16. **Protection from Medication Errors:** Few patients depart a hospital without taking considerable amounts of medication. Busy medical personnel have many patients to which they dispense pills and shots. Unless meticulous measures are taken to prevent accidental mix-ups, on occasion patient A may receive patient B's medication, which can prove disastrous to patient A. And patient B may or may not get his or her correct medication. Another possible error is that a patient can receive an incorrect dosage of the proper medicine.

17. **Rehabilitation to the Extent Possible:** In many cases, patients will make full recoveries from their injuries, surgeries, or diseases. However, in others, particularly patients who require occupational or physical therapy, recovery will not be complete. Almost all patients will want to be as whole and functional as before their medical treatments. While much of this restoration is due to individual perseverance, trained therapists should be available to offer instructions, guidance, and encouragement.

Rehabilitation to the best extent possible is the most anyone can expect. Yet striving for more is often healthy, for people are sometimes able to surprise themselves and medical personnel with more than what was expected.

18. **Relief from Pain:** Physical pain is something everyone goes through, too much it sometimes seems. Pain serves at least one useful purpose: it alerts the person that something is wrong, that damage to the body has occurred. This allows the person to do what he or she can to alleviate the pain, and therefore perhaps stop the damage from worsening.

Pain accompanies almost all injuries, and many diseases. Other than a smattering of masochists, very few people enjoy pain. Most will want relief whenever possible. A major problem with deadening all pain is that often pain is needed to aid in diagnosing medical problems. When pain has been eliminated artificially, hidden problems can go undetected, undiagnosed, and therefore untreated.

19. **Responsive to Patient's Needs:** Some patients treat a hospital stay as though it were a vacation in a plush hotel. Others dread it as though people only go into hospitals to die. The former often are difficult and demanding, as though the hospital staff has no one else to tend to except them. The latter are also

sometimes difficult because of their fear. Happily, most are in between.

All patients have legitimate needs, which must be taken care of, if possible. Most have a myriad of wishes, and most want these wishes gratified as soon as possible. Some want immediate gratification. Regardless of what patients think they should have, the hospital staff should be responsive to their actual needs, and staffs should try to accommodate as many reasonable desires as they can.

20. **Right to Refuse Treatment/Informed Consent:** Some patients will have religious beliefs which will not allow certain medical procedures. In addition, as mentioned earlier in this chapter, patients usually do not wish to be experimented upon. Every patient should have the right to refuse treatment he or she does not want. Prior to every medical procedure, the patient (or legal guardian) must give informed consent. This also has many exacting guidelines which must be followed in order to preserve the patient's rights.

21. **Safe Environment in the Hospital:** Safety in a hospital has many aspects. One is simply an environment where precautions have been taken to prevent further injury or illness, considering that the people inside may be unfamiliar with their surroundings, and often they will be physically incapacitated in some way, and therefore more susceptible to further injury.

Another form of safety is the absence of violence. Unfortunately, violence is everywhere and becoming more prevalent. Hospitals recently have become targets for several reasons.

22. **Short Waiting Times for Obtaining Treatment:** Patients have two opportunities to wait before obtaining treatment. The first is in acquiring an appointment through the hospital. The second is at the appointed time, in the waiting room. Unless the patient has an emergency, and must be seen immediately, most people realize that some delay is to be expected at both of those times. Even urgent care sometimes must be postponed for several hours. The shorter these waiting times are the more pleased patients will be.

23. **Treated with Respect/Consideration/Dignity:** Respect entails treating a patient in a manner that preserves self-esteem. This can include speech that uses the patient's preferred form of addressing, and lack of condescension when explaining medical terminology. Consideration requires that the hospital staff be mindful of the needs and feelings of the patient. Dignity refers to as gentle the treatment as

possible; the absence of rough handling. When normal privacy cannot be maintained, the procedure must be carried out with respect.

24. **Understanding/Compassion/Empathy:** Most patients are apprehensive about their experience in the hospital. Although an individual patient may be "just another case of ..." to the staff, to the patient he or she is special. This requires concern for the patient; an inclination to give support and aid. Patients want and need the staff to be able to identify with their fears and feelings. Patients who do not receive this may become more apprehensive about their hospital stay.

5. COMMUNITY

1. **Chronic Disease Care:** As people grow older, chronic disease problems often require more frequent care. Although individual patients may be treated for these troubles, often it can be beneficial to both hospital and people if care for chronic diseases is provided for many patients at a time. This can be done, among other health care services, in skilled nursing facilities, senior citizen centers, community colleges, or when necessary and cost effective, at home.

2. **Comprehensive Health Care:** People need some elements of health care throughout their lives. For many years, most American parents have planned to have their children born in a hospital setting rather than at home, although there can be an unplanned setting when a baby demands it is time to be born. At the end of life, most people die in a hospital or in a medically supervised environment. At every point between birth and death a hospital plays a large role in the health and well-being of the individual.

People, as a community, want their health and medical needs met promptly and completely. This means that trained personnel, supplies, and a facility should be available for almost any health or medical situation that might be needed. Usually this is only attainable through a hospital or a health care system.

3. **Cooperation with Medical, Nursing, and Allied Health Schools:** Students in the medical field need training on real patients, not only education through lectures, theory, and readings. Hospitals can do much in providing patients for interns and other health care training programs, although there must be strict supervision and patient protection. No one should treat a patient without having the proper credentials that indicate the person has the knowledge and the experience to warrant this work. By the administrator being the liaison between schools and patients, the

community benefits. Students have the opportunity to perform internships in the hospital prior to full time medical practice or other employment. Persons who otherwise may not be able to receive medical care will, by agreeing to be treated in a training setting.

4. **Cooperation with Other Health Facilities or Hospitals:** Although most hospitals are not-for-profit, they should be run as though they were for-profit. Usually hospitals are in competition with other hospitals in the same geographical location. Frequently this may not have beneficial results for the hospitals nor the community they serve. As an example, CAT Scans were popular years ago, and although any one hospital would only use it an average of 20% of the time, every hospital wanted one (usually because of the demand by physicians). This resulted in expensive idle time for the machines and the technicians who staffed the CAT Scans. Multiply this waste by all the hospitals in the area which had one, and that amounts to a large quantity of money and resources expended needlessly. Had the hospitals cooperated with each other, they could have worked out an arrangement whereby only one would actually buy the CAT technology, and the others would rent time on it.

Another way hospitals could cooperate with each other would be to specialize in different areas. For example, not every general hospital needs to have an intensive burn center. Each should be able to treat the more routine burn cases. Yet once a badly burnt patient has been stabilized, he or she can be transported to a regional burn center, where the specialists can repair and rehabilitate the patient.

5. **Cost Containment:** In the most recent 20 years, health care costs have escalated. This topic has caused numerous speeches and debates as to the causes. While there are many reasons, one thing is for certain: rising costs must cease, or the entire health care system in America may collapse.

6. **Ease of Getting Health Information:** Informed health care consumers want to have medical information available to them. In order to be useful, the information should be easily obtainable and in a readable and concise format. Consumers often do not wish to research medical texts, because of the difficulty in understanding the terminology.

7. **Education of Disease Prevention and Health Matters:** Information brochures are one thing. Education of disease prevention and other health matters is another. Often these topics are put in seminar form, and publicized through the media.

The community wants this education and hospitals are in ideal locations, and with the knowledge, to provide it. If fewer resources are spent early in averting easily preventable diseases, more resources will be available to combat those diseases for which medical technology currently has no treatment. This form of education could allow for redistribution of the health care resources. Forward-thinking administrators will do what they can to help this admirable endeavor.

8. **Equality of Access:** Each person in the community must have the same opportunity to request health services from the hospital.

9. **Equitable Distribution of Health Care Services:** This item refers to the idea that each person should receive an equal portion of the health care services. However, people have different health care needs throughout their lives. Some need very little, others require medical and health services more often. For more practical purposes, equitable distribution means that any needed health service request should be provided within a reasonable time frame.

10. **Health Education Programs/Workshops/Health Fairs:** These types of activities are much greater in depth than educational brochures. Health education programs can be on-going seminars on varied topics such as smoking cessation, the benefits of exercise, weight loss, and a plethora of others. Workshops may include the same topics, but more emphasis is placed on actual participation. Health fairs are usually day-long events covering many of the individual programs. Participants are free to listen to any topic of interest. Often there will be mass screening of easily detected diseases, and routine tests such as vision and hearing will be performed.

11. **Home Care:** Many times a person requires some medical treatment, yet not enough to warrant being in the hospital. Home health care is often an ideal choice. Once out of the more intensive care portion of their hospital stay, where nursing care is needed several times a day, many people can recuperate more fully and faster when in the familiar surroundings of their own homes.

An administrator who institutes a home health care program provides several benefits. The hospital will gain by the financial profit from this ancillary business. Patients often will be pleased at being able to continue to receive care in their homes. The resulting good will is often immeasurable in cost.

12. **Hospice Availability:** Patients who have a terminal disease reach a point when medicine is no longer able to provide any curative treatment, and palliative treatment is the last option. Receiving care in an expensive hospital is not the optimum location for these patients. A hospice is an idea, not a facility. The concept of a hospice is to provide the patient with the knowledge and tools to maintain his or her life with as much dignity and as pain free as possible. The goal is to allow the patient with a terminal illness to end life at home.

13. **Nursing Homes as Extensions of Hospitals/Long Term Care:** As with hospices, often recuperation may be done in a health care facility much less expensive (on a daily basis) than a hospital. Often a nursing home is the desired place for treatment. Many people may require minimal daily care, yet they need this care over a long period of time. Hospitals may integrate vertically and incorporate skilled nursing facilities under their umbrellas as an extension of their own hospital. In this manner they will maintain continuity over the patient's treatment.

As Americans are living longer, and yet not nearly as often with family members, long term care has become an issue of concern. People that probably would have died because of diseases that are now curable are able to live longer, yet they are often unable to take care of themselves. They need someplace to live. Nursing homes, or skilled nursing facilities (SNFs) are the most logical alternatives.

14. **Research On and Prevention of Diseases:** Disease will always be with humanity. Much research can be done on many aspects of diseases - from earlier detection, more effective treatments, better rehabilitation from the after effects, and cures, if possible, when preventative measures did not work.

15. **Patient Education:** When an individual patient has a medical problem, he or she should be educated about it. Hospitals are finding that as patients know more about their disease or condition their anxiety level decreases, and their ability to survive increases.

16. **Patient Information:** When someone is admitted to a hospital, many people may want to know the patient's status. Yet the patient's privacy is also important. Guidelines must be drawn so as to ensure the privacy of the patient, yet provide information to the degree possible to those requesting such information. This item does not refer to such mandated required patient data, which must be submitted to authorized organizations and agencies.

17. **Positive Relations with the Local Media:** Because of the nature of hospitals, too often they receive unwarranted bad publicity. To avert this unfavorable coverage, hospitals should have a public relations department to provide information on all the good things the hospital does for the community. The hospital spokesperson must consistently provide truthful information to the media regarding any occurrence with the hospital.

18. **Public Service Announcements:** Most hospitals provide ancillary programs not directly tied to patient care. These include, among others, disease education, workshops, and health fairs. Information regarding these activities need to be disseminated through the community. Often the local media will provide this information through public service announcements. The only stipulation is that, although a fee may be charged, no profit will be generated by the activity.

19. **Screenings for Diseases such as HIV/AIDS:** Communicable diseases can be a scourge for any community. A hospital that provides confidential screenings for any type of disease will be doing the community a great service. Disease screenings are less expensive when done on a large scale, for all the equipment and supplies can be assembled in one location. Supporters claim that the number of people who are discovered with the disease have the benefit of earlier detection than if they had waited until the symptoms appeared. Early detection avoids the cost that would have been spent in treating one person than the cost of screening all those that did not have it.

20. **Vaccines/Immunizations:** The survival rate for children used to be much lower than what it is now. In large part this is due to vaccines and immunizations against many childhood diseases. The low cost per capita is small when compared to the cost of treating just one child who contracts the disease, not to mention the misery associated with the child's death, if that were to occur.

Three reasons for vaccinating children: 1) Full immunity from eight childhood diseases, including the four most common: diphtheria, measles, polio, and tetanus. 2) Less chance of death from an infectious disease. 3) Immunizations unleash disease-fighting antibodies in a child, which can "recognize and destroy microorganisms that otherwise could viciously attack"[22] a child.

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[22] ________, "Deadly childhood diseases resurge," Sacramento Bee, Healthscene, Spring 1992, p 5.

6. THIRD-PARTY PAYERS

1. **Control Payments to Providers:** Third-Party Payers would like to be in command of when and for what they reimburse providers for the care rendered. They also wish to determine if the treatment was authorized and deemed necessary according to their own auditors and/or policies. Providers, however, do not want to be under such scrutiny and they want reimbursement at the time of treatment, or very soon thereafter. Somewhere between the two wants will probably be a compromise.

2. **Controls on Price Increases/Rate Setting:** Third-Party Payers want controls on price increases. They also want to be part of the process that guides rate settings. Numerous studies have shown that the cost assigned to the same procedure varies widely among hospitals, even in the same city. It seems to depend on exactly what charges get listed for that particular procedure. Some hospitals "bundle" every small portion or function into one bill, and others charge for such items separately, called "unbundling."

3. **Efficient Allocation of Resources:** There are always finite resources in any endeavor. Wastage should always be kept to a minimum. Administrators have the responsibility to ensure that resources are not expended frivolously. This can be done in several ways, perhaps by establishing a tracking system to monitor consumption, in which case anytime consumption deviates from the norm, that item is questioned.

4. **Elimination of Unneeded Care:** The fee-for-service system used by physicians for hundreds of years has worked well in one respect; that is, if a patient was willing to pay the physician's price, treatment was rendered, unless the care was given under charity. That system has changed for most Americans. Only a small proportion of people are now self-payers. Some persons contend that a sizable number of medical care providers are dispensing care that is not needed, because, among other reasons, the Third-Party Payers will pay. And if the reimbursement rate gives a profit to the provider, it is in his or her best fiscal interest to generate as much care as possible, regardless of the necessity. New approaches to quality of care and care review should diminish the unnecessary care given in the future. Currently most hospitals have review committees that serve this function. Other review mechanisms may be designed and implemented for the future.

5. **Equitable Contracts for All Third-Party Payers:** Although the rates may not be the same for all Third-

Party Payers, the administrator has a responsibility to be fair to all. In other words, the distinctions between contracts should be based on fair negotiations.

6. **Focus on Managed Care:** Historically, when people felt the need for a physician they called their family doctor, who then decided if he could treat the patient at home or arrange admittance to a hospital. When many physicians became specialists, some people began to bypass the general practitioner began referring themselves to the specialists. This was usually inefficient on all parts, and especially wasteful of the specialist physicians' expertise, since it assumes that the patient has the knowledge to determine when the services of the specialist are needed. Managed care eliminates the self-referral by establishing the family physician as the "gatekeeper." The family physician then uses his or her knowledge to determine when the patient needs to be referred to a specialist. This method reduces duplication, and the care is managed more smoothly.

Third-Party Payers want managed care because it provides the most efficient use of their financial resources. If a General Practitioner's office visit for seeing a patient with a sore throat costs $50, which includes a throat culture, and a visit to an Otolaryngologist would cost $150 for the same examination and culture, it makes much more sense to control costs with keeping the patient with a General Practitioner. Although many people believe that more expensive is better, with medical care that is most often not the case. In almost all cases, a person with a headache does not need brain surgery, merely a pain-reliever.

7. **Limitations on Benefits:** A health insurance company can only remain in business as long as its revenues, in the form of premiums, are greater than its expenditures. One of the ways this can be accomplished is by establishing a limit to any one individual patient's benefits. Most people who have health care insurance do not use the maximum allowed in benefits. However, the few persons who have high-cost diseases can offset the many who do not. Two main ways exist to place a cap on the disbursements: (1) a limit on the amount of expenditures per year, and (2) a limit per medical problem. Unfortunately, these limits may be at odds with the patients' wishes. Physicians also are not pleased at the caps. Generally, physicians will do whatever it takes to effect a cure, or, if incurable, to mitigate the symptoms, regardless of the cost. If the insurance ceiling has been reached, the patient is unable to pay, and yet treatment has been rendered, some form of cost-shifting may occur, which may pose

other problems, or the cost may be absorbed by the hospital.

8. **Negotiated Contracts:** Starting with Medicare, the federal government paid the rate charged by hospitals and physicians. When the number of Third-Party Payers was growing, they also paid the going rate. Then the charges began to escalate, and after some time the Third-Party Payers realized they could no longer afford to pay increases of up to twenty percent a year charged by hospitals. Thus, negotiation of rates began.

The largest problem is caused by a term called "bundling." Some accounting systems break out every single item involved in a procedure or treatment, and then consequently bill for each item. Other systems have one charge for a given treatment or procedure, and bill for that one, plus any incidentals not normally included. The latter is termed "bundling," and the former is called "unbundling." Third-Party Payers want to know exactly what it is they are paying for, so they prefer the unbundled bills. Yet that creates a nightmare during negotiations. The representative for the insurance company will want to negotiate for every single type of item, producing havoc with the billing system, because hospitals have many Third-Party Payer accounts. And if every one of them negotiated a different price for each item, the variety of procedures necessary for the provider to bill for services increases dramatically.

9. **Physician Delivery Systems:** Often physicians with the same specialty will come together and form a group practice. This way they may share support services, and in general keep their operating costs down. This simplifies their billing to various Third-Party payers, because the bills are done as a group. In addition, they may cover for each other when one is unavailable for his or her patients. The hospital administrator is constantly involved in negotiating with the many physician groups and systems either as part of a health care system or in rate-setting with a group offering coverage.

10. **Power to Define Quality Care:** Prior to the advent of Third-Party Payers, most physicians had the autonomy to provide the medical care they deemed appropriate for their patients' ills. This could include referrals to specialists as well as limit treatment for needs deemed to be less important. In an effort to ensure uniform, preferably high quality care to all patients, Third-Party Payers began to standardize treatments for diseases and other medical problems.

Patients want high quality of care and physicians want to give it. Third-Party Payers accept the fact

that if the care given to their insured is of high quality, it may cost a bit more at the time. Yet in the longer run it may help prevent higher costs in the future. Somewhere in between casual and excessive treatment is an optimum level of medical and nursing care. The trouble is, everyone involved has a different idea of where the optimum level is. Third-Party Payers, since they are paying the bills, want to define that level for their constituents.

11. **Protection Against Over-Utilization:** As long as people have unlimited wants, and someone else is paying for it, most people will want every medical problem they have taken care of, and preferably by a specialist. On the one hand, Third-Party Payers know that if they pay for small problems before they escalate into major, more expensive problems, money ultimately will be saved. On the other hand, many small problems will clear up by themselves without medical intervention. Third-Party Payers should not be expected to pay for every splinter, scrape, and scratch. There needs to be a watchdog to prevent abuse of scarce funding resources. Hospital administrators cannot be held responsible for what patients do in physicians' offices. But they can and should be held accountable for what transpires within their hospitals.

12. **Reasonable Cost Reimbursement:** Third-Party Payers are in business to make a profit. Yet their business is to pay for the medical care provided to their policy holders. The best way for both of those goals to be realized is for the charges to the payers be reasonable for the services rendered. This means that fees be within accepted standards for the service in the same locality and within the scope of actuarial charge for the premiums collected.

13. **Reduction of Duplication of Services:** For several reasons, during one course of treatment, many medical procedures are performed, and some that might not be quite necessary. Those may or may not be disputed. Yet duplication of services is a waste that could and probably should be eliminated. For example, if a patient is preparing to be admitted to a hospital, and needs to have several X-Rays taken, they do not need to be taken at both the physician's office and in the hospital, then charged to the Third-Party Payer twice. X-Rays taken at one place would be sufficient.

14. **Quality Care:** As in the item - Power to Define Quality Care, Third-Party Payers want their constituents to receive high quality care, because poor quality will be detrimental to the patient as well as cost more in the long run. The difficulty lies in

defining high quality. Patients, medical personnel, and other agencies all may have different definitions. Hospital administrators have the responsibility to everyone involved, including the Third-Party Payers, to ensure their medical personnel furnish the highest quality possible when they provide medical care.

15. **Willingness to Negotiate Contracts:** Everything in the medical field changes. Procedures that used to be complicated can become simpler, and sometimes less expensive. Yet other procedures that were once considered too risky for certain categories of patients can now be done, albeit at an increased cost, and often complications arise. These conditions require that prices be negotiated periodically so that the hospital is adequately compensated, yet at the same time the Third-Party Payer must not overpay for services. The administrator needs to be willing to negotiate contracts at agreed upon intervals to ensure both parties are satisfied that they are receiving a proper value.

Appendix E: Structured Interviews

Appendix E consists of the Structured Interview Data Collection Instruments.

The first document is the letter sent to twenty-two health care experts in the San Francisco Bay area, who have some connection to Golden Gate University.

The second document is a Dissertation Overview.

The third document is the Appointment Confirmation Letter that was sent to the eighteen persons who agreed to be interviewed.

The fourth through the sixth documents are the Structured Interview Guide. It consists of a cover page, a two-page Top Fourth of the Items from the Questionnaire to be Ranked, and a one-page list of Discussion Questions. The interviewee was free to chose any or all of the questions to discuss.

The seventh document is the cover letter that accompanied a draft of the person's comments for their review, for comments or clarification.

The eighth document is the "Thank You" letter that accompanied a twenty-six-page summary of all the comments from those interviewed.

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

January 23, 1992

Health Care Expert
Address

Dear Expert:

Robert L. Goldman, Ph.D., Chair, Health Services Management of Golden Gate University in San Francisco, suggested I contact you because of your expertise in the health care field and your association with the school. I am a doctoral candidate attending Golden Gate University. For my dissertation I am studying the changing responsibilities of hospital administrators in response to the needs and wants of constituent groups. Enclosed is a short study overview.

My dissertation is divided into three time periods: "Yesterday," "Today," and "Tomorrow." "Yesterday's" data came from the literature. "Today's" data came from mailed questionnaires to the administrators of 100 hospitals in California. For "Tomorrow," I wish to interview persons knowledgeable about where hospitals are headed for the next twenty years. The interviews should not take more than one-half an hour.

I am still at the planning stage of my Structured Interview Guide. If you agree to be interviewed, I will send you an advance copy of my questions. I anticipate conducting the interviews in late February or early March. I will call your office the first week of February to arrange an appointment at your convenience.

Sincerely,

Andrea M. Scheffelin

DISSERTATION OVERVIEW

The Hospital Administrator: Yesterday, Today, and Tomorrow

Background and Purpose of Study: A hospital administrator's job has never been easy, and in today's health care environment it is tougher than ever. Hospital administrators have always had many responsibilities to a wide spectrum of constituent groups: Patients, Board of Trustees, Medical Staff, Other Staff, Third-Party Payers, and the Community.

More importantly, the needs and wants of these groups today may not be what is most important to the individuals in the future. In addition, the groups may continue to have conflicting needs and wants. The purpose of this study is to examine the changing spectrum of responsibilities of hospital administrators over three time periods.

The research questions to be addressed are:

(1) How have hospital administrators' responsibilities to constituent groups changed since pre-1983, and how are such responsibilities expected to change in the near future?

(2) What are some of the conclusions to be drawn from such changes?

(3) What recommendations can be made to schools of public health, public health agencies, and interested individuals in response to the anticipated changes?

Data Sources: Past responsibilities ("Yesterday") were gleaned from the literature. Current responsibilities ("Today") were gathered from the responses to questionnaires mailed to the administrators of 100 California hospitals. Anticipated future responsibilities ("Tomorrow") will be garnered from structured interviews of practicing administrators or others knowledgeable of the health care field in California.

Data Analysis and Interpretation: Comparisons between past, current, and future responsibilities will be made, conclusions drawn, and recommendations made.

Use of the Results: The goal of this dissertation is to help in the education and training of future hospital administrators, as well as clarify the responsibilities of those currently in the field.

Andrea M. Scheffelin (916) 485-8196
3015 Root Avenue Carmichael, CA 95608

January 23, 1992

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

March 12, 1992

Health Care Expert
Address

Dear Expert:

Thank you for agreeing to meet with me as part of the final research for my dissertation from Golden Gate University. Our appointment is scheduled for (March date) If you need to reschedule, please call me at (916) 485-8196.

For your convenience I have enclosed a Structured Interview Guide, which consists of two parts.

Part I: A list of the importance of needs and wants for the future for six constituent groups.

Part II: A list of discussion questions from which you may choose your areas of interest.

When my dissertation is completed, I will send you a copy of the executive summary. I am looking forward to our meeting.

Sincerely,

Andrea M. Scheffelin

Enc: Structured Interview Guide

STRUCTURED INTERVIEW GUIDE

for Health Care Expert

on March (Date)

Doctoral Dissertation
Golden Gate University

The Hospital Administrator: Yesterday, Today, and Tomorrow

An Analysis of the Changing Responsibilities
of the Hospital Administrator in Response to
the Needs and Wants of Constituent Groups

Part I: Importance of Needs and Wants for the Future

Prior to our appointment, I would appreciate your completing the attached two-page list of needs and wants of six constituent groups (Board of Trustees/Directors, Medical Staff, Patient, Third-Party Payers, Other Staff, and Community). Current needs and wants were gathered from the responses to mailed questionnaires to the administrators of 100 hospitals in California. The administrators ranked those needs and wants which they feel are the most important today. I am asking you to tell me if you think these items will be more important, less important, or of the same importance in the future. We can then discuss your responses.

Part II: Discussion Questions

Although my dissertation topic is the responsibilities of hospital administrators to constituent groups, I am also interested in gaining knowledge on the issues of health care for the future. Attached is a list of questions. Please choose those that you are interested in discussing for the remainder of our time.

Thank you. Your time is greatly appreciated.

Andrea M. Scheffelin (916) 485-8196
3015 Root Avenue Carmichael, CA 95608

March 12, 1992

PART I: IMPORTANCE OF NEEDS AND WANTS IN THE FUTURE Page 2

Instructions: Please place an "X" in the block that corresponds to how you feel the future importance of the specific need or want will be to the particular group, as compared to today.

Board of Trustees/Directors: (Usually composed of physicians, business leaders of the community, and consumer members.)

Future importance of needs and wants:	Less	Same	More
1. Trust as an administrator			
2. Quality care			
3. Understanding of hospital's goals			
4. Maintenance of financial solvency			
5. Accountability from physicians and management			

Medical Staff: (All physicians who currently have privileges at the health care facility, its ancillary services locations, or clinics.)

Future importance of needs and wants:	Less	Same	More
1. High quality of patient care			
2. Cooperation and trust from hospital administrator			
3. Highly skilled nurses/other staff			
4. Good reputation of hospital			
5. High quality of other physicians on staff			
6. Good communication			

Patient: (A person who is or has been under some type of medical care or treatment, either in the health care facility or as an outpatient referral by a physician.)

Future importance of needs and wants:	Less	Same	More
1. Competent medical personnel			
2. Responsive to patient's needs			
3. Treated with respect			
4. Safe environment in the hospital			
5. Protection from medication errors			
6. Understanding/compassion			
7. Emergency room availability			
8. Protection from infectious diseases			
9. Confidentiality			

Third-Party Payers: (Private health care plans such as Blue Cross, or the Foundation Health Plan, and government programs such Medicare, Medi-Cal, CHAMPUS, medically indigent, and other publicly-funded programs.)

Future importance of needs and wants:	Less	Same	More
1. Quality care			
2. Willingness to negotiate contracts			
3. Reasonable cost reimbursement			
4. Efficient allocation of resources			
5. Protection against over-utilization			
6. Elimination of unneeded care			

Other Staff: (All non-physician persons employed or volunteers utilized by the health care facility.)

Future importance of needs and wants:	Less	Same	More
1. Trust as an administrator			
2. Good communication			
3. Fair performance appraisals			
4. Good supervision			
5. Job satisfaction			
6. Appropriate salary ranges			
7. Good working conditions			
8. Protection from infectious diseases			

Volunteers:			
1. Recognition			
2. Good supervision			
3. Orientation			
4. Training			

Community: (The community is composed of many inter-related and overlapping groups. Some examples are: minority/ethnic groups, the media, researchers, service groups such as Rotary, Lions, Kiwanis, City Councils and County Boards, planning commissions, other organizations, businesses, and individuals.)

Future importance of needs and wants:	Less	Same	More
1. Cost containment			
2. Equality of access			
3. Comprehensive health care			
4. Patient information			
5. Positive relations with the local media			

Signature: ______________________

PART II: LIST OF DISCUSSION QUESTIONS

Please choose those questions that you are interested in discussing.

1a. What do you see as the one or two major health care issues beginning with Year 2000?

b. How will these issues impact your organization?

2a. What do you see as the major changes that may occur?

b. How will your organization adjust to the changes?

c. What current plans does your organization have to prepare for the foreseen changes?

3. Which scenario is more likely? More emphasis on prevention of health problems and diseases or expensive equipment and high tech cures?

4. Is it reasonable to enforce healthy life-styles for employees in order to gain lower health insurance premiums for the employers?

5. What is your opinion of the Harvard resource-based relative value system (RBRVS) on payment to physicians?

6. Where does the consumer's desire to have information regarding a physician's or hospital's Patient Outcomes Record stop in favor of the physician's or hospital's desire for privacy?

7. Should health care insurance companies be able to engage in selective enrollment or refuse to enroll high risk patients?

8. Will health care rationing become more obvious?

9. By the year 2000, will "coordinated care" cover at least 75 percent of Americans who have health care insurance?

10. What, in your view, is the future of private health insurance in the United States?

11. Is the traditional three-legged stool (Hospital Administrator, Board of Trustees, and Medical Staff) becoming obsolete? If so, what will replace it?

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

April 13, 1992

Health Care Expert
Address

Dear Expert:

Last month you graciously gave me your time while providing knowledge of the health care field for my dissertation for a Ph.D. though Golden Gate University.

My aim is to prepare a succinct summary of the points you made about the discussion questions on the future issues of health care. The enclosed draft is what I prepared from the notes I took during our interview. I want to ensure I have an accurate reflection of your views. Please look this draft over. I will call your office on April 21 or 22 to receive any comments or clarifications you may wish to give.

After an analysis of the information from all 18 interviewees has been completed, I intend to send you a summary of the responses to the discussion questions as well as the final version of your specific comments.

Sincerely,

Andrea M. Scheffelin

Enc: Draft Summary of Interview

Andrea M. Scheffelin, MBA
3015 Root Avenue
Carmichael, CA 95608
(916) 485-8196

May 20, 1992

Health Care Expert
Address

Dear Expert:

A few weeks ago I sent you a draft of your comments from our meeting in late March. After I contacted everyone to ensure the accuracy of my notes, I summarized the responses to each discussion question. Enclosed for your information is a copy of the summary. I believe you will find it interesting, particularly those discussion questions where there were diverse opinions.

Thank you again for the original interview and additionally for your time in reviewing my draft of your comments.

As I indicated in a previous letter, when my dissertation is finalized, I will send you a copy of the executive summary.

Sincerely,

Andrea M. Scheffelin

Enc: Summary of Responses to Discussion Questions

Appendix F: California Hospital Characteristics

A plan was designed to yield profiles of all California hospitals from which a sample of one hundred hospitals could be drawn. The information on the characteristics of the hospitals was gathered from the 1991 Annual Survey of the American Hospital Association Guide to the Health Care Field, augmented by information from the California State Office of Statewide Health Planning and Development. The characteristics of interest to this study were as follows: for-profit or not-for-profit status, geographic location within California, size (number of beds), membership in a health care system, and the category within the United States classification coding system.

All the characteristics were assigned numbers specifically for this study for computer coding, except for the codes for the United States Classification Codes, which were left as given in the 1991 Guide.

DESCRIPTION OF CHARACTERISTICS

a. Profit vs Not-for-Profit

Although almost all organizations have budgets, and must balance expenditures with income, most hospitals are classified as "not-for-profit." For the purpose of this dissertation, every hospital was either classified as for-profit or not-for-profit.

The computer code for these two choices were:

Profit Status

1 = Not for Profit
2 = For profit

b. Geographic Location within California

All of the sampled hospitals were located in one of six areas in California. They are: the Central Valley, the San Francisco Bay area, the Los Angeles area, the Desert, and the San Diego area. These locations encompassed all of California with the exception of the large rural area north of Sacramento, the rural desert east of Los Angeles and San Diego, and the mountainous area east of the Central Valley. These areas were coded under "Other." The computer code for these six choices were:

Location

1 = Central Valley
2 = San Francisco Area
3 = Los Angeles Area
4 = Desert
5 = San Diego Area
* = Other

c. Size by Number of Beds

The size of a hospital can be determined in several ways. For the purpose of this dissertation, the criterion to be used for size was decided to be the number of beds. Although most of the sample was from the larger hospitals in California, all possible sizes

were included. The divisions and computer code for these five choices were:

<u>Size</u>

1 =   1 - 199 beds
2 = 200 - 299 beds
3 = 300 - 399 beds
4 = 400 - 499 beds
5 = 500 or more beds

d. <u>Health Care System Membership</u>

Many hospitals and health care facilities have been merged or bought by a larger organization, forming larger health care systems. Although the American Hospital Association classifies health care systems under several types of systems, for the purpose of this dissertation, every hospital was classified either as part of a health care system or not. The computer code for these two choices were:

<u>Health Care System Membership</u>

1 = Not part of a health care system
2 = Part of a health care system

e. United States Classification Codes

The American Hospital Association classifies hospitals under four headings as shown below.

Investor-Owned (For-Profit)

32 = Partnership
33 = Corporation

Nongovernment, (Not-for-Profit)

21 = Church
23 = Other

Government, Non-Federal

12 = State
13 = County
14 = City
15 = City-County
16 = Hospital District

Government, Federal

41 = Air Force
42 = Army
43 = Navy
45 = Veterans Administration
47 = Public Health Service - Indian
48 = Dept of Justice

The sampled hospitals fell into seven of these classifications: 12, 13, 15, 16, 21, 23, and 33.

2. Tables Profiling California Hospital Characteristics

The following five multi-page tables portray the characteristics of the hospitals in California in the following groups:

a. Table 21: Selected Characteristics of Sampled General Hospitals in California Whose Administrators Responded to the Questionnaire

b. Table 22: Selected Characteristics of Sampled General Hospitals in California Whose Administrators Did Not Respond to the Questionnaire

c. Table 23: Selected Characteristics of Non-Sampled General Hospitals in California

d. Table 24: Summary of Selected Characteristics of All General Hospitals in California

e. Table 25: Summary of Selected Characteristics of Sampled General Hospitals in California

The format of each table is similar, with six columns: Hospital Name; Profit Status; Size; Location; and Classification. The Code Legend is displayed only on the last page of each set of tables. After each set, a description is provided to aid the reader in interpreting the data.

Within each category, the number and percentage of hospitals falling into each code are listed in rank order. Within the Code Legend, only Table 23 contains a "*" under the categories Location and Classification. No sampled hospitals fell under these categories.

TABLE 21

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in
California Whose Administrators Responded to the Questionnaire

Hospital Name	Profit Status		Size					Location					HC System		Classification						
(N = 54)	1	2	1	2	3	4	5	1	2	3	4	5	1	2	12	13	15	16	21	23	33
Cedars Sinai	1						5			3			1							23	
Martin Luther	1				3					3				2		13					
Calif Pacific	1				3				2				1							23	
San Francisco Gen	1					4			2				1				15				
White Memorial	1				3					3				2					21		
Brookside	1		1						2				1					16			
Daniel Freeman 1st	1				3					3				2					21		
Daniel Freeman 2nd	1				3					3				2					21		
Garfield MC		2		2						3				2							33
UCLA MC	1						5			3				2						23	
Highland Gen	1			2					2					2		13					
Longbeach MC	1						5			3			1							23	
Riverside Univ MC	1			2							4		1			13					
Brotman		2			3					3				2							33
Davies MC	1		1						2				1							23	
El Camino	1				3				2				1					16			
Glendale Advent	1					4				3				2					21		
Grossmont	1					4						5	1					16			
UC San Diego	1					4						5		2	12						

Source: American Hospital Association Guide to the Health Care Field,
1991 Annual Survey, 1992, Chicago, Illinois

Table 21 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in
California Whose Administrators Responded to the Questionnaire

Hospital Name	Profit Status		Size					Location					HC System		Classification						
(N = 54)	1	2	1	2	3	4	5	1	2	3	4	5	1	2	12	13	15	16	21	23	33
San Bernardino MC	1			2							4		1			13					
Valley - Fresno	1				3			1					1			13					
Beverly	1			2						3			1							23	
Fresno Community	1					4		1						2						23	
Glendale Memorial	1				3					3			1							23	
Humana West		2	1							3				2							33
Queen of Angels	1				3					3			1							23	
San Antonio	1				3						4		1							23	
Santa Monica	1			2						3				2						23	
Seton MC	1			2					2					2					21		
St Johns	1			2						3				2					21		
Riverside Com	1				3						4		1							23	
San Bernardino Com	1				3						4		1							23	
Huntington Memorial	1						5			3			1							23	
Marin General	1			2					2				1							23	
Methodist	1				3					3			1							23	
O'Connor	1				3				2					2					21		
Pomona Valley	1				3					3			1							23	
Intercommunity	1			2						3			1							23	

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

Page 2 of 4

Table 21 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in
California Whose Administrators Responded to the Questionnaire

Hospital Name	Profit Status		Size					Location					HC System		Classification						
(N = 54)	1	2	1	2	3	4	5	1	2	3	4	5	1	2	12	13	15	16	21	23	33
Mercy Gen	1				3			1						2					21		
N.T. Enloe	1			2				1					1							23	
Palomar	1				3							5		2				16			
Samuel Merritt	1			2					2					2						23	
San Joaquin	1			2				1					1			13					
Sequoia	1			2					2				1					16			
St Bernardine	1				3						4			2					21		
St Joseph	1					4				3				2					21		
St Joseph's	1			2				1						2					21		
St Mary	1					4				3				2					21		
Good Samaritan	1				3					3			1							23	
Washington	1			2					2				1					16			
St Luke's	1			2					2					2						23	
Western - Anaheim	1			2						3				2						23	
Alameda	1		1						2					2						23	
Alvarado		2		2								5		2							33
Totals:	50	4	19	20	7	4	6	14	24	6	4		27	1	6	1	6	12	24	4	

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

Page 3 of 4

Table 21 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in California Whose Administrators Responded to the Questionnaire

CODE LEGEND

Profit Status	Size (# of Beds)	Location	Classification
1 = Not-for-Profit	1 = 1-199	1 = Central Valley	12 = State
2 = For Profit	2 = 200-299	2 = San Francisco Area	13 = County
	3 = 300-399	3 = Los Angeles Area	15 = City-County
	4 = 400-499	4 = Desert	16 = Hospital District
	5 = 500 Plus	5 = San Diego Area	21 = Church
			23 = Other Non Profit
			33 = Corporation

Health Care System

1 = Not Part of a Health Care System
2 = Part of a Health Care System

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

The following information will assist in interpreting the data furnished by Table 21 (Selected Characteristics of Sampled General Hospitals in California Whose Administrators Responded to the Questionnaire).

Profit Status: Of the fifty-four hospitals whose administrators responded to the questionnaire, 50 (93%) were operated on a not-for-profit basis, and 4 (7%) were operated on a for profit basis.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 393 (71%) were operated on a not-for-profit basis, and 161 (29%) were operated on a for profit basis.

Size: Of the fifty-four hospitals whose administrators responded to the questionnaire, 4 (7%) were in the size range of 1 to 199 beds, 19 (35%) were in the size range of 200 to 299 beds, 20 (37%) were in the size range of 300 to 399 beds, 7 (13%) were in the size range of 400 to 499 beds, and 4 (7%) had 500 or more beds.

These numbers and percentages can be compared to all 554 general hospitals in California as such:
388 (70%) were in the size range of 1 to 199 beds,
77 (14%) were in the size range of 200 to 299 beds,
46 (8%) were in the size range of 300 to 399 beds,
18 (3%) were in the size range of 400 to 499 beds, and
25 (5%) had 500 or more beds.

Location: Of the fifty-four hospitals whose administrators responded to the questionnaire, 6 (11%) were located in the Central Valley, 14 (26%) were located in the San Francisco Area, 24 (44%) were located in the Los Angeles Area, 6 (11%) were located in the Desert, and 4 (7%) were located in the San Diego Area.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 98 (18%) were located in the Central Valley, 73 (13%) were located in the San Francisco Area, 203 (37%) were located in the Los Angeles Area, 37 (7%) were located in the Desert, 38 (7%) were located in the San Diego Area, and 105 (19%) were located in some other area of California.

Health Care System Membership: Of the fifty-four hospitals whose administrators responded to the questionnaire, 27 (50%) were not members of health care systems, and 27 (50%) were members of health care systems.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 252 (45%) were not members of health care systems, and 302 (55%) were members of health care systems.

Classification: Of the fifty-four hospitals whose administrators responded to the questionnaire, 1 (2%) was operated by the State, 6 (11%) were operated by a

county, 1 (2%) was operated by a city-county, 6 (11%) were operated by a Hospital District, 12 (22%) were operated by a church, 24 (44%) were operated by another non-government, not-for-profit entity, and 4 (7%) were operated by a corporation.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 16 (3%) were operated by the State, 32 (6%) were operated by a county, 2 (less than 1%) were operated by a city-county, 2 (less than 1%) were operated by a city, 54 (10%) were operated by a Hospital District, 30 (5%) were operated by the federal government, 58 (10%) were operated by a church, 199 (36%) were operated by another non-government, not-for-profit entity, 147 (27%) were operated by a corporation, and 14 (3%) were operated by a partnership.

TABLE 22

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in California
Whose Administrators Did Not Respond to the Questionnaire

Hospital Name	Profit Status		Size					Location					HC System		Classification						
(N = 47)	1	2	1	2	3	4	5	1	2	3	4	5	1	2	12	13	15	16	21	23	33
Stanford	1					4			2				1							23	
UC Davis	1					4		1						2	12						
Centinella	1				3					3			1							23	
Doctors MC		2			3			1						2							33
Eden	1			2					2				1					16			
Good Samaritan	1					4			2					2						23	
Loma Linda	1						5			3				2					21		
UC Clinics	1						5		2					2						23	
Santa Clara Valley	1						5		2				1			13					
Beverly Hills		2		2						3			1								33
Calif Pacific	1			2					2				1							23	
USC MC	1						5			3				2		13					
UC Irvine	1				3					3				2						23	
UCLA - Harbor	1						5			3				2		13					
Mt Zion	1			2					2					2	12						
Calif MC	1				3					3				2						23	
S Buenaventura	1		1							3			1							23	
Desert	1				3						4		1							23	
Donald Sharp	1					4						5		2						23	

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

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Table 22 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in California
Whose Administrators Did Not Respond to the Questionnaire

Hospital Name	Profit Status		Size					Location					HC System		Classification						
(N = 47)	1	2	1	2	3	4	5	1	2	3	4	5	1	2	12	13	15	16	21	23	33
San Jose MC	1			2					2					2						23	
St Francis	1					4				3				2					21		
San Pedro Pen	1		1							3			1							23	
Scripps La Jolla	1					4						5		2						23	
St Agnes MC	1				3			1						2					21		
St Francis Memorial H	1			2					2				1							23	
St Joseph - Orange	1				3					3				2					21		
Little Co Mary	1			2						3				2						23	
Mt Diablo	1			2					2				1					16			
Long Beach Community H	1			2						3				2						23	
Midway		2		2						3				2							33
Presbyterian	1			2						3			1							23	
Kern MC	1			2				1					1			13					
Los Robles		2		2						3				2							33
Mercy-San Diego	1					4						5		2					21		
Mills Peninsula	1					4			2				1							23	
Northridge	1				3					3				2						23	
Providence	1			2					2					2					21		
S B Cottage	1				3					3			1							23	

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

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Table 22 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in California
Whose Administrators Did Not Respond to the Questionnaire

Hospital Name	Profit Status		Size					Location					HC System		Classification						
(N = 47)	1	2	1	2	3	4	5	1	2	3	4	5	1	2	12	13	15	16	21	23	33
St John's	1						5			3				2					21		
St Jude's	1			2						3				2						23	
St Vincent	1				3					3				2					21		
Torrance	1				3					3			1							23	
Western MC	1			2						3				2						23	
Sutter Memorial	1			2				1						2						23	
Valley Presby	1				3					3			1							23	
Alexian Brothers	1		1						2					2					21		
Alhambra Community	1		1							3			1							23	
Totals:	43	4	17	12	8	6	5	13	25	1	3		18	29	2	4	0	2	9	26	4

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

Table 22 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Sampled General Hospitals in California
Whose Administrators Did Not Respond to the Questionnaire

CODE LEGEND

Profit Status	Size (# of Beds)	Location	Classification
1 = Not-for-Profit	1 = 1-199	1 = Central Valley	12 = State
2 = For Profit	2 = 200-299	2 = San Francisco Area	13 = County
	3 = 300-399	3 = Los Angeles Area	15 = City-County
	4 = 400-499	4 = Desert	16 = Hospital District
	5 = 500 Plus	5 = San Diego Area	21 = Church
			23 = Other Non Profit
			33 = Corporation

Health Care System

1 = Not Part of a Health Care System
2 = Part of a Health Care System

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

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The following information will assist in interpreting the data furnished by Table 22 (Selected Characteristics of Sampled General Hospitals in California Whose Administrators Did Not Respond to the Questionnaire).

Profit Status: Of the forty-seven hospitals whose administrators did not respond to the questionnaire, 43 (91%) were operated on a not-for-profit basis, and 4 (9%) were operated on a for profit basis.

These numbers and percentages can be compared to all 554 general hospitals in California as such:
393 (71%) were operated on a not-for-profit basis, and
161 (29%) were operated on a for profit basis.

Size: Of the forty-seven hospitals whose administrators did not respond to the questionnaire,
4 (9%) were in the size range of 1 to 199 beds,
17 (36%) were in the size range of 200 to 299 beds,
12 (26%) were in the size range of 300 to 399 beds,
8 (17%) were in the size range of 400 to 499 beds, and
6 (13%) had 500 or more beds.

These numbers and percentages can be compared to all 554 general hospitals in California as such:
388 (70%) were in the size range of 1 to 199 beds,
77 (14%) were in the size range of 200 to 299 beds,
46 (8%) were in the size range of 300 to 399 beds,
18 (3%) were in the size range of 400 to 499 beds, and
25 (5%) had 500 or more beds.

Location: Of the forty-seven hospitals whose administrators did not respond to the questionnaire, 5 (11%) were located in the Central Valley, 13 (28%) were located in the San Francisco Area, 25 (53%) were located in the Los Angeles Area, 1 (2%) was located in the Desert, and 3 (6%) were located in the San Diego Area.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 98 (18%) were located in the Central Valley, 73 (13%) were located in the San Francisco Area, 203 (37%) were located in the Los Angeles Area, 37 (7%) were located in the Desert, 38 (7%) were located in the San Diego Area, and 105 (19%) were located in some other area of California.

Health Care System Membership: Of the forty-seven hospitals whose administrators did not respond to the questionnaire, 18 (38%) were not members of health care systems, and 29 (62%) were members of health care systems.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 252 (45%) were not members of health care systems, and 302 (55%) were members of health care systems.

Classification: Of the forty-seven hospitals whose administrators did not respond to the questionnaire, 2 (4%) were operated by the State, 4 (9%) were operated

by a county, 2 (4%) were operated by a Hospital District, 9 (19%) were operated by a church, 26 (55%) were operated by another non-government, not-for-profit entity, and 4 (9%) were operated by a corporation.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 16 (3%) were operated by the State, 32 (6%) were operated by a county, 2 (less than 1%) were operated by a city-county, 2 (less than 1%) were operated by a city, 54 (10%) were operated by a Hospital District, 30 (5%) were operated by the federal government, 58 (10%) were operated by a church, 199 (36%) were operated by another non-government, not-for-profit entity, 147 (27%) were operated by a corporation, and 14 (3%) were operated by a partnership.

TABLE 23

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Modoc MC	1		1										*		2		13						
Anaheim Gen		2	1							3					2								32
Anaheim Memorial	1		1							3				1							23		
Humana-Anaheim		2		2						3					2							33	
Kaiser	1		1							3					2						23		
Martin Luther	1			2						3					2						23		
Delta Memorial	1		1										*		2						23		
St Mary Desert	1		1								4			1						21			
Mad River Community		2	1										*	1								33	
Arroyo Grande		2	1										*	1								33	
Pioneer		2	1							3				1									32
Atascadero	1						5						*	1		12							
Bloss Memorial	1		1					1						1					16				
Auburn Faith	1		1					1							2						23		
Avalon Muni	1		1							3				1							23		
Avenal	1		1					1						1					16				
Glenbrook		2	1							3					2							33	
Alliance Community	1		1					1						1							23		
Bakersfield	1			2				1						1							23		
Kern View	1		1					1						1							23		

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Barstow Community	1		1								4				2					21			
USAF Beale	1		1					1							2								41
Alondra Crest		2	1							3					2							33	
Bellflower		2	1							3					2							33	
Bellwood		2	1							3					2							33	
Kaiser	1				3					3					2						23		
Belmont		2	1						2						2							33	
Alta Bates	1					4			2						2						23		
Ernest Cowell	1		1						2						2						23		
Bear Valley	1		1								4			1						21			
Northern Inyo	1		1										*	1					16				
Palo Verde	1		1										*	1							23		
Pioneers Memorial	1		1										*		2				16				
Brea Community		2	1							3				1								33	
CPC Brea Canyon		2	1							3					2							33	
Mono Gen	1		1										*	1			13						
Buena Park		2	1							3					2							33	
Buena Park Mds		2	1							3					2							33	
Thompson Memorial	1		1							3				1							23		
Woodview		2	1							3					2								32

Source: American Hospital Association Guide to the Health Care Field
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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Calexico	1		1										*	1					16				
Camarillo	1						5						*	1		12							
Pleasant Valley	1		1										*	1							23		
USN Pendleton	1		1									5			2								43
Chemical Depend		2	1						2					1								33	
American River	1		1					1							2						23		
Thompson Memorial	1		1							3				1							23		
Woodview		2	1							3					2								32
Calexico	1		1										*	1					16				
Camarillo	1						5						*	1		12							
Pleasant Valley	1		1										*	1							23		
USN Pendleton	1		1									5			2								43
Chemical Depend		2	1						2					1								33	
American River	1		1					1							2						23		
Mercy San Juan	1		1					1							2					21			
USAF Castle	1		1					1							2								41
Laurel Grove	1		1						2					1					16				
Surprise Valley	1		1										*	1					16				
College Hospital		2	1							3				1								33	
Seneca District	1		1										*	1					16				

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Chico Community		2	1					1							2							33	
Canyon Ridge		2	1							3					2								32
Chino Community		2	1							3					2							33	
Institute for Men	1		1							3				1		12							
Chowchilla	1		1					1							2				16				
Chula Vista Community	1		1									5			2						23		
Scripps - C V	1		1									5			2						23		
Southwood Psych		2	1									5		1								33	
Vista Hill	1		1									5			2						23		
Redbud Community	1		1										*	1					16				
Clovis Community	1		1					1							2						23		
Coalinga	1		1					1						1					16				
Colusa	1		1					1							2						23		
Coricoran	1		1					1						1					16				
Ami Circle		2	1								4			1								33	
Charter Corona		2	1								4				2							33	
Corona Community	1		1								4			1							23		
Coronado	1		1									5		1							23		
College Mesa		2	1							3				1								33	
Charter Oak		2	1							3					2							33	

Source: American Hospital Association Guide to the Health Care Field
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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Sutter Coast	1		1										*		2						23		
Washington		2	1							3				1								33	
Capistrano		2	1										*	1								33	
Sutter Davis	1		1					1							2						23		
St Helena	1		1										*		2					21			
Delano Reg MC		2	1					1						1								33	
Alta District	1		1					1							2				16				
Dos Palos Memorial	1		1					1						1							23		
Downey Community	1		1							3				1							23		
Rancho Los Amigos	1					4				3					2		13						
Rio Hondo	1		1							3				1							23		
City of Hope	1		1							3				1							23		
Santa Teresita	1			2						3				1						21			
USAF Edwards	1		1								4				2								41
Rancho Park		2	1									5		1									32
Valley Medical		2	1									5			2							33	
El Centro	1		1										*	1									14
Sonoma Develop	1						5						*	1		12							
San Luis Rey		2	1									5			2							33	
Scripps	1		1									5			2						23		

Source: American Hospital Association Guide to the Health Care Field
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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Eureka Gen		2	1										*		2							33	
St Joseph	1		1										*		2					21			
Exeter Memorial	1		1					1						1							23		
Fair Oaks		2	1					1							2							33	
Northbay	1		1										*		2						23		
Mayers Memorial	1		1										*	1					16				
Fallbrook	1		1										*	1					16				
Mercy Folsom	1		1					1							2					21			
Kaiser Fontana	1				3						4				2						23		
Mendicino Coast	1		1										*	1					16				
Weed Army Community	1		1								4				2								42
Silas B Hays	1		1										*		2								42
Redwood Memorial	1		1										*		2					21			
FHP Fountain Valley		2	1							3				1								33	
Fountain Valley		2		2						3				1								33	
Fowler Community	1		1					1						1							23		
Sierra Gateway		2	1					1							2							33	
Cedar Vista		2	1					1							2							33	
Sierra Community	1		1					1							2						23		
Valley Children's	1		1					1						1							23		

Source: American Hospital Association Guide to the Health Care Field
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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Veterans Affairs	1		1					1							2								45
South Humboldt	1		1										*	1					16				
Ami Garden Grove		2	1							3					2							33	
Gardena Community		2	1							3					2							33	
Gardena Memorial		2	1							3					2							33	
USAF George	1		1								4				2								41
Valley Gilroy	1		1										*		2						23		
Verdugo Hills	1		1							3				1							23		
Foothill Presbyterian	1		1							3				1							23		
Glendora Community		2	1							3				1									32
Memorial Grass Valley	1		1					1						1							23		
Indian Valley	1		1										*	1					16				
Biggs-Gridley	1		1					1						1							23		
Hanford Community	1		1					1							2					21			
Sacred Heart	1		1					1							2					21			
Charter Community		2	1							3					2							33	
Hawthorne		2	1							3					2							33	
Robert Kennedy	1			2						3				1							23		
Kaiser Hayward	1			2					2						2						23		
St Rose	1		1						2						2					21			

Source: American Hospital Association Guide to the Health Care Field
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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Healdsburg		2	1										*		2							33	
Hemet Valley	1			2							4			1					16				
San Benito	1		1										*		2				16				
Humana Hunt B		2	1							3					2							33	
Pacifica Community		2	1							3					2							33	
Huntington Park		2	1							3					2							33	
Mission		2	1							3					2							33	
JFK Indio		2	1								4			1								33	
Inglewood		2	1							3				1								33	
Amador H	1		1					1							2		13						
Hi-Desert	1		1								4			1					16				
Kentfield		2	1						2						2							33	
Ross Hospital		2	1						2						2							33	
George Mee	1		1										*	1							23		
Friendly Hills		2		2						3				1								33	
Green Scripps		2	1									5			2							33	
La Mirada		2	1							3					2							33	
La Palma	1		1							3					2						23		
Saddleback	1			2							4			1							23		
Mountains Community	1		1								4			1					16				

Source: American Hospital Association Guide to the Health Care Field
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TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Kern Valley	1		1										*	1					16				
Lakeside	1		1										*	1							23		
Doctors Lakewood		2		2						3					2							33	
Antelope Valley	1			2							4			1					16				
High Desert	1		1								4				2		13						
Lancaster		2	1								4				2							33	
USN Lemoore	1		1					1							2								43
Lindsay	1		1					1							2						23		
Valley Livermore	1		1										*	1							23		
VA Livermore	1			2									*		2								45
Lodi Memorial	1		1					1						1							23		
J Petis	1				3						4				2								45
Loma Linda Community	1		1								4				2					21			
Lompoc	1		1										*	1					16				
Penitentiary	1		1										*	1									48
South Inyo Hospital	1		1										*	1					16				
Charter Longbeach		2	1							3					2							33	
Longbeach Mds		2	1							3				1								33	
Los Altos		2	1							3					2							33	
USN Longbeach	1		1							3					2								43

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Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Pacific	1		1							3				1							23		
Redgate MC	1		1							3				1							23		
VA MC	1						5			3					2								45
Woodruff Community		2	1							3					2							33	
Los Alamitos		2	1							3					2							33	
Ami N Hollywood		2	1							3					2							33	
Ami Tarzana		2		2						3					2							33	
Barlow	1		1							3				1							23		
Bay Harbor	1		1							3				1							23		
Century City		2	1							3					2							33	
Children's of LA	1				3					3				1							23		
Cigna		2	1							3				1								33	
CPC Westwood		2	1							3					2							33	
Crossroads		2	1							3				1								33	
East LA Doctors		2	1							3				1								33	
Edgemont		2	1							3				1								33	
Encino		2	1							3					2							33	
Estelle Doheny	1		1							3					2						23		
Fed Correctional	1		1							3				1									48
Gateways	1		1							3				1							23		

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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Granada Hills	1			2						3				1							23		
Hollywood		2	1							3					2							33	
Holy Cross	1			2						3					2					21			
Kaiser Harbor	1			2						3					2						23		
Kaiser LA	1						5			3					2						23		
Kaiser Panorama	1			2						3					2						23		
Kaiser Woodland	1		1							3					2						23		
Kaiser W LA	1			2						3					2						23		
Kaiser Mental	1		1							3					2						23		
LifePlus Cold Water	1		1							3					2						23		
Lincoln		2	1							3				1								33	
LA Community		2	1							3					2							33	
LA Jail	1				3					3				1			13						
LA Doctors		2	1							3					2							33	
Motion Picture	1		1							3				1							23		
Nu-Med Regional		2	1							3					2							33	
Olive View	1			2						3					2		13						
Orthopaedic	1		1							3				1							23		
Pacific Alliance	1		1							3				1							23		
Pacifica Valley		2		2						3					2							33	

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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Panorama Community		2	1							3					2							33	
Santa Marta	1		1							3				1						21			
Sherman Oaks		2	1							3					2							33	
Shriners	1		1							3					2						23		
Temple Community		2	1							3				1								33	
UCLA Neuro	1		1							3					2						23		
USC Norris	1		1							3				1							23		
Valley Van Nuys	1		1							3					2						23		
Van Nuys Community		2	1							3					2							33	
Van Nuys Hospital		2	1							3				1								33	
VA MC Sepulveda	1						5			3					2								45
VA MC West LA	1						5			3					2								45
Westside LA		2	1							3					2							33	
Los Banos	1		1					1							2						23		
Los Gatos		2		2									*		2							33	
Mission Oaks		2	1										*	1								33	
Sierra Valley	1		1										*		2						23		
Madera Community	1		1					1						1							23		
Centinella	1		1										*	1							23		
Doctors		2	1					1							2							33	

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THE HOSPITAL ADMINISTRATOR:
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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
USAF March	1		1								4				2								41
Daniel Freeman	1			2						3					2					21			
John Fremont	1		1					1						1					16				
Kaiser Martinez	1		1						2						2						23		
Merrithew	1		1						2					1			13						
VA Martinez	1				3				2						2								45
Rideout	1		1					1							2						23		
USAF Mather	1		1					1							2								41
Merced Community	1		1					1						1			13						
Mercy Merced	1		1					1							2					21			
Mission Viejo		2	1										*	1									32
Memorial Hs Assoc	1			2				1						1							23		
Modesto City		2	1					1							2							33	
Scenic Gen	1		1					1						1			13						
Monrovia		2	1							3					2								32
Doctors Montclair		2	1							3					2							33	
Community Monterey	1		1										*	1							23		
Monterey Park		2	1							3					2							33	
St Louise	1		1										*		2					21			
St Catherine	1		1						2						2					21			

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Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Mercy Mt Shasta	1		1										*		2					21			
Napa State	1						5						*	1		12							
Queen Valley	1		1										*		2					21			
Paradise Valley	1		1									5			2					21			
Needles-Desert	1		1										*		2								14
Newhall		2	1							3				1								33	
West Side	1		1					1						1					16				
Hoag Memorial Pres	1				3					3				1							23		
Newport Harbor		2	1							3					2							33	
Coast Plaza		2	1							3					2							33	
Metropolitan	1						5			3				1		12							
Norwalk		2	1							3					2								32
Novato Community	1		1										*		2						23		
Oak Valley	1		1					1						1					16				
Calif Surgical	1		1						2					1							23		
Children's	1		1						2					1							23		
Gladman Memorial		2	1						2					1								33	
Kaiser Oakland	1			2					2						2						23		
USN Oakland	1		1						2						2								43
Oakland H		2	1						2					1									32

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Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Tri-City	1				3							5		1					16				
Ojai Valley		2	1										*		2							33	
Ontario Community		2	1							3					2							33	
CareUnit		2	1							3				1								33	
Chapman		2	1							3					2							33	
Children's Hospital	1		1							3				1							23		
Oroville	1		1					1						1							23		
Palmdale		2	1								4				2							33	
Children's Stanford	1		1						2					1							23		
VA Palo Alto	1						5		2						2								45
Feather River	1		1					1							2					21			
Charter Paramount		2	1							3					2							33	
HCA Las Encinas		2	1							3					2							33	
Impact Drug	1		1							3				1							23		
St Luke		2	1							3					2							33	
Del Puerto	1		1					1						1					16				
Patton State	1						5				4			1		12							
Christian Perris		2	1								4			1								33	
Petaluma Valley	1		1										*	1					16				
Pico Rivera		2	1							3				1								33	

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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Doctors Pinole		2	1						2						2							33	
Los Medanos	1		1										*	1							23		
Placentia-Linda		2	1							3					2							33	
Marshall	1		1					1							2						23		
Casa Colina	1		1							3				1							23		
CPC Horizon		2	1							3					2							33	
Lanterman	1						5			3				1		12							
Anacapa	1		1										*		2					21			
Porterville	1						5	1						1		12							
Sierra View	1		1					1						1					16				
Eastern Plumas	1		1										*		2				16				
Pomerado	1		1									5			2				16				
Plumas	1		1										*		2				16				
Eisenhower	1			2							4			1							23		
St Elizabeth	1		1					1							2					21			
Mercy Redding	1		1					1							2					21			
Redding MC		2	1					1							2							33	
Redlands	1		1								4			1							23		
Ami S Bay		2		2						3					2							33	
Kaiser Redwood	1		1						2						2						23		

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THE HOSPITAL ADMINISTRATOR:
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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Woodside Womens'		2	1						2						2							33	
Kings View	1		1					1						1							23		
Sierra-Kings	1		1					1							2				16				
Kaiser Richmond	1		1						2						2						23		
Ridgecrest	1		1										*	1							23		
Kaiser Riverside	1		1								4				2						23		
Parkview	1		1								4			1							23		
CPC Alhambra		2	1							3					2							33	
Ingleside		2	1							3				1								33	
Roseville	1			2				1						1							23		
Heritage Oaks		2	1					1							2							33	
Sierra Vista		2	1					1							2							33	
Kaiser Sacto	1				3			1							2						23		
Kaiser South Sacto	1		1					1							2						23		
Methodist	1		1					1						1							23		
Sutter Psych	1		1					1							2						23		
Sutter Memorial	1				3			1							2						23		
Natividad	1		1										*	1			13						
Salinas Valley	1			2									*	1					16				
Mark Twain	1		1					1						1							23		

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Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Samaritan	1		1										*		2						23		
Children's San Diego	1		1									5		1							23		
Harbor View		2	1									5			2								32
Hillside	1		1									5		1							23		
Kaiser El Cajon	1			2								5			2						23		
Mesa Vista	1		1									5			2						23		
Mission Bay		2	1									5			2							33	
USN San Diego	1					4						5			2								43
San Diego Portal	1		1									5		1			13						
San Diego Psych	1		1									5		1			13						
San Diego Gen		2	1									5		1								33	
Sharp Cabrillo	1			2								5			2						23		
VA San Diego	1						5					5			2								45
Villa View	1		1									5		1							23		
Ami San Dimas		2	1							3					2							33	
San Fernando	1		1							3				1							23		
Chinese	1		1						2					1							23		
Kaiser San Francisco	1				3				2						2						23		
Laguna Honda	1		1						2					1				15					
Langley Porter	1		1						2						2						23		

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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
USA Letterman	1				3				2						2								42
Pacific Coast	1		1						2					1							23		
Shriners	1		1						2						2						23		
St Mary's	1				3				2						2					21			
VA MC San Francisco	1				3				2						2								45
San Gabriel Valley	1		1							3					2						23		
Santa Teresa	1		1						2						2						23		
Fairmont	1		1						2						2		13						
Humana S Leandro		2	1						2						2							33	
Physician's Community		2	1						2						2								32
Ami Sierra Vista		2	1										*		2							33	
Calif Men's	1		1										*	1		12							
French		2	1										*		2							33	
San Luis Obispo	1		1										*	1			13						
San Mateo	1		1						2					1			13						
Kaiser San Rafael	1		1						2						2						23		
Sanger Gen		2	1					1						1								33	
Coastal Communities		2	1							3					2							33	
CPC Santa Anna		2	1							3					2							33	
Doctor's		2	1							3					2							33	

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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Santa Anna MC		2	1							3					2							33	
Goleta Valley	1		1										*	1							23		
Rehab Santa Barbara	1		1										*	1							23		
Shick Shadel		2	1										*		2							33	
St Francis	1		1										*	1						21			
Kaiser Santa Clara	1			2					2						2						23		
Dominican	1			2									*		2					21			
Marian MC	1		1										*	1						21			
Valley Community		2	1										*		2							33	
Santa Paula	1		1										*	1							23		
Santa Rosa Community	1		1										*	1			13						
North Coast Rehab		2	1										*	1								33	
Santa Rosa Memorial	1			2									*		2					21			
Warrack MC		2	1										*	1								33	
Star Lodge		2	1										*	1								33	
Palm Drive		2	1										*		2							33	
Selma	1		1					1						1					16				
Simi Valley Advent	1			2									*		2					21			
Santa Ynez Valley	1		1										*	1							23		
Sonoma Valley	1		1										*	1					16				

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Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
Sonora Community	1		1					1							2					21			
Tuolumne Gen	1		1					1							2		13						
El Monte Community		2	1							3					2							33	
S Coast MC	1		1										*	1							23		
Barton Memorial	1		1										*	1							23		
Kaiser South SF	1		1						2						2						23		
Sun Crest		2	1							3				1								33	
Dameron	1			2				1						1							23		
St Joseph's Behav	1		1					1						1						21			
Lassen Community	1		1										*	1						21			
West Side Taft	1		1					1						1					16				
Tehachapi	1		1										*	1					16				
Twin Cities		2	1										*		2							33	
Ami Del Amo		2	1							3					2							33	
Charter Torrance		2	1							3					2							33	
Tracy Community	1		1					1						1							23		
USAF David Grant	1			2									*		2								41
Tahoe Forrest	1		1										*	1					16				
Tulare	1		1					1						1					16				
Emanuelle	1		1					1						1						21			

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Hospital Name	Profit Status		Size					Location						HC System		Classification							
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2	12	13	15	16	21	23	33	*
HC MC Tustin		2	1							3				1								33	
Ukiah Valley MC	1		1										*		2						23		
Calif Vacaville	1			2									*	1		12							
Vaca Valley	1		1										*		2						23		
Henry Mayo	1		1							3				1							23		
Kaiser Valejo	1			2									*		2						23		
Sutter Solano	1		1										*		2						23		
USAF Vandenburg	1		1										*		2								41
CPC Vista Del Mar		2	1										*		2							33	
Ventura County	1		1										*	1			13						
Victor Valley	1		1								4			1							23		
Kaweah Delta	1		1					1						1					16				
Visalia		2	1					1							2							33	
CPC Walnut Creek		2	1						2						2							33	
John Muir	1			2					2					1							23		
Kaiser Walnut Cr	1		1						2						2						23		
Watsonville	1		1										*	1							23		
Trinity	1		1										*	1			13						
Covina Valley		2	1							3				1									32
Doctors W Covina		2	1							3				1								33	

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Hospital Name	Profit Status		Size					Location					
(N = 453)	1	2	1	2	3	4	5	1	2	3	4	5	*
Queen Valley	1			2						3			
Westlake MC		2	1							3			
Humana Westminster		2	1							3			
Whittier		2	1							3			
Inland Valley		2	1								4		
Frank Howard	1		1										*
Glenn Gen H	1		1					1					
US Indian Ft Yuma	1		1										*
Woodland	1		1					1					
Yolo Gen	1		1					1					
Yountville	1		1										*
Siskiyou	1		1										*
Fremont Yuba City	1		1					1					

Hospital Name	HC System		Classification							
(N = 453)	1	2	12	13	15	16	21	23	33	*
Queen Valley	1							23		
Westlake MC		2							33	
Humana Westminster		2							33	
Whittier		2							33	
Inland Valley		2							33	
Frank Howard		2					21			
Glenn Gen H	1			13						
US Indian Ft Yuma		2								47
Woodland	1							23		
Yolo Gen	1			13						
Yountville	1		12							
Siskiyou	1							23		
Fremont Yuba City		2						23		

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

CODE LEGENDS

Profit Status	Size (# of Beds)	Location	Classification
1 = Not-for-Profit	1 = 1-199	1 = Central Valley	12 = State
2 = For Profit	2 = 200-299	2 = San Francisco Area	13 = County
	3 = 300-399	3 = Los Angeles Area	15 = City-County
	4 = 400-499	4 = Desert	16 = Hospital District
	5 = 500 Plus	5 = San Diego Area	21 = Church
		* = Other	23 = Other Non Profit
			33 = Corporation
			* = Other

Health Care System

1 = Not Part of a Health Care System
2 = Part of a Health Care System

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

TABLE 23 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Selected Characteristics of Non-Sampled General Hospitals in California

Hospital Totals

	Profit Status		Size					Location						HC System	
	1	2	1	2	3	4	5	1	2	3	4	5	*	1	2
TOTAL HOSPITALS:	300	153	380	41	14	3	15	87	46	154	30	31	105	207	246

Classification

	12	13	14	15	16	21	23	32	33	41	42	43	45	47	48
TOTAL HOSPITALS:	13	22	2	1	46	37	149	14	139	8	3	6	10	1	2

Note: The five category totals are displayed in two sections because of the expanded number of classifications into which the non-sampled hospitals fell.

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

The following information will assist in interpreting the data furnished by Table 23 (Selected Characteristics of Non-Sampled General Hospitals in California).

Profit Status: Of the 453 hospitals that were not included in the sample that were sent questionnaires, 300 (66%) were operated on a not-for-profit basis, and 153 (34%) were operated on a for profit basis.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 393 (71%) were operated on a not-for-profit basis, and 161 (29%) were operated on a for profit basis.

Size: Of the 453 hospitals that were not included in the sample that were sent questionnaires, 380 (84%) were in the size range of 1 to 199 beds, 41 (9%) were in the size range of 200 to 299 beds, 14 (3%) were in the size range of 300 to 399 beds, 3 (1%) were in the size range of 400 to 499 beds, and 15 (3%) had 500 or more beds.

These numbers and percentages can be compared to all 554 general hospitals in California as such:
388 (70%) were in the size range of 1 to 199 beds,
77 (14%) were in the size range of 200 to 299 beds,
46 (8%) were in the size range of 300 to 399 beds,
18 (3%) were in the size range of 400 to 499 beds, and
25 (5%) had 500 or more beds.

Location: Of the 453 hospitals that were not included in the sample that were sent questionnaires, 87 (19%) were located in the Central Valley, 46 (10%) were located in the San Francisco Area, 154 (34%) were located in the Los Angeles Area, 30 (7%) were located in the Desert, 31 (7%) were located in the San Diego Area, and 105 (23%) were located in some other area of California.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 98 (18%) were located in the Central Valley, 73 (13%) were located in the San Francisco Area, 203 (37%) were located in the Los Angeles Area, 37 (7%) were located in the Desert, 38 (7%) were located in the San Diego Area, and 105 (19%) were located in some other area of California.

Health Care System Membership: Of the 453 hospitals that were not included in the sample that were sent questionnaires, 207 (46%) were not members of health care systems, and 246 (54%) were members of health care systems.

These numbers and percentages can be compared to all 554 general hospitals in California as such: 252 (45%) were not members of health care systems, and 302 (55%) were members of health care systems.

Classification: Of the 453 hospitals that were not included in the sample that were sent questionnaires,

13 (3%) were operated by the State, 22 (5%) were operated by a county, 1 (less than 1%) was operated by a city-county, 46 (10%) were operated by a Hospital District, 37 (8%) were operated by a church, 149 (33%) were operated by another non-government, not-for-profit entity, and 139 (31%) were operated by a corporation.

In addition, 30 hospitals were operated by the federal government. They included: 8 (2%) were operated by the US Army, 3 (1%) were operated by the US Air Force, 6 (1%) were operated by the US Navy, 10 (2%) were operated by the Veterans Administration, 1 (less than 1%) was operated by the US Public Health Service (Indian), and 2 (less than 1%) were operated by the Department of Justice. Also in addition, 16 hospitals were operated by non federal government organizations other than those included in the sample. They were: 2 (less than 1%) were operated by a city, and 14 (3%) were operated by a partnership (for-profit).

These numbers and percentages can be compared to all 554 general hospitals in California as such: 16 (3%) were operated by the State, 32 (6%) were operated by a county, 2 (less than 1%) were operated by a city-county, 2 (less than 1%) were operated by a city, 54 (10%) were operated by a Hospital District, 30 (5%) were operated by the federal government, 58 (10%) were operated by a church, 199 (36%) were operated by

another non-government, not-for-profit entity, 147 (27%) were operated by a corporation, and 14 (3%) were operated by a partnership.

TABLE 24

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Summary of Selected Characteristics of All General Hospitals in California

	Respondents (N=54) *		Non-Respondents (N=47)		Total Sample (N=101) *		Non-Sampled (N=453)		Total (N=554) *	
Profit Status										
Not-for-Profit	50	93%	43	91%	93	92%	300	66%	393	71%
For-Profit	4	7%	4	9%	8	8%	153	34%	161	29%
Size (Number of Beds)										
1-199	4	7%	4	9%	8	8%	380	84%	388	70%
200-299	19	35%	17	36%	36	36%	41	9%	77	14%
300-399	20	37%	12	26%	32	32%	14	3%	46	8%
400-499	7	13%	8	17%	15	15%	3	1%	18	3%
500 Plus	4	7%	6	13%	10	10%	15	3%	25	5%

* Note: Total number of hospitals in California was 549 when the American Hospital Association collected its data for 1991. The total sample chosen was 100. However, two administrators responded to the questionnaire from the same hospital. One completed and returned the original survey just after the follow-up mailing was sent, which was completed by the successor administrator.

** Note: All percentages are rounded to whole numbers

Source: American Hospital Association Guide to the Health Care Field
1991 Annual Survey, 1992, Chicago, Illinois

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TABLE 24 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Summary of Selected Characteristics of All General Hospitals in California

	Respondents (N=54) *		Non-Respondents (N=47)		Total Sample (N=101) *		Non-Sampled (N=453)		Total (N=554) *	
Location										
Central Valley	6	11%	5	11%	11	11%	87	19%	98	18%
San Francisco Area	14	26%	13	28%	27	27%	46	10%	73	13%
Los Angeles Area	24	44%	25	53%	49	49%	154	34%	203	37%
Desert	6	11%	1	2%	7	7%	30	7%	37	7%
San Diego Area	4	7%	3	6%	7	7%	31	7%	38	8%
Other	0	-	0	-	0	-	105	23%	105	19%
Health Care System										
Not Part of System	27	50%	18	38%	45	45%	207	46%	252	45%
Part of a System	27	50%	29	62%	56	55%	246	54%	302	55%

* Note: Total number of hospitals in California was 549 when the American Hospital Association collected its data for 1991. The total sample chosen was 100. However, two administrators responded to the questionnaire from the same hospital. One completed and returned the original survey just after the follow-up mailing was sent, which was completed by the successor administrator.

** Note: All percentages are rounded to whole numbers

Source: American Hospital Association Guide to the Health Care Field 1991 Annual Survey, 1992, Chicago, Illinois

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TABLE 24 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Summary of Selected Characteristics of All General Hospitals in California

Classification	Respondents (N=54) *		Non-Respondents (N=47)		Total Sample (N=101) *		Non-Sampled (N=453)		Total (N=554) *	
Government										
State	1	2%	2	4%	3	3%	13	3%	16	3%
County	6	11%	4	9%	10	10%	22	5%	32	6%
City	0	-	0	-	0	-	2	***	2	***
City-County	1	2%	0	-	1	1%	1	***	2	***
Hosp District Auth	6	11%	2	4%	8	8%	46	10%	54	10%
Federal	0	-	0	-	0	-	30	7%	30	5%
Not-for-Profit										
Church	12	22%	9	19%	21	21%	37	8%	58	10%
Other	24	44%	26	55%	50	50%	149	33%	199	36%
For Profit										
Corporation	4	7%	4	9%	8	8%	139	31%	147	27%
Partnership	0	-	0	-	0	-	14	3%	14	3%

* Note: Total number of hospitals in California was 549 when the American Hospital Association collected its data for 1991. The total sample chosen was 100. However, two administrators responded to the questionnaire from the same hospital. One completed and returned the original survey just after the follow-up mailing was sent, which was completed by the successor administrator.

** Note: All percentages are rounded to whole numbers

*** Note: Less than 1%

Source: American Hospital Association Guide to the Health Care Field 1991 Annual Survey, 1992, Chicago, Illinois

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The following information will assist in interpreting the data furnished by Table 24 (Summary of Selected Characteristics of All General Hospitals in California).

Profit Status: Of all the 554 general hospitals in California, 393 (71%) were operated on a not-for-profit basis, and 161 (29%) were operated on a for profit basis.

Size: Of all the 554 general hospitals in California, 388 (70%) were in the size range of 1 to 199 beds, 77 (14%) were in the size range of 200 to 299 beds, 46 (8%) were in the size range of 300 to 399 beds, 18 (3%) were in the size range of 400 to 499 beds, and 25 (5%) had 500 or more beds.

Location: Of all the 554 general hospitals in California, 98 (18%) were located in the Central Valley, 73 (13%) were located in the San Francisco Area, 203 (37%) were located in the Los Angeles Area, 37 (7%) were located in the Desert, 38 (7%) were located in the San Diego Area, and 105 (19%) were located in some other area of California.

Health Care System Membership: Of all the 554 general hospitals in California, 252 (45%) were not members of health care systems, and 302 (55%) were members of health care systems.

Classification: Of all the 554 general hospitals in California, 16 (3%) were operated by the State,

32 (6%) were operated by a county, 2 (less than 1%) were operated by a city-county, 2 (less than 1%) were operated by a city, 54 (10%) were operated by a Hospital District, 30 (5%) were operated by the federal government, 58 (10%) were operated by a church, 199 (36%) were operated by another non-government, not-for-profit entity, 147 (27%) were operated by a corporation, and 14 (3%) were operated by a partnership.

TABLE 25

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Summary of Selected Characteristics of
Sampled General Hospitals in California

	Respondents (N=54) *		Non-Respondents (N=47)		Total (N=101) *	
Profit Status	Total	%	Total	%	Total	%
Non-Profit	50	93%	43	91%	93	92%
Profit	4	7%	4	9%	8	8%
Size (Number of Beds)						
1-199	4	7%	4	9%	8	8%
200-299	19	35%	17	36%	36	36%
300-399	20	37%	12	26%	32	32%
400-499	7	13%	8	17%	15	15%
500 Plus	4	7%	6	13%	10	10%
Location						
Central Valley	6	11%	5	11%	11	11%
San Francisco Area	14	26%	13	28%	27	27%
Los Angeles Area	24	44%	25	53%	49	49%
Desert	6	11%	1	2%	7	7%
San Diego Area	4	7%	3	6%	7	7%
Health Care System						
Not Part of a System	27	50%	18	38%	45	45%
Part of a System	27	50%	29	62%	56	55%

* Note: Total sample is 101 because two administrators responded to the questionnaire from the same hospital. One completed and returned the original survey just after the follow-up mailing was sent, which was completed by the successor administrator.

Source: Tabulated for this dissertation

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TABLE 25 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Summary of Selected Characteristics of
Sampled General Hospitals in California

	Respondents (N=54) *		Non-Respondents (N=47)		Total (N=101) *	
	Total	%	Total	%	Total	%
Classification						
Government, Non-Federal						
State	1	2%	2	4%	3	3%
County	6	11%	4	9%	10	10%
City-County	1	2%	0	-	1	1%
Hospital District Authority	6	11%	2	4%	8	8%
Non-Government, Not for Profit						
Church	12	22%	9	19%	21	21%
Other	24	44%	26	55%	50	50%
Non-Government, For Profit						
Corporation	4	7%	4	9%	8	8%

* Note: Total sample is 101 because two administrators responded to the questionnaire from the same hospital. One completed and returned the original survey just after the follow-up mailing was sent, which was completed by the successor administrator.

Source: Tabulated for this dissertation

Appendix G: Analysis of the Curricula of American Schools of Public Health

Appendix G consists of consists of five documents.

The first document lists the name of the school and the degree offered from twenty schools that offer an MPH or MBA in Health Care Administration or related field.

The second document lists the major topical areas that the courses fell under.

The third document is Table 25, which shows how many courses from a topical area were required, how many schools required that topical area, and then the topical area.

The fourth document is a nine-page listing of the topical areas under which the Schools of Public Health have courses. They are listed in descending order. The topical area that has the most courses under it is listed first; the area with the least is listed last. It also shows the number of schools requiring courses within the topical area. The number in parentheses is the school, which is identified in the first document.

The fifth document is sixteen pages that lists each school alphabetically, tells what degree it offers, and whether or not it offers a doctorate. (If so, it has an asterisk before the Master's degree.) It also states whether the school operates on the quarter or semester system. Following is a list of the courses the school requires as core, and electives offered.

Curricula of Nineteen Schools of Public Health

School bulletins and course catalogs were requested from twenty-one Schools of Public Health in the US and the commonwealth of Puerto Rico, listed in the 1988 edition of a brochure prepared by the Health Professions Career Opportunity Program of the State of California. Nineteen usable responses were received. One school sent only application materials, and another had no specific course requirements in its bulletin. Therefore, those two schools were not included in this analysis. The schools that did respond with school bulletin and/or course catalog were:

School Number	School Name Degree
1	**University of Alabama at Birmingham** M.P.H.
2	**University of California at Berkeley** M.P.H. in Health Policy and Administration
3	**Columbia University** M.P.H. in Health Policy and Management
4	**Harvard School of Public Health** Master of Science in Health Policy and Management
5	**University of Hawaii** M.P.H. in Health Services Administration and Planning
6	**University of Illinois at Chicago** Master of Public Health
7	**The Johns Hopkins University**, School of Hygiene and Public Health, M.P.H.
8	**Loma Linda University** Master of Health Administration
9	**University of Massachusetts at Amherst** M.P.H. in Health Policy and Management
10	**University of Michigan** Master of Health Services Administration
11	**University of Oklahoma**, College of Public Health M.P.H., Health Administration

School Number	School Name Degree
12	**University of Pittsburgh,** School of Public Health Master of Health Administration
13	**University de Puerto Rico** Master's Degree in Administration of Health Services
14	**San Diego State University** M.P.H. in Health Services Administration
15	**University of South Carolina** Master of Health Administration
16	**University of Texas,** Health Science Center M.P.H.
17	**Tulane University** Master of Health Administration
18	**University of Washington, Seattle** Master of Health Administration
19	**Yale University** M.P.H.

Topical Areas of Curricula

Curricula most closely matching an M.B.A. in Hospital Administration were identified. If the school did not offer that degree, a Master of Public Health (M.P.H.) curricula was chosen. The core courses and electives in each school's curriculum were listed.

A preliminary review of the courses revealed a number of topical areas under which the courses could be grouped. Arranged alphabetically, these topical areas were:

- Access to Medical Care
- Accounting in Health Care
- Ambulatory Care
- Biostatistics
- Community and Public Health Concepts, Development, and Practice
- Community Health Education
- Comprehensive Seminar/Capstone Course
- Decision Analysis
- Development and Evaluation of Health Care Services
- Economics of Public Health/Health Care
- Environmental Health
- Epidemiology
- Ethics
- Finance/Fiscal Management
- Health
- Health Systems Environment
- Hospital Administration/Management
- Human Resources Management in Health Care
- Insurance for Health Care
- International Health
- Legal Aspects and Regulations in Health Care
- Management Information Systems for Health Care/Computer Applications
- Management Principles of Health Care
- Marketing of Health Care
- Nursing
- Operations Research
- Organizational Behavior in Health Care
- Politics of Health Care
- Public Affairs
- Quality Assessment
- Research
- Public Health Programs and Policies
- Social Aspects of Health/Illness
- Statistical Analysis/Quantitative Methods
- Strategic Planning
- Technological Issues in Health Care
- Theory and Composition of Health Care Organizations
- Urban Planning

In addition to core courses, several schools had extra requirements in the forms of practical experience, research papers, or special projects. These were:

Community Project/Field Work
Comprehensive Exam
Essay/Thesis
Practicum
Residency/Internship
Study Plan

Table 26

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Number of Courses and Schools

Number of Courses	Number of Schools	Topical Areas
31	15	Hospital Administration/Management
19	10	Theory and Composition of Health Care Organizations
18	12	Finance/Fiscal Management
15	12	Economics of Public Health/ Health Care
14	12	Epidemiology
14	10	Management Information Systems for Health Care/Computer Applications
14	11	Public Health Programs and Policies
13	10	Community Public Health Concepts, Development, and Practice
12	12	Organizational Behavior in Health Care
12	9	Strategic Planning
11	11	Legal Aspects and Regulations in Health Care
10	10	Environmental Health
9	6	Accounting in Health Care
9	8	Biostatistics
9	8	Social Aspects of Health/Illness
9	7	Statistical Analysis/Quantitative Methods
7	7	Management Principles of Health Care
7	6	Marketing of Health Care
6	5	Human Resources Management in Health Care
4	4	Decision Analysis
4	3	Development and Evaluation of Health Care Services
4	4	Operations Research
3	2	Comprehensive Seminar/Capstone Course
3	3	Ethics
3	1	Nursing
3	2	Politics of Health Care
3	2	Research
3	3	Technological Issues in Health Care

Source: Course Catalogs from Schools of Public Health

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Table 26 (Continued)

THE HOSPITAL ADMINISTRATOR:
YESTERDAY, TODAY, AND TOMORROW

Number of Courses and Schools

Number of Courses	Number of Schools	Topical Areas
2	2	Health
2	1	Health Systems Environment
2	1	Insurance for Health Care
2	1	International Health
1	1	Access to Medical Care
1	1	Ambulatory Care
1	1	Community Health Education
1	1	Public Affairs
1	1	Quality Assessment
1	1	Urban Planning

Number of Courses	Number of Schools	Extra Requirements
7	7	Residency/Internship
6	5	Community Project/Field Work
5	5	Essay/Thesis
3	3	Practicum
2	2	Comprehensive Exam
1	1	Study Plan

Source: Course Catalogs from Schools of Public Health

Page 2 of 2

Course Titles under Topical Areas

The following topical areas are listed in the order of the number of course titles beneath. Often a course title included information that went under two or even three topical areas. In those instances the course was listed under both or under all three. These courses have been marked with an asterisk (*) if under two topical areas, and a double asterisk (**) if under three. The school's number is listed in parentheses.

Hospital Administration/Management 31 Courses, 15 Schools

Case Studies in Hospital Administration (3)
* Colloquium in Nursing Administration (3)
* Complex Health Care Organization and Its Management (3)
* Survey Research and Applications in Health Services Administration (3)
Tutorials in Health Administration (3)
Management of Health Care Organizations (4)
Coursework in College of Business Administration (5)
* Fundamentals of Health Administration (5)
* Health Services Administration in Advanced Public Health Practice (5)
* Hospitals and Their Management (5)
* Leadership and Organization Behavior in Health Services (5)
* Introduction to Health Policy and Management (7)
Managing Health Services Organizations (7)
* Seminar: Health Administration Practice and Policy (8)
Seminar: Health Systems Operations (8)
Synthesis Seminar in Health Administration (8)
* Health Care Organization and Administration I (9)
* Health Care Organization and Administration II (9)
* Health Care Organization and Administration III (9)
Case Studies in Medical Care Administration (10)
* Organization and Administration of Medical Care Programs I (10)
* Organization and Administration of Medical Care Programs II (10)
* Health Organization and Administration (11)
Strategic Management in Health Organizations (12)
System of Provision of Health Services I (13)
System of Provision of Health Services II (13)
** Planning, Policy Analysis, and Administration of Health Programs (14)
Hospital Administration (15)
Managerial Communication (17)
Business Administration (18)
** Integrative Policy Analysis Seminar or Integrative Management Seminar (19)

Theory and Composition of Health Care Organizations
19 Courses, 10 Schools

Comparative Health Systems (3)
* Complex Health Care Organization and Its Management (3)
The Health Maintenance Organization Delivery System (3)
Organization Theory (3)
* Hospitals and Their Management (5)
Medical Care Systems (5)
Health Care Organization (8)
* Health Care Organization and Administration I (9)
* Health Care Organization and Administration II (9)
* Health Care Organization and Administration III (9)
* Organization and Administration of Medical Care Programs I (10)
* Organization and Administration of Medical Care Programs II (10)
* Health Organization and Administration (11)
Medical Care Organization (12)
Organization Analysis (12)
Organizational Systems of Health Care Delivery (12)
Health Service Systems (16)
Introduction to Health Systems (17)
* Health Systems and Policy Analysis (19)

Finance/Fiscal Management 18 Courses, 12 Schools

* Economics and Finance of Public Health (1)
Finance (2)
Financial Management (3)
Health Care Financial Management (3)
Financial Analysis and Control (4)
Principles of Fiscal Management for Health Services (5)
Financial Aspects of Health Care Administration II (8)
Health Care Finance (8)
Corporate Finance for Health Care Administrators (10)
Capital Formation in the Health Sector (12)
* Health Accounting and Finance (12)
Introduction to Financial Management (12)
Fiscal Management (13)
Financing of Health Care (15)
Advanced Elective in Fiscal Management (17)
* Financial Accounting for Health Systems (17)
* Environmental Health and Risk Assessment (19)
Financial Decision-Making in Health Care (19)

Economics of Public Health/Health Care 15 Courses, 12 Schools

- * Economics and Finance of Public Health (1)
- Economics (3)
- Economics (4)
- Economics of Health Service (5)
- Health Care Economics (8)
- Economics of Health Services (10)
- MicroEconomic Theory I (10)
- Health Economics (12)
- Managerial Economics I (12)
- Managerial Economics II (12)
- Health Economics (13)
- Health Economics (15)
- Economics for Health Systems (17)
- Economics (18)
- Introduction to Health Economics (19)

Epidemiology 14 Courses, 12 Schools

- Introduction to Epidemiology (1)
- Epidemiology (4)
- Principles of Epidemiology (6)
- * The Biological Basis of Public Health (7)
- Principles of Epidemiology (7)
- Principles of Epidemiology (8)
- Principles of Epidemiology (9)
- Principles of Epidemiology (11)
- Principles of Epidemiology (12)
- Epidemiology (14)
- Basic Concepts and Methods of Epidemiology (15)
- Principles of Epidemiology (17)
- Concepts of Molecular Biology in Public Health (19)
- Principles of Epidemiology (19)

Management Information Systems for Health Care/Computer Applications 14 Courses, 10 Schools

- Information Management (3)
- Management Information System (4)
- Health Information Systems (7)
- Introduction to Computing (7)
- Database Fundamentals (8)
- Directed Study/Special Project in Computer Application to Administration (8)
- Spreadsheet Fundamentals (8)
- Fundamentals of Microcomputers for Health Services Administration (10)
- Computer-Based Information Systems (12)
- Management Systems and Decision-Making (12)
- Management Information Systems in Health Services (13)

Management Information Systems for Health Care/Computer Applications (Continued)

Information Systems in Health Administration (15)
Microcomputer Application in Health Sciences (17)
* History and Philosophy in Public Health and Data Management (19)

Public Health Programs and Policies 14 Courses, 11 Schools

Introduction to Public Health Programs and Policies (1)
Policy Analysis (2)
Seminar in Health Policy and Analysis (3)
* Foundations of Health Policy and Planning (5)
* Introduction to Health Policy and Management (7)
* Seminar: Health Administration Practice and Policy (8)
* Health Policy, Politics, and Regulations (12)
Policy Bases of Health Care Systems (13)
** Planning, Policy Analysis, and Administration of Health Programs (14)
Health Policy Analysis (16)
* Government and Health Policy (19)
* Health Systems and Policy Analysis (19)
* History and Philosophy in Public Health and Data Management (19)
** Integrative Policy Analysis Seminar or Integrative Management Seminar (19)

Community and Public Health Concepts, Development, and Practice 13 Courses, 10 Schools

Overview of Medicine for Students of Public Health (1)
* Health Services Administration in Advanced Public Health Practice (5)
Seminar in Community Health Development (5)
Public Health Concepts and Practice (6)
* The Biological Basis of Public Health (7)
History of Public Health (7)
Management of Public Health Practice (7)
Philosophy of Health (8)
Ecology of Health (11)
Health and Development (13)
Perspectives in Community Health Organizations (15)
Public Health and Community Medicine (18)
* History and Philosophy in Public Health and Data Management (19)

Organizational Behavior in Health Care 12 Courses, 12 Schools

Behavioral Science and Health: An Overview (1)
* Leadership and Organization Behavior in Health Services (5)
Behavioral Sciences in Public Health (6)
* Social and Behavioral Aspects of Public Health (7)
Organization Behavior in Health Care (8)
Behavior Science in Business (12)
Organizational Behavior (13)
* Behavioral and Social Science in Public Health (14)
Organizational Behavior (15)
Organizational Behavior (16)
Organizational Behavior (17)
* Social and Behavioral Factors in Health (19)

Strategic Planning 12 Courses, 9 Schools

Contemporary Dilemmas in Health Planning I and II (3)
Methods of Health Planning (3)
Tutorials in Health Planning Projects (3)
Strategic Planning (4)
Advanced Public Health Practice - Health Planning (5)
* Foundations of Health Policy and Planning (5)
Seminar: Health Systems Strategic Planning (8)
Forecasting and Planning Procedures for Hospitals (10)
Planning and Control (12)
** Planning, Policy Analysis, and Administration of Health Programs (14)
Health Planning (15)
Strategic Planning (17)

Legal Aspects and Regulations in Health Care 11 Courses, 11 Schools

Legal Issues (2)
* Legal Aspects of Nursing (3)
Legal Basis for Health Services (5)
Legal and Regulatory Issues in Health Admin (8)
The Law of Hospital Admin and Medical Care (10)
* Health Law and Ethics (12)
Legal Aspects of Administration of Health Services (13)
Health Law (15)
Health Law and Regulation (16)
Health Law (17)
* Government and Health Policy (19)

Environmental Health 10 Courses, 10 Schools

Fundamentals of Environmental Health (1)
Environmental Issues (2)
Principles of Environmental Health Sciences (6)
Institutional Environmental Health (8)
Environmental Health Practices (9)
Environmental Health (11)
Health, Disease, and Environment (12)
Environmental Determinance of Human Health (14)
Survey of Environmental Health (17)
* Environmental Health and Risk Assessment (19)

Accounting in Health Care 8 Courses, 6 Schools

Accounting and Budgeting (3)
Managerial Accounting for Health Care Administrators (10)
* Health Accounting and Finance (12)
Managerial Accounting I (12)
Managerial Accounting II (12)
Accounting in Business Organizations (15)
* Financial Accounting for Health Systems (17)
Managerial Accounting for Health Systems (17)
Managerial Accounting for Health Care Institutions (19)

Biostatistics 9 Courses, 8 Schools

Biostatistics I (1)
Biostatistics II (1)
Biostatistics I (6)
Introduction to Biostatistics (7)
Introductory Biostatistics (9)
Introduction to Biostatistics (11)
Biostatistics (14)
Introductory Biostatistics (15)
Introductory Biostatistics (17)

Social Aspects of Health/Illness 9 Courses, 8 Schools

Sociocultural Aspects of Health and Illness in Developing Countries (1)
Social Issues (2)
* Social and Behavioral Aspects of Public Health (7)
* Behavioral and Social Science in Public Health (14)
Sociology of Health for Health Services Managers (15)
Human Health and Disease (17)
Social Work (18)
Sociology (18)
* Social and Behavioral Factors in Health (19)

Statistical Analysis/Quantitative Methods 9 Courses, 7 Schools

Statistics (4)
Quantitative Methods in Health Care Management (8)
Probability and Statistical Analysis I (12)
Probability and Statistical Analysis II (12)
Statistical Analysis (13)
Quantitative Methods for Health Administration (15)
Quantitative Methods in Health Services (16)
Introduction to Statistical Thinking (19)
Quantitative Methods in Health Services (19)

Marketing of Health Care 7 Courses, 6 Schools

Health Care Marketing (3)
Marketing (4)
Health Care Marketing (8)
Introduction to Marketing Management (12)
Marketing Health Services (12)
Health Care Marketing (15)
Health Care Marketing (17)

Management Principles of Health Care 7 Courses, 7 Schools

Management (2)
* Fundamentals of Health Administration (5)
Principles of Management in Public Health (6)
Principles of Administration in Public Health (8)
Administrative Theory (13)
Principles of Management (15)
Management and Organizational Principles (16)

Human Resources Management in Health Care 6 Courses, 5 Schools

Collective Bargaining in Health Institutions (3)
Introduction to Human Resources Management (12)
Personnel Administration (13)
Health Professions Workforce (16)
Career Planning (17)
Human Resources Management (17)

Decision Analysis 4 Courses, 4 Schools

Decision Analysis (4)
Management Systems and Decision-Making (12)
Decision Analysis (13)
Decision Models (17)

Development and Evaluation of Health Care Services
4 Courses, 3 Schools

Program Development and Evaluation (2)
Assessment of Health Care (3)
Evaluation of the Range of Health Services (13)
Planning, Development, and Evaluation of Health Services (13)

Operations Research 4 Courses, 4 Schools

Operations Research Methods in Health (3)
Operations Research and Control Systems (10)
Introduction to Operations Management (12)
Operations Research (16)

Comprehensive Seminar/Capstone Course 3 Courses, 2 Schools

Comprehensive Seminar (13)
Integrative Seminar (13)
** Integrative Policy Analysis Seminar or Integrative Management Seminar (19)

Ethics 3 Courses, 3 Schools

Ethical Issues (2)
Approved Course in Ethics (8)
* Health Law and Ethics (12)

Nursing 3 Courses, 1 School

* Colloquium in Nursing Administration (3)
* Legal Aspects of Nursing (3)
Nursing and the Health Care Scene (3)

Politics of Health Care 3 Courses, 2 Schools

Political Aspects of Health Care (10)
The Politics of Health Care (10)
* Health Policy, Politics, and Regulations (12)

Research 3 Courses, 2 Schools

* Survey Research and Applications in Health Services Administration (3)
Evaluation Research (16)
Health Services Research (16)

Technological Issues in Health Care 3 Courses, 3 Schools

Technological Issues (2)
Health Care Delivery Systems: Safety and Efficacy of Medical Technologies (3)
Health Care Technology Assessment (16)

Health 2 Courses, 2 Schools

Health (3)
Health Measurement (16)

Health Systems Environment 2 Courses, 1 School

Seminar: Health Systems External Environment (8)
Seminar: Health Systems Internal Environment (8)

Insurance for Health Care 2 Courses, 1 School

Organization and Management of Health Insurance in the US (3)
Rate-Setting and Reimbursement Methods (3)

International Health 2 Courses, 1 School

Colloquium on Issues and Concepts in International Health (3)
Management of Health Systems in Developing Countries (7)

Access to Medical Care 1 Course, 1 School

Access to Medical Care (16)

Ambulatory Care 1 Course, 1 School

Management of Ambulatory Care Service (5)

Community Health Education 1 Course, 1 School

Principles of Community Health Education (9)

Public Affairs 1 Course, 1 School

Public Affairs (18)

Quality Assessment 1 Course, 1 School

Quality Assessment (16)

Urban Planning 1 Course, 1 School

Urban Planning (18)

Extra Requirements

Residency/Internship 6 Requirements, 6 Schools

Six Months Full-Time Residency (2)
Residency in Institutional Administration (300 Hours) (8)
Management Residency (12)
Administration Internship (15)
Residency of Nine to Twelve Months (17)
Summer Internship (19)

Community Project/Field Work 5 Requirements, 4 Schools

Projects and Rotation I (8)
Projects and Rotation II (8)
Field Work (Maximum of 8 Hours) (11)
Supervised Field Placement (14)
Community Project (19)

Essay/Thesis 5 Requirements, 5 Schools

Master's Essay in Health Administration (3)
An essay may be required at the discretion of the academic program area (6)
Research Report (8)
Thesis, Major Review Paper, or Comprehensive Exam (14)
Thesis (19)

Practicum 3 Requirements, 3 Schools

Practicum (3)
Practicum - Varied from 196 to 320 Hours (6)
Practicum in Administration (13)

Comprehensive Exam 1 Requirement, 1 School

Thesis, Major Review Paper, or Comprehensive Exam (14)

Three school bulletins (University of California, Berkeley; Columbia University; and University of Minnesota) simply listed the general subjects under the core curriculum (such as economics, health, environmental issues, etc.) instead of the actual course title. In these cases the general subject was listed under the appropriate topical area.

List of Courses (Core and Elective) for each School of Public Health

* = Institution offers a Doctorate

University of Alabama at Birmingham * MPH (Quarter System)

Core Courses

Introduction to Epidemiology
Biostatistics I
Biostatistics II
Introduction to Public Health Programs and Policies
Fundamentals of Environmental Health
Overview of Medicine for Students of Public Health

One of the following:

Behavioral Science and Health; An Overview
Economics and Finance of Public Health
Sociocultural Aspects of Health and Illness in Developing Countries

Required = 21 Credit Hours

Elective Courses

15 Hours of Electives

Total = 36 Credit Hours

University of California at Berkeley * MPH in Health Policy and Administration (Semester System)

Core Courses

Social Issues
Environmental Issues
Ethical Issues
Legal Issues
Technological Issues
Finance
Program Development and Evaluation
Management
Policy Analysis
Six Months Full-Time Residency

Elective Courses

45 academic units plus field work

Columbia University * M.P.H. in Health Policy and Management (Semester System)

Core Courses

Accounting and Budgeting
Financial Management
Health
Economics
Organization Theory
Practicum

Elective Courses

Introduction to Health Economics
Health Policy and the Political Systems
Hospital Organization and Management
Legal Aspects of Hospital Administration
Politics of Health Administration and Planning
Legal Aspects of Health Services Administration
Health Care Facilities Planning
Government Regulation of Health Care
Health Needs Assessment
Accounting and Budgeting for Health Administration
Issues and Approaches in Health Administration
Personnel Administration and Labor Relations
Strategic Planning in Health Care Institutions
Current Issues in Mental Health Planning and Administration
Dynamics of Health Planning Administration
Health Care Financial Management I
Nursing Services Planning and Evaluation
Community Assessment and Analysis in Public Health
Organization Theory and Health Services
Health, Poverty, and the Low-Income Consumer

Advanced Graduate Level Courses

Health Care Delivery Systems: Safety and Efficacy of Medical Technologies
Comparative Health Systems
Survey Research and Applications in Health Services Administration
Case Studies in Hospital Administration
The Health Maintenance Organization Delivery System
Colloquium on Issues and Concepts in International Health
Assessment of Health Care
Operations Research Methods in Health
Complex Health Care Organization and Its Management

Columbia University (Continued)

Organization and Management of Health Insurance in the United States
Master's Essay in Health Administration
Nursing and the Health Care Scene
Colloquium in Nursing Administration
Contemporary Dilemmas in Health Planning I and II
Seminar in Health policy and Analysis
Health Care Financial Management
Information Management
Legal Aspects of Nursing
Rate-Setting and Reimbursement Methods
Health Care Marketing
Collective Bargaining in Health Institutions
Tutorials in Health Administration
Tutorials in Health Planning Projects
Methods of Health Planning

Harvard School of Public Health * Master of Science in Health Policy and Management (Semester System)

Core Courses

Epidemiology
Statistics
Economics
Management of Health Care Organizations
- Financial Analysis and Control
- Marketing
- Management Information System
- Decision Analysis
- Strategic Planning

Elective Courses

Cost-Benefit/Cost Effectiveness Analysis
Quality Assurance
Risk Management
Physician Performance

University of Hawaii * M.P.H. in Health Services Administration and Planning (Semester System)

Core Courses

Medical Care Systems
Fundamentals of Health Administration
Economics of Health Service
Foundations of Health Policy and Planning
Seminar in Community Health Development

University of Hawaii (Continued)

Advanced Public Health Practice - Health Planning - or - Advanced Public Health Practice - Health Services Administration

Administration Supplement

Legal Basis for Health Services
Leadership and Organization Behavior in Health Services
Principles of Fiscal Management for Health Services
Hospitals and Their Management
Management of Ambulatory Care Service
Coursework in College of Business Administration

Elective Courses

Human Resources Management
Marketing
Fiscal Management
Decision Planning
Computer Applications in Public Health
Biostatistics

University of Illinois at Chicago * Master of Public Health (Semester System)

Core Courses

Principles of Epidemiology
Biostatistics I
Principles of Management in Public Health
Public Health Concepts and Practice
Principles of Environmental Health Sciences
Behavioral Sciences in Public Health

Practicum - Varied from 196 to 320 Hours
An essay may be required at the discretion of the academic program area.

Elective Courses

Various Requirements

The Johns Hopkins University, School of Hygiene and Public Health * MPH (Quarter System)

<u>Core Courses</u>

Introduction to Biostatistics
Health Information Systems
Introduction to Computing
Social and Behavioral Aspects of Public Health
History of Public Health
Principles of Epidemiology
The Biological Basis of Public Health

Management: One of the following:
- Introduction to Health Policy and Management
- Managing Health Services Organizations
- Public Health Practice
- Management of Health Systems in Developing Countries

Total = 35-40 units

<u>Elective Courses</u>

Behavioral Sciences and Health Education
Environmental Health Sciences
Epidemiology
Health Finance and Management
Health Policy
Human Genetics
Immunology and Infectious Diseases
International Health
Maternal and Child Health
Mental Hygiene
Nutrition
Occupational Medicine/Health
Physiology
Population Dynamics and Reproductive Health
Public Health Protection and Practice
Toxicology
Tropical Medicine

Total = 80 units, 34 in required core courses

Loma Linda University * Master of Health Administration (Quarter System)

<u>Core Courses</u>

Institutional Environmental Health
Principles of Epidemiology
Principles of Administration in Public Health

Loma Linda University (Continued)

Health Care Economics
Organization Behavior in Health Care
Legal and Regulatory Issues in Health
Administration
Financial Aspects of Health Care Administration II
Quantitative Methods in Health Care Management
Health Care Organization
Health Care Marketing
Health Care Finance
Projects and Rotation I
Projects and Rotation II
Seminar: Health Systems Operations
Seminar: Health Systems Internal Environment
Seminar: Health Systems External Environment
Seminar: Health Systems Strategic Planning
Seminar: Health Administration Practice and Policy
Research Report
Directed Study/Special Project in Computer
Application to Administration
Synthesis Seminar in Health Administration
Approved Course in Ethics
Philosophy of Health
Spreadsheet Fundamentals
Database Fundamentals
Residency in Institutional Administration
(300 Hours)

Elective Courses

Approved Electives
Area of Concentration (12)

Total = 84 units

University of Massachusetts at Amherst * MPH in Health Policy and Management (Semester System)

Core Courses

Health Care Organization and Administration
Introductory Biostatistics
Principles of Epidemiology
Environmental Health Practices
Principles of Community Health Education
Health Care Organization and Administration II
Health Care Organization and Administration III

University of Massachusetts at Amherst (Continued)

Elective Courses

Program Evaluation in Health Administration
Research Methods in Health Services Administration
Quantitative Methods in Health Management
Organization and Administration in Hospital
Administration

Total 42 Credit Hours

University of Michigan * Master of Health Services
Administration (Semester System)

Core Courses

Fundamentals of Microcomputers for Health Services
Administration
Organization and Administration of Medical Care
Programs I
Organization and Administration of Medical Care
Programs II
Managerial Accounting for Health Care
Administrators
Corporate Finance for Health Care Administrators
Forecasting and Planning Procedures for Hospitals
The Law of Hospital Administration and Medical
Care
Operations Research and Control Systems
MicroEconomic Theory I
Economics of Health Services
Case Studies in Medical Care Administration
The Politics of Health Care
Political Aspects of Health Care

Elective Courses

Hospital Organization and Management
Methods of Health Services Research
Health Insurance
Individual and Group Behavior in Health Services
Organizations
Health Care Marketing
Analysis of Organizations
Ethical Issues in Health Services Management
Legal Aspects of Regulation of the Health Care
Industry
Topics in Health Economics
Seminar in Managerial Economics
Computer Information and Decision Support Systems
in Health Care

University of Michigan (Continued)

Advanced Seminar in Health Care Financial
Management
Organization and Management of Ambulatory Care
Programs
Health Maintenance Organization
Organization and Administration of Long Term Care
Programs
Sociology of Medicine
Multi-Institutional Hospital System
Quality Assurance in Health Care Institutions
Regulation and External Control of Health Care
Organizations
Readings in Health Services Management and Policy
Politics in Economics of Health Care Policy
Seminar in Long-Term Care

Total = 60 Credit Hours

University of Oklahoma, College of Public Health *
Master of Public Health, or Health Administration
(Semester System)

Core Courses

Introduction to Biostatistics
Principles of Epidemiology
Environmental Health
Health Organization and Administration
Ecology of Health
Field Work (Maximum of 8 Hours)

Elective Courses

Introduction to Medicine for Public Health
Professionals
Theories of Organizational Behavior
Health Organization and Administration
Health Economics
Advanced Health Economics
Health Policies and Politics
Public Health Law and Regulations
Principles of Health Care Management
US Health Care Systems
Psycho-Social Aspects of Adjustment in Old Age
Health Planning, Theory and Methods
Health Planning Projects
Marketing of Health Services
Personnel Management and Labor Relations in Health
Care Organizations

University of Oklahoma, College of Public Health (Continued)

Communications and Group Dynamics
Health Care Financial Management
Budgeting for Public Health
Risk Management in the Health Sector
Research Methods in Health Administration
Health Program Evaluation
Hospital Administration
Decision Making
Public Health Practice and Administration
Health Information Systems
Field work in Health Administration
Directed Reading
Seminar and Health Administration
Research for Master's Thesis
Research in Health Administration

Total 44 Credit Hours

University of Pittsburgh, Graduate School of Public Health * Master of Health Administration (Semester System)

<u>Core Courses</u>

Behavior Science in Business
Computer-Based Information Systems
Management Systems and Decision-Making
Managerial Accounting I
Managerial Economics I
Medical Care Organization
Probability and Statistical Analysis I
Health, Disease, and Environment
Introduction to Financial Management
Introduction to Human Resources Management
Managerial Accounting II
Managerial Economics II
Organization Analysis
Organizational Systems of Health Care Delivery
Probability and Statistical Analysis II
Management Residency
Principles of Epidemiology
Health Accounting and Finance
Health Economics
Health Law and Ethics
Health Policy, Politics, and Regulations
Capital Formation in the Health Sector
Introduction to Marketing Management
Introduction to Operations Management
Marketing Health Services

University of Pittsburgh (Continued)

Planning and Control
Strategic Management in Health Organizations

Elective Courses

10 Hours of Electives

Total = 75 Credit Hours

University de Puerto Rico Master's Degree in Administration of Health Services (Semester System)

Core Courses

Decision Analysis
Evaluation of the Range of Health Services
Administrative Theory
Policy Bases of Health Care Systems
Organizational Behavior
Health and Development
Personnel Administration
System of Provision of Health Services I
System of Provision of Health Services II
Planning, Development, and Evaluation of Health Services
Fiscal Management
Practicum in Administration
Management Information Systems in Health Services
Legal Aspects of Administration of Health Services
Integrative Seminar
Health Economics
Statistical Analysis
Comprehensive Seminar

Elective Courses

Total of 21 Units

San Diego State University * MPH in Health Services Administration (Semester System)

Core Courses

Epidemiology
Biostatistics
Behavioral and Social Science in Public Health
Environmental Determinance of Human Health
Supervised Field Placement

San Diego State University (Continued)

Planning, Policy Analysis and Administration of Health Programs

Thesis, Major Review Paper, or Comprehensive Exam

Elective Courses

Planning, Regulation, Utilization, and Evaluation of Health Services
Current Emphasis on Health Administration
Administration of Mental Health Services

Total = 55 units

University of South Carolina * Master of Health Administration (Semester System)

Core Courses

Basic Concepts and Methods of Epidemiology
Introductory Biostatistics
Administration Internship
Health Law
Sociology of Health for Health Services Managers
Hospital Administration
Information Systems in Health Administration
Health Economics
Perspectives in Community Health Organizations
Quantitative Methods for Health Administration
Financing of Health Care
Health Planning
Health Care Marketing
Principles of Management
Organization Behavior
Accounting in Business Organizations

Elective Courses

6 units of Electives
Total = 57 Credit Hours

University of Texas, Health Science Center, M.P.H. * (Semester System)

Core Courses

Access to Medical Care
Evaluation Research
Health Measurement
Health Professions Workforce

University of Texas (Continued)

Health Policy Analysis
Health Law and Regulation
Health Services Research
Health Service Systems
Management and Organizational Principles
Operations Research
Organizational Behavior
Quality Assessment
Quantitative Methods in Health Services
Health Care Technology Assessment

Elective Courses Variety of Electives Offered

Tulane University * Master of Health Administration (Semester System)

Core Courses

Human Health and Disease
Survey of Environmental Mental Health
Principles of Epidemiology
Introduction to Health Systems
Economics for Health Systems
Health Law
Introductory Biostatistics
Microcomputer Application in Health Sciences
Decision Models
Financial Accounting for Health Systems
Managerial Accounting for Health Systems
Health Care Marketing
Managerial Communication
Career Planning
Organizational Behavior
Human Resources Management
Strategic Planning
Advanced Elective in Fiscal Management
Residency of Nine to Twelve Months

Elective Courses

15 units of Electives

Total = 60 Credits

University of Washington, Seattle * Master of Health Administration (Semester System)

Core Courses

Public Health and Community Medicine

University of Washington, Seattle (Continued)

Business Administration
Public Affairs
Social Work
Urban Planning
Economics
Sociology

Yale University * MPH (Semester System)

<u>Core Courses</u>

Introduction to Statistical Thinking
Principles of Epidemiology
Health Systems and Policy Analysis
Environmental Health and Risk Assessment
Concepts of Molecular Biology in Public Health
Social and Behavioral Factors in Health
History and Philosophy in Public Health and Data Management
Government and Health Policy
Quantitative Methods in Health Services
Introduction to Health Economics
Financial Decision-Making in Health Care and/or Managerial Accounting for Health Care Institutions
Integrative Policy Analysis Seminar or Integrative Management Seminar
Community Project
Summer Internship
Thesis

<u>Elective Courses</u> Variety of Electives

Total = 60 Credit Hours

University of North Carolina No bulletin was sent, only application materials.

University of Minnesota Master of Health Care Administration Program (Quarter System)

No specific details were given in the school bulletin as to core and elective courses. Total = 45 credit hours, plus Master's Project, plus Comprehensive Exam, plus Study Plan, plus Residency of at least two quarters in length.

Courses Removed from Elective List:

Columbia University

Perspectives in Ambulatory Care
Ambulatory-Care Management
Ambulatory-Care Information Systems

University of Michigan

Societal Analysis of Aging

University of Oklahoma

Health and Illness in Old Age
Dental Care Delivery Systems and Program Administration
Public Policy and the Aged
Preventive Dentistry and Oral Health Research Methods
Long Term Care Administration
Ambulatory Care Administration
Geriatric Dentistry

San Diego State University

The Administration of Long Term and Ambulatory Care Facilities
Administration of Dental Services
Administration of Clinical Laboratories

University of South Carolina

Long-Term Care Administration

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Appendix J: Selected Bibliography

The Selected Bibliography is organized into three sections. The first contains the books reviewed; the second contains the articles from journals, magazines, and newspapers; and the third contains the dissertations reviewed.

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